Issues and Concerns of
Men who have Sex with Men (MSM) and Transgender (TG)

Communities in Vadodara - Gujarat

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An Exploratory Study conducted by

SAHAJ

in collaboration with

Lakshya Trust

2009-2010

This study is a part of larger multi-country three year research on Sexual and Reproductive Health Rights and Millennium Development Agenda from the perspective of Gender Equity and SRHRs.

This is an initiative of Development Alternatives for Women's Network (DAWN).

Acknowledgements

We would like to thank all respondents and participants of group discussions for sharing their views with the researchers. We deeply appreciate the support extended by Lakshya Trust in identifying the respondents, facilitating data collection for the study and for allowing use of their premises for the purpose.

We acknowledge the help from members of SAHAJ team with Gujarati translations and typing of the information sheet and consent letters for the study.

This study was a part of a larger study funded by Development Alternatives for Women's Network (DAWN).

Contents

Abbreviations

AIDS	Acquired immune-deficiency syndrome
CBO	Community-based organisation
GIDC	Gujarat Industrial Development Corporation – refers to the industrial area near Vadodara
GOI	Government of India
GSACS	Gujarat State AIDS Control Society
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IPC	Indian Penal Code
LT	Lakshya Trust
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
ORW	Outreach Worker
PfA	Platform for Action
PoA	Programme of Action
RH	Reproductive Health
SACS	State AIDS Control Societies
SRH	Sexual reproductive health
SRHR	Sexual and Reproductive Health Rights
SSG	Shr Sayajirao Gaikwad Government Hospital, Vadodara
STD	Sexually transmitted diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgendered persons
VD	Venereal Diseases
WHO	World Health Organisation

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Executive summary

Introduction

Traditionally in Indian society, same-sex relations were tolerated though not accepted as an integral part of the society (Chakrapani et al, 2007). The persons who engaged in same sex relations have always been on the periphery of the community. The last century saw increased stigmatisation and discrimination against men who have sex with men and transgendered persons (Narrain, date unspecified; UNAIDS, 2006). The Indian law with Section 377 indirectly supported the negative perspective, forcing the men who have sex with men (MSM) and transgenders (TGs) into invisibility even from discourses on health issues and rights. The special sexual and reproductive health needs of these groups do not find mention in the social and medical health literature. Their needs were acknowledged only as recently as in the 1990s in the context of HIV epidemic when the groups were identified globally as one of the vulnerable and invisible groups (Chakrapani et al, 2002; GOI MOFHW, 2007; Khan, 1998).

In terms of disease control policies, focus on MSM and TGs intensified only in the third phase of the National AIDS Control Programme (NACP III) – almost a decade after India launched the national programme for controlling the AIDS epidemic. The State AIDS Control Societies were mandated to organise MSM into community based organisations (CBOs) and to actively engage with these for prevention activities. However the focus of the activities has remained limited to promotion of safe sex by distribution of condoms and ky jelley along with some inputs for behaviour change communication, STI treatment, creation of an enabling environment. to the MSM and TGs. The larger sexual – reproductive health needs and rights of these groups do not find a mention in the policies (NACO, 2006).

Background

The present study was a part of a larger study on progress towards Millennium Development Goals in India that aimed to assess the translation of SRHR promises ratified by the Government of India in the ICPD Programme of Action and the Beijing UN Conference on Women in 1994 and 1995 respectively into the government policies and their reach to the intended beneficiaries. The report is based on an exploration that was carried out in May 2009 within weeks of the repeal of Section 377 of IPC. This qualitative study explored the psycho-social and physical health needs of the MSM and TG persons from Vadodara, Gujarat in the context of their sexualities. The study also documented the MSM and TG communities' expectations from the larger society as well as from the government. Lakshya Trust (LT), Gujarat's first CBO working with MSM and TGs on HIV prevention facilitated the study by providing access to the MSM and TG communities in Vadodara. The LT has won the 'UNAIDS Civil Society Award 2006' for its contribution in preventing HIV/AIDS among homosexual men and TG population.

Methodology

A female researcher conducted six in-depth interviews and two group discussions (24 participants) with representatives of koti community and an in-depth interview and a group discussion with representatives of TG community (10 participants). All respondents and participants for group discussions were identified by the LT from among its peer educators. All interviews and group discussions were conducted in Hindi in presence of a LT representative (a senior member of LT team) who facilitated the interaction between interviewer and respondents. In addition, to get an overview of the issues specific to the MSM community, interviews were conducted with three key informants – (1) Project Coordinator, LT; (2) Counsellor, LT and (3) Quality Control Officer for Targetted Interventions, Gujarat State AIDS Society (GSACS) who earlier worked as a counsellor at LT. Interviews with key informants were conducted in English. Informed consent from the respondents and participants were obtained before inclusion in the study sample. Soft copies of interviews and group discussions were handed over to LT for reference.

In this report, the respondents are referred by codes (R1 to R7) to protect their identities.

Since the respondents were purposively selected and relatively empowered peer educators from a CBO, their views presented here may not be representative of the less empowered MSM and TGs from the community.

Results

Findings from the study are presented separately for the Koti and TG communities where relevant.

Profile

- The Koti interviewees (respondents) were in the age group of 22 – 36 years; all had less than 12 years of education and had been associated with LT as outreach workers (ORW), duration of association with LT ranged from one year to ten years (since formation of LT). Monthly income ranged between Rs.5,000 and Rs.6,500. Four of the six respondents were unmarried; one was married and stayed with wife, and children; and the other was separated.

- The representatives of TG community who participated in the group discussion were between 20 and 32 years of age; and had been with the TG community for one to 22 years. Not all members of the group had undergone castration. These participants were from a faction of the TG community that had separated from (thrown out of) the main aakhada because some members of the group were from 'lower castes' though the guru himself was a Brahmin.

- The representative of TG community who was interviewed was more than 40 years of age and had joined the community at the age of 20 – 22 years after ritual castration. At the time of the interview the respondent (R7) headed another faction of the local TG community that had separated from the main aakhada.

General health concerns and help seeking

- General illnesses reported did not vary among the koti and TG communities. Common illnesses included cough, cold, fever, typhoid, jaundice, malaria, diarrhoea, vomiting, cholera and at times major illnesses like TB, HIV, and non-communicable diseases like diabetes among the elderly MSM population. Additionally, TGs reported skin infections because of poor hygiene – because of sharing each others' cloths.

- Private practitioners were largely preferred because of easy accessibility, lower levels of discrimination as well as possibility of treatment on credit. Public sector was accessed when a large treatment expense was anticipated. Experiences with staff behaviour ranged from respectful to insensitive. Some people who were aware of / familiar with LT clinic, chose to consult there even for non-sexual conditions – primarily because of comfort they experience and free treatment.

Sexual health problems and help seeking

- Koti respondents were aware of a number of conditions experienced by MSM from the community. Burning

[1]Koti is a term that refers to the passive male partner in a same-sex couple

micturation, boils, warts, lumps, ulcers on or around genitals (scrotum, inguinal area), swollen lymphnodes in the inguinal region, scrotal swelling, pain in lower abdomen, urethral as well as anal discharge, piles, anal bleeding, anal tears, tears in the foreskin, hepatitis B, HIV, gonorrhoea, and Chlamydia infections were reported to be the conditions for which the MSM commonly sought treatment.

- Majority of the Kotis from community consult qualified medical practitioners for symptoms of sexual problems. Those who know about LT clinic choose to avail of the clinical services. Individuals who are not aware of / sure of where to seek care from approach government tertiary hospital. Friends are also consulted to decide on a provider for treatment of these conditions.

- According to the respondent and participants of group discussion, members of TG community do not talk much about sexual health problems but had heard of cases of ulcers, sores, boils, warts on genital area, itching in genital area, urethral discharge, anal discharge, piles etc. As with general health conditions, private practitioners were preferred for treatment of sexual health problems.

Perception of 'sexual health' and 'healthy sexual practices'

- 'Sexual health' for most respondents meant 'looking after sexual organs', 'measures for prevention of infections'.

- 'Healthy sexual practices' for all respondents meant use of condom for protecting oneself from infections of all sorts. After probing, a few mentioned concerns for safety of both partners, intercourse without mental stress and emotional satisfaction.

- All respondents reported using condoms during anal sex – for most the use was consistent. Use of condoms during oral sex was not regular. Often condoms were not used with regular partners 'who trusted each other completely'. A married respondent who stays with his wife reported using condoms regularly with his male partner during anal and oral sex but never with his wife – because he trusts her to be loyal to him.

Sexual harassment / Coerced sex / Rape

- The Koti respondents and participants of the group discussions talked about experiences of harassment at the hands of policemen as well as other MSM.

- Rape is not uncommon. Some experienced it in adolescence. Even as adults, kotis are chased and harassed by groups of men, at times a koti is sexually assaulted by groups of young men for refusing sex. Mostly, the kotis felt helpless in such situations with running away as the only solution. However, the group felt that kotis who were accepted by families could retaliate against the injustice.

Reproductive health concerns

- There is little awareness about reproductive health among the Kotis and TGs.

- Married kotis reported experiencing mental harassment because of taunts from society and their male partners about impotence / virility. The stresses resulting from this expectation were however not recognised as reproductive health issues.

- Being a parent was important for four of the six Koti respondents. The two married respondents were happy to have children though both said that having sex with their wives was traumatic for them. Of the four unmarried respondents two felt a strong urge for parenthood and had at some point thought about

[2]Aakhada is a term that refers to an hierarchical closed community system of TGs which is lead by a Guru who enjoys a position very similar to a patriarch of a traditional Indian / Hindu family, The Guru exercises power and control over the 'disciples' – newer entrants to the community and is entitled to a share of their income in return for providing them with shelter and care as well as a certain social status accorded to the members of a particular aakhada.

adoption. At the same time, the respondents were aware of difficulties in the process of adoption and as a way out, many kotis were reported to take on the responsibility of looking after / providing for their nephews or nieces.

Social health concerns

- Koti respondents and group discussion participants reported experiences of discrimination at all stages in their lives and at all places.
  - Within family the discrimination manifests in the form of lesser attention and affection from parents and being made to feel unwelcome at family gatherings. In addition to non-acceptance of sexuality, some are exploited by the family because of their docile natures.
  - In their neighbourhoods the Kotis avoided, ridiculed, insulted and harassed by other residents. Confrontation, fighting for respectful treatment often helps put a stop to overt harassment but results in avoidance not acceptance. Kotis also find it difficult to find accommodation at hotels and guest houses. A safe haven for MSM – a place where there would be acceptance and no fear – is a cherished dream of respondents.
  - At school taunts and teasing by other students affects a koti's interest and performance in studies. The person also experiences extreme isolation and loneliness.
  - Kotis find it difficult to find employment to their satisfaction. Most are employed in unskilled menial jobs like domestic help or cleaning at tea stalls. Occasionally when employed in skilled / white collared jobs, a koti is denied opportunities for promotion.
  - HIV positive kotis are further discriminated against. They are blamed for spreading the infection and are also discriminated at the hospitals. Other persons are given priority over them.
  - Within the multi-layered MSM community, Kotis are accorded secondary status to ghadiyas and often are abused by ghadiyas. At times kotis are beaten by ghadiyas after sex, their money, mobiles are stolen.
  - Financial status and caste too form basis for discrimination within the koti community. However, ghadiyas from lower castes are acceptable to the kotis from higher caste.

- The TG community faces discrimination from the society. There is a feeling of hurt at being disowned by their families and their interaction with the rest of the community is also strained. Considered representation of a goddess, generally the neighbours talk to them out of fear – that they might curse them if displeased or disrespected. They experience humiliation and abuse when they go from house to house seeking alms. TGs also shared difficulties in finding rental accommodations.

- Discrimination within community is more acute. The TGs who participated in the study had been outcast by the larger TG community based on their caste, and restrictions were imposed on their alms seeking activities that forced them to ask for alms on the trains – a demeaning activity with significantly lower incomes. In main community, the younger / newly inducted TGs are exploited by the more senior ones face severe exploitation. They are forced to work long hours but do not have control over earnings and freedom. It is extremely difficult for TGs to find respectable employment.

Psychological health concerns

- Psychological health needs of the Koti community are acute but largely neglected. Common problems included -
  - Confusion regarding one's sexuality, lack of confidence, loneliness, sense of helplessness, insecurity, and suicidal thoughts were reported to be very common to the community – almost every participant admitted having been through these at some point or other.
  - Stress from keeping their sexuality from their families (parents, siblings, extended family, wife etc) and others (neighbours, co-workers etc).
  - Obsessing over sexual activity resulting in psychological stress and distraction in routine activities.
  - Stress from being forced into sexual relations with a woman against wishes, pressure from wife and family for producing a child, taunts from neighbours as well as male partners about fertility, blackmail from male partner about disclosing his sexuality to his wife, demands from male partner for 'fixing up

[3]Ghadiya is the term used to refer to active / penetrative male partner in a same sex couple.

his wife with the male partner.
- Insecurity regarding relationship with male partners.
- Trauma of failed relationships, break-up with long term partners.
- Loneliness and depression.
- A diagnosis of being HIV positive adds to the stresses of kotis – pushing more kotis towards suicide.

