



**needs assessment of males who have sex with males in
Calcutta and its suburbs**

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NEEDS ASSESSMENT OF MALES WHO HAVE SEX WITH MALES IN CALCUTTA AND SUBURBS

prepared by:
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Praajak (formerly Naz Calcutta Project)

PREFACE

Praajak, is extremely proud to publish this report on the Needs Assessment of males who have sex with male (MSM) in Calcutta and its suburbs. The Assessment was carried out over five months from mid-November 1996 to mid-April 1997.

This report is the first comprehensive report on MSM anywhere in India. The findings indicate that male to male sex is widespread in Calcutta and its suburbs. Such behaviour has been so far not acknowledged in official discourses largely due to its invisibility.

This report is attempt to make visible the existence of male to male sex so that effective intervention programmes can be designed to prevent the spread of HIV/ AIDS through this route.

We have purposely used the work “male” instead of “men” in designating our target population. By “male” we intend to embrace all categories of biological males including age structured categories like “men” and “boys” and the gender specific ones of “masculine” and “feminine”

Sexual identity is largely a non-issue among MSM at present. We have tried, therefore, not to fall into the trap of labelling our target population either as “gay”, “homosexual”, or “bisexual”

We hope this report will go a long way in promoting sexual health of MSM not only in Calcutta but all over the country.

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INTRODUCTION

Praajak is an HIV/AIDS and sexual health agency. The project was started in June 1995 as Naz Calcutta Project since when we have been running a male sexual health programme. A special focus of this has been out reach work with males who have sex with males (MSM) who meet in cruising areas in Calcutta. Naz Calcutta Project became Praajak in October 1997.

In September 1996 NAZ Calcutta Project submitted a proposal to the West Bengal Sexual Health project for a contract to conduct an assessment of the sexual health needs of MSM in Calcutta. This would build on Naz'S established work.

It was agreed that the needs assessment would be conducted over a period of 5 months from 15th November 1996 to 15th April 1997.

The findings of the assessment are contained in this report. "An Assessment of the Sexual Health Needs of Males who Have Sex with males In Calcutta."

MALES WHO HAVE SEX WITH MALES AND SEXUAL HEALTH IN INDIA

Male to male sexual behaviour is “systematically denied” in India (ABVA report on gay men, 1995). Consequently there is little knowledge of the affects of men having sex with men, sex between boys, and sex between men and boys and STD and HIV transmission.

Some research on sexual behaviour and health in India makes brief mention of males having sex with males, for instance the recent 65 cities study of sexual health in India (Nag 96) However, this contributes little to understanding the impact of male to male sex on the nations sexual health.

Some proponents believe, that in the climate of denial in India, evidence of male to male HIV transmission has been silenced. Ashok Row Kavi, Mumbai (Bombay) gay activist, has argued that an official seroprevalence survey undertaken in 1990 in Bombay and Pune found at 20% of MSM in the area were HIV positive. The results have never been published (Panos 1996).

However, given the barriers to accessing the largely invisible population of MSM in India, it is difficult to assess the accuracy of any statistics on male to male sex and seroprevalence of STD rates.

Most of the scarce research data available on male to male sex comes from studies of the behaviour of regional sample groups, for instance the report. “Men Who Have Sex With Men: Assessment of the Situation in Madras”.

This type of qualitative research examines the networks of male sexual contact in a given location and assesses the predominance of sexual health risk behaviour. Such local studies provide the best basis for assessing the impact of male to male sexual behaviour on sexual health in the sub continent.

A predominant conclusion about MSM in India is that they cannot be categorised according to western labels for same sex desire. Words such as ‘gay’ of ‘homosexual’ which imply an individualistic sense of identity based on same sex attraction do not describe the experience of most Indian males. Many MSM in India identify as heterosexual, or have no sense of sexual identity at all. Many MSM also have sex with females.

To take an example of inappropriate terminology usage, the West Bengal Voluntary Health Association study of truck drivers in West Bengal observes that some of the drivers and *khalasis* (driver’s helpers) that the project worked with have sex with one another. However, the report simply states that some of the males are homosexual. This does nothing to analyse the social context and psychology of these males’ sexual activity with one another, let alone provide any information about how the males do, or don’t, articulate their same sex behaviour. Consequently there is no information basis for sexual health promotion.

