Redefining Vulnerabilities: A Study of Men Having Sex with Men in the Wake of HIV Epidemic in Mumbai, India

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Introduction

India has a high HIV burden. Studies have shown that the certain segments of population such as adolescents and youths, and those belonging to disadvantaged sections, migrants, pavement dwellers, out of school, and certain fragments such as street children, younger sex workers, slum dwelling males and females, and those working in the informal sector are more vulnerable to the risk of catching the HIV/AIDS virus. This is because they are more susceptible to unsafe sexual practices and intravenous drug use (IDU) due to ignorance and marginality. Therefore researchers and action groups are trying to understand the sexual and other practices of this segment of population and devise appropriate communication and intervention programmes (UNAIDS, 2004). They are making efforts to identify the most vulnerable groups, and design suitable and effective strategies for each. So far, little attention has been paid to the process of transmission of the virus from the high-risk groups to general population. However, in case of HIV, the high risk groups are not separated from the general population and the virus is spreading from the former to the latter, making the problem very grave. In this context, there is a definite need to understand how the virus is spreading from the high risk groups to general population. For example, married truckers have sexual relationship with sex workers as well as their wives. Males having sex with males MSM have sexual relationship with wives. Many married and unmarried migrants going to sex workers have sexual relationship with unmarried and married neighbours, relatives, as well as their wives when they return home (Baskar, 2004). The issues are: when and how does the infection transmits from the high-risk group to the general population and vice versa. This paper makes an attempt to understand how HIV passes from the high-risk group of (MSM) to others, and demands the need for redefining vulnerabilities in the wake of HIV in India. MSM as a high risk group are of special importance due to high rate of HIV/AIDS among them and their contact with the general population.

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Objectives

As said above, this study explores how HIV spreads from the high risk group of MSM to the general population. Thus the main objectives of the study are as follows:

1. To explore the general socio-economic characteristics of MSM;
2. To unearth the process of entry into MSM activity;
3. To examine the sexual practices among MSM;
4. To examine their knowledge of HIV/AIDS and ways of preventing it; and
5. To identify groups from the general population to which HIV is transmitted from MSM and suggest ways of preventing the spread of the virus.

Identifying MSM

MSM is a general term to encompass wide range of different sexual orientations and not a term to refer to homosexuals alone. There are several questions regarding MSM: Is 'MSM' behavior freely chosen? Does the process of socialization makes them homosexual or some other factors are responsible? Is their behavior influenced more by genetic factors or by socio-psychological processes? It may be noted that 'MSM' activities in India are not restricted to any one place. Indian intelligence bureau had identified seven different cities across India where these activities are rampant (Times of India, 18th, July1998). In Indian culture sex between men and men is tabooed and thus a stigma is attached with the act, making it difficult to reach MSM. As a result of this there is very little epidemiological information regarding HIV transmission from male to male (UNAIDS, 2000). The two major subgroups coming under the umbrella of MSM are '*hijra*' and self- identified '*gay/kothi/panthi/do-partha/bisexuals*'. There is a difference between '*hijras*' and self identified gays. Phenomenologically Hijras never identify themselves with MSM group. According to them they are not involved in MSM activities. They pointed towards males behaving as females who are regarded as beggars by the people. They were of the opinion that due to this MSM community their existence will soon come to an end.

In India marriage is universal. Many MSM are married or will have to marry for just fulfilling their societal, cultural and religious necessity. Many of them have to prove their masculinity by procreating children. Moreover, many of the MSM like to have sex with a female also (Aamirkhanin et.al., 2000; UNAIDS, 2000). Observations show that bisexuality is common to MSM. It is worthwhile to mention that there are different categories among homosexuals like *'Panthi'* (active), *'Kothi'* (passive), *'Do –Partha'* (active and passive). It is very difficult to differentiate between *'Panthi'* and *'Do Parthas'* where as, *'Kothi'* can be identified from their appearance.