- **Coping mechanisms** can also be equally disastrous. Participants reported Kotis getting involved in casual relations with multiple partners 'in search of love', taking to addictions like alcohol and cigarette smoking. In absence of formal support systems, and lack of support from families in most cases Kotis turn to peers for support. Others **keep aloof** and avoid contact and confrontation with others. **Keeping low expectations** also appears to be another way of keeping oneself from getting hurt as one participant put it while discussing discrimination in the society.

- Regrets at having joined the TG community is common among the TGs. Insecurity about survival in the old age is a major cause of worry – since livelihood depends of seeking alms. Humiliation at hands of larger community, distancing from relatives, harassment / fear of harassment by others from TG community and constant worry about future and about old age makes TGs feel sad and lonely. The discrimination based on caste and religion is prevalent – so is untouchability.

- Sources of support are scarce. Generally the members of the TG community keep to themselves. Generally people do not seek counselling as a friend is more trusted than a counsellor. Proportion of suicides is very high among the TG community. There are others who take to addictions mostly alcoholism.

- Providing counselling to MSM in itself proves to be a challenging task – the counsellor needs to be well aware of the specific issues of MSM and be sensitive towards them. There are professional challenges such as the counselee becoming attached to and dependant on the counsellor.

Expectations from health systems

- The Kotis' experiences with public health services ranged from unbiased respectful treatment to instances of extreme humiliation and dismissive treatment from the doctors and other support staff at the hospital. Discrimination was the highest for extremely feminine Kotis. Respondents reported having dealt with these problems in different ways. Some chose to confront the system while others avoided it. The kotis' expectation from the public health services was merely that of humane and respectful treatment.

- The counsellor at LT expressed the need to sensitise the doctors and other staff towards specific health needs of the MSM community. This could be done by incorporating sexuality education in the curricula.

- Private practitioners were preferred as they maintained confidentiality and did not discriminate against MSM.

- A separate / exclusive clinic facilitated access for MSM. Respondents said that the Kotis would find the clinics most accessible and acceptable if the doctor at the clinic is sensitive to the MSM's specific needs and preferably a koti. Confidentiality, location of the clinic in a 'safe space' where MSM can easily access services were other expectations from the clinic.

Policies and programmes relevant to MSM

According to the key respondents the following would facilitate rights of sexual minorities -

- **Recognition, acceptance and tolerance.** The state should acknowledge that MSM exist and that is responsible for their welfare as well.

- **It should be acknowledged that the MSM population is not a uniform / homogeneous entity.**

- Suitable employment is a specific need for this community. **Skill building for gainful employment is also important** for the entire MSM community.

- **Health aspects other than HIV/AIDS** should also be paid attention to. For example facilitating sex reassignment surgery, castration surgeries, mental health counselling are some of the major issues and should be addressed by the health systems.

- **Generating awareness among general public about different sexualities** would help reduce discrimination against MSM. For this sexuality education should be made a part of the school education as well as of the curricula of doctors and other para-medical personnel.

- **Specific interventions** should **be designed for addressing the bridge population.**

Expectations from government

- Measures for de-criminalisation of same-sex relationships, mainstreaming MSM into the society, a life of dignity and respect, opportunities to improve social status and political recognition are some of the expectations of the Koti community from the government. The respondents and participants appreciated the repeal of Section 377 of IPC but felt that more active measures were necessary for ensuring acceptance and equity. These would include counselling for parents of adolescents for better acceptability within family, and counselling of teachers and awareness generation for students for facilitating education. Some believe that legalising same-sex marriage will help bring stability to the MSM population.

- Difficulty in finding employment is an important concern among the MSM community. Schemes / subsidies from government for MSM for skill building as well as to initiate self employment would be a welcome intervention.

- Because of absence of family support, the MSM community experience acute insecurity about old age. Establishing old age homes, pensions for elderly would be helpful.

- The expectations of the TGs are not much different from those expressed by the members of the koti community. Specific expectations by TGs were that they should not be clubbed with beggars, the police should not regard them as sex workers and not harass them. The participants felt that the TGs' right to employment should be respected and protected by the government.

Discussion

The MSM in India are a marginalised group – invisible to the policy makers and society at large. Their specific sexual – reproductive needs have been neglected by the health system. The MSM communities came into focus in 1990s when globally MSM gained the status of a 'high risk group'. Still, the programmes developed under the NACP largely focussed on promotion of safe sex practices and condom distribution – without addressing the underlying issues of SRHR and equity; which has been stated as one of the ways of ensuring non-stigmatising enabling environment for prevention strategies..

Despite the promises in the NACP III, midway through the implementation period, the interviews with MSM in one of the more developed, low HIV-prevalence Indian state highlight the inadequacy of efforts at addressing the vulnerabilities of MSM in general and specifically in terms of sexual and reproductive health. The interactions with the MSM reveal the constant fear of rejection they live in -- by their families, neighbourhood, larger society, employers, health care providers and even their male sexual partners.

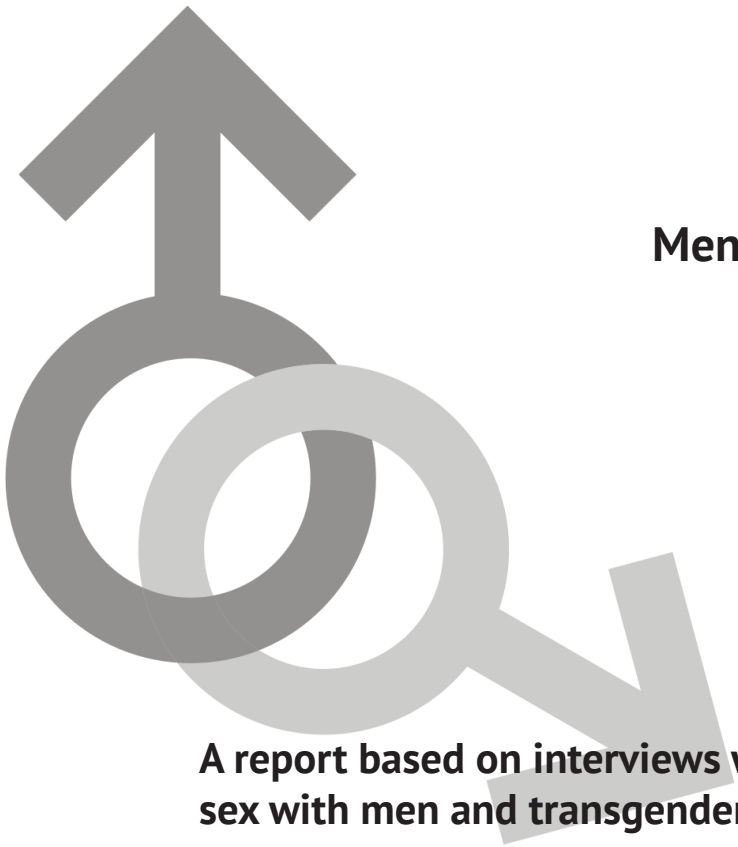
In India, STI clinics providing services for oral and anal STIs are almost non-existent (Kavi AR, 2008). There are limited services / facilities for counselling and support. Though acknowledged by National AIDS Control Organisation (NACO) as an essential component of NACP III, counselling services at clinics managed by CBOs / NGOs and ICTCs mainly are focussed on pre-and post test counselling with little attention to addressing other mental health issues for the MSM. What is more important to note is that the stresses that result from denial of their sexuality by the larger society are not understood by the MSM as well as the programme, as denial of their sexual and reproductive health and rights and therefore as a violation of basic human right.

To meet the goal of sexual health as well as to contribute to the stabilisation and reversal of HIV epidemic, it is necessary to pay attention to the sexual health needs of the MSM and other sexual minorities. High levels of stigma that result in increased vulnerability, poverty, disempowerment, and unsafe sexual behaviour, need to be

addressed for preventing transmission of STIs (Gupta, 2004).

A more tolerant society where MSM can pursue education without the fear of being harassed, an equal opportunity employment market where one is not denied employment on the basis of one's sexuality, a sensitive health sector that responds to the specific physical and mental health needs of the MSM without prejudices and biases, laws and law enforcement agencies that 'respect, protect and fulfil the human rights of all persons regardless of their sexual orientation or gender identity' in accordance with the Yogyakarta Principles (O'Flaherty and Fisher, 2008) are some of the basic needs of the community that have been reiterated by the respondents of the present study.

Recent developments reported in India such as the opening an old age home in Rajpipla, Gujarat for MSM which is the first of its kind in India (Chaturvedi, TNN, June 27, 2010); legalising of sex reassignment surgery in public sector hospitals in Tamil Nadu (Priyamvatha, IE, March 7, 2007) are encouraging but far from adequate to respond to the inequities that the MSM in India face. Conducted within weeks of repeal of 377, findings of this study are a reminder of lacunae that exist in terms of SRH rights of a section of the community and also point towards a way forward.



Issues and Concerns of Men who have Sex with Men (MSM) and Transgender (TG)

Communities in Vadodara, Gujarat

A report based on interviews with representatives of men who have sex with men and transgender persons from Vadodara, Gujarat)

1. Introduction

Traditionally, specifically the Hindu and generally the Indian culture has acknowledged same-sex behaviour and has largely been tolerant towards it (Chakrapani et al, 2007). However, in the recent past men who have sex with men and transgender persons have been heavily stigmatised, criminalised and discriminated against (Narrain, date unspecified; UNAIDS 2006). Sexual and reproductive health (SRH) of these marginalised communities found mention in the Indian health literature only in the context of HIV – as a vulnerable but invisible group – and as recently as in the late 1990s (Chakrapani et al, 2002). In terms of representation at policy level, the MSM and TG find mention only in the HIV prevention strategies – as a high risk group – with disproportionately high chances of acquiring an infection and of transmitting the infection to a large population of men and women (GOI, MOHFW, 2007). This focus too was gradual. Till the late 1990s, social stigmatisation, invisibility and denial of male to male sexual behaviours resulted in almost all STD / HIV services focussing on issues of heterosexual transmission (Khan, 1998).

Though the Indian National AIDS Control Programme (NACP) recognised the need to reach out to certain population groups and initiated 'targeted interventions programmes'; these were planned based on the then understanding of the nature of HIV/AIDS epidemic and focussed primarily on women or men in heterosexual relationships. NACP II acknowledged MSM as a high risk group and realised the importance of working with MSM population through forming community based organisations (CBOs) and targeted intervention projects for prevention of HIV among this population. The focus on MSM as a group sharpened in National AIDS Control Programme (NACP III) (NACO,2006) . The National AIDS Control Organisation (NACO) policies made it mandatory for the State AIDS Control Societies to organise the MSM into CBOs and to engage actively with these CBOs. The scope of activities regarding MSM also widened with NACP III from mere condom distribution to focusing on comprehensive health, and social issues such as discrimination and poverty among the MSM. **(http://www.nacoonline.org/National_AIDS_Control_Program/Programme_Priorities_and_Thrust_Areas/).** However, the programmes remained largely limited to promotion of safe sex and directed towards prevention of HIV infection. There appears to be limited documentation of comprehensive SRH needs of the MSM and TG communities. The Section 377 of Indian Penal Code that criminalised sex between men posed a barrier to efforts at addressing comprehensive SRH of men who have sex with men and TG persons **(http://data.unaids.org/pub/ExternalDocument/2009/20090702_section_377_en.pdf).**

On this background the exploration on which this report is based was carried out in May 2009 within weeks of the repeal of Section 377 of IPC. This qualitative study explored the psycho-social and physical health needs of the MSM and TG persons from Vadodara, Gujarat in the context of their sexualities. The study also documented the MSM and TG

communities' expectations from the larger society as well as from the government.

This report is part of a larger study on the progress towards the Millennium Development Goals in India. The objective is to assess the meaning of the SRHR promises made in the International Conference on Population and Development (ICPD) and the Beijing UN Conference on Women in 1994 and 1995 respectively. How do the SRHR promises ratified by the Government of India in the ICPD programme of Action (PoA) and the Beijing Platform for Action (PfA), and translated into policies and programmes, are actually experienced by vulnerable sections of society.

