Community-based participatory research (CBPR) has gained considerable popularity in recent decades given its ability to address social inequities, improve health outcomes and enhance community participation and ownership with respect to various health-related interventions. This paper describes the engagements of a community of self-identified men who have sex with men, most of whom also identified as male sex workers, in a long-term iterative and systematic process of knowledge production, reflection, and action. The project took place in 2006 in Mysore, South India, under the larger umbrella of an HIV intervention formed by the University of Manitoba and the sex workers collective known as Ashodaya Samithi, funded by the Bill & Melinda Gates Foundation (Avahan). CBPR is revealed as uniquely suited for tackling stigma and discrimination as subjects of scientific inquiry and as key methodological obstacles. As the community cultivated their own analysis around stigma, the concept became a key rallying point for increasing equity with respect to access to health services for this community. CBPR proved highly effective in mobilizing community participation and increasing access to sexual health services, over the long-term, because it was supported by and was able to feed community insights into a much larger infrastructure that sought to mobilize sexual minorities. More broadly, by highlighting various positive effects arising from CBPR, we have sought to further emphasize the greater possibilities of public health practitioners working more democratically with disenfranchised and highly stigmatized communities.

Keywords: MSM; India; HIV prevention; CBPR

Introduction

Men who have sex with men (MSM) in India continue to be a highly stigmatized group. Although there have been recent moves towards the decriminalization of homosexuality in India, MSM continue to face discrimination and violence in social, legal, and health care settings across the country (Logie et al. 2012). Stigma is most prevalent among MSM who demonstrate feminine traits, openly identify their sexual identity, have depressive symptoms, and engage in sex work (Thomas et al. 2012). Those who disclose their sexual orientation often experience family rejection, public
humiliation, harassment by authorities, and discrimination by health care professionals (Thomas et al. 2012). Furthermore, MSM who engage in sex work have been found to be vulnerable to psychological distress, ‘maladaptive coping,’ social isolation, and increased risk of HIV (Thomas et al. 2012).

Despite declining rates of HIV infection among the general population, MSM continue to be disproportionately affected by HIV, with a growing epidemic among MSM in low, middle, and high income countries (Baral et al. 2007). Sexual network and social-structural factors combine to increase HIV risk among MSM. Whereas new prevention technologies, such as antiretroviral therapies, microbicides, and male circumcision, have the potential to greatly reduce the spread of HIV transmission, community-level approaches are needed to address the persistent stigma and discrimination faced by MSM communities that limit access to HIV testing, treatment, and prevention services (Nguyen et al. 2011; Das and Horton 2012). It has been estimated that HIV prevention services reach less than one in ten MSM globally (Global HIV Prevention Working Group 2007).

The hidden nature of ‘at-risk’ communities and the stigma faced by MSM point to the need for collaborative and community-based research methods. Community-based participatory research (CBPR) calls for the active involvement of community members at every stage of the research process, with community members bringing their knowledge, experience, and expertise to the research for the purpose of education, action, and social change (Minkler 2000; Rhodes, Malow, and Jolly 2010).

Theoretical approach

Recognizing the socially constructed nature of scientific knowledge, CBPR accents the influence of nonacademic researchers in knowledge created during investigator–participant interactions (Israel et al. 1998). As Minkler (2000) explains, CBPR is not a method but an orientation that draws upon local forms of knowledge and ways of knowing throughout the research process. Informed by critical theory, this approach challenges conventional notions pertaining to where scientific expertise is assumed to reside by regarding those directly affected by social problems, such as socially or politically marginalized groups, as possessing key insights for understanding these problems and devising solutions through action and social change (Cornwall and Jewkes 1995; Israel et al. 1998; Viswanathan et al. 2004; Cashman et al. 2008; Rhodes, Malow, and Jolly 2010). In theory, CBPR mobilizes the experiential knowledge of disenfranchised communities through various collaborative and collegial relationships and, by unsettling power relations that inhere in conventional research methodologies, it sets up a process that allows for co-learning and the reciprocal transfer of expertise between the investigator and the participants (Israel et al. 2005).