Data and Study Design

This study was carried out in December 2003 at Mumbai. The basic data used for this study have been collected from different parts of Mumbai through a suitably developed research design with a combination of qualitative as well as quantitative research tools. In order to select the study sites, five key informant interviews were conducted at the primary stage for understanding the life style, networking, and cruising places of the MSM in the different parts of Mumbai. It is needless to mention that the selection of key informants was based on their experience of working with such communities. Subsequently, some of the leading NGOs who are working with MSM communities in Mumbai were utilized as windows to enter in the MSM communities located in different parts of Mumbai. With the help of community workers of those NGOs, all the prominent sites were identified and a location map was developed. Selection of the sites was based on the magnitude of the MSM activities on different sites included in the location map .A total of ten sites were selected for study in order to facilitate comprehensive data collection. Subsequently, a structured questionnaire was canvassed among twenty MSM engaged in MSM activities from each of the sites following quota-sampling procedure. Of course, the process of selecting the individual for the study was a complex process evolving tremendous amount of stigma. As a result, different networks of MSM were approached with the help of community workers and one-two persons from each such network were interviewed so that the quota of twenty interviews could be completed from each of the sites. It is worthwhile to mention that the existing procedure may not statistically represent the entire MSM population in the Mumbai but definitely ensured a wider heterogeneity in the coverage. In order to facilitate the data collection process, a former community worker of one of the NGOs working among MSM in Mumbai was appointed as research investigator for one month who worked with the researcher in all the ten sites. Of course, the targeted sample size was two hundred but due to a number of operational constraints only one hundred and sixty interviews were completed within a specified time period.

In addition, 10 in-depth interviews were conducted among those who suffered from any type of STD symptoms in the last three months with an in-depth interview guide covering various issues and concerns relevant with the study objectives. The criterion of selection of MSM for the in-depth interview was their extent of enthusiasms during the interaction at the time of survey and willingness to participate in further discussions. Further a comprehensive insight into problems and prospects of sexual risk reduction among MSM was gained by interacting with a selected group of stakeholders such as officers of Maharastra State AIDS control Society (MSACS), Mumbai District AIDS control society (MDACS), NGO personals and police personnel, with an interview guide. These stakeholders' interviews also provided the researcher an opportunity to understand the nature of support system required for the MSM in Mumbai.

Care was taken to ensure that no questions were remaining unanswered. The interviews were conducted in Hindi and English both. In order to maintain data collection and error check, questionnaire were checked every day and edited. The data was analyzed using Statistical Package for Social Sciences (SPSS).

Major Findings of the Study

The major findings of the study are given under the heads of socio-demographic characteristics of MSM, process of entry into MSM practices, sexual behavior of MSM, knowledge of risks and safe sex practices among MSM; and the ways of transmission of HIV from MSM to general population.

Socio-Demographic Characteristics of MSM

Table 1 provides a clue that the MSM activities are not only restricted to unmarried youths or adolescents but also among married who often experiment unsafe sex with their wives. In many of the cases wives are not aware of their sexual orientation. The qualitative enquiry shows that due to social stigma and fear of isolation from both family and society had driven MSM to adopt a dual role in their everyday life. This duality of maintaining two sexual identities makes them to suffer from self-conflict within oneself. This self-conflict not only provides them an opportunity to indulge in risk taking behaviors but also creates mental hazards for them. This mutual exclusivity of two worlds –homosexuals and others further barred them from coming out of the cocoon of their own network. Revelation of identity in some cases built up guilty feelings among other members of family too. Consequently, all MSM felt more free and comfortable in their own known world rather than the outside world of heterosexuals.
Being the eldest member of family and holding family responsibilities provide a relaxing situation for them, because their family members are not worried about their sexual orientation, even though sexual orientation is known to them. It is clearly emerging that, as in general human life, families are having some expectations from their son and if he is performing his roles / duties perfectly then family members are less bothered about the sexual orientation. This is simply the law of economics of demand and supply. Here, one can understand the families are having a very utilitarian approach, and the kind of exchange that is taking place shows the individualistic/ materialistic nature of the world. One can see the kind of changes coming up in the primary institutions of the society where the family ties are restricted only up to means and ends.

Majority of the respondents are currently engaged in some work from which they earn some money. From the qualitative enquiry, the possibilities of being indulged in sex work cannot be ruled out because they don't want to being labeled as sex workers (Table 2). Most of the respondents (49 percent) are working in private sector. As per their migratory status is

concerned, majority (65 per cent) are born and brought up in Mumbai while remaining are migrants mainly from Bihar, Uttar Pradesh and Tamil Nadu. It was found that half of the respondents are used to consume alcohol regularly/sometimes.

Process of Entry into the World of MSM

First sexual encounter has a deep-rooted and long lasting impact on the orientation of a person, which later gets transformed into his behavior. The quantitative exploration of the study reveals that the majority of the respondents (61 per cent) performed the first sexual activity with a male. The remaining 39 per cent had it with a female partner (Table 3).

Interestingly, 70.4 percent of all those engaged in the sexual encounter first time with male suffered no guilt because they had indulged in it willingly (Table 4).

