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INDIA 'MSM SITUATION PAPER' SERIES
TECHNICAL BRIEF 3

Sexual Violence against Men who have Sex with Men in India
Intersections with HIV

SEPTEMBER 2011

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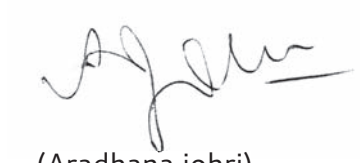
सत्यमेव जयते

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

सत्यमेव जयते

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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We recognize the guidance and support of the state AIDS Control Societies of Delhi, Maharashtra, Manipur, Orissa, Uttar Pradesh, Tamil Nadu and West Bengal in the successful implementation of the qualitative component of the study in these states. We thank the field researchers who collected data from the study sites: Priti Prabhughate, Anindya Hajra, Arif Jafar, Rupesh Chettri, Sandeep Mane, Dinesh Kumar, Jaishankar, Souvik Ghosh, Basanta Kumar K, and Sanoja Kumar Mohanty.

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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
CBO	Community Based Organisation
FGD	Focus Group Discussion
FIR	First Incident Report
HIV	Human Immuno Deficiency Virus
ICTC	Integrated Counselling and (HIV) Testing Centre
IEC	Information, Education and Communication
IPC	Indian Penal Code
IRB	India Reserve Battalion
KI	Key Informants
KII	Key Informant Interview
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 Workers
PEP	Post-exposure Prophylaxis
PPN	Positive People Network
PTSD	Post-Traumatic Stress Disorder
SACS	State AIDS Control Society
S-PEP	Sexual Post-Exposure (antiretroviral) Prophylaxis
STI	Sexually Transmitted Infection
TG	Transgenders
TI	Targeted Intervention
TNSACS	Tamil Nadu State AIDS Control Society

Contents

A. INTRODUCTION

Violence of any form physical, sexual or psychological on the basis of one's sexual orientation (actual or presumed) or gender expression or identity is a violation of human rights. In addition, among other health concerns, violence has connections with HIV risk. Sexual violence, especially unprotected sex, carries obvious and direct risk of HIV transmission or acquisition. However, sexual violence does not refer to physically forced penetrative sex alone. The World Health Organization defines sexual violence as: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting, including but not limited to home and work".[1]

Violence against men who have sex with men (MSM) and transgender (TG) people in India is a largely hidden epidemic, and along with Human Immuno Deficiency Virus (HIV), forms a 'syndemic' [i ii iii] that needs to be effectively addressed. Many MSM, especially those who are feminine and/or who engage in sex work, face violence on the streets, in the sex work places, or in their personal lives and this increases their vulnerability to HIV and other health concerns. Available studies demonstrate that a significant proportion of self identified MSM face violence. For example, more than one-third (40.5%) of MSM recruited from cruising sites or public sex environments in Chennai, reported forced sex in the past year and one-third (35.0%) reported daily/weekly harassment.[iv] Sexual violence and harassment by goons and police against MSM, MSM in sex work and peer outreach workers (ORWs) have been reported.[v vi vii] in Chennai and other cities.

HIV epidemic among MSM in India is severe too, with both violence and HIV fuelling each other. HIV among MSM is 7.3 percent (national average), which is 20 times more than the general population rate of 0.36 percent [viii]; those who engage in sex work even have a greater risk.[xi x]

Violence and the HIV syndemic, thus, point out the need to address violence, especially sexual violence, in HIV programmes. This report demonstrates the interconnections between HIV and sexual violence, discusses the existing sexual violence prevention strategies and support services for victims of sexual violence and put forward action points to mitigate the impact of the syndemic.

Summative recommendations

The key recommendations are summarised below and elaborated on in the last section of this report. The recommendations focus on two areas: 1) prevention of sexual violence; and 2) providing services for victims of sexual violence.

[1] The term syndemic is used to label the synergistic interaction of two or more coexistent afflictions/diseases contributing to excess burden of disease in a population.

To prevent sexual violence against MSM, the steps that can be taken through current and future targeted HIV interventions include: violence prevention and mitigation education for MSM; meetings with police in the local police stations; and crime mapping by NGOs/CBOs to help MSM avoid risky areas. In addition, an enabling environment needs to be created to prevent and report violence. The activities include: a) awareness raising among MSM communities through targeted interventions (TIs) and online sites about sexual violence and its consequences to gain support for victims; and b) training police, lawyers, and healthcare providers to promote understanding and acceptance of human rights and the right to health of sexual minorities, to adapt and implement sensitive procedures in handling male victims of sexual violence and to provide appropriate and sensitive medical and psychological care.

