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INDIA 'MSM SITUATION PAPER' SERIES
TECHNICAL BRIEF 1

Hard-to-Reach Men who have Sex with Men in India
Recommendations for HIV Prevention

SEPTEMBER 2011

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सत्यमेव जयते

NACO

PREFACE

India has largely a concentrated epidemic, thus an important focus area of the National AIDS Control Programme is reaching out to high risk groups. In this context, there has been a rapid scale up of targeted interventions in the third phase of the National AIDS Control Programme (NACP-III).

National AIDS Control Organisation (NACO) has recognised that Men who have Sex with Men (MSM) and *Hijras*/Transgenders are an important group. There is considerable evidence related to MSM but there is a need to collect more evidence in regard to *Hijras*/Transgenders so that their vulnerabilities can be appropriately understood and addressed.

Three key studies have been done by Technical Assistance Support Team (TAST), Futures Group International funded by UKaid from the Department for International Development (DFID). These studies pertain to hard-to-reach MSM, women partners of MSM and the overall vulnerabilities of MSM to sexual violence. The studies have thrown up certain insights, which I am sure will be extremely useful in reaching out to these communities.

(Aradhana Johri)
Additional Secretary, NACO

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FOREWORD

National AIDS Control Organization (NACO), in collaboration with its civil society partners, has been taking lead in controlling the spread of HIV infections and to provide treatment, care and support for people living with HIV.

NACO has made significant progress in bringing the HIV prevalence among marginalised communities such as sex workers, injecting drug users and migrant workers. However, the outcomes of the HIV interventions among Men who have Sex with Men (MSM) have been mixed in spite of the rapid scale-up of TIs among MSM across the country. In some areas of the country, HIV prevalence among MSM is still not satisfactorily coming down and there has even been an increasing trend (such as in Andhra Pradesh) in the recent years.

While the available data with NACO suggest that most MSM coming to the cruising sites (hot spots) have been covered, there seems to be an elusive group of MSM who are hard-to-reach, and who may not be accessing or using NACO-supported services. Similarly, while significant efforts have been taken to reach to MSM coming to cruising sites, the women partners of MSM, especially HIV-positive MSM, have so far not been given due attention, which means those women partners and their unborn children are at higher risk of HIV. While NACO has introduced crisis intervention systems in the targeted intervention projects to deal with police interference and ruffian harassment, an explicit focus on prevention of sexual violence and providing or linking victims of male-to-male sexual violence to necessary services have been limited – until now. Thus, NACO wanted evidence based recommendations of what needs to be done in these three areas: Hard-to-Reach MSM; Women Partners of MSM; and Sexual Violence against MSM, which lead to the commissioning of the studies on these three topics. The study findings of this 'MSM Situation Paper' series are thus very timely and useful to NACO especially when country-wide consultations have been held to design the fourth phase of the National AIDS Control Programme (NACP-IV).

We hope that we are able to effectively address the unmet needs of MSM communities and thus improve the health status of men who have sex with men.

Mr. Sayan Chatterjee
Secretary & DG, NACO

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The India 'MSM Situation Paper' series includes the following technical briefs:

1. Hard-to-Reach Men who have Sex with Men (MSM) in India: Recommendations for HIV Prevention
2. Women Partners of Men who have Sex with Men (MSM) in India.
3. Sexual Violence against Men who have Sex with Men (MSM) in India: Intersections with HIV

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
CMIS	Computerised Management Information System
DD	Double Deckers
DIC	Drop in Centre
FGD	Focus Group Discussion
FU	Follow-up
HIV	Human Immuno Deficiency Virus
HRB	High Risk Behaviour
HRG	High Risk Group
ICTC	Integrated Counselling and (HIV)Testing Centre
IDU	Injecting Drug Users
IEC	Information, Education and Communication
KI	Key Informant
KII	Key Informant Interview
KP	Key Population
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NCHI	National Coalition for Health Initiatives
NGO	Non Governmental Organisation
ORW	Outreach Worker
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
PPN	Positive People Network
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
TAST	Technical Assistance Support Team
TG	Transgenders
TI	Targeted Intervention

Contents

A. INTRODUCTION

This paper makes recommendations for the development of HIV prevention work with 'Hard-to-Reach' men who have sex with men (MSM), with the view to advancing new strategies that can be taken forward in the fourth phase of National AIDS Control Programme (NACP-IV).

The term 'Hard-to-Reach MSM' indicates those men who have sex with men and who to date have not been well included in HIV prevention work. MSM may be hard-to-reach because prejudice in society can mean that some men have a strong investment in being secretive and private about their sexual practices with other men. As such they may have little desire or incentive to have contact with an MSM focused targeted intervention (TI). In other cases, some MSM may not have a sense of identity associated with same sex sexual practices, and are typically not well included in targeted MSM interventions which have tended to focus on men who more readily self identify as MSM (whatever term of identity they may choose). As such, 'non-self identified MSM' are an especially important target population.[1] it is important to recognise that it is not only that some MSM are hard-to-reach because of their social and personal circumstances but also to consider that current HIV prevention strategies may actually render some MSM hard-to-reach, or unreached.

It is important to stress that TIs to date have been predominantly organised and implemented by *kothi* identified outreach workers (ORWs). Whilst it is important that work of this kind continues, it is vital to recognise that such approaches have tended to exclude men who may self identify in other terms (*gay* identified men, for example, have not been well included within existing HIV prevention efforts). Moreover, existing TIs tend to focus on 'younger MSM' (men in their 20s and early 30s). Men over this age group are not well included in existing interventions. Given that men in older age groups are likely to comprise the majority of 'married MSM', it is especially important to reach out to such men, in synergy with health promotion initiatives aimed at addressing the needs of the wives and female partners of MSM. This briefing makes recommendations with the aim of better including a broader population of MSM in TIs and other HIV prevention actions.