Thus to structure research on male to male sex and sexual health in India in terms of homosexual and heterosexual dichotomies is inappropriate and misleading (Khan 1996). Certainly if research sets out to work with homosexually identified males the picture of male to male HIV and STD transmission in India will be inadequate since so few males fall into this category.

However, when analyses is expanded in consideration of Indian behaviour patterns, to study the homosexual behaviour of non- homosexual males, male to male sex appears a much more predominant sexual health risk. Some estimates put the number of Indian males who have had a same sex encounter in their lifetime at 50% or more (Panos 1996).

To overcome the terminological problems presented by use of identity based sexuality labels the term ‘males who have sex with males’ is used as a neutral umbrella term under which to describe all males, men and boys, engaging in same sex behaviour. This nomenclature describes behaviour and encompasses a wide variety of males whatever their identity construction. This emphasis is important in sexual health intervention because it is behaviour not identity which transmits virus and infection. It is also important to remember that in India it is only a particular type of homosexual behaviour i.e. anal penetration, not identity which is criminalised. Sections of the Indian penal code used to threaten MSM are:

Section 377, which carries a possible ten year prison sentence to anyone who ‘voluntarily has carnal intercourse against the order of nature’.

Sections 269 and 270, which are used to prosecute for acts likely to cause infection.

Section 294, used to prosecute obscene acts in public places.

Whilst these articles do not explicitly mentioned homosexuality their contents are sufficiently vague to allow MSM to be threatened and prosecuted by them by prejudicial authorities.

It is prejudice at all levels of society that means for many males their sex with other males will be conducted in secret, in contexts where they do not develop any relationships with their partners, and in places where they are under threat of harassment, violence and extortion.

These circumstances have a great bearing on the sexual health of MSM. In quick anonymous sexual encounters males are unlikely to spare much thought for the protection of themselves and their partners. For MSM, concerns about sexual risk are much more about threats from harassment than from infection.

Praajak incorporates these concerns in its work. We believe that in order to promote safer sexual practice we must promote a safer environment for MSM. This means empowering the males we work with, addressing social discrimination, and establishing a supportive service sector.

The WHO definition of sexual health is:

“The integration of physical emotional intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love”

Praajak believes that in order to work with MSM on sexual health a wide range of concerns must be addressed. In the following report the many needs identified by MSM we have worked with in Calcutta are presented and discussed. We hope that by addressing these needs we will promote personality, communication and love not just amongst the males we work with, but between the males and their partners, both male and female, and amongst all people who the project touches.

OBJECTIVES OF THE NEEDS ASSESSMENT

Our overall objective was that the information we acquired from the needs assessment would enable us to develop a sexual health intervention programme appropriate to the needs of MSM in Calcutta and its suburbs.

Our principal mode of work was outreach in places where MSM meet. We decided that it was practical in the time and personnel boundaries of the needs assessment to limit our outreach work to making contacts with MSM in 15 cruising areas in central Calcutta already mapped by Praajak outreach workers. We had sufficient information to know that the social composite of these 15 outreach sites represented a demographic cross section of MSM in Calcutta. We identified 10 categories of males that we wanted our sample group to include. These were:

1. Males who sell sex (MSS)
2. Males who buy sex (MBS)
3. Non-commercial cruisers (NCC)
4. Self-identified gay/homosexual males (SIGM)
5. Muslim males who have sex with males
6. Hindu males who have sex with males
7. Males from lower income groups and migrant labourers (LIG MSM)
8. Males from upper and middle income groups (UIG/MIG MSM)
9. Young males (including boys) who have sex with males (YMSM)
10. Males who have sex with males who are married or have female sex partners (MMSM)

Most of these categories are not mutually exclusive. For example, a male who sells sex could be married, Muslim, from a low income group, who also sometimes cruises non-commercially or pays for sex. The absence of fixed boundaries between these categories increases the difficulty in selecting a representative sample. However, we feel that our sample was more or less representative of the various communities that build up the MSM networks.

In all our target was to reach approximately 300 males.