Within the health sciences, CBPR has gained considerable acceptance in recent decades given its ability to address social inequities, improve health outcomes, and enhance community participation and ownership with respect to various health-related interventions (Cornwall and Jewkes 1995; Israel et al. 2005). However, it must also be recognized that cultivating ‘participation’ may not be entirely a straightforward, ‘liberatory,’ or positive transformative process. The critical social science and health literature is awash with examples of the ironic effects of participatory health and development projects that seek to ‘empower’ oppressed communities but which unwittingly constitute new forms of inequality by diffusing and more deeply embedding the regulatory power of public health authority within local contexts (Lupton 1995). Furthermore, community
participation can be uneven, temporary, sporadic, and, in some instances, burdensome for the community that is expected to sustain its outcomes beyond project funding (Cornwall and Jewkes 1995). While we take these criticisms seriously and are certainly aware that CBPR may set up uneven collaborations and new relations of power and inequality (even as it moves to undo prevailing ones), we contend that CBPR can still play an instrumental role in the development of community health projects among marginalized communities. Moreover, solutions to this unevenness in collaborations and power relations as well as inequality, we argue, can and ought to be found, through constant reflection and dialogue, within the framework of CBPR.

This paper describes the engagements of a community of self-identified MSM, most of whom also identified as male sex workers (MSWs) (see Lorway, Reza-Paul, and Pasha 2009 for an in-depth analysis on the trajectories through which men come to be involved in sex work in Mysore), in a long-term iterative and systematic process of knowledge production, reflection, and action. CBPR enabled this marginalized group to effectively navigate the web of power relations emanating from a multi-state HIV intervention to become more forcefully positioned within the local HIV prevention arenas and redefine the health needs of their community. In particular, CBPR is revealed as uniquely suited for tackling stigma and discrimination as subjects of scientific inquiry and as key methodological obstacles. As the community cultivated their own analysis around stigma, the concept became a key rallying point for increasing equity with respect to access to health services. CBPR proved highly effective in mobilizing community participation and increasing access to sexual health services over the long term, because it was supported by and was able to feed community insights into a much larger infrastructure that sought to mobilize communities of sexual minorities.

**Project setting**

The project took place in Mysore, South India, under the larger umbrella of an HIV intervention formed by the University of Manitoba and the sex workers collective known as Ashodaya Samithi, funded by the Bill & Melinda Gates Foundation through Avahan. Since 2003, the Avahan initiative has focused on epidemic prevention in India’s six highest HIV prevalence zones. The purpose of the intervention is to reduce the risk and vulnerability to HIV among high-risk groups, including female sex workers (FSWs) and MSM, through community mobilization schemes that seek to increase access to vital clinical and health promotional resources. At the start of this CBPR project in 2006, the HIV prevalence in Karnataka was 1.0% among women seeking care at antenatal clinics, which may reflect the HIV prevalence in the general population, but was as high as 9.6% among FSWs and 19.2% among MSM (NACO 2008).

Several events ignited this study. The first author was introduced to a group of MSM community leaders who were working as community outreach workers and mobilizers for the sex worker organization known as Ashodaya Samithi (Reza-Paul et al. 2008, 2012), which primarily focused on meeting the HIV prevention needs of FSWs. Because a growing number of MSM had begun to present with high rates of sexually transmitted infection (STI) symptoms at the clinic run by Ashodaya, the organization made the commitment to also cover this population. However, outreach workers explained to the first author that less than 50% of the MSM contacted through outreach actually utilized the clinic’s free sexual health services, due to rumors and distrust that initially circulated about the intervention. As one leader explained, ‘There are many people in the community who believe that Bill Gates is selling our blood.’
During a tour of the various local community cruising spots, where community leaders promoted Ashodaya’s health services, one of the community leaders adamantly stated to the first author that, ‘we are more than just sex workers, we also have ideas for solving our own problems!’ The same community leader spoke candidly about his recent experience with a survey research project. He stated, ‘They asked me, “what is your sexual identity? Do you practice sex work? Do you wear condoms? Are you HIV positive?” Then they took the information and we never heard back from them. I was left feeling very badly after this.’ The first author then explored with this leader and other community outreach workers whether they would be interested in leading a research process that would examine their key issues and that would generate information that they would own. The community expressed considerable enthusiasm with the idea of conducting a research project for and by their community. They claimed that it would be empowering to contribute directly to the information gathering process and the interpretation of findings. It was decided to focus the research study on identifying barriers to accessing health services for MSM due to high rates of HIV and STIs in this community and the low utilization of available health services (Reza-Paul et al. 2008). Furthermore, community leaders were clear that they wanted not only to generate information about why their community was reluctant to access health services, but also to break down identified barriers to accessing these services through community engagement in the research process.