[1] A significant proportion of MSM who practice same sex sexualities do not have a self-identity related to those practices and they can be referred to as 'non-self-identified MSM'. In general, the term MSM refers to both MSM with self-identities such as *gay*, bisexual and *kothis*, as well as MSM who do not self-identify with any of these terms. However, in India, as elsewhere, MSM is frequently equated with feminine self-identified same sex attracted males (such as *kothis*) and used as a euphemism to refer to same sex oriented/attracted men. Hence, the current situation necessitates the introduction of the term 'non-self-identified MSM to refer to those MSM who do not have any sense of identity related to their same sex- sexual practices. The introduction of this term is not intended to promote an idea that all MSM should self-identify with a sexual category or label. Rather, this term is used to raise awareness among policy makers and national/ state HIV programme managers that a significant proportion of MSM may not self-identify with terms such as *kothi* and *gay*, and importantly, they may not even think of themselves as men who have sex with men. Complementary HIV prevention strategies are needed to provide safer sex messages and other services to this vulnerable population.

This briefing paper is based on research carried out between October and December 2010 in 11 urban, suburban and rural sites in India. The aim of the study was to explore both the circumstances and the needs of MSM in these various locations (through qualitative interviews and focus group discussions (FGDs)) It was also to elicit feedback on the current situation regarding TIs for MSM from relevant stakeholders including peers, ORWs, State AIDS Control Society (SACS), staff members of other relevant experts from the non governmental organisation (NGO) and community based organisation (CBO) sectors. This data is combined with a review of literature covering both research on MSM in India and relevant comparative examples from other countries. The data was also further examined and refined during a consultation meeting with field researchers held in Chennai in January 2011. A preliminary report was presented in a national consultation meeting conducted in New Delhi on July 7, 2011 and the feedback and the suggestions that were received in that meeting were used in fine tuning the report.

This briefing paper makes specific recommendations for new actions that ought to be taken forward over the next five years, in order to improve and enhance the coverage of MSM in national and state level HIV prevention programmes particularly with the aim of including men who have to date remained unreached within existing TI initiatives. Recommendations are grounded in the evidence obtained during this research, offering an up-to-date assessment based on the experiences of people who are at the forefront of HIV prevention work with MSM.

The recommendations put forward in this briefing are grouped into three key action areas. The recommendations made here are specifically oriented toward actions that may be undertaken by NACO or by other agencies with NACO support.

Summative recommendations

Expansion and development of TI target populations and models. To date, TIs have targeted a range of MSM who are understood according to different sub groups such as *kothis*, *panthis*, *double deckers* (*DDs*) and variants of these terms. Predominantly, many ORWs have been recruited among *kothi*-identified MSM, as *kothis* have been especially important leaders in HIV prevention work and also important in accessing sexual partners (such as *panthis* and *DDs*) for HIV prevention work. Nonetheless, a strong finding of the research is that this approach significantly excludes many other MSM, particularly those who do not self identify with any terms of same sex sexuality and also '*gay*' identified and 'upper-class' populations. We recommend a diversification of TI approaches during NACP-IV, to incorporate a wider and as yet unreached population of MSM moving beyond the hot spot-based TI models, and specifically including a focus on suburban and rural areas. We recommend that this should also include the development of new counselling approaches that are more sensitive to the needs of MSM who are at present hard-to-reach.

1. **Development and refinement of the monitoring and evaluation (M&E) and target quota systems that have currently guided and organised the work of peers and ORWs in TIs.** Data indicates that extensive work monitoring formats and outreach contact targets that peer educators and ORWs must follow tend to preclude against the development of contact with hard-to-reach MSM. We recommend the development of enhanced systems of M&E, in line with NACO's planned programme developments in this area with a specific focus on the development of monitoring formats that are better suited to addressing the needs of hard-to-reach MSM.

2. **Development of outreach and TI services via communication technologies such as the mobile phone and the internet.** Increased ownership of mobile phones across the population in India suggests their potential as sites for health education in general which ought to include HIV prevention. We suggest that an important component of NACP-IV should be the development of effective means of reaching out to many MSM who are otherwise harder to reach. Similarly, the internet is an important context where MSM increasingly socialise and meet sexual partners. The present study has indicated that some TI work is already ongoing in relevant internet sites and we recommend that exploration and enhancement of the potential of this work be developed during NACP-IV.

B. METHODOLOGY

A combination of qualitative field research and literature review was used. The field research protocol was approved by the ethics review committee constituted by the DFID Technical Assistance Support Team (TAST) of NACO.

Qualitative field research

Qualitative field research used a collective case study design to collect field data from 11 sites[2] (based on maximum variation sampling) in seven states among 401 study participants through 57 focus groups (364 participants) and 37 key informant interviews (KIIs).

Purposive sampling was used to recruit participants for focus groups. Recruitment was mainly through NGOs/CBOs implementing TIs, some of which are supported by NACO/SACS. Focus group participants included 70 full time staff of NGOs/CBOs working with MSM, 75 peer educators and 105 beneficiaries.

Key informants (KIs) were from different categories: Officials of SACS, Technical Support Unit of SACS, and NACO (10); NGO/CBO leaders (12); Healthcare providers that included doctors (10); and five others (such as Police, and Positive People Network (PPN) leader).

Literature review

For the literature review component, multiple data sources such as peer reviewed academic articles (published in the past 10 years: 2001–2010) and data and reports from the Indian government (NACO) were used. The literature were searched and gathered primarily via electronic sources. Key academic databases searched were Medline and PsycINFO using Ovid interface. General search engines such as Google and Google scholar were also used. For the topic on hard-to-reach MSM, key words used included combinations of: HIV, AIDS, HIV prevention, MSM, unreached, difficult to reach, hard-to-reach, hidden (and variants of these terms), non-identified MSM, non self identified MSM, risk behaviour, bisexual behaviour, violence, stigma, programme, interventions, Asia and India.

Data analysis and inferences

Data from the focus groups and interviews were explored using a combination of framework analysis approach (using *a prior* codes) and grounded theory approach (inductive codes) to identify categories and derive themes. Potential interventions proposed are based on the inferences drawn by synthesising both the literature review and field research data.