It is often believed that in India socialization into sex occurs with in family or among the close friends and relatives. This study shows that sexual encounter with male occurred at comparatively younger ages than with female (Table 5) and the majority of respondents experienced their first sex with male with a friend or neighbor (Table 6). At the same time, almost one third of the entire respondent, who reported their sexual debut with a male partner, reported that the partner was either a close relative or a family member. Thus, one finds that environment; surroundings and relationships play a vital role in shaping sexual orientation of persons particularly during adolescent stage of life.

Further, the qualitative exploration leads to the understanding that the foundations of 'MSM' orientations were laid during their early stages of development. It was learnt that most of them had their first sexual experience with another person of the same sex between their childhood and adolescence, with a man older to him who was in some way close to him. As one of our respondents aged 34 described:

> *"…My neighbour, a 24-year-old guy next door used to take me with him to his house when no body was there. We used to enjoy a lot. I was eight then…"*

In words of another respondent:

> *"…He was my tuition teacher. I was only seven and was in class two. One day he removed my pants and caressed my penis. I did not resist…"*

For many, it was their first ever-sexual experience, which left lasting impressions on them and shaped their sexual orientation/preferences. One of our respondents reported:

> *"…In my school days we had two paying guests (men) at our residence. I used to enjoy secretly watching them doing 'that'. Once they caught me peeping and invited me in. It was exciting. Later on, it became regular till they left…"*

The exploratory nature of the tender age and the excitement from a totally new experience, whether coerced or friendly, moulded the youngster's urge for sexual gratification with the same sex. Negligence of parents coupled with the encouragement/exploitation by those who lured them, though mostly goaded by their own sexual needs, acted as a factor in shaping the boy's sexual preferences. Peers were sources of information to 'MSM' behavior for many. Gradually they established intimate relationship with a person from the same sex. Some preferred to be *'Kothi'*, some '*Panthi'* and some others both (*Do-partha*).

Further, MSM managed to find other people with similar interests and thus established their own networks. From their experience they identified another MSM simply picking up from the cues and body language at potential cruising points. They even go for trial and error methods by rubbing their erection on another's body. Some preferred to satisfy themselves within the limited network while some others preferred to have sex with strangers rather than establishing their own network since they did not want to maintain their identity as 'MSM'. One of our respondents put it:

> *"…Whenever I feel the urge, I go to a particular railway station far from my residence and try to find out my sexual partner and have it…"*

Even those who had networks ventured for strangers since it was pleasurable and also fetch them money and at times friends/lovers were not available. One of the respondents casually put it as follows:

> *"…Lakshmi bhi aajati hay to kya dikkat hai (Obviously it is pleasurable for me, and what's wrong if I get some money also)?..."*

With a stranger, the MSM, whether received or provided sex, tried not to maintain any emotional attachment and simply adhered to the 'business'. The urban anonymity in a way was bliss for MSM in Mumbai as it was easier to find someone from the crowd / rush which seldom interfered in others' matters. The adult stereotype in the Indian socio-cultural context demanded individuals to conceal their MSM identity and hence most MSM had to conform to the social norms by yielding to an arranged marriage with a woman while he continued his MSM activities in camera. In fact a fair proportion of MSM were bisexual and they had sexual relationships with women now and then. As a man 32 reported:

> *"…I am married with two kids, but I always look out for males to have sex with them. My wife does not know about this at all…"*

The above discussion provide comprehensive insight to understand the context of the MSM activities, where environments and surroundings has been reported to contribute significantly in formation of values, norms and practices relating to sex and sexuality.

Sexual Behavior

From the table-7 it is clearly coming out that the majority of the respondents are *'Kothis'*, and *'bisexuals*' are relatively lesser in numbers. It does not mean that bisexuality is not common among the MSM. From the qualitative enquiry it has come out that all these identities are temporal and intermingled with each other. Because of the fluidity of the identities certainty of fixed identity cannot be assured. By looking at the pattern of sexual debut among the respondents by their categories based on self-identification it is found that majority of the *'Kothis'* (passive) have a dominant male as initial sex partner (80 per cent). By looking at the social constructionist approach all these identities are shaped through the process of socialization. It has emerged from the analysis that most of the '*Kothis*' have reported their first sexual partner as male. However, a reverse trend has been reported in case of '*Panthis'* (active) where 59 percent of the respondents reported their sexual debut with a female sex partner.

It is desirable to have comprehensive information about the prevailing sexual practices among MSM for the purpose of designing any programme or intervention for the risk reduction of STDs/HIV in this subpopulation. Among others, partner exchange rate or frequency of changing the sexual partner has been considered to be a top priority risk for programme as well as action. Looking at the rate of exchange of partners in terms of numbers during the last 30 days, it is evident from table-8 that the over all exchange rate of male partners is very high among MSM (11.2/30 days) in comparison to the average number of female partners (1.5/30 days), which make them more vulnerable to the infection of STIs/HIV.