Methods

Training and opportunities for co-learning

A training program was collaboratively developed that took into account the existing knowledge, skills, and experiences of the MSM and MSW leaders. Hired by Ashodaya on a part-time basis, many of these leaders already possessed the skills to deliver safer sex information in ‘hard-to-reach locations’; and many had already participated in other kinds of research and knowledge creation activities in conjunction with Avahan’s monitoring and evaluation activities.

The training project formally began in September 2006 with the formation of the community advisory committee comprising of MSM leaders from local community-based organizations serving MSM. The committee selected community researchers (CRs) to conduct the interviews: 10 who spoke and read Kannada, the local language; one individual who spoke Hindi; and three well-respected individuals who were selected to assist with the interview recruitment process. In an effort to access a diverse sample, we chose interviewers who were connected to different social networks (according to age, cruising locations frequented, and economic status).

On the first day of training, tension erupted between MSM leaders over their different organizational affiliations: some leaders were affiliated with organizations that were accused of ignoring the needs of male sex workers. Initially, two factions formed within the group of trainees and they were unwilling to sit at the same table. These political inflammations began to subside when an influential MSM leader implored everyone to consider the needs of ‘the larger community,’ which included both MSM and MSWs. The group decided that they needed a name to instill a sense of solidarity. ‘Adarsha’ was chosen because of its positive meanings in Kannada: icon, idol, and role model. Each time political tensions re-emerged, one of the team would announce ‘Adarsha!’ to invoke group solidarity and defuse the tension.
The first day of training proceeded with an intensive session covering the cornerstone guidelines of ethical research: informed consent, coercion, confidentiality, and potential harm/benefits. On the second day, CRs formulated recruitment procedures and were trained to approach members of their community using a recruitment script. It was stressed by Adarsha that the recruitment procedure must not disrupt sex work transactions or disturb clients and that research participants should be provided with a gift as a sign of appreciation for their time, as a sex worker who gives their time as an interview respondent may lose income.

Prior to the training, two community leaders with technical assistance from the first author formulated a tentative interview guide around the following key themes: stigma, sexual practice, harassment, health-seeking and protection behavior, and HIV knowledge. On the third day of training, Adarsha modified the question set by rewording questions that they felt would make their community feel uncomfortable. For instance, rather than asking about sex work directly, they advised that a more useful question would be to ask ‘have you ever given or received gifts in exchange for sex?’ This became a crucial question for understanding the interactions between sex workers and their clients (see Lorway, Reza-Paul, and Pasha 2009). Adarsha wanted the interviews to flow like a natural conversation so that the participants would feel comfortable talking about their experiences. To achieve this, Adarsha concluded that the question set must be worded in ‘kothi language’ (a secret language used by the MSM community) in order to break down the social distance maintained between ‘the researcher’ and ‘the interviewee’ during conventional research. The CRs were trained on how to conduct a qualitative interview, which also served to pilot the interview guide. Pairs of CRs practiced the interviewing techniques they had learned. Then, each pair conducted mock interviews in front of the larger group, which provided constructive feedback. The group described how they felt while being interviewed as a way to consider the ethical questions previously raised, resulting in further revisions to the interview guide. Probing techniques were discussed in relation to the ethical concern of coercion. In anticipation of a respondent becoming upset during an interview, probing questions would be limited or halted and information on free counseling resources available at Ashodaya would be provided. In line with the project goal of breaking down barriers to accessing health services through community engagement in the research process, the Adarsha team felt that it was important to correct any misinformation regarding HIV/AIDS following an interview, at which time they would provide safer sex information pamphlets, condoms, and a description of Ashodaya health services.