[2] Delhi, Mumbai, Sindhudurg, Lucknow, Bhubaneswar, Ganjam, Kolkata, Jaipalguri, Chennai, Pudukottai, Imphal.

Validity

We used peer debriefing and member checking to enhance validity of the findings. Peer debriefing was conducted by discussing interpretations of the data with community experts on MSM. Member checking (respondent validation) was implemented by re engaging select KIs to discuss and clarify their interview data and reflect on emerging findings. Data source triangulation between participants and KI service providers increase the trustworthiness of the findings. Data was also further examined and refined during a data validation consultation meeting with field researchers held in Chennai in January 2011.

Sociodemographic characteristics of focus group participants (n=364)

The age of the participants ranged from 18 to 67 years (mean and median=30 years): <30 years (57%), between 30 and 40 years (27%), and > 40 years (16%). The self reported identities of the participants included *kothi* (68%), *DD/dupli* (17%), bisexual (10%), and *parikh/panthi* (5%). About one third (33%; n=119) have studied between the sixth and the tenth grades. A considerable proportion (23%; n=83) reported to have completed at least their graduation degree. Nearly half (46%; n=166) were married. Thirty participants self reported as being HIV positive.

C. DISCUSSION OF FINDINGS AND LITERATURE

Whilst MSM have been a priority for HIV prevention for over a decade, increasingly renewed international attention is being brought to the development of work with this key population. Among other factors, this renewed interest has arisen from recognition of the fact that even in areas of medium HIV prevalence, MSM have been found to be nine times more vulnerable to infection than the general population (*Baral et al.*, 2007). This is because such men are often, especially *structurally vulnerable* to HIV infection, because of issues related to violence and prejudice, as well as, particular *sexual risks* for HIV transmission associated with unprotected anal sex (*Chakrapani* et al., 2007).

Around the world, much HIV prevention to date has focused on the most identifiable MSM, often men with self identities based on same sex sexuality which is mostly prevalent in urban areas. Work aimed at MSM (based on male to male sexual *behaviour* and not identities) has been advanced-out of recognition that not all, but perhaps the majority of, MSM may not have a sense of identity related to same sex sexual practices. Nonetheless, the tendency has been to focus on specific cultural categories of MSM, often the most identifiable, that is, those with overtly feminine attributes and self identities. Thus, for example, in Asia, it has become common to see interventions and research projects that target the *waria* of Indonesia, the *kothi* of India and the *bong kin* of Vietnam (Boyce 2007, *Vu et al.*, 2008, Boellstorf 2008).

Whilst undoubtedly work of this kind has made significant inroads into HIV prevention with MSM, it has also tended to limit the field of practice, and has to some extent obscured the broader prevalence of male to male sexual practices in societies around the world; practices that are not necessarily labelled as male to male sexualities, but which are intrinsic to an understanding of broader HIV epidemiologies among MSM (and their female partners). Given this, the last few years have seen growing recognition of the need to reach MSM who are not well included in existing interventions and research (USAID 2010). UNAIDS has recently started estimating that globally "collective responses [in HIV prevention for MSM] are failing far more often than they are reaching scale or succeeding" (UNAIDS 2009). Similarly, the World Bank Group has stressed that:

> *[...] the sexual identity and sexual behaviour of MSM only slightly overlap. In fact, the large majority of MSM do not identify themselves as homosexuals, [...]the cost to society of maintaining the taboo of same-gender sexual practices, and marginalising people engaging same-gender sexual contact is very high (The World Bank Group 2004a: vi excerpted in Camarg and Mattos 2008).*

Against the background of these concerns, social change in India over the last decade has made MSM increasingly socially visible, especially in urban areas. In significant part these changes are attributable to the HIV prevention actions and activism that has raised awareness of the rights and needs of self identified MSM. The recent 'reading down'[3] of Section 377 of the Indian penal code has been significant within a shifting moral climate in India and has brought new visibility to specific MSM communities, most explicitly (but not exclusively) to the 'Gay' and 'Kothi' identified, who have been most evident in the campaigns for the repeal of section 377.

The politics of sexual identity associated with this movement belie a broader cultural scenario in India where much male to male sex is not associated with explicit identities and identification. Such sexualities are typically rendered invisible in political and health intervention strategies that focus on visible MSM, but research indicates, that more nuanced approaches, that take into account a broader range, and harder to define MSM is necessary, in order to take HIV prevention forward in India (Boyce and Khanna 2011, Khanna 2009, CREA 2006).

Ongoing prejudice remains a significant factor in inhibiting access to MSM for HIV prevention work. Prejudicial attitudes of families and friends, as well as, in people in relevant professions such as health, law and policing have profound effects on the lives of MSM, compounding social invisibility and sexual risk. Social prejudice not only compounds secrecy among many MSM making them hard-to-reach, it also affects sexual practices and risks. Men may have multiple sexual partners because there are no contexts within which sexual relationships with other men may be approved and sustained. This is not to concur with a viewpoint that judges multiple partnerships as a moral problem but it is to indicate the lack of choices many MSM experience in their personal lives. Moreover, in prejudicial social circumstances regarding same sex sexualities, many MSM may have low self-esteem and may not be concerned with sexual safety or risk.

Throughout the country, healthcare providers are often explicitly prejudiced toward men who openly admit having sex with other men and who seek services for related sexual health concerns (such as anal trauma of STIs) or psycho social support services. MSM (and transgendered people) are often explicitly excluded from health services, and remain unreached within many public and state health service environments (*Chakrapani* et al., 2007 & 2011). Even when MSM are explicitly referred to or included in (sexual) health and services, they are often required to identify themselves with sexual categories or labels for male to male sexuality, which can be especially off-putting for men who do not identify in such terms. This significantly reduces the numbers of MSM who are accessing TI services.