2. Background

Lakshya Trust (LT), Gujarat's first CBO working with MSM and TGs on HIV prevention and has won the 'UNAID Civil Society Award 2006' for its contribution in preventing HIV/AIDS among homosexual men and TG population. The organisation, chaired by Mr. Manvendra Singh Gohil, a member of Rajpipla royal family who came out in public about his sexuality, was established in July 2000 and now works in three districts in Gujarat (Vadodara, Surat, and Rajkot). LT is supported by Gujarat State AIDS Control Society (GSACS).

Since its inception LT has actively engaged in many activities such as interventions, research, advocacy and service provision for prevention of HIV / AIDS. In Vadodara the activities of the LT include condom distribution at community level through a network of peer educators, a clinic situated at the LT office for MSM where they can get themselves investigated, diagnosed and treated for STIs, a VCTC that provides pre-post-test counselling for HIV, STI investigations as well as mental health counselling for MSM and their families. The LT actively engages in activities for sensitising stake holders such as doctors, and police. Skill building activities for MSM and TGs are in the pipeline at the LT.

By 2007 LT was reaching out to more than 17,000 MSM in Vadodara, Surat and Rajkot cities. (Bhattacharya, in Indian Express, 2007).

3. Methodology

3.1 Sample

Data collection for the present exploration was facilitated by LT. Respondents were identified by LT from among their peer educators who represent the views of the grassroots at the same time are empowered enough to articulate the issues.

Six in-depth interviews and two group discussions (24 participants) were conducted with representatives of koti community. Issues specific to trans-gender population were explored through an in-depth interview and a group discussion with representatives of TG community (10 participants). In addition, to get an overview of the issues specific to the MSM community, interviews were conducted with three key informants – (1) Project Coordinator, LT; (2) Counsellor, LT and (3) Quality Control Officer for TI, GSACS who earlier worked as a counsellor at LT.

All interviews and group discussions were conducted by a female researcher in presence of a LT representative (a senior member of LT team) who facilitated the interaction between interviewer and respondents. All interviews and group discussions with community representatives were conducted in Hindi. At times, the LT representative also acted as a translator for the respondent / participant as well as for the interviewer. Interviews with key informants were conducted in English.

3.2 Areas of enquiry

The interviews as well as group discussions explored –

1. General health concerns
2. Sexual health concerns
3. Reproductive health concerns
4. Social health concerns
5. Psychological health

[4]Koti is a term that refers to the passive male partner in a same-sex couple

6. Expectations from health system
7. Expectations from government in terms of policies for MSM / TG communities

3.3 Analysis
All the interviews and group discussions were recorded using electronic recording device. The interviews were later transcribed, translated and summarised whereas the key points from the group discussion were summarised to highlight the issues. Quotes from interviews and narrations during group discussion are used to support the analysis.

3.4 Ethical considerations
Interviews and group discussions were conducted only after seeking written consent from all respondents and participants. By signing the consent form, the respondents and participants consented to giving an interview, being interviewed in the presence of a senior LT representative, recording the interview as well as for including issues and/or quotes from the interview in the study report. Soft copies of interviews and group discussions were handed over to LT for reference.

In this report, the respondents are referred by codes (R1 to R7) to protect their identity.

3.5 Limitations
This was an exploratory study conducted through a community based organisation with a small sample of purposively selected respondents. The views presented here may or may not represent those of the less empowered MSM from the community who have not yet come to terms with or disclosed their sexuality. A much wider study that specifically covers representatives across the spectrum would be needed to claim representation of the entire community.

4. Results
The findings are arranged according to the areas of enquiry. The key points emerging from interviews with koti and TG communities are presented separately.

4.1 Profile
4.1.1 Koti community
The interviewees (respondents) were in the age group of 22 – 36 years; all had less than 12 years of education and had been associated with LT as outreach workers (ORW), duration of association with LT ranged from one year to ten years (since formation of LT). Monthly income ranged between Rs.5,000 and Rs.6,500. Four of the six respondents were unmarried. Of the remaining two respondents, one was married and stayed with wife, and children; and the other was separated (Table 1).

4.1.2 Trans-genders
The representatives of TG community who participated in the group discussion were between 20 and 32 years of age; and had been with the TG community for one to 22 years. One of the participants had joined TG community at the age of 4 years while the person to have most recently joined the community had been 22 years of age at the time. Not all members of the group had undergone castration. These participants were from a faction of the TG community that had separated from (thrown out of) the main aakhada because some members of the group were from 'lower castes' though the guru himself was a Brahmin.

The representative of TG community who was interviewed could not tell the exact age but was more than 40 years of age and had joined the community at the age of 20 – 22 years after ritual castration. At the time of the interview the respondent (R7) headed another faction of the local TG community that had separated from the main aakhada.

[5]Aakhada is a term that refers to an hierarchical closed community system of TGs which is lead by a Guru who enjoys a position very similar to a patriarch of a traditional Indian / Hindu family, The Guru exercises power and control over the 'disciples' – newer entrants to the community and is entitled to a share of their income in return for providing them with shelter and care as well as a certain social status accorded to the members of a particular aakhada.

[6]MSM who act as passive as well as active partners in a same-sex relationship describe their sexuality as double.

Table 1: Profile of the respondents

Respondent code	Sexuality	Age (years)	Completed education	Occupation	Monthly income (Rs.)	Marital status
R1	Koti	25	-	ORW at LT since 1 year	5,200	Unmarried
R2	Koti started as 'double ' considering sex realignment surgery	22	11th	ORW at LT since 4 and a half years	6,500	Unmarried
R3	Koti	26	9th	ORW at LT	5,000	Married with two children
R4	Koti	36	12th	ORW at LT since 8 years	6,550	Separated with one child
R5	Koti	31	11th	ORW at LT since 3 years	5,250	Unmarried
R6	Koti	30	10th	ORW at LT since 10 years	6,500	Unmarried
R7	TG	>40	7th	-	-	-

4.2 General health concerns

4.2.1 Koti community

The outreach workers worked with MSM in slums or slum-like areas across the city. The illnesses they commonly saw among the community included cough, cold, fever, typhoid, jaundice, malaria, diarrhoea, vomiting, cholera and at times major illnesses like TB, HIV, and non-communicable diseases like diabetes among the elderly MSM population.

Preferred health providers varied from local private practitioners (general practitioners irrespective of training), to allopaths who had been on medical panel at LT to public sector health care facilities. Among those who sought public sector health services some people preferred large hospitals (SSG, Jamnabai) for inexpensive, good treatment whereas some preferred dispensaries and smaller clinics because they were more accessible. Private practitioners were largely preferred because of their proximity and easy accessibility as well as because some allowed treatment on credit. However, generally people turned to public sector when they foresaw a large treatment expense. Some people who were aware of / familiar with LT clinic, chose to consult there even for non-sexual conditions – primarily because of comfort they experience and free treatment.

4.2.2 Trans-genders

Common health problems are not any different than those reported by the other respondents. These include fever, diarrhoea, vomiting, typhoid, weakness. Hepatitis is common. Occasionally a case of TB or HIV is seen among the TGs. Skin infections because of poor hygiene – because of sharing each others' cloths are seen among the community members.

Local private practitioners are preferred source of treatment mainly because of proximity and lesser fees. However, participants of the group discussion believed that more people seek care at the government hospital because it is free of cost and anonymity is possible over there.

However, experiences regarding staff behaviour were varied. One of the participants narrated his experience of treatment from the government tertiary hospital for a lump on leg. This participant felt that behaviour of doctors towards him was not the same as with other patients - "there was no respect at all". But another participant had good experience when he sought treatment for a dislocated shoulder at the same hospital. Though there was a long queue, he was given priority and the doctors were very respectful. Whether or not they are respectful depends on their personality. The other participants from the group said that in general the behaviour of staff was

not respectful at the hospital and not all doctors showed sensitive behaviour.

Discrimination at private doctors' was reportedly is very less.

4.3 Sexual health concerns

4.3.1 Koti community

4.3.1.a Sexual health problems and help seeking

Burning micturation, boils, warts, lumps, ulcers on or around genitals (scrotum, inguinal area), swollen lymphnodes in the inguinal region, scrotal swelling, pain in lower abdomen, urethral as well as anal discharge, piles, anal bleeding, anal tears, tears in the foreskin, hepatitis B, HIV, gonorrhoea, and Chlamydia infections were reported to be the conditions for which the MSM commonly sought treatment.

Respondents, based on their extensive interactions with the community members, believed that majority of the people opt for formal treatment (consult qualified medical practitioners) for symptoms of sexual problems. However, there were examples where a small proportion of extremely poor or 'ignorant' persons were known to have consulted the quacks that set up shops by the roadside. These persons however after experiencing no relief and on finding out about the LT clinic chose to consult there. Majority of the MSM population in contact with LT choose to avail of the clinical services at the LT clinic. However some who are worried about their sexuality being disclosed avoid LT clinic. These people often consult the local private practitioners – not necessarily trained in allopathic medicine, or go to doctors who had earlier been on the LT medical panel or opt for services at the government tertiary hospital for the sake of anonymity. The respondents also felt that those who are not aware of / sure of where to seek care from approach government tertiary hospital.

At the same time, some of the respondents talked of people who avoided public sector services for the fear of disclosure (lack of privacy), disrespectful treatment, as well as inconvenient timings and difficulty in access in terms of longer distances.
One respondent said that often persons with symptoms suggestive of STIs consult friends and based on their advice use ayurvedic medicines that are available at medical shops. Friends are also consulted to decide on a provider for treatment of these conditions.

"Not the roadside people. These are proper ayurvedic medicines that are available at medical shops which sometimes suit some people and do not suit some. If someone gets something like this (symptoms of STI) one cannot talk to anybody in the family – cannot talk to mother, father or even brother. So if a friend has had similar symptoms and if you remember that, then you could talk to him – ask him what he did when he had the problem. I would not ask for myself – I would pretend to ask for someone else. I would say a friend of mine has this problem so what would you suggest, what had you done for your problem. Then he would say that I had taken this medicine – that, I got it from such and such place and it helped me. So tell him to try that." (R6)

4.3.1.b Perception of 'sexual health' and 'healthy sexual practices'

The respondents were asked their perception of the concepts of sexual health and healthy sexual practices. The responses were varied. In general the respondents found it easier to articulate their thoughts about 'healthy sexual practices'. All the respondents mentioned use of condom for protecting oneself from infections of all sorts. After probing, a few mentioned concerns for safety of both partners. Intercourse without mental stress and emotional satisfaction were mentioned by some respondents.

Perceptions about 'healthy sexual practices' (Koti community)

- Healthy sexual practices are relationship with only one partner, consistent use of condoms – safe sex, ensuring good health, preventing HIV/AIDS for safety of both partners, as well as caring for one'. (R1)
- Healthy sexual practices are when one thinks of both partners, it should be low risk, protected sex (protection from infections), at a safe place where there are no tensions so there is more enjoyment, there should be some amount of emotional involvement not just physical interaction – partners should at least stay friends (R2)

- Sex without worries is healthy sex, therefore sex using condom is a healthy sexual practice. (R5)
- Healthy sexual practices include long term relationship with a single partner, not involving in frequent sex and consistent use of condom. But there is more to sexual relationship beyond safety and prevention of infections. It should be pleasurable for both partners – "not just a give and take situation". Sex when both partners are willing for it is more pleasurable "because in that situation once cares for one's partner". It is not okay to force someone to have sex against one's wishes. (R6)

Sexual health for most respondents meant 'looking after sexual organs', 'measures for prevention of infections'. For one respondent sexual health covers thoughts pertaining to sexual activity – possible problems, and how to avoid these. One respondent also mentioned 'having knowledge about one's body and how to care for it'.

4.3.1.c Condom use

Respondents varied in their views about condom use. All respondents reported using condoms during anal sex – for most the use was consistent. Use of condoms during oral sex was not regular. But one respondent who had earlier contracted hepatitis B from a casual partner because of unprotected oral sex said that since six months before the interview he had started insisting on use of condom even for oral sex. He said he refused to have sex with a person if he did not agree for condom use – he cited personal hygiene as a reason for his insistence. He also interpreted a potential partner's refusal to use condom (saying he did not have any infection) as an act of cheating – lying to get a partner – and he then refused to have sex with him.

Another respondent who has been in a steady relationship with his partner for almost a decade believes that use of condom is not relevant when the couple trusts each other completely and is open with each other – as is the situation with him and his partner. He and his partner use condoms for experimentation but not regularly and not for protection.