**Recruiting interview participants**

Early morning, mid-day, and late evening are the peak times for male sex work in Mysore. To ensure the safety of the field research team, Adarsha agreed that recruitment would take place in the daytime period in parks, bus stops, the railway station, lodges, and at major intersections where MSM regularly congregate. Recruitment overlapped with regular community outreach rounds in which condoms and sexual health information were provided. When recruiters approached MSM after a few days, most of them had already heard about the research project by word of mouth. While rapid communication indicated that the closely knit MSM community was well informed about the project, this was also a hindrance. Negative rumors circulated quickly, such as the interviews were going to be videotaped and played on television or radio. The recruitment team worked hard to dispel such rumors. Because of the strong rapport that the Adarsha
team already had with the community, only two members out of 72 refused to participate in the interviews.

**Interview location and process**

The CRs completed 70 in-depth qualitative interviews in four days. Adarsha chose a lodge (small hotel) as the location for the interviews because of its close proximity to the main cruising areas and Ashodaya. The lodge was considered to be a discreet and politically neutral location for MSM, since it was unaffiliated with NGOs working with MSM, an important consideration as the project strived to recruit participants who were reluctant to frequent such organizations and their affiliated clinics. Furthermore, the owner was trusted by the wider MSM community and provided a generous discount on the rooms. Five rooms were rented for the interviews, and a sixth room served as an office for organizing the interview materials and provided a safe space where MSM could socialize, share experiences, exchange sexual health information, and continue to talk after the interviews were completed.

**Thematic analysis of the transcripts**

Following the four days of interviews, Adarsha held a session to discuss their experience of doing the research. Facilitated by the first author, who is an experienced qualitative researcher, 11 Adarsha CRs reviewed five of the transcripts (in English and Kannada) and compiled a list of significant themes related to sexual health from reading and rereading the transcripts. Transcripts were translated from Kannada to English, by a translator who has been working with this community for a number of years and is intimately familiar with the language used by participants. Seventeen major themes were identified through thematic analysis. Based on accepted approaches to qualitative analysis (see e.g. Boyatzis 1998), themes were identified in two ways: first, at the ‘manifest level’ (from direct observation of the content in the transcripts) and second, at the ‘latent level’ (from previous knowledge of the context in which MSM live).

The research team then prioritized the themes into four groups. Themes were prioritized to reflect sexual health needs for the MSM community, in line with the study’s main goal of exploring barriers to accessing sexual health services among the MSM community in Mysore. Moreover, they were prioritized to align with the degree of concern that local community leaders placed on these themes (Table 1).

<table>
<thead>
<tr>
<th>Priority 1</th>
<th>Priority 2</th>
<th>Priority 3</th>
<th>Priority 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use</td>
<td>Police</td>
<td>Poverty</td>
<td>Extending services to talukas</td>
</tr>
<tr>
<td>Sexual health information</td>
<td>Rowdies</td>
<td>Sex work</td>
<td>Empowerment</td>
</tr>
<tr>
<td>HIV knowledge</td>
<td>Stigma</td>
<td>Age of initiation into sex work</td>
<td>Sharing information</td>
</tr>
<tr>
<td>Sexual behavior</td>
<td>Discrimination</td>
<td></td>
<td>Spots for sex work</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Ashodaya services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Government support</td>
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</tbody>
</table>
Next, the themes were collapsed into six main priority areas Table 2.

After Adarsha assigned a code to each of the six priority areas, they reread the transcripts and marked out each theme with the assigned code. The first author used the condensed themes created by Adarsha to analyze the remainder of the translated transcripts. This analysis was then presented to Adarsha for further contextualization and reinterpretation. Color coding was used to illustrate to Adarsha how the data was analyzed using the themes they had generated.

Participants
Participants ranged from 18 to 40 years of age, with most participants between the ages of 21 and 23. Twenty-six percent of participants had never attended Ashodaya’s sexual health clinic. Seventy-three percent received income from sex work (which may be related to the networks to which the recruiters were connected and the purposive sampling technique they employed). Of the 51 participants involved in sex work, 63% received their main source of income from sex work. Participants who drew income from sex work came from a variety of educational backgrounds. Some participants held university diplomas, including bachelors and graduate degrees, and held jobs in business, teaching, computer information technology, and at NGOs, while also earning income through sex work (see Table 3).