Age plays a significant role in the exiting partner exchange rate among the MSM community in Mumbai. With increase in age, most of the MSM, like any common Indian male, gets socially trapped into the ties of marriage and marital social responsibility does not offer them full fledged freedom to access the male sexual partners of their choice. However, their eternal desire remains unchanged, as it was earlier. Also, they do not deny the fact that marriage puts a lot of pressure and woes for them particularly when they think about their wives. Sometimes such kind of behavior leads to guilt feelings among them but sometimes it is beyond their control to suppress the sexual urge of experimenting sex with males. The qualitative insights show that their desire to get married is related to their feeling of loneliness at later ages in life, caring for their older parents and fulfillment of the desires of the parents to procreate children.

An analysis of various kinds of sexual partners (Table 9) conveys that most of the MSM perform sex with casual partners. Most often these casual partners are strangers and the respondents are unaware of the sexual background and past sexual behavior of their partners. As a result, these types of sexual networks prevailing among the MSM community in Mumbai may have a higher chance of getting infected with STIs/HIV once the infection enters into the network. Another important issue is that 37 percent of the respondents reported to have sex

even with casual female partners. From the above context one can easily draw an inference that even bisexuality is a common phenomenon among MSM in Mumbai (Table 9). Even though they explore sex with strangers and one of the reasons regarding their choice of strangers as casual partners is that they are not keen to make any kind of emotional relationships and commitments with their sexual partners. This might be due to the bargaining power of the MSM with their clients and also their desire to look for variety regarding choice of partners.

It is evident that the use of condom is very low at the higher ages for their first as well as last sexual act. Among those having sex with casual partners, with majority of the cases where the sexual history of the last partners is hardly known to the respondents (Table 11), the use of condom is substantially lower in higher age groups (52 per cent) as compared to younger ones (78 per cent)(Table 12). Further, it is encouraging to note that the younger respondents are more likely to use condom irrespective of their first or the last sexual encounter. It may be due to increasing awareness about practice of safer sex and easy access to condom.

However, there is a need for a concerted effort among young MSM preferably among teenagers or late adolescents to ensure condom use with their wives. It is too ominous to note that a very low proportion of married MSM are using condoms with their wives (Table 12). Lack of awareness about their sexual orientation, possible suspicion of wives about their indulgence in homo/heterosexual activities may be some of the important reasons behind this. There is a definite relationship between education of respondents, exposure to mass media and condom use irrespective of types of partners - casual or regular. Reduction in sexual pleasure has been reported as the most significant reason for not using condom by the MSM irrespective of their background characteristics.
The above discussion provides information about their risk taking behavior. It was reported that most of the family members are not acquainted with their behavior. It was found bisexuality is the norm of socialization into sexual process

Knowledge of HIV/AIDS and Ways of Preventing it

The idea of providing or creating knowledge and awareness of HIV/AIDS is a prerequisite to prevent the march of HIV /AIDS. For many researchers this idea is often challenging, as the individuals who go for unsafe sexual practices are sometimes well informed about the modes of transmission and prevention of this deadly virus. Increasing the level of awareness does not necessarily mean that the individual will perform the action. There is something beyond knowledge and awareness, which needs to be controlled in order to translate it into action. According to Bandura (1994), providing knowledge to the individual may not reflect his intentions towards actions and therefore emphasis should be given to build the self efficacy of the individual.

On the similar lines this small survey among MSM shows that a high degree of awareness and knowledge about STD/HIV/AIDS is prevalent among the MSM sub-population. Almost 84 percent of the respondents have heard about the 'Gupt Rog' (Table 13). Though more than nine-tenths of the respondents have heard about HIV/AIDS still it may be a cause of grave concern from the programme point of view, as still 8 percent of respondents have not heard about this disease. It is heartening to note that both Government and NGOs have made critical efforts to educate them about HIV. However, nearly 14 percent respondents are not aware about the STIs. This situation becomes more sadistic when it comes to the correct knowledge about the HIV where only four fifths (36 percent) of the respondents have reported correctly about all the modes of transmission of HIV/AIDS. The severity of risk can be assessed by the result, which shows that married respondents have low level of knowledge, which makes their wives vulnerable as well.