> "…And we both trust each other completely. We also have very good communication. We talk about our day – what we do at office, our experiences, the people we meet, there is a healthy discussion. Where there is this thing of using condom – even the heterosexual couples, if the man goes out to someone, he may or may not use condom. But when he comes to his wife he never uses condom. So like that – I have this partner and we trust each other, then condom is not used. But as and when newer varieties of condoms come in the market, like the flavoured ones or the dotted ones, then we use them occasionally. …
>
> Yes. He also feels the same. Now we discuss, share even the smallest things our lives with each other so then…this thing about condom use does not make sense. And still we get check up done every three months. " (R6 -- Has a steady partner since nine years)

Another respondent who is married and stays with his wife also reported using condoms regularly with his male partner during anal and oral sex but never with his wife – because he trusts her to be loyal to him.

4.3.1.d Sexual harassment / Coerced sex / Rape

The Koti respondents and participants of the group discussions talked about experiences of harassment at the hands of policemen – their complaints are not recorded, and sometimes they are forced to have sex with the policemen. However, the respondents also said that this is not very common. One respondent who has been an outreach worker for a long time said he had encountered only a couple of cases like this.

Kotis suffered coercion / sexual violence from other members of the MSM communities as well. At times the ghadiyas / male partners of kotis also force sex onto them. At times kotis are physically abused and beaten up by their male partners after sex.

[7]Ghadiya / ghariya / giriya is the active male partner in the same sex relationship.

Rape is not uncommon. Some experience it in adolescence. Even as adults, kotis are chased and harassed by groups of men, at times a group of young men approaches a koti for 'group sex' and refusals from kotis are not taken kindly. There was discussion on what a koti could do when attacked by men – after much debate the group said that koti could try and get support from other people but largely running away was the only real possibility that the group could come up with. There have been examples of kotis avenging rapists by talking about it to the perpetrators' families. However, the group felt that only those kotis whose sexuality was known to their families and those who were accepted by families could take such steps. Others would have no choice but to bear the pain by themselves.

Rape

"We had shifted residence. I had joined new school. Everyone would tease me. I looked good (pretty). I was so like a girl. I used to play with girls. Then someone told me that there is someone like you in the school, do you know him? …I went to find him,…he had long hair…people (other students) used to tease him, pinch him, taunt him – at first I was scared (apprehensive) of talking to him. Then slowly I started talking to him. After school he looked after his small shop (laari). I would go to his place and spend time with him. On one Saturday, it was 'half day' at school, I went to find him at his shop, he was not there. There were these local hoodlums, they told me he had gone to such and such place. I went there to find him. It was a deserted area. They followed me there -- tied me down, gagged me and 15 persons raped me. …I was badly hurt…there was bleeding, I could barely walk…I had fever for a month and a half after that… but I could not tell anyone, not even at home, not even my mother. I suffered through this all alone." (R4)

4.3.2 Trans-genders

4.3.2.a Sexual health problems and help seeking

According to the respondent and participants of group discussion, members of TG community do not talk much about sexual health problems but the respondent as well as other participants had heard of cases of ulcers, sores, boils, warts on genital area, itching in genital area, urethral discharge, anal discharge, piles etc.

For sexual health problems, members of the TG community generally seek treatment from a doctor who earlier was a panel doctor at LT. His services are preferred because of proximity of his clinic, less fees, effective medicines, and because 'he has a light hand and does not hurt'. According to the respondent, only those who are absolutely poor go to the government tertiary hospital. However, generally, the decision regarding place of treatment is based on advice from other members of the TG and koti community. Home remedies or non-formal sources of treatment are neither advised nor tried out because "nobody wants to be responsible for any mishap that might happen as a consequence". There was awareness that for STIs (gupt-rog) skin and VD specialist needs to be consulted.

Experience at the government tertiary hospital is varied. One of the respondents shared his experience when he had sought treatment at the hospital for complications of castration. This was many years back. He could not pass urine and had to undergo a surgery and was admitted at the hospital for almost a week. The overall experience with services including that about behaviour of doctors and support staff was satisfactory. The treatment had cost around Rs. 8,000.

Treatment seeking however is dependent on perceived seriousness of symptoms. A group discussion participant who had been suffering from symptoms of STIs had not thought it to be serious and hence had not sought treatment for it.

When specifically asked about sexual activities and safe sex practices, the respondent said that very few members of the TG community indulged in sexual activities and that he had very little knowledge about condoms.

4.4 Reproductive health (RH) concerns

4.4.1 Koti community

Suspicion of impotence and ridicule from society were strongly mentioned during interviews as well as in group discussions. The respondents said that in a society where masculinity is linked with siring children and therefore with a heterosexual relationship, it is a common misconception that kotis are impotent and incapable of reproduction. Larger society commonly believes that people who are impotent or infertile opt to be TGs. As a result, married kotis face immense pressure because of constant taunts from the community and even their male partners. The stresses resulting from this expectation were however not recognised as reproductive health issues.

The respondents were not clear about the distinction between sexual and reproductive health. Some of them also believed that reproductive health had something to do with women, pregnancy etc. One respondent said he did not know anything about reproductive health. One of the key informants commented on the respondents' inability to relate to issues around sexual and reproductive health saying that throughout its course, the focus of work with MSM has been restricted to HIV/AIDS and RH needs and rights have not been thought of. However, discussion on RH is relevant and important for the MSM community.

The respondents were asked if they ever felt the urge to be a parent. The two married respondents were happy to have children though both said that having sex with their wives was traumatic for them and one of them even reported feeling immensely guilty about it (having sex with wife).

Of the four unmarried respondents two did not feel the need to be parents whereas the remaining two strongly felt the urge to be parents, raise children and had at some point thought about adoption. Respondents associated having a child with the notion of being a complete family along with a steady partner. Children were also regarded as source of support – the ones who would look after them and care for them in the old age (budhape ka saharaa). One of the two respondents who said he never felt the need to raise a child explained why – he said that he has seen examples where children disowned parents and did not look after them in their old age so he does not feel strongly about being a parent. But if he has a steady partner who wishes to be a parent, he has no objection to raising a child – he personally does not think that a child needs to be one's own flesh and blood but if his partner wishes so, he is open to the idea of raising his partner's biological child (born through a surrogate mother).

Perceptions about parenthood

"I think that me and my partner would get married and stay together, I would love him and he would love me, we would adopt a child…who would call me 'mummy' and call him 'papa'…the child would be my support in later life. I would adopt a child – a boy or a girl – from a poor family, someone who needs support and educate him/her, take care of him/her, I would give him/her everything that I did not get." (R1)

"A child makes one feel like being in a family…a child is a source of emotional support in case the partner leaves …" (R6)

At the same time, the respondents were aware of difficulties in the process of adoption. Non-acceptance of same-sex couples in the society, the stress of dealing with one's own confusion around sexuality, the search for identity in the larger society, insecurity in the relationship were mentioned as reasons for same-sex couples not adopting a child. One respondent who received a cold response from his long term partner when he mentioned adoption did not push for it for the same reason; though raising a child is very important for him personally.

> "…there is right time for everything. Now, we have been staying together for nine years. The society has a problem with us staying together, my family has a problem with that, his family has a problem with that. So till now we are sorting that out / trapped into this (is mehi ghoom rahe hai) -- that we can find our place in this society."(R6)

The respondents said that as a way out, many kotis take on the responsibility of looking after / providing for their nephews or nieces.

4.5 Social health concerns

4.5.1 Koti community

4.5.1.a Discrimination within family

Koti respondents and group discussion participants reported experiences of discrimination at all stages in their lives and at all places. Discrimination starts in the early adolescence at home where the person is taunted for his feminine traits. Most parents allow the child to stay in the family when they find out about his sexuality but often the person is discriminated against in terms of attention and affection from parents.

> "In some families when they find out they accept the boy. Some throw the person out. 15% would accept. And about 50% would accept but have differential behaviour – say there are five or six siblings in the house and there is a festival, others would get new clothes but this one may get hand-me-downs or not get anything… The person feels it, feels that parents, elder siblings treat me differently." (R6)

They are made to feel unwelcome at family gatherings as well –

> "…if I ever went for a wedding or something, there would be people who would say – 'why have you come, this is not your city, it's a village. People will talk here.' They would say so to my face." (R2)

As a result kotis avoid social gatherings and the sense of non-acceptance increases. For some it causes deep trauma whereas some accept it in their stride and keep to themselves.

> "I avoid going for weddings etc. Nobody has said anything but it is better to control oneself. Why go to such places? There are many people at such places. Some people come to know from one's mannerisms…" (R4)

In the end, some families come to terms and accept the person usually when either the person threatens to join the TG community, or to commit suicide.

Exploitation within families can be of another type as well. Being generally docile in nature they at times are forced to bear the burden of the entire family (put others' welfare before their own) and taunted for not doing enough.
A group discussion participant narrated the situation experienced by one of his friends also an LT worker, whose elder brother is married with two children and is unemployed. The parents don't say anything to him but the younger one who is a koti, is criticised for not doing enough for the family despite striving to earn a living as a vendor.

> "Older son (who is straight) will not be asked to contribute but if the younger one if he is koti he would be expected to pay up even if he earns through menial labour. But he is taunted for not doing enough. The parents never ask the elder brother why he produced two children if he could not support them."(Participant of a group discussion)

4.5.1.b Discrimination in the neighbourhood

Kotis experience discrimination in their neighbourhoods as well. Neighbours keep their children away from kotis – tell their children that these are bad persons and to not to go near them. The youth from the area make fun of them, call names, insult them, at times even attack / assault them when they move out of their houses. Confrontation, fighting for respectful treatment, dignity often helps. A number of participants shared experiences where the normally docile kotis resorted to verbal or at times even physical confrontation to put a stop to the abuse by neighbours or boys from the locality or even the ghadiyas. As one respondent put it – "There are only two options for a koti – be prepared to hide for ever or be prepared to fight at every step. And every koti has to remember it always." The confrontations however result in avoidance and not acceptance from the larger community. People avoid those who confront them for the fear of self-humiliation.

MSM also find it difficult to find accommodation at hotels and guest houses. A participant shared an example where he and some of his friends were asked to leave a beer bar because of their sexuality. There also is a problem in finding rental accommodations. At times they are refused accommodation when the owner finds out about their sexuality or at times they are forced to pay higher rents for lesser facilities. Often the land-lords put down restrictions on who could come and go at the house – the kotis are told not to entertain their friends at home. One respondent talked of his experience where he was forced to vacate the house after his sexuality was disclosed.

"I stay in a rented house here. In my mohalla nobody knew about me – that this person is like this (a koti). Some of my other friends had come to my place and they were applying mehendi. I told them do not apply mehendi over here. I am new in this area. If someone finds out then I may have to vacate the house. But my friend said that we will apply here, wash it off and then go. But one friend left without washing off the mehendi. When they got down, the boys from the neighbourhood had gathered there. So they found out that this person is like that. After that people started calling names. I would then return home late at night to avoid them. Many times I would feel (get angry at myself, feel bad about people's reaction) – why am I like that?. So this also bothers me a lot."(R6)

One of the 'dreams' that a respondent talked of was of a safe haven for MSM – a place where there would be acceptance and no fear.

"There is also this thing that there should be a separate housing society of MSM – people think it would be so nice if there could be a society like this, there would be our own people around. We would be able to move around freely, go to each other's homes, talk to neighbours. There would be no fear." (R6)

4.5.1.c Discrimination at school

Period around puberty that coincides with school days is often doubly traumatic for a koti. This usually is the period when he first becomes aware of his sexuality – and is going through emotional turmoil coming to terms with it. At the same time he has to face the school bullies for being different.

"During school time, boys start developing attraction towards girls. At that time the MSM starts feeling he is different he cannot identify with the boys' feelings; cannot tease girls. His thought processes are like girls. So boys who do not participate in eve-teasing are labelled by others." (A participant from group discussion with representatives of MSM community)

Taunts and teasing at school by other students distracts a koti and affects his interest and performance in studies. At times the child is shifted from one school to another to avoid harassment from other children adding to the sense of loneliness and non-belonging. All this affects the person's interest in education and results in poor educational qualification.

Experience at school

"When I was at school I had a very thin voice (patli awaz) – now my voice is okay but then I had a very thin voice. So if I had to speak at school -- I never spoke at school. I would worry that if I spoke someone would mimic my voice, make fun of me. Because of that I never participated in any school activity. I could never make any friends at school. I never spoke with anyone…I could never speak with anyone or mix with others because I was always worried that if they found out about me what would happen to me at school… It (harassment) did not happen but I had cocooned myself – (I told myself) that if I spoke with them they would tease me or do something to me, so I never spoke with anyone." (R5)

4.5.1.d Discrimination at place employment

Discrimination regarding employment is common. Kotis find it difficult to find employment to their satisfaction. The ones who are more feminine face more problems. Poor education and skill levels; and lack of confidence resulting from lifetime of being teased and discriminated against are also responsible for this. However, discriminatory attitude of potential employers, co-workers and society in general makes it very difficult for kotis to find employment. Often while seeking employment kotis are taunted and asked to get into sex work instead of seeking jobs. The employers are taunted for hiring a koti. Co-workers harass koti for his feminine traits. At workplace a koti is denied opportunities for promotion. At times there is exploitation at workplace – employers get work done from a koti but do not pay him. Kotis often are employed in unskilled menial jobs like domestic help or cleaning utensils at tea shops etc.