- * To build rapport with 300 males frequenting the 15 cruising sites.
- * To learn about the sexual behaviour of 300 MSM.
- * To assess the degree of risky sexual behaviour and appropriate condom use amongst 300 MSM.
- * To assess the males knowledge of STD'S and HIV/AIDS, an appropriate means of sexual protection.
- * to identify at least 10 constraints and barriers to accessing sexual health services reported by MSM
- * To identify sexual health needs of MSM and any other problems they identify associate with their sexual activity/orientation.
- * To encourage males contacted during outreach to attend focus group discussions and other activities organised by Praajak.

It makes little sense to promote sexual health amongst MSM without simultaneously addressing the social and institutional prejudice they encounter. Hence the other component of the needs assessment was an advocacy programme. The objectives of this were:

- * To interview 20 external stakeholders to identify their attitudes towards MSM, and their beliefs about male to male sexual behaviour and sexual health. External stakeholders were health service providers, police personnel, media representatives, lawyers psychiatrists, psychologists, and other NGO's

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- * To assess social and structural prejudice about MSM.
 - * To identify the training needs of external stakeholders in order that they may become more sensitive to MSM's and their sexual health needs.
 - * To identify potential collaborators in setting up a medical, legal and counselling referral system of NAZ Calcutta clients.

DIFFICULTIES FACED BY THE NEEDS ASSESSMENT

- A. During our Needs Assessment period no contact could be made with migrant labourers. No literature on male sex between migrant labourers was available.
- B. Our Needs Assessment was carried out during most of the winter. This is a time when there is a considerable fall in the number of people coming to cruising sites. This made it difficult to contact members of our target population.
- C. The month of Ramadan, when Muslims fast and practice abstinence, also fell during our Needs Assessment period. Most Muslim males stayed away from cruising areas making it impossible for the project to reach out to them during the month.
- D. The Needs Assessment period coincided with a particularly bad phase of violence directed at MSM in cruising areas by police, park guards and local hoodlums. This also kept numbers of cruisers low during the period.
- E. The spillover effect of the violent incidents was felt by our outreach executives some of whom faced harassment, abuse and even extortion from both local hoodlums and MSS. Outreach in at least 4 sites had to be abandoned for a considerable period.

METHODOLOGIES OF THE NEEDS ASSESSMENT

Given the invisibility of MSM and consequent difficulties in accessing males to work with, most suitable methodologies for needs assessment are qualitative tools applied to a small sample population.

Praajak also favours these methods as they allow us to gather more substantial information about needs from the males we work with, and complement our outreach work and rapport building with males. We wanted to involve the males we work with in the needs assessment as much as possible, hence we placed much emphasis on participatory methodologies. We also believe that these methods encouraged the participating males to think about solutions to their needs, and to internalise sexual health messages generated during the assessment research.

Methodologies were:

Outreach observations.

Outreach executives recorded their nightly observations of the behaviours and events in the cruising areas they worked in. The 15 outreach sites were visited 4 times a week each during the first 4 months of the needs assessment period. In the final month outcome analysis work curtailed outreach to weekly visits.

One to one discussions.

Outreach executives conducted 100 questionnaire based interviews with a cross section of respondents from the 15 cruising areas. The questionnaire provided a structured basis for discussions with males. The data provided us with a quantifiable representation of our findings which has been used in this report to illustrate demographic characteristics of our client group, and incidence of risk behaviours.

Focus Group Discussions.

Outreach executives invited males to attend focus group discussions (FGD'S) on sexual health needs. These employed Participatory Rapid Appraisal methods, role play and games. We completed 40 discussion sessions in the needs assessment period. 72 males including 17 street children participated in the discussions.

Sexual Anecdotes

It was planned to have at least 20 men befriended by our outreach executives to keep diaries of their sexual practices. However, this was not successful. Therefore these 20 males were asked to record sexual anecdotes related to them by other males. Anecdotes related by 86 males were recorded.

Stakeholder Interview.

The advocacy programme executive interviewed 25 external stakeholders from all our target fields.

Literature review.

The reading of available relevant literature informed our ongoing work and analysis.