One of the respondent 32 years says:

> *"…Ek din to marna hi hai"'I am not using condom because one day everybody has to die in this world if I do something wrong then god will give me punishment.'*
> *Again he said, "… there is no such proof that HIV is an infection or disease"...*

The severity of the problem can be imagined from the level of myths and misconceptions. There is a common misconception that piles can be treated if they practice the anal sex. In this study most of the respondents have reported that the homosexual intercourse is not a cause of HIV infection. They have many misconceptions like HIV cannot infect healthy looking persons. A substantial proportion of the respondents have this misconception that HIV can be infected through the mosquitoes/flea and bed bug bites.

Though the various targeted intervention programs are going on under the aegis of MSACS and MDACS they are not able to capture the whole MSM population. One can understand that only 51 percent of the respondents have reported that they had gone for voluntary testing for HIV/AIDS. Out of them 21 percent was found to be HIV positive (Table 14). Most of the MSM who are not going to the VTCT centers for testing are scared of the consequences if tested HIV positive. Even if they go for testing, then do not come back for the results. They feel that going through VTCT is a kind of traumatic experience, which leads them to face anxiety disorders. Many of them are afraid that if they are tested positive, they would have to live with the double stigma of being MSM as well as HIV positive.

Sometimes, the poor service delivery system provides an opportunity to them for avoiding getting HIV result. One can understand by the following narrative:

One respondent 24 years:

> *"…Once I had gone for the testing but when I revisited the clinic to get my results, they did not give it to me …later I had not tried to go again"…*

Though the majority of the MSM are clear about the fatality of HIV/AIDS, a large number of MSM do not know the full implications of contracting the disease, and this makes the task of

prevention more difficult. The knowledge with respect to curability of STDs is more inadequate.

The biggest challenge of organizations working in the field of sexual health is to overcome the stigmatization of MSM activities. The high percentages of such men are invisible which makes it impossible to access any services designed for them. There is also lack of education, awareness and sensitivity about issues concerning MSM in the Indian context. The role of mass media is also not supportive and they need to handle such issues more sensitively rather than making it a matter of fun.

According to one NGO personnel

> *"…the programmes that are run by MSACS /MDACS are not enough for the welfare of this community. They are just promoting the distribution of condoms but many other aspects are also needed to be covered"…*

It has been found from the interviews of MSACS and MDACS officials that they are just providing the financial supports to those NGOs, which are run by the community members itself. They have no direct interaction with the MSM individuals or beneficiaries. The condition is quite dismal when funding agencies are not able to judge the success and failures of the programmes. Due to high level of stigma attached with homosexuality, many MSM are not coming in the contact of programmes. The success of any such programmes can only be evaluated when they reach even those hidden population whose status might not be the same as others who are in the contact of programmes. Many NGOs working in this area are also to some extent, responsible for creating problems in programme delivery. They seem to be reluctant to reveal the real situation regarding MSM activities in the city.

Routes of Transmission to General Population

The paper entails that HIV/AIDS is not restricted up to the high risk behavior groups and there is a need to redefine the boundaries between risky and safe. The study was aimed at exploring how HIV/AIDS virus spreads from MSM to general population. It has been found that in Mumbai MSM is a diverse group with varied background. Thus MSM activity is not confined to any particular class or community or age. It was found that youngsters who belong to this group stand in an elevated risk of contracting HIV/AIDS in the wake of AIDS endemic in India. Some of them are married and some others will get married due to high degree of social pressure for leading a 'normal' life. In order not to reveal their identity, they succumb to this pressure and thereby make their wives and children more vulnerable to risk of HIV or other STIs. Due to stigma the married MSM do not want to reveal their status within the family. On the other hand, due to the presence of powerful stigma, the MSM sub-population remains isolated and vulnerable. Most of the MSM experienced their first sexual encounter with males during the formative stage of life i.e., during teen ages or late adolescence with an elder person. Looking at process of entry into MSM activities, in most of the cases, environment and

surroundings were reported to shape their sexual orientation. These findings seem to be consistent with other studies reporting that family members, close friends/ relatives and neighbours acted as first sexual partner.

Analyzing the sexual orientation and behaviors of self identified types of MSM, it has been emerged that *'Kothis'* experienced their first sex much before *'Panthis'* or *'Dopartha'*. This category of MSM also reported a higher partner exchange rate. Most of them had sex with casual partners with little or no knowledge about their sexual background or history. It makes them more prone to get infected with STD/HIV in comparison to other categories. Of course, lower use of condom at the time of first sex (28 per cent) might have influenced by the nature and causation of the act but a low condom use with last sexual partner is matter of serious concern in the present era of HIV/AIDS epidemic. Though the condom use is substantially higher among receptive partners as compared to active ones but the overall level and pattern of condom use needs a concerted effort. Condom use was reported to be negligible in the case of wives. A reduction in sexual pleasure stands out to be a major barrier in condom promotion among MSM community.