"There are some kotis who do not look like or act like kotis they do not have any problem finding jobs. Those who look like 'ladies' they have a problem. They get jobs but where? In a bungalow as a domestic help. If

they try to get job elsewhere, they face problems. This is what I have seen. ...even if they get a job, they think whether people will accept them, whether they will behave well or not." (R5)

The kotis' exploitation at work – even as domestic help – was seen as a result of their constrained social position – as one participant of a group discussion presented it – situated even lower than that of women engaged in similar employment situation. Participants believed that employers often took advantage of limited employment opportunities available to a koti – even as domestic help.

"If a koti works as a domestic help, he is at times exploited by the employers because they know that the koti cannot retaliate. A woman would have retaliated. If she does not come for two days and if she is asked to wash an extra bucket-load of clothes she will refuse – say that it does not mean that because I took leave for a couple of days that you should make me do extra work. But with kotis exploitation occurs.' (A participant from a group discussion with representatives of MSM community)

However, not all kotis have unpleasant experiences at workplace. One respondent who earlier had worked at a large company as a cook said that though he faced a bit of ridicule in the beginning, he later on was accepted by his co-workers. .

"Initially when they found out that I was like a girl, there was this teasing, they would make fun of me etc. That happens everywhere, people do suspect that something is different about this person. But later on they accepted me. ..then everyone knew about it. I would go there in full make-up. The manager was such a nice person – when he went abroad, he got (cosmetic) contact lenses for me. At that time when it was not so common, I had five pairs...Not even in GIDC ... I had no problem even there." (R4)

Those who worked as domestic help also found acceptance. One of the participants talked of his experience of working as domestic help at a bungalow. He no longer works with the family he worked as a domestic help for many years. But his ex-employers often call him to help out when they have parties etc.

"They do not mind his being seen by guests. There are some people who do not discriminate" (A participant at a group discussion with representatives of MSM community)

"many people prefer kotis as domestic servants. They are not ashamed of their guest noticing the person and saying – what?! you did not find anyone else as a servant? This is because they feel more secure to have kotis as domestic help. Kotis are better at domestic work" (A participant from a group discussion with representatives of MSM community).

The respondent who shared an experience of acceptance by staff at a company felt that earlier the problem in finding employment was far more common, but the situation has changed over the years.
I have helped many find jobs – when there were vacancies in companies or at some other places. Now there are not many problems.(R4)

4.5.1.e Discrimination because of HIV positive status
HIV positive kotis are further discriminated against. They are blamed for spreading the infection and are also discriminated at the hospitals. Other persons are given priority over them.

4.5.1.f Discrimination within MSM community
The MSM community is multi-layered and there are multiple layers of discrimination that MSM face. The hierarchy is based on one's sexual orientation with heterosexual men at the top, followed by the bisexuals, followed by ghadiyas, then the kotis and TGs forming the lowest rung) Ghadiyas consider themselves to be superior to kotis because they are the active partners. Being a koti is stigmatising – at times the active partners taunt them, humiliate them for playing 'a woman's role' in a sexual act. Kotis are accorded secondary status even among the MSM community. Kotis thus suffer abuse at hands of ghadiyas as well – at times kotis are beaten after sex, their money, mobiles are stolen.

"Kotis are used as 'things for sexual pleasure'. If a koti tries to seek love from a partner, he is more often than

not rejected by the partner. In homosexual relation, it is a physical relation only, in 99% relations there is no emotional involvement. Ghadiyas have sex with kotis but do not respect them. They look down upon them, ridicule them for their feminine feelings and then others also pick up from them. So that other MSM also do not respect kotis." (A participant from a group discussion with representatives of MSM community)

Even within the koti community there is discrimination based on financial status and caste. Kotis from higher caste socialise with only those from higher castes, the same is true for financial status. The poor kotis are ignored by the others. Interestingly, while seeking partner, the kotis from higher caste are not bothered by the ghadiya's caste.

"There is discrimination within the koti community based on caste. There is grading – people say this one is B Grade and that one is D grade. But kotis from higher caste do not see caste when considering a ghadiya – ghadiya from any caste is acceptable – there are no grades for ghadiyas (ghadiyeka koi grade nahi hota)".(A participant from a group discussion with representatives of MSM community)

4.5.2 Trans-genders

4.5.1.a Discrimination in the neighbourhood

The TG community faces problems – discrimination from the society. There is a feeling of hurt at being disowned by their own families – the TGs are not invited over to the house but the only solace is that family members talk to them if they cross paths on the road.

TGs' interaction with the rest of the community is also strained. On one hand, they are respected as representation of the goddess and given generous alms on happy occasions in the family. However, on other occasions, the neighbours talk to them out of fear – that they might curse them if displeased or disrespected. The interactions are more out of fear not acceptance and TGs do not have friends among the other people.

The respondent also talked of instances of humiliation and abuse when the TGs go from house to house seeking alms. But they have no choice but to go on despite the insult and hurt they experience as seeking alms is the only livelihood granted to this community.

Difficulties in finding rental accommodations were also discussed. Since the TGs are not allowed to stay in another faction's area, this problem becomes very acute.

4.5.2.b Discrimination within TG community

Discrimination within community is more acute. The main aakhada has thrown this group out because some of the members of the group are from backward castes. Since they have been outcaste, they are not allowed to go from house to house and seek alms at happy occasions, and therefore they are forced to ask for alms on the trains.

The members of the group that participated in the group discussion talked about the rigidity of rules at the main aakhada where the members are required to observe strict discipline. The younger members are required to handover the day's income to the guru and have no right over the money they earn.

Other rules also are tiresome – there are rigid routines and breaking these is not taken lightly. The younger persons are verbally abused and feel trapped because they have nowhere else to go. One of the participants talked about a TG who was diagnosed with cancer and disowned by the main aakhada.
In their present situation where they stay away from the main aakhada, the guru accepts whatever they give out of respect and the younger ones are allowed to keep the rest of the amount.

"We also want to live our own life. If we have money, we can also send some money to our parents and also spend for ourselves." (A participant at the group discussion)

Younger chelas (disciples) are forced to do all the household chores – fill water, cook, wash clothes everything – and at times then run away from the aakhada. Many however come back because they have no place to go to.

"…the situation of women of the past is what situation of the hijras is today". (A participant from group discussion)

4.5.2.c Discrimination in employment

There are limited opportunities for the members of TG community when they try to seek employment elsewhere. One participant talked about his experience where he got a job as an office assistant at an office. He even worked there for 15 days but was asked to leave because others taunted the manager for giving him a job. Physical appearance is a barrier in finding employment for members of TG community who traditionally accept women's clothes, hairstyle etc when they are inducted into the TG community. However, as one participant from the group discussion who cut his hair in the hope of landing a job found out – the reluctance to give job was not only because of the clothes and the long hair – possibly the TGs' mannerism disclosed their sexuality and became a barrier in their finding respectable employment. This participant was unsuccessful in finding a job despite looking around for six months.

4.6 Psychological health concerns

4.6.1 Koti community

4.6.1.a Psychological problems commonly seen among koti community

Psychological health needs of the MSM community are acute but largely neglected till now. The group that participated in the discussion felt that among koti community, mental health problems are most important and most commonly seen-- mental health problems are more common than even sexual health problems. Confusion regarding one's sexuality, lack of confidence, loneliness, sense of helplessness, insecurity, and suicidal thoughts were reported to be very common to the community – almost every participant admitted having been through these at some point or other.

"It is the confusion about who am I? Am I a female, a male, a koti who am I? He is unable to decide on that. When they come in contact with MSM community then only they know about their sexual identity that there are others like him and that he is a part of the community. He then feels reassured that he is not alone in the world. He gets peace of mind. He then does not go into depression." (A participant from a group discussion with representatives of MSM community)

Psychological problems among the MSM community are largely because of the stress of keeping their sexuality from their families (and others). During adolescence there is stress of keeping it from parents and fellow-students along with constant turmoil of figuring out one's feelings. Kotis who are married live in constant fear of their wives finding out about their sexuality and the stress of engaging in sexual activity with women against their wishes.

" I will tell about myself – If someone I know or a relative sees me I feel very scared, anxious; I cannot sleep that night, I break into sweat – what do I do now, what if family finds out, what will happen to me. I experience stress and can't sleep." (R3)

Obsessing over sexual activity is another reason for psychological stress and distraction in routine activities.

Marriage is another stressful situation for kotis – mostly because it presents situations where the koti is forced to bear the insults directed at him (at his masculinity) as well as at his wife and at times the entire family.

"…one can tolerate if one is insulted but it is not possible to tolerate if other person is insulted (because of you). Why should another person be insulted because of me? Why should another person be hurt because of me? It feels like that." (R4)

The stress arises from being forced into sexual relations with a woman against wishes, pressure from wife and family for producing a child, taunts from neighbours as well as male partners about fertility, blackmail from male partner about disclosing his sexuality to his wife, demands from male partner for 'fixing up his wife with the male partner…

> "Koti faces pressure from all sides. Family pressurises to get married. Then there is pressure of having sex with wife. Wife pressurises for not using condom – for a child. Friends taunt about whether he can 'perform', whether it's his child. Male partner blackmails, asks to send wife to him, taunting." (Excerpt from a group discussion with representatives of MSM community)

One of the respondents who was married but separated from his wife talked about his feelings about his sexual relationship with his wife –

> "… (I would wonder) What am I doing … I would feel extremely guilty. Many times I would sit in a corner and cry. Who do I tell this to? That it should not happen. Because your own mind nags you – I used to worry how I would do the 'double role' (playing a receptive role in a relationship with a male partner and being a penetrative partner in a relationship with wife")(R4)

Another participant talked about humiliation kotis experienced when their wives became pregnant -

> "When the wife gets pregnant friends taunt – say, is it yours or someone else's? Some ghadiyas tell koti to send their wives to them." (A participant from a group discussion with representatives of MSM community)

Marriage also meant increased interaction with larger number of persons which always is a stressor for a koti – there is increased fear of someone identifying his sexuality and insults that would follow.

> "…having to go to in-laws to her uncles and others and so on – in such situations if someone recognised you – there is lot of fear of that…..I would take her out and if other people knew [about me] someone would whistle / cat-call someone would do something else—how would I deal with it? I too had such questions."(R4)

Many koti marriages end up in divorces and that also provides people another opportunity to taunt koti about fertility and masculinity.

> "Divorces are very painful because then sexuality is discussed in the court and they have to accept in court in front of many people that they are gay. This results in mental trauma."(Counsellor at LT)

To avoid this, some find courage to stand up to the pressures from their families and refuse to enter a relationship they know they would find extremely unpleasant.

"My mother forced me to get engaged but i did not want to get married because i knew i was not suitable for her. I would not be able to take her out, socialise with her, I would not even be able to praise her to people – to say how beautiful she is or how good she is because people would taunt me and her too, This would ruin two persons' lives. Then there will be divorce. Bearing insults directed at one's wife is more painful. And even after divorce people would say that see, he could not do anything so he divorced her". (A participant from a group discussion with representatives of MSM community who refused to go ahead with marriage)

Similarly, there are examples of kotis trying to move beyond primarily sexual relationship with their male partners towards a more mature relationship based on mutual understanding and respect. A respondent (R5) described the evolving nature of his relationship with his male partner of three years. Over the years his relationship with his partner has developed in such a way that they "have become very good friends" and now his partner feels guilty having sex with his best friend. So they have mutually decided that they will not engage in sexual activity and adhered to this decision for over seven months. The respondent (R5) narrated his reaction to this situation – he said that initially he felt bad "like being abandoned by his partner"; he felt that his partner said this to "push him away" and was distressed. He even sought counselling. The counsellor asked him to give his partner some time and to not judge him. Over time now the respondent feels that the partner was right in his decision and it was a right thing to give each other some time.

> "We understand each other so well, understand each other's needs and feelings so well, if there is a problem

we tell each other – sex will happen if both feel the need. There is no need to plan it – set a date and time for it." (R5)

Proportion of MSM who attempt suicide is very high – almost every participant present for the group discussion had attempted suicide. According to the participants from a group discussion with representatives of MSM community, attempted suicides are more common among younger age group of 12 to 22 years. Humiliation at being found out by family or friends at young age often drives people towards suicide. Being diagnosed as HIV+ve also makes people try suicide. Problems are more severe for kotis who are HIV+ve and have not disclosed it to their families. They face all the pressures that other kotis face but in addition they often face pressure from wife for not using condom. There are examples of wife suing the koti for not disclosing HIV status and subsequent trauma of divorce as well as disclosure of sexuality in the courtroom.