Findings
The following section presents the findings related to two of the main themes concerning sexual health prioritized by the CRs: stigma and discrimination and the state health care system. Findings are also discussed to reveal how the use of CRs was helpful in breaking down internalized stigma during the interview process, in building solidarity and providing a space for sharing information on sexual health and HIV prevention and treatment.

Table 3. Educational backgrounds of participants practicing sex work.

<table>
<thead>
<tr>
<th>Completed education</th>
<th>Sex work as primary income</th>
<th>Sex work as secondary source of income</th>
<th>No income from sex work</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=70</td>
<td>N=32</td>
<td>N=19</td>
<td>N=19</td>
</tr>
<tr>
<td>Bachelors-MA 18</td>
<td>7</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>PUC I and II 17</td>
<td>9</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Std 10-SSLC 14</td>
<td>8</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Std 7-9 9</td>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>No formal education-std. 5 12</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Notes: PUC = pre-university college; SSLC = school standard leave certificate; Std = standard/grade.
**Stigma and discrimination**

The stigma attached to homosexuality in Indian society poses a major challenge in reaching MSM with public health resources. One of the main ways that participants managed stigma in their daily lives was through concealment. Most MSM disclosed their same-sex sexual desires and behaviors only to members of the MSM community. When interviewees were asked ‘Who do you tell that you have sex with other men?’ some responded as follows:

I have disclosed only with my close friends who are also in the same profession [of sex work] like me. Other than these people, I have not told anyone. I am behaving like a woman … Society does not understand my inner feelings and the agony I pass through … Society does not understand our feelings … We can’t express ourselves with everyone … or they will not give us any respect in the society. We say that to ourselves in our mind. [22-year-old MSW]

Participants were also deeply concerned that family members would reject them, as explained by a 20-year-old, well-educated businessman who stated, ‘If my family comes to know about this, my life will be spoiled.’

Although participants consistently practiced concealment as a strategy for managing stigma relating to their same-sex behavior, this did not always enable them to escape discrimination. One man tells of his harrowing experience of discrimination when his same-sex sexual behavior was revealed:

*Participant:* One of my relatives told bad things about me to my father-in-law. Then my father-in-law and my wife went away saying that they don’t like me. Later they have spread another rumor. They said that I have HIV and that is the reason my wife has left me … The people from my own community started asking the bride’s people ‘why did you arrange a marriage for your girl with this fellow?’ He is a loafer, take him and get his blood tested. My father-in-law … he took her away. I told him that he can get my blood tested if he so wished. My wife did not wish to live with me, she took a divorce … People came from her village. Whatever they had given me as dowry – they had not given cash, they had given a watch, a ring and a chain – they took all that back and put in writing that there is no relationship anymore between them and us and went away. When my grandmother came to know that I am gay and that I am an MSM she started showing disgust … she treated me as an outsider. She stopped talking to me. Now I am a lowly person at home. I am lower than the servants. That is how they treat me.

*Interviewer:* What did your own family members say?

*Participant:* They told me ‘you don’t stay here. Please go away. We have had lot of problems because of you. You are gay. We don’t want to hear such things. You go away, find a house and live somewhere else.’ I have been looking for another house, as I don’t want my family to be blamed because of me. [32 year-old teacher]

The internalization of social stigma as shame or self-devaluation appeared across many of the participants’ narratives. When a 19-year-old electrician was asked, ‘How do you feel about being a man who has sex with men?’ he responded:

I want to be in this field [of male sex work], but if others come to know, I feel … humiliated. First, I did not have any feelings towards this; now, sometimes after sex, I feel bad for what I am doing? Why did I come to this field? While I am with other kothis [effeminate males] like me, I feel happy. But, I also feel depressed and sad.
Participants who were identified as feminine, in particular, received intense discrediting social feedback from other men. This resulted in much anxiety and depressive states as a 32-year-old businessman explained:

Exploitation will be going on once you enter this field of [sex work] ... they will bully you. At the beginning, when I came [to sex work] at 16 ... there were many incidents, of people calling me out, addressing me like a girl ... During those days I didn’t like being yelled at and called out mockingly and being addressed as a girl. As days passed they realized that 'this person will be silent' and so ... they started threatening me, calling me out in vulgar names ... saying this and that, ‘Hey! He is an “ass stealer” … ‘Gaandu’ [male fucker]. I got treated badly by this one fellow. In the beginning ... he threatened that he would go and tell my family. He said that my family would have to go and hang themselves. At that time I was shit scared and I was so scared that I attempted suicide ... I had written a letter, kept it and attempted suicide ... I apologized and said that I am sorry I have done all this and then attempted suicide.

A 22-year-old MSW who works part time at an NGO serving sexual minorities also experienced suicidal ideation as a result of discrimination:

People around us, they speak foul about us. My family members know me as an MSW, they sometimes scold me for going home late, they shout at me saying not to practice the sex work ... When I was working in a textile factory, my colleagues used to speak foul of me. Nowadays when I go to [names a bar], they refer to me as sangha [derogatory name for MSM]. There, I have felt bad many times and even felt like committing suicide.

The participants report openly disclosing their sexual identity only to other MSM and it is unlikely that participants would have shared such personal experiences with stigma and discrimination with noncommunity researchers. Concealment as a coping strategy for managing stigma was also described in the next section, exploring sexual health and interactions with the state health care system.

**State health care system**

Once when I was in the village I had anal sex done to me and there was irritation, itching and pain there and it had swollen and I could not pass stools. Then in the public hospital they did a minor surgery and removed puss from there. They stuffed cloth into my anus. My anus had gone to dogs; this is a true incident. Then slowly my wound started to heal. I still remember there used to be one nurse who would close her nose and act as if she would vomit. She told everyone that she should not be called if a patient “like me” comes, ever. Being a nurse she said that! I know I have done wrong things and God has already punished me. Who is she to say such things? [26-year-old MSW]

Most participants reported that they were reluctant to attend state or even private clinics for fear they would be stigmatized, and due to a lack of consistency in care. One respondent felt that he would not know what to expect:

If we get admitted, all doctors are not similar. There are some doctors who have food with us, sit with us and speak to us ... Others, when we are admitted, they have a bad opinion of us if they come to know we have sex with men ... At night the same doctor will come to us to have sex, and in the morning the doctor wears gloves and does the check up. [23-year-old MSW]
The stress and anxiety surrounding medical care and identity disclosure is exemplified in one man’s narrative, who was relieved to learn that he had contracted typhoid rather than an infection sexually transmitted between men:

I have not gone to other doctors [outside of the Ashodaya Samithi clinic]. I will not go. One time, there is a doctor near my home. He gave me a letter. My family people took me there. I gave my blood and urine for the test. After that I was totally terrified. What will people at home say if they come to know [I have sex with men]? That was my worry. When the report came, it said that I had typhoid and I needed a month’s rest. I was so relieved. [19-year-old MSW]

For many participants, their reluctance to access health care resources was tied to the anticipation of discrimination from health care practitioners, as exemplified by one respondent who stated, ‘I feared that the doctor may scold me or he may not give medicine.’ However, many of the participants’ responses suggest that this fear of discrimination was accurate. The following participants experienced ridicule, chastisement, and other forms of discrimination in the state and private health care systems:

After coming from the doctor’s office, people used to mock me and laughed at me, even the nurses of the hospital made fun of me. They used to laugh by saying that I was a man who goes to have sex with men only. [18-year-old hotel worker]

I told everything to the doctor, I mean, I told them that I do sex with males and I prefer to do sex with men. So he advised me not to have sex with men. In front of the doctor, I agree, saying ‘yes’ that I won’t continue having sex with men; but once I come out and see men, then I want to have sex with them … So far, the doctors have not hesitated to treat me; but the nurses, they are very horrible as they ill treat me, calling me Sangha, Gandu … [21-year-old sex worker]

One of my friends who has HIV, but I will not disclose his name … took poison in the park and later got admitted to the hospital and expired. But he did not tell anything to the doctor because he hesitated to tell that he was a sex worker. [20-year-old MSW]

Participants’ experiences with the health care system reveal that even when requiring critical care, MSM fear disclosing their sexual identity to nurses and doctors due to discrimination and poor treatment. The following section describes the experiences of interview participants with the CRs, and how the interview process itself worked to break down stigma, build solidarity, and create an environment where nonjudgmental sexual health information could be exchanged.