Services for victims of sexual violence that can be provided through the TIs include: attending to the immediate physical and mental health needs of the victim; providing free sexual post exposure antiretroviral prophylaxis at government hospitals; screening for HIV/sexually transmitted infections (STIs) and providing empirical treatment for STIs; linking victims with legal support and providing free legal services; and providing long-term mental health counselling support.

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 of National AIDS Control Organisation (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 State AIDS Control Society (SACS), Technical Support Unit of SACS, and NACO (10); Non governmental organisation (NGO)/Community Based Organisation (CBO) leaders (12); healthcare providers that include doctors (10); and five others (such as the police, and the 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 was searched and gathered primarily via electronic sources. The 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 sexual violence, key words used included combinations of: HIV, AIDS, HIV prevention, MSM, homosexual, male sex workers, anal sex, risk behaviour, bisexual behaviour, sexual violence/harassment, structural violence, programme, interventions, Asia, and India.

Data analysis and inferences

Data from the focus groups and interviews were explored using a combination of framework analysis [xi] approach (using a priori codes) and grounded theory approach[xii] (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. The 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 ages 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%), double decker/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 HIV positive.

[Study delimitations: Sado masochism in sexual behaviour and male child sexual abuse are not the focus of this report. Neither will this report examine male to male sexual assault within prisons. Also, this report almost exclusively focuses on the sexual violence faced by self identified MSM such as *kothi* identified and *gay* identified men, and not by any man.]

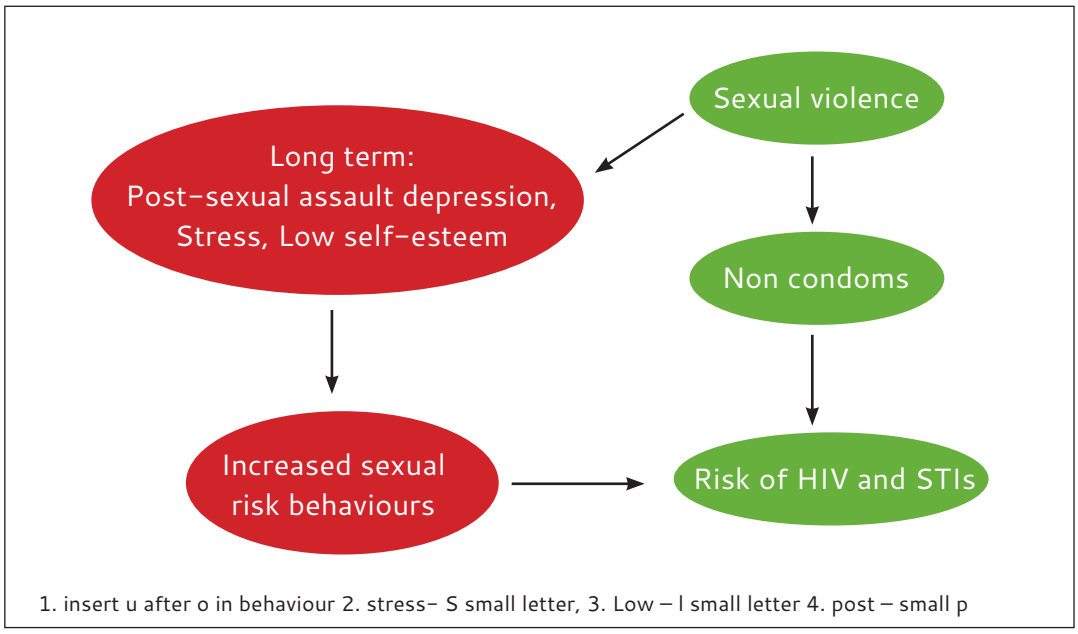
C. FINDINGS OF LITERATURE REVIEW AND RESEARCH

1 Sexual violence has direct and indirect risks of HIV to MSM and has long term mental health consequences

In coerced male to male sex, physically forced or not, condoms are almost never used.[xiii] Absence of condom use, along with trauma to anal canal, increases the risk of HIV and STIs to both the victim and perpetrator(s) and to their subsequent sexual partners.