They fail to seek their partners in a decent manner or even if they manage to get some partner they cannot reveal it to others or maintain a happy life, as our society seems to oppose such relationships. This indifferent environment certainly disgruntles their mental poise, which again works as a detrimental factor to their mental health. They rarely get full support from their families as in most of the cases the family members remain in dark about their sexual behaviors. They seek sex surreptitiously with less scope for selecting partners of their choice, which in turn pushes them for adopting indiscriminate sexual practices. To avoid the gaze of others, they perform sex in deserted uncouth places. Many a times, they fall prey to police atrocity as well. Again they rarely see doctors for sexually transmitted diseases for the fear of getting exposed before health providers. But as per the medical science, the chances of transmitting virus are more in anal sex than in peno–vaginal sex since the tissues inside the rectum are more flimsy. So from all the angles, it hints that MSM are quite vulnerable to acquire STIs and HIV and infecting others.

As far, their sexual health problems slightly one–fifth of them reported to suffer from one or other sexually transmitted infections during last 12 months, of course, a substantially higher proportion of them (62 per cent) suffered from STD/Sty's during last three months (data not tabulated in this paper). So far as treatment seeking behavior is concerned, most of them did not go for proper treatment in initial stages of infections. Self-medication was preferred mode of treatment. They did not share their problems with others, which, in turn, might have created other kind of psychological problems to them. Only half of the respondents had gone for HIV test. Those who were in the contact with NGO, got benefit of it over others who were not

associated with any such organizations. Most of them did not like to speak out their anal problems to the service providers. Qualitative insights into the sexual health problems of MSM revealed that fear of being exposed barred them to disclose their problem. It was also perceived by respondents that the MSM community was an isolated one.

There is a need to study further the nature of vulnerability among the MSM towards HIV/AIDS. They are very hard to reach and only few have so far come to the contact of any intervention programme catering their needs. The stigma and taboo attached to this particular homosexual act needs to be overhauled and the society requires to accept their support to this group of people as normal that would definitely help them to come forth and reap the benefit of any intervention programme. The importance of condoms for anal sex had to be included in all HIV/AIDS prevention communications, not only for identified MSM but for the general population as well, because many a MSM hide their preferences and would go through the materials aimed at MSM alone. Moreover, even among MSM, there exist quite a good number of non-penetrative sexual acts which are fully harmless such as inter-femoral sex or mutual masturbation, from the point of view of STI or AIDS scare. These type of sexual practices need to be encouraged to avoid their vulnerability. Another growing area of concern is partner exchange rate; they frequently change their sexual partners and hardly enter into an enduring relationship, which also put them at a higher risk. The partner exchange rate will be reduced not only through NGO intervention alone, rather society should be permissive enough to allow them to develop a strong bond between two males. Unless and until emotional attachment takes place, the enduring relationship will remain a far cry. But to achieve this, the first task is to downplay the stigma and taboo attached to it.

Conclusion

This study of MSM in Mumbai shows that line between risky and safe sexual encounters is very hazy: many people involved in risky behavior, such as MSM, also have a normal life, wife and children (Kulkarni et al., 1999). Social and cultural values force MSM to marry and hide their MSM status. They are also forced not to use condoms with wives so that their character is not doubted. They belong to all religions and castes. They may be more educated than general population. A majority of them are living with family (of procreation or orientation). For them MSM activity is normal and thus they carry no guilt. They experienced sex first time from friends and neighbors, some from relatives and family members. On the average they have 11.2 male and 1.48 female partners. Anyone of them can be carrier or a victim. The partners are all kinds of people. Some are casual and some regular. They include sex workers, married and unmarried men and women, friends, and relatives (AIMS Research, 1997).