FINDING OF THE NEEDS ASSESSMENT

1. Description of the target population.

The target population of the needs assessment were MSM frequenting 15 cruising sites in Calcutta. Our objective was to reach out of 300 males.

Given the invisibility of male to male sexual behaviour it is difficult to give an accurate figure to the number of MSM resident in Calcutta.

Praajak outreach executives estimate that the total number of males visiting all 15 outreach sites targeted in the needs assessment is 500 on an average day. Of the males we spoke to during outreach and focus groups, 3 visits to a cruising site in a week was the average number of visits per person.

The population of cruising sites is not constant. Whilst some sites have a core group of attending males the composition of this tends to shift over time with some males tailing off their visits and new males coming to the area. Praajak outreach executives found from one to one discussions that approximately 20% of males they spoke to said they had started coming to cruising sites in the last six months. This indicates that the wider 'pool' of MSM associated with the 15 target cruising sites is much larger than 500. This is to say nothing of the population of MSM in Calcutta who don't visit the 15 needs assessment outreach sites.

The population of cruising sites fluctuates. Weekends find many more males in all 15 outreach sites than weekdays. Also, seasonally, summer and the dry season are much more popular for cruising than winter and monsoon. Additionally it is informative to record that outreach executives observed a noticeable swell in population in many of the cruising sites in the period after school/college exams were completed. This indicates that a substantial number of males frequenting cruising sites are of 18 years of age or below.

Praajak outreach executives have also identified private venues and networks of MSM who don't visit cruising areas or have no or occasional contact with cruisers networks. However, a detailed study of these venues and networks could not be undertaken as this was beyond the scope of our survey. However, we have mentioned the characteristics of these MSM networks in our report at relevant places.

2. Demographic Profile of the target population.

MSM are heterogeneous, coming from all social and economic backgrounds, all religions group, all ethnic categories, having diverse levels of literacy and education, and range in age from young boys to elderly males.

In order to represent this heterogeneity in the needs assessment we designed 10 social characteristics which we wanted our core sample to represent (see objectives above). Drawing from our questionnaire data of 100 males the demographic profile of our sample group was as follows:

Religion:

74% Hindus
20% Muslims
5% Christians
1% Jain

Profession

53% Service
13% Business
12% Other
22% Unemployed

The Professional categories are broad. Service includes domestic helpers to civil servants. The category 'unemployed' means that the persons have no irregular source of income.

Age.

20% Aged 15-20
37% Aged 21-25
23% Aged 26-30
9% Aged 31-35
6% Aged 41 & over.

19% of respondents were students.
63% of these are in colleges.
16% of these are in universities.
21% of these are in vocational courses.

Marital Status

84% Unmarried
16% Married

Married males are a difficult group to access as males often keep their marital status secret in cruising areas. We estimate from our outreach work that the percentage of married MSM is much higher than our statistics indicate.

Language

73% Bengali
15% Hindi
6% Urdu
6% Other

Residence

91% Reside in Calcutta
7% Reside in suburbs.
2% Reside in villages.

Commercial sex work.

25% Males who sell Sex
16% Males who buy Sex.

8% of the MSS also stated that they occasionally paid for having sex.

In addition to this sample we are also able to hold focus group discussions with street children in association with Cini-Asha as an additional component of our research. We include observations about male to male sexual behaviours amongst these boys in this report.

Our Needs Assessment Survey revealed that our target population could be broadly divided into two categories viz. non-commercially cruising males and commercially cruising males. The latter category would include men who sell sex (MSS) and men who buy sex (MBS). However, MBS often cruise non-commercially and are frequently indistinguishable from non-commercial cruisers (NCC). In some instances, MSS also have been found to cruise non-commercially. Even among non-commercial cruisers, there have been a few instances of gift receiving from older sexual partners. By and large the categories of NCC and MSS are mutually exclusive and possess certain socio-economic characteristics that distinguish them from each other.