Attempted suicides

"A friend of mine, when he had sex with a man for the first time …he had not told anyone…the boy with whom he had sex came to us (the group) and in front of everyone said that this person had come to me for this. That day he went to the third floor of a building, he was crying…I tried to calm him down, I said don't worry, many people do this, I do it, this one does it. It is okay. Your family won't find out. He would not listen – he kept saying he wanted to end his life… only out of this fear – that his sexuality would be disclosed to the world." (As reported by a participant in a group discussion with representatives of MSM community)

"When my family found out (about my sexuality) my father had beaten me up badly. …Every day there used to be tantrums because of the same topic – so then I thought ending life would be better than facing it every day. …I had even run away from home…[before that] had even consumed medicine, even had jumped into the lake (Sukhsagar) but the fire brigade pulled me out. Then I went home. Nobody knew about it at home. …In the end I outright told him [father] that if this goes on for too long, I will join the hijras. Then if you face dishonour you deal with it. I will face whatever happens with me…. After that father was scared, what if he commits suicide tomorrow, or does something else, this son that I have – however he might be, I will lose him. So then after some days he accepted me." (R4)

"It is not that only kotis try to commit suicide, ghadiyas too do that. There was a gay couple that managed a gym at Akota. The koti forced himself on to me on the first day I joined the gymnasium. I talked about it with a good friend of mine who also was a friend of the ghadiya partner of that koti (owner of gym). That ghadiya confronted me; and I accepted it was a mistake. At the same time the ghadiya also confronted his koti partner and he denied having an affair with me . This upset the ghadiya and he tried to squash his throat using the heavy weights used for training. I then called his friend who had told the ghadiya about the affair to mediate and diffuse the situation." (As reported by a participant in a group discussion with representatives of MSM community)

There are issues related to relationships – MSM attempt suicide over failed relationship, and betrayal by partner. Though this is more common among kotis who have 'feelings like women', the group talked about suicide attempts among ghadiyas also. There is great amount of insecurity among koti community over their partners leaving them for another koti.

"More insecurity when he leaves koti for another koti. If he leaves for a woman the pain / hurt is less. If he goes to another koti there will be disrepute / dishonour (badnaami) of sorts. Other kotis would taunt saying that see your boyfriend came to me. If the man / ghadiya goes to a FSW she is not going to get in touch with the koti to brag about it but if he goes to another koti others would reach it to the deserted koti, taunt that he could not control his boyfriend. Then he wonders what is it that I lack and the other one has? Am i not able to satisfy him or what?"(A participant from a group discussion with representatives of MSM community)

In this situation kotis suffer from low self image as well. Kotis often get into multiple casual relations in search for 'true love' after betrayal by a long term partner. The helplessness and bitterness resulting from being rejected by a lover was evident in a group discussion with representatives of MSM community.

> "getting involved with a ghadiya, hoping for lasting relationship is a self destructive behaviour by the koti because it is clear right from the beginning that the relationship will not last and that the ghadiya who is bisexual will get married and move on". (A participant from a group discussion with representatives of MSM community who said that he has recovered from such betrayal,)

A few resort to measures like using 'black magic' to retain the partner – this again was reported to be more common among kotis with 10% of kotis and one or two percent of ghadiyas practising it. The kotis use these measures to seek love / long lasting relationship while ghadiyas use it to seek money.

> "A ghadiya had used black magic on a koti who is very rich and has not come out. This koti spends for all the ghadiya's expenses."(A participant from a group discussion with representatives of MSM community)

Loneliness and depression are common too and can occur at every stage of a koti's life. During adolescence when one is seeking out one's sexuality there is confusion and the person is constantly trying to make sense of his feelings and why he is different than others. This is exhausting and he feels lonely in his struggle and therefore depressed. Discrimination at school, neighbourhood – the insults hurled at him also leave a scar and make the koti feel isolated and lonely. Kotis often feel trapped within marriages. Inability to share the feelings (ghutan) with others leads to the feeling of loneliness and helplessness. Kotis often find relief when they come in contact with the larger MSM community and get a label of MSM. The counselling they get helps.

However, efforts towards addressing mental health needs of MSM community are limited and not adequate. Where attempts have been made to provide counselling, the experience has been filled with challenges. The larger society's as well as MSMs' attitude towards sexuality counselling, absence of recognition of mental health needs in the government agenda and absence of relevant data to base counselling on are some of the problems a counsellor faces.

> "People's attitude of looking at sexuality counselling should change – the way career counselling is an acceptable thing, sexuality counselling and mental health counselling should also be accepted. LT provides mental health counselling but it is not a part of the SACS agenda. It doesn't even figure in the reports / statistics that the SACS asks for. That is why NACP-3 is a failure. It does not explore the mental health component. Multiple partners are common in this community but the programme has not tried to explore the reasons behind it. The programme does not explore the reason behind the 'sexual compulsion" that results into engaging with multiple partners. The MSM form pseudo-relations but the programme has not explored the need behind these as well….for female commercial sex workers, various studies are done to find out reasons behind promiscuity – the factors that lead to risky behaviour are documented. For MSM such efforts are not made. They are grouped and targeted for HIV prevention without exploring reasons behind it." (Counsellor at LT clinic)

The person acting as a counsellor for members of MSM community needs to deal with certain professional challenges that are linked to the specific needs of the group.

> "Persons seeking counsellors' position at LT should be sensitive. Male counsellors face problems because the MSM get attracted to them. They need to maintain a balance between being sympathetic and maintaining a distance. MSM experience sudden mood changes therefore one needs to be careful about choosing words. Another issue is that when counsellor shows kind behaviour the counselee get dependant on the counsellor for decision making regarding even the smallest things. One has to exercise patience to bring in change. …Sometimes the MSM lie a lot so it is difficult to trust everything they say…There are revengeful tendencies among the MSM – "I was loyal to that partner he betrayed me, I got the infection because of him, now I will pass it on to others'. This needs to be identified in time and efforts need to be made to check it." (Counsellor at LT clinic)

4.6.1.b Commonly seen mechanisms for coping with psychological problems

With limited availability of formal structures to address their emotional, psychological problems, coping mechanisms the kotis adopt are varied. Some believe that familiarity encourages people to taunt and make fun of a person and choose to keep aloof whereas others confront their tormentors. Some also believe that not reacting to taunts, being nice to even those who insult them eventually wins acceptance and even friends.

> "I did not experience actual harassment at school but I kept aloof -- I had it in his mind all the time that the other kids would make fun of me if I interacted with them. And even as an adult I do not interact with anyone in the neighbourhood. My brother has lots of friends but I do not have a single friend. I do not even casually engage with people over there. I do not feel hurt at this (having to force oneself into isolation even in the neighbourhood) – I think it is alright the way it is.(R5)

> "…if you interact with someone, even casually exchange greetings, then after some time they also come around to the same thing – tease, make fun of you. But I did not do friendship with anyone, I did not even interact with anyone…I did not let anyone near me (get any closer to me)..that is why nobody does it (calls names, taunts) to me."(R5)

> "This used to happen with me a lot. Whenever I moved out of my house, they would call me 'gud'. I tolerated it once, twice, thrice – I kept quiet many times. Then once I went and confronted them. After that they stopped calling me 'gud' – call me 'bhai' instead. They might still be calling me names behind my back but to my face they address me with respect." (A participant from a group discussion)

> "I never got angry. They would say things but I never let myself get angry. I would say, I am like this, there must be something in me like that (what they say), then I have to listen to them. So I would listen to them. I never confronted them.(AP: Did you not feel hurt?) No, but how much can you hurt, and for what all can you hurt? The more they teased me, the more I would be nicer to them and then over time it would be alright. It was like that." (R4)

Keeping low expectations also appears to be another way of keeping oneself from getting hurt as one participant put it while discussing discrimination in the society. He said, kotis are not treated well by the community. But he feels that expectations that a person has from the community are always way more than what is possible in reality. To illustrate his point he gave an example –

> "if there is a koti who has a partner, the koti wants to stay with her partner in one home and wants others – family to accept them. That is her expectation but it will never come true." (R5)

Many times kotis' partners are married men. In such situation, the koti draws satisfaction from the assurance from the partner that he is being closer to the koti than with his wife.

The same thing was said about acceptance by family. While discussing acceptance by families once they find out about a person's sexuality, a respondent said that in his opinion about 15% families accept the persons and treat them well, another 50% accept but show differential behaviour whereby the 'persons feels that he is being treated differently / loved less by his parents'. Clarifying his point about acceptance he later said that 'not throwing a person out of the house' is the most important thing.

When in depression, most often people do not know who to turn to. Some may choose to talk to friends from the community but there are things about which they can not talk to anyone and prefer to deal with these alone than seek help for the fear of ridicule from the community itself. According to the counsellor at LT, stigma associated with seeking counselling – the fear of being labelled 'unstable' – often keeps people away from it.

> "Mostly people keep to themselves. (andarhi andar ghuta dete hai). Who can we talk to? What else can they do? Say, they will talk to me. Now, say, I have a problem with my family, then they think how can I deal with this? They have their own dilemma. Then there are problems with partners. MSM have partners as well. They cannot talk to anyone about partners. If I talk to others about my partner then others will laugh at me, taunt me, gossip about me – they think like that – this happens a lot.

If they want to come out of that (depression, frustration, confusion -- munjhvan) then they keep in touch with us (LT). They think that this is better than that (joining akhaada). I will get guidance about what I should do and what I should not do. Then there is counselling. Sometimes there also is family counselling. Because of this they get help. When others see this, they also come on their own." (R5)

However, there are some others who take to addictions. According to the respondents, tobacco smoking, alcohol consumption and even use of narcotics is common among MSM. One of the respondents talked about how he seeks relief from stress in smoking cigarettes.

"…yesterday at home there was this discussion again. …I smoked three cigarettes. Every day I smoke one but yesterday I smoked three. I left home and went and smoked three at a time.. it makes me feel better." (R5)

Unable to cope with lack of acceptance by the larger society, as a last resort, some join the TG community.

"When koti cannot find way out, feels trapped, frustrated with life runs away to hijra community – hoping for acceptance and respect. Once in saree people give respect – call mataji, maasi. So for that koti abandons everything – entire life, house, family." (A participant from a group discussion with representatives of MSM community)

In absence of formal support structures like counselling centres the kotis depend on each other for emotional support.

"We tell them don't do this. Your problems are not going to be sorted by drinking alcohol. If someone comes drunk to the group we ask why do you drink then he says I am fed up, there is lot of tension, family has found out, my ghadiya left me – I had a partner we were getting along fine and he now left me. So I am tired of this life. Now I will do whatever with my life. We say that by your drinking alcohol the partner is not going to come back. We say like that." (R3)

Ocassionally, a ghadiya also takes on the responsibility of confronting the other ghadiyas to protect his koti friends. A ghadiya participant from a group discussion talked of how he threatened other ghadiyas who come together at ST stand about not teasing any kotis from LT. His ghadiya friends are aware of his association with LT, so when they tease any koti from LT he tells them – don't do this, he will go back, get the group, the group will come here, there will be a case and you will have to face the humiliation. That helps. He feels that he needs to defend them because they are his co-workers, that they should also be able to live with respect in this society. He does not like it even if someone (ghadiya) calls them names. He felt pained that the kotis do not appreciate the gesture.

4.6.2 Trans-genders

4.6.2.a Psychological problems commonly seen among trans-genders

Regret at having joined the TG community is common among the TGs and was echoed by many who participated in the group discussion. The respondent talked of sense of regret at having joined the TG community.

"If only I were not like this, I would have been at my parents' place, among my relatives who would care for me." (R7)

Insecurity about survival in the old age is a major cause of worry – since livelihood depends of seeking alms, the TGs are worried about how they would be able to survive when they grow old. There also is an acute feeling of loneliness. Humiliation at hands of larger community, distancing from relatives and community and constant worry about future and about old age makes TGs feel sad and lonely.

"One gets tired of life…feels sad that one does not have support from anyone, that the family does not acknowledge you – your own family hates you – this one went and joined hijras..if they have not liked it, if a chela looked after as a son does not reciprocate the affection and hates you.." (R7)

The members of TG community also face harassment at hands of the other members of TG community. Especially the representatives of TG community who participated in the group discussion who belonged to a deserted faction reported harassment from the members of the main akhada - the main group from which their faction had separated out. These participants said that separation from the main akhada irked the members who then tried to make their living difficult. The members of the deserted faction did not have fixed area in the city where they could claim alms from so they had to resort to begging in trains. This exposed them to the police who in turn harassed them for begging on the train. Police also refused to register complaints of the members of the deserted faction. Participants believed this to be a direct result of bad publicity by the main akhada about the members of the deserted faction.