In 2001 during NACP II [...], the MSM population was not targeted. Organisations running TIs were not much aware about MSM practices and their social angle. Only after NACP III was rolled out, the MSM population was targeted [...]. What we generally see is that the visible MSM and those who are cross-dressers, hijras and transgenders – they are usually covered under the TIs. The general public has been almost ignorant about same sex orientations. To make the public aware and accept the existence of homosexual practice is thus a great challenge. TI partners are in need of training to handle issues around MSM. **(interview with an NGO staff member, Bhubaneswar)**

There are many friends of mine who are doctors and engineers. They have their separate partners. But they have secret sexual partners and are also not accepted by society. Now even though the law has made it legal for MSM to live with another MSM, the general people's views and perception haven't changed a bit. They still do not accept us. This makes us think that no relationship will last long and it wouldn't be possible to end up living together, as society will never accept us. This in turn serves as a reason to have multiple sexual partners. **(opinion expressed in an FGD with MSM, Bishnupur/Imphal)**

[3] Which means that Section-377 is no longer applicable against adult consensual same sex sexual practices.

When we speak to the government integrated con-selling and testing centre (ICTC) counsellor, they ask [the MSM] whether they are *kothis* or *DDs*. For this reason, MSM do not go (to ICTC or anti retroviral therapy for the reason. (ART). **(FGD with MSM, Chennai)**

Consultation with MSM and transgender (TG) communities and individuals is urgently needed across the health service sector, in HIV prevention work and otherwise. Sexual health and HIV prevention risk associated with anal sex unprotected by condoms rarely feature, if at all, in (sexual) health promotion work in India. Generalising and normalising discussion on such matters would play an important role in addressing male to male sexual risk, perhaps especially for those MSM who would not otherwise come into contact with MSM specific TIs or other outreach activities. One of the key issues that must be confronted in renewed efforts to target and reach MSM who have this far remained unreached in current TI strategies is the normalisation of male to male sex (and anal sex) within discussion in the public sphere, such that MSM who otherwise feel stigmatised in accessing health services or TIs may feel more comfortable in doing so. Some of the key barriers in reaching hard-to-reach MSM are summarised in the following table:

Table 1. Barriers in reaching hard-to-reach/unreached MSM

Individual-level barriers	Programmatic-level barriers	Systemic-level barriers	Structural-level barriers
Fear of disclosure of sexuality Unwillingness to interact/mingle with *kothi* outreach staff Not perceiving the need to get HIV services No sense of self identification as MSM	Limitations in TIs – targeting most visible MSM at physical cruising sites Limited involvement of MSM from diverse sub groups other than *kothis* Limited acknowledgment of the needs of other 'sub-groups' of MSM	Negative attitude of healthcare providers Limited understanding about same sex behaviour and sexualities in public and state health sectors Need for further training of counsellors (e.g. in issues around sexuality and well being, especially as related to hard-to-reach MSM)	Homophobia (and phobia toward feminine men) Lack of awareness, acknowledgement or recognition of same sex sexualities

Overall, the development of MSM specific interventions required building upon the achievements of previous NACPs (especially NACP-III) whilst also appraising and acting on the limitations of HIV prevention interventions for MSM to date. There is a pressing need to actively include a broader population of MSM within existing TIs and to adapt policy and practice in order to achieve this objective. There is also a need to normalise issues around male to male sexuality in health work and within the broader public sphere to better create a stronger enabling environment within which to reach the many MSM who remain unreached by TIs to-date. The remainder of this briefing takes up these concerns with respect to each of the key recommendations summarised above.

1 The expansion and development of targeted interventions, target populations and models

A striking finding of the present research is that many respondents felt that models of outreach work that tend to predominantly employ *kothis* as peer educators and ORWs actively exclude many MSM making them hard-to-reach. This view was expressed by many *kothi* ORWs themselves who felt concerned that they are not able to work effectively with all MSM because some men do not socialise with them and don't want to partake in HIV prevention activities delivered by *kothis*.

Work with *kothis* as ORWs has been a central and specific focus for NACP-III and has made an important contribution to the development of HIV prevention work with many MSM. In recommending the development of work beyond employment of *kothis* as the predominant work of ORWs in TIs, we do not want to suggest that work of this kind should be abandoned. Continued investment in HIV prevention work with and for *kothis* (and their sexual partners) is required as an important mainstay of TIs for MSM (and an area of important synergy with new TI strategies targeting TGs).

However, as TIs for MSM have evolved and developed over the last four years of NACP-III, issues around the scope and reach of outreach approaches have become increasingly tangible for ORWs themselves. Research shows strongly that one group who are often excluded are *gay* men and MSM from upper classes. Anecdotal evidence from research participants indicates a lack of HIV and safer sex awareness within *gay* social contexts mostly, but not only, associated with larger cities such as Delhi and Mumbai.

One argument put forward is that *gay* and upper class MSM are likely to be better educated and hence more aware of HIV and sexual risk than people from other social backgrounds. Whilst such men may be better educated than some of the 'lower class men' who have been more typically targeted by TIs, it is important to recognise that education and knowledge have rarely acted as a strong indicator for HIV awareness and self-efficacy in safer sex. Behaviour risk practices occur across all social strata, education levels and contexts. Indeed, many countries are witnessing a rise in HIV infection among *gay* identified men, despite high levels of HIV awareness. Indeed, a number of participants in the present study strongly expressed the view that many *gay* identified men in India have never developed a strong awareness of HIV, and may feel disassociated from the HIV and AIDS epidemic. This may be a consequence of the prevalence of HIV prevention activities concentrated among *kothis*, *panthis* and other typically lower class MSM. The absence of *gay* identified informants in the present research is indicative of the fact that such men are typically not a part of HIV prevention activities in the 11 sites covered in this study. One possibility is to reach out to *gay* identified MSM

We have seen a number of times that if a person is recognisable as an MSM, then a straight looking MSM wishes to avoid him or will not want to chat with him. **(interview with an ORW, Delhi)**

We reach out to *kothis*. Those who hide themselves, need a lot of time to open up they do not want to call themselves MSM, **(interview with an ORW, Lucknow).**

Gay people are high class people. They do not want to say openly that they are homosexual. NGO and CBO services do not reach them at all.