As majority of non-commercial cruisers (NCC) have no sense of sexual identity, most refer to each other as *game-er chhele* (being in the game) or *line-er chhele* (belonging to the line). On the other hand, most MSS have a clearly defined *dhurani* identity defined by their sexuality and sexual behaviour. In MSM slang, *dhurani* means an effeminate male who assumes the receptive role during sex. Overt 'feminine' demeanour in public often distinguishes MSS from NCC. This factor, more than anything else, precludes any social intermixing between the two groups. In fact, many NCC harbour deep-seated fears and distrust about MSS and avoid any sort of interaction with them, not only in public but also in private. Many MBS, who otherwise frequently have non-commercial sex with males, also harbour a negative attitude to MSS. However, some MBS have developed good social relationships with MSS.

While 13% of the NCC were unemployed this figure was 46% among MSS. Also, half of the MSS came from lower income groups. One-to-one interviews and focus group discussions with MSS revealed that there was a direct correlation between selling sex and low economic status. MSS from middle income groups were largely in the commercial

scene as this helped them earn some easy money. MSS also reported higher levels of STD symptoms than NCC. MSS also tend to face relatively more extortion, harassment and violence from the police and local hoodlums. They also suffer from very low levels of self-esteem when compared to most NCC. However, unlike NCC who diligently guard their identities in public place, MSS are not so secretive. Boisterous behaviour in public places by groups of MSS are often the norms rather than the exception. Moreover, some MSS have underworld connections and often indulge in mugging or blackmailing non-commercially cruising MSM.

As we proceed further, the differences between NCC and MSS with respect to risky sexual behaviour and the vastly dissimilar socio-cultural milieu in which they exist will be highlighted.

3. The ‘culture’ of the target population and sexual risk

MSM do not have a unifying culture As observed the males are heterogeneous. Though they share many common feelings and concerns related to same sex desire and behaviour, these do not constitute a cultural identity.

This is particularly so given that most MSM, especially NCC, in Calcutta have no sense of sexual identity. Although sharing a common desire for males may form a basis of friendships between some groups of NCC, homosexuality does not become an overriding cause for commonality.

In Calcutta we have found, for instance, that middle class Hindu NCC typically will not associate with Muslim, or lower class NCC. Other determinants predominate as bases for a shared cultural identity amongst the fragmented groups of NCC in the city. Nonetheless a number of common lifestyle characteristics pertaining to sexual activities of NCC can be discerned and assessed regarding their consequences for risk reduction.

MSS however, form a much more cohesive group with some sense of identity derived from their sexuality. While most construct their identities around the feminine/receptive *dhurani* role, there are of course some who don’t define themselves as such. MSS are an immensely visible group in public cruising sites. Most can be easily identified by their ‘feminine’ demeanour and a characteristic dialect which only MSS understand. While they are often harassed and ridiculed by local hoodlums, they are also quick to hurl verbal abuses in turn, The police officials in quite a few ‘thana’ areas where MSS publicity solicit are familiar with them and MSS often pay the police or have sex with them in return for being left alone on the streets. The MSS are the public face of MSM in Calcutta and the stereotypes of MSM are often constructed keeping MSS in mind.

Secrecy, invisibility and lack of space.

Secrecy is a common experience of NCC in Calcutta. In focus group discussions practically all males we worked with said that nobody knew about their same sex desire and activities other than other MSM who are in their social group or who frequent cruising areas. The exception to this was a few MSS who said their mothers and people in their neighbourhood knew about their work. Though most other MSS hide the fact, that they sell sex from their families, their sexual identity is often not secret in cruising areas.

Amongst NCC, leading a ‘double life’ is common experience. The most pronounced emotional consequences of this duality observed in our research was the guilt amongst married NCC about deceiving their wives and family. Married males were very afraid that they would be ‘found out’ and exposed to their families. Hence they told us that they don’t tell their sexual partners that they are married because this may put them at risk of blackmail.

The fear of exposure is a common characteristics of non-commercially cruising MSM. Thus accompanying secrecy, invisibility is another shared characteristics of all male to male sexual and social networks. However, this doesn’t imply that MSM don’t socialise openly. Cruising areas where males meet are public spaces which MSM appropriate and meet in. However, this is not an exclusive appropriation. Cruising sites, such as parks, maidans and railway stations are social spaces for other peoples too. MSM maintain their invisibility because males socialising together is not noteworthy to the ‘uninitiated’ member of the public.