> "Because of the publicity that the main akhaada does (the main aakhada accuses the deserted faction of being fake) the police and other people have started being disrespectful towards members of this faction" (A participant from the group discussion with representatives of TG community)

Since the respondent as well as participants in the group discussion were from the deserted factions of the TG community, their sources of income were restricted. This contributed to the insecurity regarding future – the members felt that the income is so less that, it is difficult to save anything for future. Whatever is saved is spent on illness and celebration of festivals.

4.6.2.b Mechanisms for coping with psychological problems among tran-genders

There are not many sources of support. Generally the members of the TG community keep to themselves. The family members (TGs who stay in one house and are chelas of one guru) try to talk to a person who is depressed but others – even from the community – do not interfere / intervene in what is regarded as a family matter. Generally people do not seek counselling. According to the respondent, a friend is more in a position to understand a person's pain than a counsellor. Any attempt to seek formal counselling becomes fodder for gossip within the community. This point is supported by the counsellor at LT who reported having counselled just one TG person in over eight months at the clinic. The lone counselee had approached the centre for discussing his dilemma over castration.

Proportion of suicides is very high among the TG community. The respondent has seen about 50 cases of suicide over the years and there are many more who attempt suicide. There are others who take to addictions -- try to drown sorrows in alcohol.

If there are fights / arguments between the members of a family, then others from the community try to intervene. At times other neighbours also try to mediate.

The faction that stays away from the main aakhada stays in constant fear of assault and abuse from the members of the main aakhada. The discrimination based on caste and religion is prevalent – so is untouchability. This adds to stresses. Because they are a group, and because the guru is protective, the members of the group do not feel sad, abandoned, or lonely.

4.7 Expectations from health systems

4.7.1 Koti community

4.7.1.a Experiences with and expectations from public health services

Respondents had varied experiences with public health services. Some reported having received unbiased respectful treatment while some others reported instances of extreme humiliation and dismissive treatment from the doctors and other support staff at the hospital.

> " I have too many mental problems….Sometimes think I should commit suicide or I am confused – what should I do, what would happen to me in future, I often think of suicide so my friend said – you need mental treatment, you go there (SSG).. So I went there. They asked me everything, took history. Gave me 1 -2 hours of time. I felt very good. That doctor behaved well with me. Talked to me like a friend. I felt very good talking to him. He gave me courage. So whenever I went there, I used to feel like talking to him only. But once he was

not there. I talked to another person. He also was good. He also treated me well." (R2)

Extremely feminine kotis find it uncomfortable to wait in the queue where they are stared at and a subject of whispered remarks. At times, the doctors make kotis wait longer and give preference to other patients over them. Non-discrimination against MSM was the only expectation from the health systems.

> "At the government tertiary hospital, and at the general hospital Jamnabai the behavious of doctors and nurses with MSM was not alright. One person had gone there for treatment – he had anal bleeding, he went to SSG hospital. The doctor over there, the nurse, they asked what problems he had. He openly said that he was an MSM and he liked to engage in anal sex and because of that he had this problem and for that i have come for to treatment. So the doctor said – all this is not good, stop all this, since when are you in this 'line' (implied meaning sex work) – this is how they talked to him. He could not take treatment from there. In some other cases when a MSM goes there, if the MSM is wearing an earring or has mehendi on his hands, then the students stare and talk amongst themselves. The person feels that they are talking about him only. Then they leave the hospital without treatment." (R6)

Again, respondents reported having dealt with these problems in different ways. A respondent said that whenever he experienced problems he has always confronted the system. He talked about an example where after confrontation the patient received services. Whereas some respondents talked of people they knew of who started avoiding the public hospitals after humiliating experiences.
The kotis' expectation from the public health services was merely that of humane and respectful treatment. As a respondent expressed – and his views are representative of all respondents' – that, all that a koti wants is 'to be treated as a part of the larger society'.

> "Treat us like they treat other people. Don't look at us as if we are different. See us as you see men and women, don't treat us separately. We also are humans. Same God made them and us as well. That's it." (R3)

4.7.1.b Experiences with private sector health care practitioners
According to the respondents private practitioners maintained confidentiality and did not discriminate against MSM.
"Private is private and government is government – private doctors do not pay attention to all these things. I have seen that private doctors are not concerned with what the sexuality [of the client] is, whether he is a koti, a ghadia or a double. They are concerned with treatment and their fees." (R1)

According to the project coordinator LT, having a separate / exclusive clinic is good practise because it facilitates access for MSM At the same time it is important to work with the public health system and sensitise the doctors and other staff towards specific health needs of the MSM community. This could be done by incorporating sexuality education in the curricula.

Experience with a public sector hospital
The respondent had taken a patient to an ART centre, the patient was examined and asked to get some investigations done. The doctors who were to order these investigations were busy in a meeting. The respondent and his patient waited the entire morning but at 12.30 were told to come the next day. He then argued with the doctor – "it was you who was in a meeting, we had been waiting the whole day, see to it that i get the reports today". The doctor then relented and ordered the investigations. Before investigations the patient had to go to a counsellor and there was only one counsellor and the respondent and his patient had to wait there too. After he got the services he put a suggestion in the suggestion box that there should be two counsellors so that people do not need to wait so long. After that he noticed that there were two counsellors at that place. (R5)

4.7.1.b Expectations of an ideal clinic
To all respondents the LT clinic was an example of ideal clinic. From the discussions it was expressed that the most important aspect for the MSM is comfort they experience in accessing the services. The comfort would be

maximum if the doctor at the clinic is sensitive to the MSM's specific needs and preferably a koti. Confidentiality is another aspect of the LT clinic that most respondents appreciated. The location of LT clinic in a 'safe space' where the MSM can freely interact with each other also makes it more appealable to the community. In the same context the respondents commented on labelling of case papers as 'MSM' in public sector hospitals. The respondents felt that the system should be done away with in order to protect sexual identity of persons seeking care.

> "Many people prefer to come to LT clinic. They feel comfortable to come here, that the doctor is sensitised and will understand the problems. If MSM go elsewhere the doctor asks had you done anal sex and that embarrasses the patient and he is not able to talk about his problem. At LT this problem does not happen. Therefore they prefer it. MSM would prefer a male doctor to a female one." (R5)

> "The doctor should be from the community – means there are kotis, giriye (ghadiyas) from them -- if the doctor is a koti people would prefer that. If he is a koti then people will feel comfortable talking to him, they feel that he would be able to understand the problems. If it is some other doctor then people will be embarrassed / will feel shy to even undress in front of him. But will think that this is a koti, so what is there to be ashamed of in undressing in front of a koti – some people think like that." (R6)

The ideal clinic for MSM should –
- Be located in a 'safe space'
- Be easily accessible
- Maintain confidentiality
- Have a male doctor, preferably a koti and sensitive to the specific needs of the MSM

4.8 Policies and programmes relevant to MSM

Till date MSM have found mention only in the context of the highly discriminatory section 377 of IPC and in terms of HIV prevention strategies of NACO. Apart from that there are no welfare policies and programmes for the MSM.

According to Project Coordinator, LT who also is a co-founder of the organisation; all the changes in policies and programmes related to MSM have been a result of increased focus on HIV prevention activity and pressures from international donor agencies for focussing on sexual minorities in this context. In **NACP II** almost all work around MSM has been in the context of HIV AIDS. At the national level, MSM community came in to focus with **NACP III** when forming groups / CBOs of MSM and working with them for prevention of HIV through intervention projects became mandatory for SACS. This was a development over a more passive approach of NACP II where MSM community was on the periphery of its activities – as one of the many target groups but there was no focussed input towards this group. Advocacy from the MSM groups also contributed to bringing about this change.

Organisation of or facilitation for organisation of MSM groups into CBOs or NGOs was another change that took place at the beginning of the last decade. Initiation of LT in itself is an example of the rushed approach of the SACS in involving MSM groups formally. A dedicated officer contacted founders of the organisation, organised a conference (for brainstorming on how MSM groups could be involved in the formal agenda of the SACS) and encouraged LT to get registered. Once they were registered within a week the GSACS gave them a study on needs assessment and then followed it up with appropriate training. **The NGOs / CBOs / groups of MSM** that initially had formed around the need for protection of human rights issues of the community slowly **shifted focus and got involved primarily into HIV prevention** and later into health in general. With these changes in their status in the context of the NACP III, the **MSM community** / groups gained a sort of recognition / visibility at the policy level and **because of the newer perspective they realised their own potential.**

The understanding about sexual health needs itself evolved over a period between NACP II and NACP III. The scope of activities under NACP II was limited to distribution of condoms and K Y Jelly. Neither the SACS nor the organisations working for the issues of MSM were aware of what all sexual health could encompass. However, **the nature of activities did not change much in NACP III** – focus remained on distribution of condoms and jelly **but the intensity of the intervention improved**. Earlier in NACP II the project structure was such that one peer educator was responsible for a population of 100 to 150 (MSM persons) resulting in less frequent interactions. With NACP III, the structure of intervention projects was modified such that one peer educator now looked after 60 persons and kept detailed records for these persons. This improved the reach of the interventions.

Other positive change is that **NACP III emphasised on counselling**. In NACP II counselling was restricted to pre-post-HIV test and STI test counselling but with NACP III **need for mental health counselling was recognised** and that was made a part of the service package. Another major change under NACP III was that the **partner organisations were allowed to have STI clinics at their places**. This greatly facilitated access to SH services.

Recent ruling of Delhi high court in favour of **doing away with section 377** was a major change. When Dr. Sujata Rao the NACO director submitted an affidavit to Delhi High Court stating that article 377 was interfering with HIV prevention work and should be done away with – it was a significant step with a government department taking stand on issues related to sexual minorities.

There have not been any unintended negative effects of the policy changes.

What more needs to happen for the rights of sexual minorities

- Recognition, acceptance and tolerance. The state should acknowledge that MSM exist and that is responsible for their welfare as well.
- It should be acknowledged that the MSM population is not a uniform / homogeneous entity. Efforts should be made to address the specific needs of each of the sub-groups within the MSM community. For example, the TGs are at the very bottom of the hierarchy among the MSM community. Culturally, traditionally resigned to seeking alms in modern days they find themselves grouped with beggars – denied dignity. They should have acceptance, recognition and legal status. Suitable employment is a specific need for this community. Skill building for gainful employment is also important for the entire MSM community.
- Health aspects other than HIV/AIDS should also be paid attention to. For example facilitating sex reassignment surgery, castration surgeries, mental health counselling are some of the major issues and should be addressed by the health systems.
- Generating awareness among general public about different sexualities would help reduce discrimination against MSM. For this sexuality education should be made a part of the school education as well as of the curricula of doctors and other para-medical personnel.
- Specific interventions should be designed for addressing the bridge population.

4.9 Expectations from government

4.9.1 Koti community

Measures for de-criminalisation of same-sex relationships, mainstreaming MSM into the society, a life of dignity and respect, opportunities to improve social status and political recognition are some of the expectations of the MSM community from the government.

> "First treat us as humans – we are humans first, MSM later. Count us as humans and then talk of rights. People term MSM as perverts" (A participant from a group discussion with representatives of MSM community).

> "Do not treat MSM as aliens – we also have a right to live our lives just like other humans, so what if we are MSM, we also have a right to live, we also have rights. .. we are not saying put us on a higher status but at least treat us with respect - -consider us a human being like you – we are not different. It is like this – some people eat with right hand and some with left – it is their choice."(R6)

Though the respondents realised the importance of removal of section 377 of IPC that decriminalises homosexuality, mere ruling in favour of its dismissal will not be enough for changing the situation for the MSM. Participants stressed the need for active measures for ensuring acceptance and equity.

"Rules can be made but they will not remove discrimination from people's minds. For example today my family does not know I am a koti. Tomorrow I go home and tell them that 377 has been removed and I want to marry a boy, they are not going to give permission. Because to begin with they do not know of, believe in 377. Change should be brought about in the way people think."

Respondents have repeatedly stressed the importance of acceptance of a MSM by his family. The respondents felt that a person who is accepted by his family has a much higher chance of being accepted by the larger society; which would then lead to decreased abuse and increased self esteem among the MSM.