Field data has particularly demonstrated that during sexual violence, the primary concern of *kothi* identified victims was not about using condoms but about how to get out of the situation; the other possibility is that at that time, they are simply too 'frozen' to do anything. Although some wanted to protect themselves from HIV, they were too afraid to ask their perpetrators to use condoms at the time of violence. For instance, a Chennai study described that an HIV positive *kothi* identified MSM could not negotiate condom use in a coerced sexual encounter with a ruffian because he was afraid of physical assault if his HIV status was revealed.[xiv]

Figure 1. Sexual violence and HIV risk



1. insert u after o in behaviour 2. stress- S small letter, 3. Low – l small letter 4. post – small p

Lack of availability of or awareness about sexual post exposure antiretroviral prophylaxis (sPEP) limits the opportunity to decrease the risk of HIV to victims. If at all the victims report , the sexual assault to the healthcare provider or the police, they do so only after 48 to 72 hours, therefore, sPEP is unlikely to be helpful because it has to be provided within 72 hours of sexual assault.

Long term mental health consequences of sexual violence are often not addressed in the existing government clinical services or even by most CBOs/NGOs that implement HIV TIs for MSM. Many victims often suffer from post traumatic stress disorder (PTSD), especially from a specific form of PTSD known as 'post rape syndrome'. Lack of attention to mental health issues and lack of availability of appropriate mental health counselling services mean that many victims' self-esteem and sense of self are severely damaged with devastating consequences like increased sexual risk taking[xv xvi xvii] (not bothered about using condoms) and not taking care of one's health (even if they are HIV positive). This in turn, leads to increased risk for HIV and STIs to oneself or to their partners.

Victims from *kothi* or *gay* communities often do not reveal the violent incident to one's own peers to avoid discrimination. This non-disclosure prevents them from getting necessary psychosocial support which might have been available to them from at least some supportive peers. Similarly, some attribute their same sex sexuality as the possible 'reason' (and justification) behind the violence and also perceive that their community members are not supportive, especially when their friends run away during the incident instead of trying to help them. This leads to self isolation and becomes a barrier, at least temporarily, in accessing HIV prevention and treatment services.

2 MSM experience multiple forms of violence in various settings by diverse perpetrators

Any man who is or presumed to be attracted to the same sex could be a victim of male to male sexual violence. However, available studies in India have primarily documented violence against *kothis*, especially those involved in sex work, besides documenting violence against hijras/TG women.[xviii xix] The latter are more likely to be targeted because of their 'visibility', as feminine gender expression is seen as a proxy for same sex behaviour or a license for unleashing violence; thus, in a way, one can view it as a form of gender-based violence. *Kothis* in sex work need to be at their 'sex work sites' on an almost daily basis to earn money for survival. This necessity is then exploited by ruffians and policemen who demand money as well as sexual services which are sometimes even physically forced.

Those *kothis* who are not in sex work but who come to cruising sites (such as beaches and abandoned places) during late night hours in search of potential sexual partners, face violence, including sexual violence, from men from all walks of life. For example, field data showed that perpetrators can be fishermen in beaches (Chennai), college youth (Delhi), drug users (Imphal and Delhi), policemen (all sites) and armed forces (Imphal). Some, if not most, perpetrators seem to have coerced or forced sex with victims, not for sexual gratification, but acting as self appointed custodians for 'punishing' those males who transgress gender norms or who are perceived to have

same sex sexual orientation. Thus, paradoxically, they facilitate or justify the perpetrators' sexual act with the victim as not being due to sexual desire. It is also possible that some perpetrators may actually have same sex sexual desires but would like to 'exorcise' themselves from their conflicting same sex attraction by 'punishing' men whose gender expression is indicative of their sexual orientation ("exorcist syndrome"[xx]). Considering anything that is feminine as inferior (misogyny) and a sexual object could be another reason. Thus, a complex set of reasons[xxi] psychological, social and structural could account for the violence, including sexual violence faced by MSM.