However, the invisibility enjoyed in public spaces becomes threatened when males engage in sexual activities with other males which make their sexual orientation apparent. Many males we spoke to report often having sex in public places because they have nowhere else to go. Consequently fear of exposure and assault at the time of sex is a common experience of many of the males we worked with. This has consequences for risk reduction because many males thus have hurried sex and give little thought to safety. A number of males told outreach executives that they don’t have time to think about condoms when having sex in cruising sites.

MSS on the other hand don't suffer from the fear of exposure to the extent of NCC. Many of them who solicit near railway stations or toilets in downtown Calcutta are often blatant about their intentions. However, most MSS suffer from a low level of self-esteem. This is related to their feminine *dhurani* identity. Prevalent patriarchal value systems which rundown 'femininity' have been internalised by the MSS. This makes most of them indifferent about health risks during sex with clients.

However, unlike among NCC, where small social support networks exist, MSS don't form such networks among themselves. Outreach executives observed a fierce sense of 'competition' between MSS which makes it difficult to foster mutual trust among themselves.

Gendered and non-gendered selves.

It has been observed that MSS in developing countries generally adopt a gendered sense of identity which influences the role they take in male to male sexual activities. In Calcutta these gendered selves are expressed in the concepts of *dhurani*, feminine man who takes the so-called "passive" role in sex with men, and *parikh*, masculine man of whatever sexual orientation, but who takes the so-called 'active' role in sex with men. In our questionnaire survey we found that 7% of males sought *dhurani* partners, and 49% sought *parikh*.

4. Awareness of STD's , HIV and AIDS

Awareness about STD's, HIV and AIDS, and appropriate means of sexual protection was generally poor amongst the males we worked with. Knowledge differentials within the sample group were principally related to socio-economic status and related educational backgrounds.

Across the sample population the only STD's respondents had heard of were the words gonorrhoea and syphilis. Nobody we spoke to had any knowledge about the symptoms of these infections.

With reference of AIDS, respondents from upper and middle income groups had heard of the disease, citing their principal sources of information as television radio and newspapers. Amongst males we categorised as coming from lower income groups there was no knowledge of AIDS at all. Further, no respondents, amongst those aware of AIDS, were clear about the distinction between HIV and AIDS.

Mistaken beliefs reported in focus groups about sources of transmission of 'AIDS' were that it may be caught from toilet seats, urinals, mosquitoes and sharing clothes or utensils.

Some males were aware of the risks involved in sex. In focus group exercises where different sexual activities were ranked according to risk for virus transmission, anal sex was unanimously designated most risky in all focus groups doing this exercise. The majority of our FGD participants were middle class so a bias is present in this finding. Outreach executives's discussions with LIG MSM revealed almost no awareness of sexual risks.

Fear of exposure of AIDS because of past and present sexual behaviour was also recorded among UIG and MIG MSM.

In a focus group discussions with married MSM, participants were anxious that by having sex with males they may be exposing their wives and children to infection. Men felt guilty about this. Introducing condoms into marriage was seen as difficult to do without arousing suspicion.

Males also felt they may be unsafe during their sexual activities with other males because desire was so overwhelming that they had no control over their behaviour.

Even given some class based knowledge of sexual risk, we found that across our sample group knowledge of safer sex was uncertain amongst middle income groups to non-existent amongst lower income groups.

Among MSS however, relatively more males had heard of AIDS and seemed to be more aware of the fact that male to male sex could be a route for HIV and STD transmission. Though our sample survey reported low levels of STD prevalence, one to one interview with MSS revealed alarmingly high levels of STD related symptoms.

However, most MSS couldn't be bothered about the risk they were taking. "I couldn't care" was a common refrain. Some MSS actually reacted with hospitality to the idea of spreading awareness about STD's and HIV/AIDS as they thought that this could discourage people from coming to cruising areas and having sex with them, thus adversely affecting their business.

A commonly voiced concern of middle class males was regarding the safety of oral sex. Our questionnaire survey revealed oral sex to be very popular. Of our sample of 100 males, 81% participate in oral sex as the person sucking, and 74%[^] as the person getting sucked. This popularity may account for the high rate of concern encountered amongst males aware of AIDS as to whether virus transmission was possible via fellatio.