We are not able to get *DDs* [into HIV programmes]. We cannot identify them. *DDs* do not disclose their identity like *kothis*. Approaching them is very difficult. **(opinions from and FGDs with ORWs, Chennai)**

"[NGO/CBOs] have limited their focus with kothi, dupli, and hijras. We are not focusing on *parikhs*. NACO also ask us to focus only on receptive MSM. However, *parikhs* never admit to engaging in receptive roles. **(opinion from an FGD with ORWs, Jaipalguri)**

College students who had homosexual contacts, were there but they didn't want to come out. **(KI interview, Pudukottai)**

Only a very few people who migrated from rural to metropolitan cities might be using the internet. Otherwise, most people here [a small town in a rural district] do not cruise over the internet. People here have a low literacy rate. It is difficult to see even the general population using internet **(the KII, Pudukottai)**

through existing *gay* networks (primarily e-group-based, who may also organise social events for *gay* men). However, given the apparent disinterest of key gate keepers in talking about HIV issues, developing work with *gay* identified peers will require investment of time and resources in order to create suitable dialogues and approaches. The potential for this approach is likely to be higher in some settings/cities as compared to others, and possible sites ought to be explored.[4]

Other than *gay* men, another 'group' of men who to date have remained especially unreached in TIs for MSM are those who do not identify with a sense of same sex sexuality. This is an especially difficult to reach population via MSM specific outreach strategies but as noted, such men are likely to constitute a significant majority of MSM. "Non self identified MSM"[5] (referring to those MSM who do not self identify in terms of their same sex or bisexual behaviour) are a diverse, and in many ways, not specifically identifiable population. Such men are sometimes differently categorised under the labels *DD*, *panthi* or *parikh* in TI work, but it is important to note that such terms rarely constitute self identities, and may not be especially strong categories for promoting the inclusion of MSM within TIs. Also, whilst so called *panthis* or other non self identified MSM may constitute an important component of the sexual network of *kothis*, they do not necessarily feature in common *social* networks, and may actively disassociate from these. As such, specific social network approaches are required in order to reach non identified MSM.

And when one comes to the TI clinic one is asked so many detailed questions that one who doesn't identify as MSM feels uncomfortable. When one goes outside to a civil hospital he is not asked so many questions. But at a civil hospital in order to escape stigma one hides one's MSM behaviour. (opinions from an FGD, Mumbai)

The pressing need to target such MSM points to broader issues regarding the need to generalise health promotion messages specific to male to male and anal sex within a range of health promotion contexts, and not only to those associated with the MSM TIs. Generalising relevant health promotion messages in this way means that non identified MSM are likely to encounter knowledge about male to male safer sex and sexual risks, even without accessing MSM specific services.

It is also important to include 'older MSM' in intervention strategies including men who may or may not self identify as MSM. It was notable that many research participants were aware of the 'young orientation' of TIs and drop in centres (DICs), with far more contact during outreach work with men in their 20s, over and above other age groups. The circumstances and needs of MSM over this age group are typically not well addressed in current TI strategies. It may also be that 'older MSM' are those more likely to have become heterosexually married, and consequently, to have moved away

[4] Fieldwork data and also from: Shahani, P. (2008). Gay Bombay: Globalization, love and (be)longing in contemporary India. New Delhi: Sage.

[5] Not to be confused with the English expression commonly used among NGO/CBO staff in India – 'identifying MSM' – which refers to the need to reach (thus 'identify') MSM through TIs.

from socialising in MSM specific contexts, at least in as open a way as is associated with younger MSM.

In addition, a number of respondents also stressed the need to develop services for MSM of the school going and college going age group. Older members of this age group may access to MSM TIs, but many do not. Boys and men of college age are often sexually active with other boys and men and yet, they are unlikely to have been exposed to relevant sexual health promotion and HIV prevention information, given the general absence of such information beyond the environment of MSM specific TIs. Including education of same sex sexualities and health within generic sexual health education is an important strategy in such contexts.

Data from the present research indicates that MSM outside of urban centres may have specific needs and vulnerabilities, especially pertaining to the enhanced risks of exposure in small town and village environments. In research sites such as Sindhudurg, Ganjam, Jaipalguri and Puddukottai, it was not that MSM may have been less exposed to discourses or terms that designate male to male sex as a form of sex or sexuality (as compared to MSM in urban areas) but that they are unlikely to identify as 'MSM' and may not even have a language for expressing the idea of sex between men. It was also noted that people in such areas are less likely to access the internet as compared to urban populations, again indicating that exposure to information regarding male to male sexuality, HIV and sexual risk is likely to be limited. Outreach work with MSM in rural areas can be especially time consuming since ORWs (who are typically based in regional towns) need to travel to many areas to make and develop contacts with MSM in outlying smaller towns and villages. Considerable investment in time may be required by ORWs to build up networks and contacts with MSM in rural areas.[6] Further research is required in suburban and rural areas of India in order to better understand the relevant needs and vulnerabilities in this context and we recommend consultative studies of this kind as an early stage component to NACP-IV. Previous research has indicated significant rates of unprotected sex among MSM (and with their female partners) in both urban and rural India, whilst in general, there is a need for improved discussion about sexuality, sexual diversity, HIV and health in rural areas (*Dandona et al.,* 2005, *Rompay et al.,* 2008, Verma & Collumbien, 2004).

Finally, it is also important to note that MSM can also be hard-to-reach because the counselling services on offer in TIs and health services may not adequately address their needs. In both TIs and sexual health clinics counselling can often be oriented toward sexual histories and HIV testing,

[6] Issues pertaining to work with MSM in small towns and rural areas was explored in recent ethnographic research carried out in North West Bengal. Findings complement those of the present research, especially those regarding non self-identification among MSM and the complexities of outreach work when great distances need to be travelled (Boyce forthcoming).

and as noted, MSM are often asked to identify with a label or category. Whilst these may be important strategies in ascertaining knowledge of same sex sexual behaviour, such approaches may be especially alienating for men who are reluctant to disclose or who do not self identify as MSM. In other health services, such as ICTCs or ART centres, same sex sexual behaviours in sexual history taking – has again lead to non identification of those MSM who require appropriate risk reduction counselling.