Table 1. Direct and indirect consequences of sexual violence

High HIV risk due to non-use of condoms in forced anal sex "I was called to have sex with a person with whom I had had sexual contacts before. But this time, he beat me up and had sex with me without a condom. In spite of all awareness about HIV, I was forced to have sex without a condom." **(CH, FGD5)** "Once a person who was drunk entered into my friend's home. He forced my friend to have oral and anal sex without a condom and he also harassed him physically. My friend had no option except to obey that man." **(BW, FGD2)** "If a *kothi* insists on using condoms, his *panthi* [here, casual male partner] will say 'I do not use a condom during sex' and continue to have anal sex without condoms. His act will leave the back [anus] bleeding and torn." **(CH, FGD1)** "An acquaintance called me to his home and offered me a cold drink and after that, he started seducing me. Then he turned off the light and forcefully had anal sex without a condom resulting in anal rupture." **(DL, FGD5)**
Mental health consequences "My friend and I were stopped by five boys while returning home late at night. First they made us sing and laughed at us. Later they asked us to have oral sex with them. They did not let us go until we did that. That incident made me feel bitter, low in self-esteem and often frustrated because we could do nothing about it." **(IM, FGD1)** "A friend of mine used to cruise near the Fort William area for about 10 to 12 years and used to have sex with the army men there. Suddenly, he disappeared for quite some time. When we met him again he narrated that about six months back he had been picked up by an army man, brutally gang-raped, and beaten up. He is still suffering from that trauma. Even now he believes that those men are following him and confines himself to his home." **(KOL, FGD 3)** "One night near the airport, we were stopped by local goons. They took all our money and beat us. One goon held a knife against my throat and my friends were let go. Then the goons took me to a crematorium and I was repeatedly raped. That incident really shocked me. I even thought of committing suicide." **(IM, FGD1)** "While I was cruising at the central railway station in Chennai, I got a person for sex. He caught hold of my ID [identity] card and said that he was a policeman. Then he started blackmailing me and asked for money. As I didn't have money he held my college ID card and asked me to come there to give him money the next day. I was in deep distress and thought of committing suicide." **(CH, FGD5)**

(Abbreviations: **BW** – Bhubaneswar / **CH** – Chennai / **DL** – Delhi / **GM** – Ganjam / **IM** – Imphal / **LK** – Lucknow / **MU** – Mumbai / **PKT** – Pudukottai / **SD** – Sindhudurg / **KOL** – Kolkata / **JPG** – Jalpaiguri **FGD** – Focus group discussions)

Gay identified men or youth who are same sex attracted and who cruise for sexual partners online, fall into a trap in which the perpetrator (called 'cheater' by some participants) lures them by agreeing to meet them in a public place and from there they go to the potential victim's home. While having sex the decoy gives a signal (by making a cell phone call or sending a text message); other accomplices of the cheater come, and they demand money, and sometimes sex from the victim, threatening otherwise to reveal his sexuality to others.

Thus, in the majority of situations, victims are overpowered by more than one perpetrator. Even if there is only one perpetrator such as a policeman or ruffian, *kothis* or *gay* men may not physically resist the sexual violence, considering the negative consequences of doing so. For example, the police may file a false case or a ruffian may come back with reinforcements.

Because some perpetrators see sex with *kothis* as a way of punishing their behaviour, sexual violence is often accompanied by physical violence and verbal abuse. In fact, a high concurrence of verbal and physical harassment and forced sex has been reported in a study among MSM in Chennai.[xxii] Often verbal abuse includes words that indicate the femininity of the victim and/or his same sex sexuality or behaviour. This kind of abuse, in addition to the physical and sexual violence, is quite damaging to the sense of self and identity of the victim, especially when it becomes cumulative over a period of time. In some cases, the actual sexual violence incident might have been preceded by repeated verbal and physical abuse of the victim, after which a gang would be waiting for the arrival of the victim (especially those MSM who are in sex work) in a particular place and time or a decoy would lure the victim to a trap. Some violent acts do not, however, seem to be pre-mediated – a gang of men who happened to see a feminine male impulsively beat him and eventually it turned into a gang rape.

Field data suggests conflicting perceptions on the trend of violence epidemic against MSM after Delhi High Court's verdict to 'read down' Section 377, which effectively decriminalised consensual adult same sex relationships. Some participants, especially those from metros like Delhi, see a decreasing trend in police abuse, while people from other settings denied seeing any significant decrease in the violent incidents against MSM. KIs felt that many MSM from the lower socioeconomic status may not be even aware of the change in the legal status of homosexuality and this legal change alone may not be meaningful to those *kothis* who engage in sex work, since they can still be harassed by police for being a sex worker.

Table 2. Forms and settings of violence and perpetrators

Sexual violence by diverse perpetrators

"Policemen ask other men to come and catch *kothi* in sex work while they are in cruising spots and they demand money. If the *kothi* does not give them money then they have sex forcefully. This happens in some places. In addition, the policemen threaten the MSM to keep quiet about that incident, otherwise the MSM would be booked under some false cases" **(MU, FGD2)**

"When I was at a dandha [sex work] spot, a *panthi* told other persons that I was an item [means homosexual person]. So in a group they tortured me and had sex without condoms." **(CH, FGD5)**

"I was stopped by army personnel at a place while I was returning home after a birthday party at night. One of the India Reserve Battalion (IRB) personnel got aggressive with me. However, two of them rescued me and said they would drop me at home. It turned out that they had a different agenda. They forced me to have sex with them. I could not do anything except curse them." **(IM, FGD1)**