Mistaken beliefs about what constitutes sexual protection were also found to be prevalent.

- * There was a widely prevalent belief among males we interviewed that they didn't worry about AIDS or STD's as they were "very healthy" and had "clean habits".
- * Many males believed that STD's were not transferable between males.
- * One interesting observation made during one-to-one interviews with males of our target population as a whole was that there was a wide spread belief that male to male sex didn't transmit STD's or HIV and that it was a safer and easily available alternative to sex with females. AIDS was associated with heterosexual behaviour, especially with female sex workers. Most of the people reacted with disbelief when they were told that male to male sex was also a major route for STD/HIV transmission.
- * A common rationale of upper/middle class males was that they have sex with 'good guys' who are safe. This reflects a class prejudice prevalent amongst many of the upper/middle income males we worked with since 'bad guys' were principally identified as males from lower income groups.

It is also important to point out that many males, particularly non-English speaking lower class males, don't understand the term STD. They use the term *guptrog* meaning 'secret disease' to express the concept of genito-urinary infection. This is however, a vague and ill defined term even amongst those who use it. Nonetheless it is a reminder that research on STD prevalence and sexual health promotion must use local parlance.

5. Evidence of sexually transmitted diseases

Incidence of STD's amongst MSM in Calcutta can't be readily quantified as no private or government clinic monitors this. Indeed, given the secrecy and invisibility of MSM. Such clinical study would seem presently impossible.

A speculative picture is given by our survey of 100 MSM in which we asked them to report whether they had experienced any of a list of STD related symptoms. Results were:

8% reported discharge from the penis in the past.
0% reported this as a current symptom

13% reported pain or burning during urination in the past
3% reported this as a current symptom.

4% reported warts on the penis in the past.
0% reported this as a current symptom.

3% reported lesions on the penis in the past.
0% reported this as a current symptom.

5% reported lesions around the anus in the past.
0% reported this as a current symptom

17% reported itching in the public region in the past.
12% reported this as a current symptom.

This could be also related to fungal infection due to generally very poor genital hygiene among males we talked to especially from lower income groups.

11% reported public lice in the past.
3% reported this as a current symptom.

12% reported rashes in the public region in the past.
7% reported this as a current symptom.

2% reported swelling of the testes in the past.
0% reported this as a current symptom.

12% reported bleeding while defecating in the past
0% reported this as a current symptom.

This is related to piles among MSM who frequently take the receptive role during anal sex. This increases the risk of STD/HIV infection.

4% reported jaundice in the past.
7% reported this as a current symptom

SYMPTOMS	PAST		PRESENT	
	MSS	NCC	MSS	NCC
1. Discharge from penis	11%	7%	0%	0%
2. Pain/burning during urination	19%	11%	0%	4%
3. Warts penis	4%	4%	0%	0%
4. Lesions on penis	11%	0%	0%	0%
5. Lesions around anus	11%	3%	0%	0%
6. Burning around anus	4%	7%	0%	3%
7. Itching in public region	8%	20%	8%	13%
8. Pubic lice	11%	11%	0%	4%
9. Rashes in public region	15%	11%	8%	7%
10. Swelling of testes	0%	4%	0%	0%
11. Bleeding while defecating	31%	13%	8%	12%
12. Jaundice	65%	39%	4%	8%

MSS have reported higher percentages in contrast to NCC when talking of past symptoms. As for present symptoms, MSS have refused to record any, in most cases. This is related to their fear that they may lose business if they currently report STD symptoms.

The reported levels of STD-related symptoms recorded by our questionnaire is low when compared to other at-risk groups like female sex workers. Even among MSS, the questionnaire survey revealed low levels of STD related symptoms. However, in one-to-one interviews and FGD's MSS revealed alarmingly high levels of STD-related symptoms. However, among NCC, resistance to acknowledging STD-related symptoms in either one-to-one interviews or FGD's was noticeable. Outreach executives found that the reasons for low reporting of symptoms were as follows:

- * The widely prevalent belief that male to male sex can't lead to contracting STD's was so deep-rooted what sometimes symptoms like pain or burning during urination was treated as a normal physiological problem which could be solved by drinking lots of water, thus not important enough to mention.
- * For many NCC, there is a stigma attached to contracting an STD. This prevented them from acknowledging an STD symptom, even during one to one interviews.
- * MSM, especially NCC, have been forthcoming while reporting itching in public region, and bleeding while defecating, as they can be related to fungal infections and piles, both of which are common ailments which need not be hidden from surveyors. The same is the case with jaundice, as there was no idea among respondents that Hepatitis-B could be sexually transmitted.