More strongly conceptualised and developed approaches to counselling are required that will be sensitive to the needs of hard-to-reach MSM and will offer them ongoing psycho social support. This will not only help with reaching more MSM through counselling support services but also retaining contact with such men, as they are offered services more relevant to their needs.

Table 2. Strategies to reach 'Hard-to-Reach' MSM[7]

Subgroups of hard-to-reach MSM	Barriers to reach	**Potential strategies to reach** *(to provide information/counselling and link with services)*
Gay or bi-sexual identified MSM	• Do not visit current hot-spots of TIs • Socio-economic class differences between current TI ORWs • Do not want to be seen talking to *kothi* identified/feminine persons in public places or even allow *kothi* ORWs from TIs in *gay* parties or other *gay* specific venues • Do not want to visit DICs located within CBOs/NGOs which are seen as predominantly *kothi* oriented	• Sensitise the *gay* specific local groups (e-groups) or other social groups on the importance of HIV interventions for *gay* identified men and get their support. *Gay* peer ORWs can be identified with the help of these local *gay* groups • Employ *gay* identified ORW acceptable to the *gay* community depending on the settings (e.g., urban areas) who will then access *gay* specific venues (parties, bars, etc.)
Married MSM	• Community stigma (kothi/*gay*) related to married status • Fear of disclosure of sexuality to wives and its negative consequences	• Create conducive environment for married MSM in TIs by addressing community stigma around married status of self identified MSM • Anonymous referral and FU services (phone/internet) for married MSM who do not want to come to TI sites/DICs
Self identified MSM who do not visit DICs/TIs and cruising sites	Want to receive anonymous services	• Help line based service referrals/ follow-up • Internet based interventions

[7] For definition and explanation of 'Hard-to-Reach MSM' please refer to *Glossary*.

'Older' MSM (> 50 years of age)	Not prioritised by HIV agencies especially in HIV agencies where mostly young MSM ORWs are employed	• Need to educate TI staff about the importance of reaching out to older MSM
Same sex attracted legal minors (below 18 years of age)	Legal barrier to provide services in the current TIs	Sensitise the existing youth/ adolescent friendly clinics on the issues of same sex attracted legal minors and establish linkages with those government or non-governmental agencies. There is a need to develop guidelines to address this issue (i.e., being a legal minor as an access barrier)
Non-self identified MSM	Not coming to cruising sites and TI projects; and not even using MSM specific internet sites	• Integrate messages/counselling in existing HIV interventions for men (migrants, college youth, drug users, prisoners, truck drivers, etc.) • Mainstream mass media campaigns on HIV: generic messages on safer sex with partners of any gender. • Strengthen the capacity of healthcare providers to sensitively ask same sex sexual history among men who come to government healthcare settings sexually transmitted infection (STI) clinics, ICTCs, ART centres, etc.)

2 Development and refinement of monitoring and evaluation and target quota systems

Respondents in the present research stressed very strongly that models of target oriented monitoring of outreach work currently used in TIs for key populations (KP) (including MSM) tend to lead to the exclusion of hard-to-reach MSM. Peer ORWs commonly feel a strong pressure to perform in their work and to meet and demonstrate expected work deadlines and target quotas for contacting MSM 'in the field.' These monitoring and evaluation strategies have been important in ensuring that a good numbers of men are contacted during outreach activities during previous NACPs and within the development of HIV prevention with MSM more widely.

This same strategy, however, has certain draw backs. Some respondents felt that targets could be most easily met by contacting the most visible MSM, leaving other, harder-to-reach men excluded. Peers and ORWs spoken with during the present

At the policy level, a target-driven approach makes ORWs not concentrate on other MSM population – they are just preoccupied with completion of targets. **(opinion from an FGD with ORWs, Mumbai)**

In NACP-III, it has been laid out that one peer educator can be in charge of a maximum of 60 high risk group (HRG) individuals. However, there remains a large group outside and we hardly have any mechanism to reach out to them. It must be understood that we function under several obstacles. We basically write in 21 different formats. All of these are dependent on the fundamental format prepared by the peer educators. **(KII, Kolkata)**

Another problem with line-listing is that, say I make a group of 60 *kothis* and start a project. In a middle of the year, one of them leaves and goes somewhere else, where there is another similar group working with another 60 members. But the migrant individual cannot be enlisted there as there is no room. He has to wait for months or years to be included in the group of sixty. **(opinion from an FGD with ORWs, Kolkata)**

research, however, stressed strongly that it is not simply that they more readily meet quota targets by privileging contact with visible MSM, but rather that the demands to meet quotas actively discourage them from taking the time they need to develop contacts with harder-to-reach men. This is especially so because the work load undertaken by peers and ORWs can be especially onerous. A number of respondents indicated that the many registers and M&E formats that they are required to complete for each outreach session and field work contact are particularly time consuming. Many were concerned that they often spend more time completing M&E registers than undertaking outreach work.

Moreover, many peer ORWs do not necessarily feel secure in their TI jobs. They expressed that they felt a strong pressure to perform and meet targets, but in some ways, these targets inhibit their work, because taking time to seek out and develop contacts with hard-to-reach MSM is most often not viable. This is especially so given that many such MSM do not self identify as MSM and would probably not access MSM TIs or DICs and could not be meaningfully marked in current M&E formats as an outreach contact from among the MSM population. Developing contact with such MSM in outreach work is not readily compatible with meeting target quotas for contacting MSM.

This common interpretation of the limitations imposed by M&E and 'line listing'[8] systems may not be intended at the policy and programme development level. Indeed, NACO staff members spoken with during the present research stressed that M&E and target quota systems should not be interpreted in such a stringent manner. Nonetheless, it was striking that many ORWs felt that M&E systems were a significant problem, especially as regards the exclusion of hard-to-reach MSM. Programmatic attention to this systemic problem through new M&E formats may thus have a high potential to improve access to hard-to reach MSM via TIs better enabling ORWs to meet the targets and objectives of their work. Overall, the present research points strongly to the need to have new approaches within TIs that will enable ORWs to better develop relationships with hard to reach MSM over time, and in a manner that does not emphasise M&E and target quotas so strongly over working with the most visible MSM.