"Six to seven people will sit at night in the beach and keep a knife in the middle. If they want oral sex, we have to agree to it. If they demand anal sex, we need to obey. At that time, they never think of using a condom. Many such incidents take place on the beach and even if our community people witness this, they will not bother because they have to save themselves." **(CH, FGD1)**

"One day I was in a laundry where I worked for a few months with another colleague and no one was there except us. My colleague used the opportunity to sexually assault me; I was helpless." **(GM, FGD4)**

Physical violence

(hate-motivated attacks due to homophobia or effeminophobia)

"One day I went to see a "lai haraoba" (a cultural festival of Manipur) with three of my friends. While coming back, we stumbled upon a speed breaker on the road and all of us let out a screech [in a feminine manner]. At the same time, some seven or eight boys on their two wheelers pulled over ahead of us and told us to stop. Then they ordered us to follow them, making some of my friends even get onto their vehicles. They took us to a secluded place and started beating the two of us." (IM, FGD1)

"Once a *parikh* invited maichya [feminine MSM], who works in a courier centre, to have sex in a jungle area. The maichya agreed and when he took out a condom, the *panthi* slapped him and beat him." (BW, FGD1)

"I went with a *panthi* to have sex in a cruising spot and he took out a weapon, similar to a knife which was about a foot in length and hit me. I managed to block it with my hands but I got hurt severely. I never bothered about the pain till I reached the nearby railway station." (CH, FGD5)

"Those people who hate us (MSM) may not have sex with us but they will harass us by hitting us. They just beat us up and make us go away saying that we are spreading dirt out there". (DL, FGD2)

Blackmailing, extortion of money and items

"Some boys, who are mostly in need of money, will bring two rowdies and threaten us by saying that 'We will inform others that you are involved in same sex behaviour and will report this to the police. Not only that, we will inform other tenants. So you have to give us a certain amount of money every month. Then we will leave you at peace. If not, we will do whatever we want'." **(CH, FGD1)**

"I was called and picked up at a place to have sex with an acquaintance at his place. When we reached his place I saw other four guys sitting there but they left the place as soon as we reached. We both had sex and immediately after that, his friends came inside the room. They forced me to have sex with all of them and they beat me up. I was raped by all and they robbed me of both my mobile phones." **(DL, FGD5)**

"There was a friend of mine who had a partner who asked him to go for a walk at night. He took him to a dark valley where people were having sex. The police came there suddenly and caught hold of them. The police had sex with them and took away Rs. 5000 from them." **(LK, FGD2)**

Verbal abuse
"Sometimes when I go to the market or go out, I often get teased by the street hooligans calling me names like 'homo'. These remarks that are often directed against us make it difficult for us to even go out." **(A feminine MSM, IM, FGD1)**

"In my area, there is a married man [MSM] with obvious effeminate features who is very often taunted by people. They make fun of him, tease him, laugh at him and stigmatise his family." **(SD, IDI5)**

"Whenever a male has obviously feminine features, some male youth groups call him 'pottai' or 'aravani' in public places. If it is a dark place, they take him forcefully and have sex with him." **(CH, FGD1)**

3 Several barriers exist to report sexual violence

In July 2009, Delhi High Court's verdict led to the 'reading down' of the Section 377 of the Indian Penal Code (IPC), which had previously criminalised anal or oral sex consensual or not between adults of any gender. 'Reading down' means Section 377 will no longer be applicable if two adults have any kind of consensual sex in a private place. Thus, Section 377 applies only in situations where one or both the parties are below the age of 18 years and/or the sexual activity takes place without consent. However, it is possible that Section 377 can also be used if an adult male complains of sexual assault by another adult male.[3]

In spite of such a possibility of filing a case, most self identified MSM who experience sexual violence do not report it to the police or even to community organisations[4] for a variety of reasons. MSM who reported physical or sexual abuse from "beelas" (goons) explained that they often do not report the incidents to the police because they have lost faith in the police (*Chakrapani et al.*, 2007), as the police themselves are major perpetrators of violence, including sexual violence against MSM. Also, the police reportedly have an insensitive attitude towards a self identified MSM who has faced sexual violence. This is more so if they also know that the victim is a sex worker. Field study participants said that some policemen had said, "If you [victim] engage in business [sex work], then what is the big deal in having sex, forced or not, with a few more men". Furthermore, lack of faith in the legal system and perceived or actual slow and taxing bureaucratic procedures involved from filing a first incident report (FIR) to getting justice, mean many would not want to file a case.