Lessons Learnt and Policy Implications

Ignorance, gender based social norms, absence of proper testing environment and facilities, culture and customs, shame and stigma associated with disease can transmit the disease to anyone and women are particularly susceptible to HIV virus for both biological and social reasons (Ochem, 2004; Irin, 2004; UNAIDS, 2004; Anonymous, 2004). Infected and non-infected people live in the same family (D'Cruz, 2004) and often work together. The afflicted may have a perspective that is risky for others (Sharma, 2002). Once the virus enters the general population it is not so easy to control it. Controlling the HIV/AIDS requires understanding of various issues at various levels. One has to target social norms as well as individual behavior (McKee et al., 2004).There is an urgent need to learn about the relationship between MSM and the general population so that suitable intervention strategies can be devised to increase the accessibility of health care services to MSM and caution others such as women in monogamous marriage with MSM. It is a formidable task to identify MSM and reach their wives but in view of the spreading AIDS epidemic this issue will have to be addressed. Society has to be more accepting and caring of the afflicted and the afflicted should have to be counseled in both personal and moral terms. It is also imperative for the health care providers to sport a favorable attitude towards MSM community. The concerns of the programs should concentrate on both 'cause' and 'client'. Safe sex should be promoted lying due emphasis on the context of alcoholism, condom use and partner exchange rate so that holistic approach with a concerted effort mark the interventions. De Cock et al. (2002) have recently developed the concept of "demystification of HIV/AIDS". They call for universal "know-your-status campaigns and place responsibility to prevent HIV on every individual". According to them testing and knowledge of HIV should be a normal medical affair and there should be no need for anonymity and hiding the HIV status. It appears that this is the only way society can stop the linkages between the high risk groups and the general population.

Limitation of the study

The study had to rely on those respondents who have already crossed a barrier of self identification and come in contact with community level workers of different NGOs working with MSM. It might have narrowed down the scope of generalizing the findings for the whole group as such.

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TABLES:

Table-1: Percentage distribution of respondents by socio-demographic characteristics

Background Characteristics		Percentage	Number
Age	15-24	38.1	61
	25-34	44.4	71
	35+	17.5	28
Caste	General	62.0	98
	OBC	25.3	40
	SC/ST	12.7	20
Religion	Hindu	56.3	90
	Muslim	21.9	35
	Others	21.9	35
Marital Status	Married	28.1	45
	Unmarried	71.9	115
Education	Upto8th	21.9	35
	Graduation	23.8	87
	9th-12th	54.4	38
Place of education upto 10th	Rural	15.8	23
	Urban	84.2	123
Rank among Siblings	Eldest	41.3	66
	Not eldest	58.8	94
Total		**100.0**	**160**

Table-2: Percentage distribution of respondents by their current residential status and work characteristics

Characteristics		Percentage	Number
Current residential status	Alone	10.6	17
	With one or some friend	16.3	26
	With family (Parents and wife)	60.6	97
	Others	12.5	20
Nature of work	Daily wage worker	8.1	10
	Heavy Vehicle driver	8.1	10
	Light vehicle driver	2.4	03
	Casual worker	8.1	10
	Salaried private	48.8	60
	Salaried Government	17.9	22
	Others	6.5	08
Monthly Income	1-2000	18.8	30
	2001-4000	31.3	50
	40001-6000	16.3	26
	6000+	33.8	54
Total		**100.0**	**160**

Table-3: Distribution of respondents by sex of their first sexual partner and perceived experience

First sexual experience	Percentage	Number
Female	38.8	62
Male	61.3	98
Willingly	72.5	116
Guilt	38.4	61

Table- 4: Distribution of respondents by sex of their first sexual partners and feelings of guilt

First sexual experience	Female	Male	Total	Number
Guilt feelings	30.6	43.3	38.4	61
Willingly	75.8	70.4	72.5	116

Table-5: Percentage distribution of respondent by age at first sex with male and female

Age	Male	Female
<15	24.0	15.0
15-19	47.0	30.0
20-24	23.0	8.0
25+	6.0	47.0
Total	**100**	**100**

Table-6: Percent distribution of respondents with relationship with first male partner

Relationship	Percentage	Number
Relative	17.5	28
Family member	11.9	19
Friend	23.1	37
Neighbor	23.8	38
Stranger	14.4	23
Others (Hijra/CSW)	9.1	15
Total	**100**	**160**

Table-7: Percentage distribution of respondents with their self –identification

Self Identification	Percentage	Numbers
Kothi	44.0	71
Panthi	27.0	44
Do-Partha	15.0	24
Others	13.0	21
Total	**100.0**	**160**

Table 8: Average number of male and female partners during the last 30 days

Background Characteristics	Average Number of Partner	
	Male	**Female**
Self Identification		
Kothi	13.23	0.55
Panthi	12.70	2.98
Do-Partha	11.54	1.09
Others	6.05	1.55
Age of the Respondent		
15-24	13.38	1.02
25-34	11.96	1.97
35 and above	08.56	1.26
Marital Status		
Married	9.73	1.92
Unmarried	12.76	1.32
Education		
Upto-8th	11.39	0.90
9th to12th	13.14	1.93
Graduation and above	9.58	0.97
Monthly Income		
1-2000	7.53	0.50
2001-4000	12.06	1.65
4001-6000	14.88	1.92
6000+	12.83	1.67
Consumption of Alcohol		
Always	10.86	1.19
Sometimes	11.90	1.92
Never	12.55	1.42
Total	**11.20**	**1.48**