**Breaking down stigma through CR participation**

The reliance on MSM and MSW as interviewers worked to break down barriers that exist between conventional researchers and participants build trust and create a safe and supportive environment where participants felt comfortable sharing their experiences with stigma and discrimination. Disclosing their own sexual identity and involvement in sex work greatly helped to build the researcher’s rapport with the respondent. This had the following effect on many responses:

When I hear you speaking, I feel that you and I are the same. It is as though you have put a mirror to my own life … You may be a person who has come to interview us for the
project, but the way you are asking, with understanding of the hijras and with so much patience, it makes our heart lighter. I should thank you for that. [20-year-old MSW]

Participants candidly discussed sensitive issues with the community researchers – issues that they would have been unlikely to share with noncommunity interviewers:

Now I’m revealing to you those facts that have been hidden deep inside my heart. Because you are also a male sex worker like me, that is why I like to tell … [22-year old factory worker]

Once the interview concluded, many of the participants were quite emotional in expressing how the interview made them feel. Consistently, participants stated that a heavy weight had been lifted from them; most described the interview as providing a sense of relief from the burden of coping with stigma. This sentiment ran across the transcripts in statements such as ‘please ask me, I feel light hearted as I answer your questions.’ Indeed, most participants were pleased to answer questions. Conversations generated during the interviews often continued into the ‘safe space’ after the interview ended. There, sexual health information was exchanged and Ashodaya’s services were outlined and promoted by the community researchers. On one occasion, an Adarsha member provided a personal account of how the clinic had helped clear up an infection in his genital region. The respondent listened carefully to them and then requested to be taken to the clinic for a free health check-up.

Discussion
The most immediate outcome of the project was the production of strikingly rich and intimate narratives offered by participants during interviews. The personal narratives relating to the stigma experienced by participants revealed that most MSM experience widespread stigma and discrimination from family and society, resulting in shame, internalized stigma, and even suicidal ideation and attempts. These findings are mirrored in other settings where same-sex behavior is stigmatized or criminalized, and often leads to the concealment of one’s sexual identity from anyone outside of the MSM community (Bonthuys and Erlank 2012; Tadele 2012). Gender nonconformity stigma, such as that experienced by MSM who identify as kothis and display feminine mannerisms, speech patterns, and behaviors, shows that high rates of depression resulting from stigma persist even when social support is available (Logie et al. 2012). This stigma results in widespread pressure for MSM to indentify as heterosexual (Thomas et al. 2012) and leads MSM to largely remain hidden in India (Chakrapani et al. 2007).

Stigma as a perception and lived experience, reinforced by discrimination, underscores the apprehension expressed toward the state health care system. The multiple intersecting social and structural environments of stigmatization and discrimination experienced by people who are identified as MSM, sex workers, and HIV positive can create major obstacles to accessing health care (Chakrapani, Newman, and Shunmugam 2008; Mahajan et al. 2008; Mill et al. 2009). Research has shown that stigma acts as a key barrier to accessing health care for sex workers globally (Rekart 2005; Scambler and Paoli 2008). Stigma and fear of stigma limit both access to services and information (Spire, de Zoya, and Himmich 2008) and have limited access to services for sex workers in settings across India (Ghoose et al. 2008; Chakrapani et al. 2009), especially among sex workers also living with HIV (Lazarus et al. 2012).
There is little consensus about how best to define, measure, and diminish stigma (Mahajan et al. 2008). By undertaking a CBPR approach, our research process worked to break down widespread stigma and barriers to health information and access by directly linking participants to Avahan interventions. Adhering to a CBPR approach in this study not only facilitated the social scientific exploration of stigma and discrimination but it also enabled stigma, as a methodological obstacle, to be sensitively confronted and overcome during the research process. The CBPR methods and use of CRs were able to create an environment where participants were comfortable in disclosing the intense stigma that they experience as part of their daily lives. Furthermore, the use of CRs as interviewers worked to break down this stigma by building solidarity between CRs and participants, while creating a non-judgmental space where information on STI and HIV prevention and treatment could be exchanged. Participants consistently described feeling relieved and unburdened after the interview. This emotional response yielded another unexpected positive effect – bonding and an emerging sense of solidarity. Following the interviewing and the public dissemination of the results back to the MSM community, Adarsha established itself as an organization and its membership soon grew to 400 members. Over time, the membership base continued to grow and now stands at more than 2000 members. This emerging form of solidarity also became reflected in improved health-seeking behavior, almost immediately doubling the number of annual MSM clinic attendees.