Another reason for not reporting to police is the fear of retaliation from local goons. MSM in sex work do not want to create enmity with rowdies who are repeat perpetrators of physical and sexual violence, as they need to visit the same cruising sites again for sex work. Moving to another area is not an option, as they

[3] Based on discussions with legal experts like Ms Tripti Tandon, Lawyers Collective

[4] A key reason for not wanting to report sexual violence to community organisations is the perceived lack of confidentiality of any sensitive information (such as HIV or STI status) as there is a general feeling that 'if one *kothi* knows, then the entire city knows'.

have to face other rowdies in those areas. Furthermore, in some areas, ruffian gangs are perceived to be working hand in glove with the police and thus, there may be serious consequences if one reports the case. Thus, the victims are caught in a double bind.

In addition, MSM in sex work, do not want to lose the limited support of their peers, who may want to dissociate themselves from the victim if the victimisation is known to others. Field work data also revealed that most victims also do not want their parents or families to know about their sexuality or sex work because of fear of untoward consequences, especially the shame it will bring to their families and additional discrimination they will then need to face because of their same sex sexuality or behaviours.

Some victims do report to CBOs/NGOs working with MSM as soon as the violent incident takes place and the crisis intervention teams (or crisis management committees) established by these agencies then meet the victim immediately to offer support and link the victims to medical services. Previous experiences of CBOs in filing cases have shown that many victims withdraw their FIRs or do not want to file a complaint at all. Hence, sometimes no efforts are made by the CBOs to file a complaint to the police. Occasionally, when violence is accompanied by extortion of money, influential local *kothi/gay* community leaders intervene and negotiate with the perpetrators to get back at least part of the money and material taken away from the victims.

Non filing of FIRs and complaints mean lack of criminal statistics on male to male sexual assault. This apparent 'lack of evidence' for male sexual assault means the government may question the extent or even the existence of sexual assault of men especially that which is against self identified MSM. This also sustains the status quo of lack of awareness of or implementation of appropriate legal or medical procedures in male to male sexual assault. Perpetrators too may continue assaulting others as they believe that they are unlikely to be punished, as cases are not going to be filed and no one will come for the help of the victims.

Table 3. Non-reporting of sexual violence

Lack of trust in police "One night, my friend was beaten up by [police] horse riders on the beach and his head got injured. We took him to a government hospital at 10 pm. At that time, the police arrived there and said that 'He is a pottai [a derogatory term] and send him after sutures' and they did not even file a case." **(CH, FGD1)** "If an MSM is caught at a hot spot, the policemen will not only beat him but also have sex with him and threaten him to keep quiet about it. Otherwise, policemen will charge an MSM under false cases." **(DL, FGD2)** "When a *kothi* and a perpetrator went to the police station to register a complaint of sexual violence. The policemen registered the complaint of the accused and forced the *kothi* to provide sexual favours to register his complaint." **(JPG, FGD2)**
Lack of trust in legal machinery "When it comes to violence, some hesitate to share that they are harassed. They are afraid of legal issues and do not trust in legal systems." **(CH, FGD5)**

Fear of negative consequences if one's sexuality is revealed
"I once faced violence but I am ashamed and scared of reporting to the police because I don't have the courage to face the consequences if the police and my family come to know of my sexuality." **(GM, FGD4)**

"Police will come to know my sexual behaviour; in addition, my family would also come to know about my status." **(CH, FGD5)**

To avoid bringing shame to one's family
"Even though some guys get sexually harassed, they do not launch any complaint. If someone files a complaint, then his family would come to know about his same sex behaviour which would be a shame to his family." **(DL, FGD2)**

"MSM never come out due to the fear of getting their same sex behaviour exposed to their families. So they hesitate to go and seek support. They have the fear that 'they (policemen) will go to their homes directly' and it would be a disgrace to the family." **(CH, FGD5)**

4 Current responses to prevention of sexual violence and services for victims of sexual violence

Crisis management teams in CBOs/NGOs that implement targeted HIV interventions are reported to be helpful to deal with issues such as blackmailing and extortion of money by police, goons or 'cheaters'. Even though they do immediately attend to the crises faced by self identified MSM, they respond to it after the violence has taken place. Also, as the composition of the crisis management team is predominantly or exclusively from the MSM community especially at the peer educator level, the influencing and negotiating power of the team to effectively deal with the local police and other power structures is limited, as reported by the community leaders.