Table -9: Percentage distribution of the respondents by type of male and female partners

Types of Partner	Male partner	Female partner
Casual	75.60(121)	36.90(24)
Regular	04.40 (007)	50.80(33)
Both	20.00(032)	12.30(08)
Total	**100.00(160)**	**100.00(65)**

Table-10: Distribution of respondents by reasons of indulging into MSM activities

Reasons	Percentage	Number
Just for fun	34.40	55
Getting Money	13.80	22
Sexual pleasure	41.90	67
All above	01.30	02
Other	01.90	03
Can not say	06.90	11

Table-11: Distribution of respondents by marital status of their last male partner

Marital Status	Percentage	Number
Married but living with wife	10.60	17
Married but away from the wife	08.80	14
Widower	05.60	09
Divorced/Separated	07.50	12
Don’t know	67.50	108
Total	**100.00**	**160**

Table-12: Distributions of respondents by pattern in condom use according to some selected background characteristics

Back ground characteristics	Percentage of use of condom	Number of respondents	Use of condom with first sex	Use of condom in last sex	Use of condom with Casual partner	Use of condom with Regular partner	Use of condom with wife	CSW	Selling Sex
Age									
15-24	83.60	61	36.40	78.60	78.60	67.50	6.30	21.70	37.90
25-34	66.20	71	26.60	55.70	55.70	40.00	2.60	36.60	34.10
35 +	64.30	23	29.20	52.20	52.20	20.00	2.30	25.00	14.30
Marital Status									
Married	60.00	45	26.30	62.20	52.50	031.4	02.70	28.60	33.3.3
Unmarried	76.80	75	38.00	77.10	69.50	55.60	03.40	26.30	30.40
Divorced	81.30	16	31.30	75.00	46.70	30.80	00.00	36.40	33.30
Widower	75.00	04	75.00	73.00	75.00	75.00	00.00	66.70	50.00
News Paper									
Reading daily	80.00	120	35.00	84.90	72.00	54.10	35.00	29.10	37.50
Not reading daily	50.00	40	35.30 0	35.30	32.40	23.30	00.00	32.00	21.40
Kothi	74.60	71	33.90	75.00	64.50	47.90	07.10	04.30	32.30
Panthi	72.70	44	25.00	77.50	62.50	44.10	00.00	46.90	43.30
Do-partha	70.80	24	13.60	66.70	68.40	37.50	00.00	30.00	30.00
Others	66.70	21	52.60	63.20	50.00	52.90	00.00	23.30	07.70

Table- 13: Distribution of respondents by their knowledge about symptoms, modes of transmission, and modes of prevention of STDs

Information	Percentage	Numbers
Heard about Gupt Rog	83.8	134
Knowledge about symptom		
Penile discharge	83.1	133
Painful and frequent urination	81.3	130
Genital sores/ Ulcers	81.9	131
Swelling in groin region	79.4	106
Cant retract foreskin	66.3	106
Modes of transmission		
Homosexual intercourse	50.6	81
Heterosexual intercourse	81.3	130
Needles/Blades	79.4	127
Mother to child	48.1	77
Transfusion of infected blood	79.4	127
Knowledge about prevention		
Sex with one partner	35.0	56
Use of condom	67.5	108

Table-14: Distribution of respondents by their source of information, knowledge about modes of transmission, prevention and misconceptions of HIV/AIDS

Information	Percentage	Numbers
Heard about HIV/AIDS	**92.5**	**148**
Source of information		
NGO	67.5	108
Friends	23.1	37
Radio	47.5	76
TV	28.8	46
Social worker	49.4	79
News Paper	22.5	36
Doctor	33.1	53
Modes of Transmission of HIV		
Homosexual intercourse	51.90	83
Heterosexual intercourse	84.40	135
Needles/Blades	85.60	137
Mother to child	43.10	69
Transfusion of Infected blood	83.80	134
Misconception		
Healthy looking man can be infected	51.3	82
Hand shaking	5.0	8
Hugging	6.9	11
Kissing	10.0	16
Sharing of clothes	7.5	12
Sharing of utensils	4.4	7
Mosquito/flea/bed bites	23.1	37
Modes of prevention		
Sex with one partner	61.3	98
Use of condom in each sexual encounter	76.9	123
Proper checking of blood before transfusion	74.4	119
Sterilize syringe	65.6	105
Avoid pregnancy after getting HIV	61.6	98
Gone for HIV testing	51.3	81
Result (HIV+)	21.3	34