As part of establishing Adarsha, the CRs decided that they wanted to formally become a wing of the larger, well-known sex worker collective Ashodaya Samithi, so that they could have access to Avahan-sponsored infrastructure to help support the achievement of their action plan. These goals included establishing specialized clinical services and drop-in centers for MSM in neighboring talukas. Working closely alongside FSW allies, these goals were realized for both communities over the coming years (Argento et al. 2011; Dixon et al. 2012).

Efforts to demystify conventional scientific procedures throughout the CBPR project – by defining and simplifying technical jargon used by researchers – enhanced the ability of the community to participate in other research projects in the region, including a larger CBPR project that spanned three districts of Karnataka. The CRs and first author transferred and translated their experience, skills, and understanding of research to MSM communities in two other urban centers. New methodologies to explore sexual networks, based on local genealogical conceptual schemes, were also developed by these CRs, in collaboration with the first author, and were shared before expert panels at international conferences and in a peer review publication (Lorway et al. 2010). In 2010, these CRs formed a multi-district network of community researchers across Karnataka, known as Amulya Jeevan Research Network, and actively participate in a number of ongoing research projects in Karnataka State. In Mysore, CRs have played an instrumental role in executing Avahan’s monitoring and evaluation projects, guiding health professionals in various areas such as instrument design, survey administration, and deciding when, how, and where the findings should be released with respect to the community.

Limitations
CBPR has the potential to increase the relevance of research findings for communities, translate research into action, and break down the stigmatization of communities (Schnarch 2004). However, CBPR can also generate new ethical concerns. For example,
it can be challenging to obtain community-level consent for research and action that impacts the community as a whole. Furthermore, CBPR has the potential to set up uneven collaborations and new relations of power and inequality, while undoing prevailing power imbalances. This research project attempted to address these limitations of CBPR through ongoing community consultation, partnership building with community leaders, and adherence to collaborative principles including ongoing critical self-reflection. Confidentiality, privacy, and self-care are also important considerations in CBPR. These topics were focal points during CR trainings. Although the use of CRs could create concerns surrounding privacy and confidentiality, the extremely low refusal rate when one considers the intense stigma that surrounded the daily lives of MSM in India indicates that this was not a concern for participants. Finally, community participation can be uneven, temporary, sporadic, and, in some instances, burdensome for the community that is expected to sustain its outcomes beyond project funding (Cornwall and Jewkes 1995). Efforts were made to provide adequate support to CRs so that they were able to remain engaged in the project.

Conclusion

At a moment in history, when HIV prevention is increasingly being placed under the jurisdiction of biomedicine with the release and development of new HIV prevention technologies, such as antiretroviral therapies, microbicides, male circumcision, and pre-exposure prophylaxis (Nguyen et al. 2011), it is important to underscore the insight, vitality, and ingenuity of local communities in designing effective HIV prevention programs. In this study, we have tried to show how CBPR can be highly effective for producing important social scientific knowledge, mobilizing communities, and improving health and well-being in the presence of sustained infrastructure and funding support. More broadly, by highlighting various positive effects of CBPR, we have sought to further emphasize the possibilities of public health practitioners to work more democratically with disenfranchised and highly stigmatized communities through reciprocal transfer of expertise, co-learning, and shared decision-making.

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