Proactive strategies to prevent violence against MSM in general are primarily limited to NGOs, CBOs or SACS organising sensitisation training programmes for police officials and lawyers. KIs from Tamil Nadu mentioned that the Tamil Nadu State AIDS Control Society (TNSACS) has experience in conducting several advocacy training programmes with the police, using structured modules delivered by MSM and other marginalised community representatives themselves. Through several batches of training programmes, TNSACS aim to cover the entire police staff, from top officials to the lowest cadre in Tamil Nadu. But such police advocacy programmes do not seem to be conducted in a systematic manner in other states, although similar programmes may be conducted in an *ad hoc* manner.

Even in sites where advocacy activities have been conducted with the police, only a few victims report sexual violence incidents to the police or the CBOs. Thus, providing appropriate and timely post sexual assault services for most victims continue to be difficult. Even if the victim reports to the CBO/NGO staff, they usually act as an intermediary to link the victim first to medical services.

Even then, sexual violence is not officially reported and bruises and anal trauma of the victim are attributed to fictitious accidents or piles, respectively. This again means that appropriate medical, counselling and legal services may not be available to even victims who are linked to clinical services. CBOs also report the lack of sensitive and competent lawyers who are willing to work on the cases of sexual violence against MSM.

Taking sPEP within 72 hours can reduce the chances of acquiring HIV. However, almost none of the study participants, a significant proportion of whom are from CBOs/NGOs, knew about sPEP. Healthcare providers too often do not screen for or identify sexual violence unless the victim explicitly states it. Even if the victim openly admits sexual violence, there is no guarantee that he will get sPEP on time because there are no government guidelines on whether and how to provide sPEP in government hospitals. Also, the lack of counselling expertise on sexual violence against men among the healthcare providers (including counsellors in emergency or in the psychiatric department) means that there is no appropriate immediate or long term follow up mental health counselling for victims of sexual violence.

Table 4. Articulated service needs

Articulated service needs "First of all, MSM should get educated on tactics and/or their skills should be developed to avoid sexual violence. They should also be educated on their rights. It would be good if earlier they are educated on the prevention itself." **(DL, FGD2)** "Orientation is required regarding what steps need to be taken in such a situation and where they should go for addressing violence, along with sensitisation about their rights." **(BW, KII2)**
Advocacy to prevent sexual violence "I would suggest introducing laws to protect the rights of MSM and to perish the perpetrators of sexual violence or harassment against MSM." **(IM, FGD1)**
Awareness creation among MSM, their families and the general public "We need to create awareness among MSM about their legal rights. For this, a greater number of CBOs have to be established. It is essential to involve all, especially perpetrators, to educate them about the legal rights of MSM." **(LK, FGD4)** "If sensitisation is done among family members continually, then they would understand us as well as our behaviours." **(BW, FGD1)** "We need sensitisation programmes and advocacy with different stakeholders from various fields to create awareness among the general public." **(IM, FGD1)**
Training for police, health providers, and lawyers "Once, a friend of mine who also happens to work for Manas Bangla was brutally raped during one of his field visits. When we took him to the hospital, the doctor simply refused to believe that it was at all possible for a male to get raped. He kept insisting that we tell him what had actually happened. The doctors need appropriate training and I also feel that they derive a perverse pleasure by hearing out our agony in explicit detail." **(Kolkata, FGD2)** "We need to create awareness among higher officials, leaders, area leaders, doctors, police personnel and rowdies. They should be told about MSM, their issues and their rights." **(CH, FGD5)**

Psychological support
"MSM and bisexuals should be provided with counselling which would prevent violence in future." **(CH, FGD5)**

"We should focus mainly on counselling. This is most important because we need to take the victim out of the trauma and the pain he is going through." **(DL, FGD5)**

"What is worse is that there is very little provision for psychological counselling for sexual violence in our programmes, which I feel is of utmost necessity." **(KOL, FGD3)**

Free and special legal aid services for victims
"I cannot leave sex work because this is the only source of my income. Therefore, we [MSM] need necessary protection to live our lives peacefully." **(GM, FGD1)**

"We would also demand for a welfare board for the sexual minorities like the one existing in Tamil Nadu." **(BW, FGD1)**

"We need to have a lawyer in all our NGOs/CBOs which are working for MSM and addressing their issues." **(CH, FGD5)**

D. RECOMMENDATIONS

Prevention of sexual violence

1.1 Steps that can be taken through NGOs/CBOs implementing TIs and future non-hot spot-based interventions

Currently, most NACO/SACS funded TIs have crisis management teams that attend to, among other crises, physical and/or sexual violence faced by MSM. Some practical proactive prevention strategies that can be adapted by the TIs working with MSM are as follows:

- **Violence prevention and mitigation education for MSM:** Educating MSM about: how to avoid or how to get oneself out of the situations that lead to sexual violence; current legal status of consensual and non consensual adult same sex relationships (Section 377 of the Indian Penal Code); legal rights if MSM or MSM in sex work are arrested or if they want to file a case in relation to sexual assault; and medical services including HIV PEP for victims of sexual violence. Education can take place through face-to-face meetings, or through cell phone-based or internet-based educational interventions. Appropriate educational materials need to be prepared and provided.