> "Introduce sexuality education at school so that in future if someone from their family turns out to be like this (MSM) they would be able to understand him and be able to accept him. So like this eventually the society will also accept him. Because when family accepts, the society finds it easier to accept – this has been his experience. Say for example if the family does not know about a koti's sexuality, he would find it very difficult to talk at home about people calling names etc because talking about harassment might bring out the topic of his sexuality. So he keeps quiet. But if his family knows then the person can seek support at home, he is not worried. And when others who call names etc come to know that his family knows all about him and accepts him, they lose interest in harassing that person – "they feel that this person's family knows everything, what is the point in teasing him". (R5)

Often school is the first major hurdle that MSM face. The respondents have stressed the importance of generating awareness regarding sexualities among school children. Sensitising teachers, sensitising children, preparing them to accept people who might be different and teachers keeping an eye for protecting the MSM from abuse from other children are suggested as some of the measures.

> "Education. MSM who go for education – with some their mannerism are feminine since childhood, so then other children tease him and that affects the boy's education. For this something should be done. Teachers and principals should take meetings and talk to students and explain to them that there are some people who are like this but they are not different they are like us. Then others would not discriminate. The teachers should also keep an eye on the MSM. They should also provide them with knowledge that they want." (R6)

Some believe that legalising same-sex marriage will help bring stability to the MSM population. At present because of absence of any legal support, the MSM cannot seek redress in case a long term relationship breaks up. The counsellor at LT, discussed the indirect effects of absence of legal support. She feels that because of this the relationships are short lived and temporary in nature – constantly feeding to the insecurity that MSM experience. Broken relationships drive the MSM especially kotis into depression – either leading to self destructive behaviour as taking to addictions, unprotected sex with multiple causal partners in search of true love or attempted suicides. Some kotis even show a revengeful behaviour when they are diagnosed with STI or HIV and express the desire to harm others by engaging into unsafe sexual practices with multiple partners.

Difficulty in finding employment is a key concern among the MSM community. The participants and respondents were of the opinion that measures to address the underlying causes for dissatisfactory employment such as poor education, absence of or inadequate skills, low self esteem and lack of guidance would be useful in dealing with the problem. Schemes / subsidies from government for MSM for skill building as well as to initiate self employment would be a welcome intervention.

> "Government has employment schemes for females – there should be similar schemes for kotis also. Some kotis can do tailoring, manage beauty parlours so they should be given a chance and some support." (A participant from group discussion with representatives of MSM community)

Because of absence of family support, the MSM community experience acute insecurity about old age. Establishing old age homes, pensions for elderly would be helpful.

At present the TGs are categorised as beggars in the census. They are also denied identifying documents such as a ration card, election card etc. The laws do not allow the insurance companied to take out a life insurance policy for a TG. These should be addressed and efforts should be made to make all identifying documents available for all TGs.

> "When LT wanted to take out insurance policy for its employees an insurance company had denied saying we cannot do an insurance policy for TGs. But we are not TGs. People do not understand the difference. It is very difficult to explain to people that we are kotis we are MSM but not TGs. TGs are a part of the MSM com-

munity. But people do not understand." (A participant from group discussion with representatives of MSM community)

Expectations from the government
- Pension for the elderly
- Shelter for the destitute elderly
- Employment opportunities without discrimination
- Legalise same-sex marriage
- Legalise adoption by MSM individuals and couples
- Allow life insurance policies for MSM and TG – eliminate the need to provide a proof for sexuality
- Sexuality education to be introduced in the school, college curricula to deal with discrimination
- Facilitate education at schools -- redress mechanisms for students teased by other kids
- Do away with harassment by police – police should not treat all MSM as sex workers, should take notice of offenses against
- Facilitate process for acquiring basic identifying documents (ration card, election card) for MSM
- Schemes for self-employment
- Skill development for kotis

Expectations from health system
- Do not discriminate at public hospitals – treat with respect; files, case papers should not be labelled MSM, it discloses identity
- Facilities for dealing with loneliness, depression – counselling services should be made available
- Provide special condoms (lubricated, thicker) for MSM

4.9.2 Trans-genders

The expectations of the TGs are not much different from those expressed by the members of the koti community. The first and most important demand of the TGs is that they be treated with respect, be counted as persons, not be grouped along with beggars in the census and be granted basic identification documents such as the ration card, election card etc. Insecurity about old age is very common and the TGs expect the government to take measures such as provision of old age pension and shelter for older and destitute TGs. TGs should be allowed to take out LIC.

The police should not harass – should not treat them as sex workers.
Traditionally the community is expected to live off alms. The members therefore would appreciate government to provide help / scheme for medical treatment of the members. However, many participants were willing to explore other employment options as well. Lack of appropriate skills was also discussed. The participants felt that the TGs' right to employment should be respected and protected by the government.

> "We can work from home but we cannot do say tailoring because men and women won't come…We could work as a group." (A participant from a group discussion with representatives of TG community)

Since TGs do not have ration cards, they find it difficult to buy food as well. As one participant pointed out – there are schemes under which grains are provided at subsidised rates – such schemes should be made available for the TGs as well.

5. Discussion

The situation of MSM in India is similar to that of the other marginalised groups – on one hand it is known that traditionally MSM have been a part of the Indian society (Dandona, 2005) and on the other the traditional cultural norms as well as the modern law have forced them to be invisible and exist on the periphery of the society (Gupta,

2004). The social intolerance that stems from the traditional emphasis on heterosexuality and procreation has resulted in the MSM living their entire lives in fear and anxiety (Chakrapani et al, 2007). That the MSM are subject to discrimination and stigma is well documented (UNESCO,2002; Eckstrand, 2003; Gupta,2004, Chakrapani et al, 2004). Stories of discrimination, stress, loneliness and depression similar to the ones narrated by the respondents for the present study have been documented elsewhere (UNESCO, 2002; Chakrapani et al, 2004) and shed light on the emotional social aspects associated with one's sexuality.

However, often these have been explored only in the context of HIV transmission and prevention, where awareness of sexual practices and psychological consequences of these is believed to better equip policy makers to chalk up culturally acceptable policies for addressing the high risk behaviour of MSM (UNESCO, 2002; Gupta, 2004, Eckstrand, 2003). Though helpful, this approach offers a very limited perspective on social and mental dimensions of sexual and reproductive health of this section of the society. The dilemmas, confusion and feelings (emotions) of Indian MSM about reproductive health are rarely documented and discussed in the health literature. Presence of Section 377 of Indian Penal Code that existed for over a century is largely responsible for this apathy. The law that criminalised sodomy and was interpreted to penalise same sex relations between adults is known to have debilitating effects on psychological and emotional wellbeing of men who have sex with men who were also forced to be silent about their sexuality and related feelings (Gupta, 2006).

The neglect of the MSM sexuality is not limited to the country and is a result of the larger global thought processes that have chosen to conservatively interpret and exclude MSM from the widely accepted definitions of sexual and reproductive health (box). Though these definitions of sexual-reproductive health do not exclude men, the focus of the definitions and actions in response to these predominantly focuses on women, especially on maternal health and outcomes. The UN document clearly acknowledges that 'men too have reproductive needs and concerns' but goes on to say that 'reproductive health instead must be understood in the context of relationships: fulfilment and risk; the opportunity to have a desired child or alternatively, to avoid unwanted or unsafe pregnancy' (italics added).

Some widely referred definitions of sexual and reproductive health

WHO in 1975 defined sexual health as 'the integration of the somatic, emotional intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love' (WHO, Education and Treatment in Human Sexuality: A training of health professionals, 1975 – as cited in Khan S, 2004).

United Nations' Population Information Network (POPIN) in its 'Guidelines for reproductive health' defines reproductive health as 'a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity' and stresses that 'Reproductive health deals with the reproductive processes, functions and system at all stages of life'. (http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html)

The ICPD –POA states that 'reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases' (http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html),

Criminalised by law and marginalised by the society, the MSM (including TGs) came into focus when global HIV epidemic identified them as a high risk group – on account of their unsafe sexual practices. In India the focus was gradual. The first sentinel survey focussed on assessing prevalence among the heterosexual population. MSM were termed as difficult to reach groups. However in NACP II, proportion of targeted interventions aimed at MSM increased. NACP III built on the lessons learnt from NACP II, one of which was that NACP II could not adequately focus on MSM and IDUs. Promoting social ownership and community participation is one of the guiding principles and one of the priority areas of NACP III. Working on socio-economic determinants of vulnerability and high risk of

HIV is one of the thrust areas of NACP III. After acknowledging that MSM as one of the three groups at the highest risk of HIV the NACP III prevention strategies focus on this group with a comprehensive package of preventive services. Ensuring enabling environment for these groups is an important action area of NACP III (NACO, 2006).

The 'Strategy and Implementation Plan for NACP III' reiterates Indian Government's commitment towards achieving Millennium Development Goals (MDGs); and the primary goal of NACP III is to halt and reverse the epidemic in India over the five years (2006 - 2011) by integrating programmes for prevention, care, support and treatment. The document identifies 'reducing vulnerabilities and breaking silence surrounding issues related to sexuality' as one of the important ways of ensuring a non-stigmatising, enabling environment for success of prevention strategies (NACO, 2006).

Despite these promises in the NACP III, midway through the implementation period, the interviews with MSM in one of the more developed, low HIV-prevalence Indian state highlight the inadequacy of efforts at addressing the vulnerabilities of MSM in general and specifically in terms of sexual and reproductive health. The interviews highlight the need for looking beyond the prevention, diagnosis and treatment of STIs and HIV / AIDS. The interactions with the MSM reveal the constant fear of rejection they live in -- by their families, neighbourhood, larger society, employers, health care providers and even their male sexual partners. As reported elsewhere, the stigma associated with MSM sexuality, and stresses arising from trying to keep their sexuality secret, take a toll on the MSM in terms of reduced self esteem, lack of confidence and limited opportunities for self development – these in turn set a vicious trap which the MSM struggle to break (Khan, 2004). There is enough evidence about higher prevalence of psychological problems and suicidal attempts among sexual minorities as well as relation between sexuality and stresses experienced by people (King et al, 2008; Chakrapani et al, 2007;Fergusson et al, 2005; Gruskin and Gordon, 2006; Eskin et al, 2005). Yet, in India, The health services largely remain insensitive to the sexual health issues of MSM as is reflected in almost absence of STI clinics providing services for oral and anal STIs (Kavi AR, 2008, Chakrapani et al, 2004). There are limited services / facilities for counselling and support. Though acknowledged by NACO as an essential component of NACP III, counselling services at clinics managed by CBOs / NGOs and ICTCs mainly are focussed on pre-and post test counselling with little attention to addressing other mental health issues for the MSM. What is more important to note is that the stresses that result from denial of their sexuality by the larger society are not understood by the MSM as well as the programme, as denial of their sexual and reproductive health and rights and therefore as a violation of basic human right. That the CBOs/NGOs working with MSM are not encouraged to address health issues affecting the community is of a greater concern (Kavi AR, 2008).

To meet the goal of sexual health as well as to contribute to the stabilisation and reversal of HIV epidemic, it is necessary to pay attention to the sexual health needs of the MSM and other sexual minorities. High levels of stigma that result in increased vulnerability, poverty, disempowerment, and unsafe sexual behaviour, need to be addressed for preventing transmission of STIs (Gupta, 2004). The 17th international AIDS conference in 2008 saw a strong emphasis on need to address and protect human rights of vulnerable groups including gay and other MSM in the country level planning for HIV/AIDS programmes (Baijal and Kort, 2009). The psychological needs of the group – that are closely linked to their sexuality and sexual health – need to be addressed as well. Addressing barriers such as laws that criminalise homosexuality and sex work; as well as strengthening the capacity of the health care delivery system (including personnel) to respond to the specific needs has been widely regarded as one of the key measures for better addressing the health needs of MSM (Baijal and Kort, 2009).

A more tolerant society where MSM can pursue education without the fear of being harassed, an equal opportunity employment market where one is not denied employment on the basis of one's sexuality, a sensitive health sector that responds to the specific physical and mental health needs of the MSM without prejudices and biases, laws and law enforcement agencies that 'respect, protect and
fulfil the human rights of all persons regardless of their sexual orientation or gender identity' in accordance with the Yogyakarta Principles (O'Flaherty and Fisher, 2008) are some of the basic needs of the community that have been reiterated by the respondents of the present study.

Recent developments reported in India such as the opening an old age home in Rajpipla, Gujarat for MSM which is the first of its kind in India (Chaturvedi, TNN, June 27, 2010); legalising of sex reassignment surgery in public sector hospitals in Tamil Nadu (Priyamvatha, IE, March 7, 2007) are encouraging but far from adequate to respond

to the inequities that the MSM in India face. Conducted within weeks of repeal of 377, findings of this study are a reminder of lacunae that exist in terms of SRH rights of a section of the community and also point towards a way forward.

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