[8] Referring to registering the personal details of the MSM outreached in an attempt to improve accuracy in coverage information. Some MSM do not want to give their personal information and get registered.

3 Development of outreach and TI services via communication technologies such as the mobile phone and the internet

An area for development that was also especially stressed by a number of respondents was the development of outreach work via the internet and mobile phones. Around the world, chat rooms and other MSM and *gay* oriented sites are increasingly prevalent and popular ways for men to meet male sexual partners and to build up social networks with other MSM (*Ybarra et al., 2007*). Whilst in India the demographic profile of MSM internet users may be more toward the middle and upper classes, and to some extent those who are English speaking, the social scope of internet usage is growing considerably in urban and suburban areas. Just as outreach work in cruising sites such as parks, toilets and street corners is a model of health promotion premised on meeting MSM where they socialise and meet sexual partners, so too the internet now presents an important social milieu where outreach work must increasingly take place by meeting MSM in their social contexts.

I would like to say that India is now an internet user country and that our community [of MSM] is also using the internet. So today, through the internet we can approach everyone, especially those who are hard-to-reach. We can contact them through emails and chatting, and give them information.

I also believe so because I myself am an internet user and I talked to fifty to a hundred people on the net. A number of people shared their problems with me and also their feelings. We can develop a room on the yahoo sex rooms where people can elaborate while talking or chatting on the net. There will be privacy and nobody can see them. There they are free and we can ask any questions. **(opinions from an FGD with ORWs, Delhi)**

Cruising in hotspots is decreasing day by day. A lot of technologies have been developed. MSM use chat rooms and mobile contacts to get partners. **(KII, Chennai)**

There are a number of models for MSM outreach work via the internet. One model is for ORWs to join chat rooms for MSM, either specifically in their region or nationwide, and to explicitly invite conversations of questions concerning HIV and safer sex. Such discussions can take place in general chat rooms or in private one-to-one chat windows. The aim is to encourage and normalise conversation about safer sex among MSM. Referrals can also be made to other online resources (where people can pick up additional safer sex information) and also to DICs and other local services. A key aspect of this model is for ORWs to be explicit online about their role, just as they are explicit about their role as health educators when working in cruising spots. Internet-based outreach work presents specific advantages in reaching hard-to-reach MSM, some of whom may be more inclined to make contacts with other MSM online. Similarly, people may feel more open to discussing issues regarding same sex sexuality and safer sex via online media, where anonymity is more possible as compared to face to face outreach interactions.[9] It is notable that in the present study, respondents indicated that some ORWs, were already using the internet as an outreach medium (reported for example

[9] See for example Weldon J.N. (2003) for a discussion of how internet outreach with MSM can be specifically used to normalise discussion of HIV and safer sex, using ORWs trained in online outreach skills. E.L. Roland (2006) has reported on internet outreach with MSM in the USA as a means to address social isolation and associated sexual risk practices (sometimes in cases of low self esteem). Work in this setting also focused on encouraging HIV testing on-line, through referral to appropriate clinics. Research in China (W. Quang 2004) has indicated differences between MSM who use chat rooms as compared to those who use email as a means of online contact (through sex and dating web sites). The latter were found to be typically more isolated and were less inclined to practice safer sex. This acts as a reminder that there are different kinds of on-line fora for MSM, and further exploration of these contexts is required in India. See also Zhang *et al.,* 2007, who found significant high risk sexual practices among MSM using the internet in China.

in Bhubaneswar, Delhi and Mumbai). Field researchers strongly advocated the development of the internet as an outreach medium, as to some extent, it is a practice that is already emerging, given the changing social context of male to male sexual lives.

Table 3. Potential spaces for providing interventions to various sub-groups of MSM – especially to those who are currently harder to reach

Nature of space	Physical spaces	Virtual spaces
Public	*(Traditional)* • Hot spots (cruising sites) • DICs in NGOs/CBOs • Work places (through existing workplace HIV interventions)	• Internet: dating sites; adult sites • Mass media (especially for non-self identified MSM)
Private	*Examples:* • *Gay* specific venues (e.g., socialising parties) • *Gay* specific bars	Mobile phone networks e-groups: e.g., *gay* specific socialising e-groups

(Note: Ethical issues need to be clearly thought-through, especially if interventions are considered in private spaces - physical or virtual)

Recent research on mobile phone use among MSM in India has indicated a close synergy between a need for discretion in making sexual contacts, coupled with a desire to be seen:

> *The mobile phone is a key figure in a tension between display and anonymity. Kothis talk about watching each other (and phones in particular) to assess the extent of competition for a pool of panthis. This results in a curious paradox. On the one hand, there is a desire to be seen and noticed by other kothis and panthis but at the same time, kothis spend a considerable amount of energy being un seen and having to hide part of their identities away from the gaze of family and society (Ganesh 2010. 16).*

Mobile phones act both as a means by which to meet partners and other MSM secretively and also to convey social status and sexual desirability. ORWs interviewed in the present research stressed that they have many contact numbers for MSM on their phones, often a number larger than they could actually meet in person in physical cruising sites. Indeed, mobile phone networks have become a cruising milieu for many MSM. To some extent, this may be especially so in the case of hard-to-reach and non self identified MSM who may have enhanced desires of maintaining privacy.

Moreover, mobile phones are an important attribute of social mobility in India, disrupting barriers between private and public space and facilitating new forms of social connection and relatedness between people by offering them a new scope for social and sexual relationships. For people of marginalised and stigmatised sexualities such as MSM, mobile phones are playing a vital role, in expanding their sexual networks whilst maintaining their social invisibility. The need to reach out to MSM via mobile phone networks is increasingly vital in this context, in order to address the potentially expanding contexts of sexual risk that is taking shape beyond the established parameters and sites of hot spot based cruising areas. At the same time, mobile phone based outreach present specific ethical and practical challenges in respecting the anonymity of MSM.