- **Meetings with police:** Having periodic face-to-face meetings with the police in the local police stations and sensitising them about the issues of sexual minorities (and other marginalised groups). SACS can facilitate such meetings. Educational materials (especially in local languages) for the police on the rights of sexual minorities can be prepared and disseminated among all levels of the police force.

- **Crime mapping[5]:** CBOs/NGOs can map the areas and timings where previously violence (including sexual violence) against MSM have been reported and inform MSM and MSM in sex work about 'high risk' areas and timings. If the profiles of the major perpetrators (e.g., police, local goons, etc.) are known, then specific strategies can be developed to prevent further incidents of violence.

1.2 Creating an enabling environment to prevent violence and to report violence

- **Awareness raising among MSM communities:** Through TIs, create awareness about sexual violence and its consequences among the MSM communities to gain their support for victims and to facilitate victims to come out for support. Similarly, internet sites that offer dating services for same sex attracted people can issue warnings about the possibility of violence and blackmailing by the persons who are met online. CBO networks can initiate dialogues with those internet sites.

[5] Crime mapping is a technique used by law enforcement agencies to map, visualise, and analyse crime incident patterns. This can be adapted by NGOs/CBOs to develop plans to prevent or reduce violence against MSM.

- **Training for police, lawyers, and healthcare providers:** SACS can take the lead in conducting training programmes for the police, lawyers, and healthcare providers to: 1) promote understanding and acceptance of the human rights and the right to health of sexual minorities, including those who engage in sex work, 2) adapt and implement sensitive procedures in handling male victims of sexual violence, for example, using victim friendly procedures similar to that available for women victims of sexual violence (such as anonymous case filing, ensuring confidentiality about the name and identity, and fast track justice system), and 3) provide appropriate and sensitive medical and psychological care. An advocacy officer can be appointed in SACS as the nodal person for advocacy activities with key populations. The possibility of even training some police as peer educators for other police can be considered.

- **Promote intolerance to violence:** Through mass media messages of NACO/SACS, create a better understanding of sexual minorities among the general public and promote a culture of intolerance towards violence perpetrated against anyone, including MSM.

Services for victims of sexual violence

2.1 Services through TIs

Immediate medical referrals: If a male sexual violence victim reports to a CBO/NGO, then with his consent he needs to be accompanied to the nearby hospital where his immediate medical and physical needs can be attended to (e.g., anal trauma).

Linking with legal support: NGOs/CBOs need to be trained on the procedures required, to file a case of sexual assault against men. Also, they can facilitate getting legal support for the victims. (Note: In the TI budget, money can be allocated to hire a lawyer).

Immediate and long term counselling support: The counsellor (existing or a separate counsellor) in the TI project can then follow up with the victim to provide ongoing counselling to cope with the assault. That counsellor should have been trained on how to deal with MSM who have experienced sexual violence. Hence, a submodule on 'sexual violence against MSM' needs to be incorporated into NACO's TI module for counsellors.

2.2 Prepare and enforce guidelines for medical and counselling services for male victims of sexual violence in government hospitals

Healthcare providers, including those who handle patients coming to emergency department, need to be trained to screen for sexual violence and to provide sensitive and competent counselling and clinical services to victims of sexual assault. Training modules on these topics need to be prepared and incorporated into appropriate existing training modules (e.g., HIV, emergency medicine) and training programmes. Specific guidelines also need to be devised for forensic medical examination of male victims of sexual violence.

HIV PEP[xxiii] needs to be made available (within 48 to 72 hours of the sexual assault) to victims of sexual violence through the same mechanisms by which currently healthcare providers are getting occupational PEP (for example, through the residential medical officer in government hospitals). Directives need be issued by NACO/SACS to the government hospitals that are in charge of providing PEP and guidelines need to be developed and provided to healthcare providers for issuance and follow up with S-PEP.

2.3. Free legal aid services

Similar to the mechanisms available in certain states (like Tamil Nadu), legal clinics or legal aid cells supported by SACS and located within government hospitals can be established to provide free legal services to sexual minorities who have faced sexual violence and to other core groups and people living with HIV. NACO/SACS can also explore the possibility of whether the national or state legal services authority can provide free legal services to sexual minorities who are victims of violence, including sexual violence.

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