There are some MSM who are not reached. These are men who do not reveal their identity as MSM or say that they belong to this group. There may be still more networks that we have not been able to touch. Then there are also MSM who are a part of the virtual network, who find partners by using the internet or cell phones. We have no means of reaching them as of now. They are what I feel a kind of invisible MSM. **(KII, Mumbai)**

Now we can see the mobile phone revolution. People prefer mobile contacts to cruising spots. MSM comfortably decide the place and the time over phone and meet in person. **(interview with ORW, Chennai)**

D. RECOMMENDATIONS

Key recommendations arising out of the present research with reference to the three key action areas put forward in this briefing:

The expansion and development of TI target populations and models

- Non self identified MSM need to be explicitly targeted during NACP-IV. This requires a synergy between actions that may be undertaken in the context of TIs (by ORWs) and an expansion of MSM-oriented HIV prevention activities across a broader range of sites, to include places that are not specially associated with male to male sex (such as hot spots). The aim should be to enhance opportunities to reach non identified MSM, who would not otherwise attend DICs or become involved in social support networks of TIs for MSM. Such sites might include work places, general medical settings, colleagues, and schools. Actions ought to include the inclusion of education on male to male sexual health and anal sex within sexual health work in such places and production of posters and sexual health materials to be distributed in such contexts.

  We recognise the sensitiveness that may be involved in such work. To reach out successfully beyond the established catchment population of existing MSM TIs must entail a planned expansion of relevant HIV prevention and health education into new environments. We recommend specific research and consultation with existing ORWs or how to advance such work within NACP-IV. This work might also entail close synergies with parallel efforts, to improve contact with and services for women partners of MSM across a diverse range of non MSM specific environments (see the briefing paper on this subject area).

- Each TI needs to be supported in specific efforts to recruit and train at least one and preferably more peers from among the *gay* community. The recruitment process should not be undertaken via *kothi* identified ORWs, but by other workers, with a distinct emphasis on meeting potential *gay* peers in environments where they feel comfortable (initially, for example, *gay* peer ORWs should not be required to attend DICs, if such spaces are felt to be alienating, because they are overtly identified with *kothis*). This strategy ought to be initially piloted in approximately six TI sites, where the largest *gay* communities are present and they ought to be monitored and evaluated, so as to develop a model of this work that may be rolled out more extensively.

- Health promotion activities targeting *gay* identified men, in *gay* venues, are also required, including the development of well designed information, education, communication (IEC) materials that will appeal to *gay* men.

- In the context of these issues, and the specific issues relating to 'Hard-to-Reach' MSM, an investment in improved understanding of the emotional issues faced by MSM is called for, especially in the contexts of the pressure and expectations to marry, pressures to identify as MSM in order to access services, and the general psychological well being of men who are attracted to and or have sex with other men in a social context that does not support such sexual orientation of practices.

  A significant investment is required in better understanding and responding to the varying life circumstances of such men in order to encourage MSM to take HIV and sexual risk seriously. To date, counselling approaches in TIs have been largely peer led or oriented around counselling for HIV testing. Whilst these activities are important, sustained and effective behaviour change communication (BCC) activities among MSM will require more nuanced and emotionally engaged counselling approaches, across all aspects of MSM HIV prevention programmes. We recommend both investment in research that seeks to better comprehend the social and psychological well being of MSM and the development of counselling training modules and practices based on such work.

Development and refinement of monitoring and evaluation and target systems

- NACO is currently developing new computerised M&E systems for use within TIs (Computerised Management Information system CMIS). We recommend that the development of these systems explicitly seeks to simplify and rationalise the workload of peer ORWs, such that, less time is spent on M&E work and more time can be taken in the field with time given over to developing contacts with hard to reach MSM.

- Consultation between NACO, SACS, TI managers and peer ORWs is needed to help to develop an improved understanding of target systems of outreach work. ORWs need reassurance that the time taken to reach harder-to-reach MSM will not result in penalisation if target quotas are not reached.

- At the same time, we recommend that target quotas are modified such that, successful outreach work is not overly valued in terms of numbers of MSM reached and categorised, but in terms of new and improved systems for measuring the value and depth of field contacts, thereby enhancing the focus on quality of services.

Development of outreach and TIs services via communication technologies such as the mobile phone and the internet

- ORWs require specific training in online and mobile phone based outreach skills. We recommend that eight sites are initially included in training and roll out of work of this kind within the first phase of NACP-IV. Selected

sites ought to include urban, suburban, and appropriate rural areas, so as to gain a representative sample for the analysis of efficacy.

- Internationally, till now there has been little analysis of the cost effectiveness of the internet and mobile phone based outreach work with MSM. We recommend that along with the first stages of the programme roll out, a specific cost effectiveness analysis of internet and mobile phone-based outreach is undertaken. This should analyse the number of MSM reached, the quality and effectiveness of contacts (in terms of HIV prevention and reported behaviour change), sustainability contacts and so forth, as related to expenditure over the course of two years of intervention.

- Consultation with experts in the field of work with MSM and mobile/ internet communication technologies as a means of developing a specific strategy that can be implemented with a number of TIs.[10] In addition it is important to remember that in any case, many ORWs have the experience of using the internet and mobile phones, as tools that are being started to be used in outreach work. ORWs have considerable insight into the relevant issues, and the potential for means of work. We would suggest that each TI begins by dedicated time for peer ORWs to work on chat sites, as specific and monitored field outreach activity, and to develop an appropriate system for documenting those virtual outreach activities.

Overall, there is much scope for the development of new HIV prevention strategies for hard-to-reach MSM within NACP-IV. The achievements in reaching out to MSM thus far, will build a strong foundation for further work with MSM who have been unreached by TIs to date. Lessons learned point the way to a range of actions that, taken together, can significantly improve the scope and reach of MSM interventions.

[10] People such as Maya Ganesh (IDS, University of Sussex, UK) and Anupama Roy (University of Nottingham, UK) are among people to have recently completed studies exploring the potential of mobile phones as sites for outreach activities with MSM in India, as well as others who are also working in this field.

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