6. Treatment seeking behaviour.

Treatment seeking for STD's is low amongst the target population in general.

Males mostly get treated by general physicians and family doctors. In these circumstance they don't discuss their sexual behaviour with other males as a potential source of infection.

Some MSS we spoke to told us about a 'quake' doctor they visit who offers treatment for STD's and anal ruptures.

Most males either leave STD's untreated or apply 'home made' remedies. A number of males told us that they wash their pubic region with dettol as a means of treatment.

In one case a respondent reported self-treating penile warts with the application of acid. Often lime is applied by males from lower income groups in case of anal ruptures.

The idea that male to male sex is 'safe' from the infection point of view, often contributes to males leaving symptoms like pain or burning sensations while urinating and lesions on the penis untreated. They don't relate these symptoms to sexual contacts but to weather, constitution or minor system problems which are not serious enough to merit professional medical attention.

7. Sexual scattering and cruising.

A high rate of sexual partner exchange is another risk enhancing characteristic of male to male sexual networks. Drawing principally from one to one discussions Praajak outreach executives estimate that the average number of partners per person per month is 10. For some persons this is much higher.

Thus a pattern of 'sexual scattering' is common enhancing the potential for rapid transmission of HIV and other STD's within the male to male sexual networks.

Males reported their male sexual partners to be:

Strangers	89%
Friends from cruising sites	78%
Friends from neighbourhood	48%
School Friends	45%
Other neighbours	38%
Distant relatives	31%
Cousins	25%
Close relatives	23%
Office colleagues	21%
Males who sell sex (MSS)	16%
Servants	10%
Teachers	7%
Students	6%
Own brother	4%

The most popular places where males cruise/pickup partners were:

Parks	81%
Railway platforms/Bus stands	56%
Trains/Buses	55%
Acquaintances/Friends home	52%
Toilets	50%
Tourist/Picnic spots	42%
Gym/Swimming pools	25%
Cinema Halls	22%
Neighbourhood Clubs	20%

It is significant that the two highest categories are 'strangers' and 'cruising friends'. The following table gives a comparative picture of preference for an availability of strangers or cruising friends as partners among MSS, LIG NCC and UIG/MIG NCC.

	MSS	NCC LIG	NCCUIG/MIG
Strangers	100%	100%	81%
Cruising Friends	92%	87%	69%

Interestingly among married MSM, 88% said that they had sex with strangers and 76% has sex with cruising friends. This would mean that the risk of contracting STD/HIV infection for wives/female partners of MSM is significant. Besides, 14% of the non-commercially cruising married males frequently had sex with MSS. 43% were having sex with office/business colleagues which is considerable.

With large numbers of MSM having sex with strangers and cruising friends (who are also having sex in turn with strangers themselves) coupled with the fact that there is frequent partner changes shows that there is a grave risk for the spread of STD/HIV infection among them especially MSS and NCC LIG males.

Interestingly, LIG males stated that many of them had sex with other males with whom they slept with either on the footpath or in their places of work (leather factories).

100% of students from colleges and universities stated that they were having sex with college mates and fellow university students. 25% said that they were having sex with teachers. 33% of them were also into selling sex.

19% of NCC stated that they had sex with MSS. 29% with office/business colleagues. 26% with domestic servants and 34% with neighbourhood friends.

Among MSS 88% were having sex with neighbourhood friends (much higher than the average) and 31% with other neighbours. Our discussions with them revealed that in these cases too they charge money. Thus MSS not only solicit at cruising sites but often provide sexual services to other males of the neighbourhood.

For cruisers the most popular cruising sites are parks, railway stations, bus stands, buses or trains, and toilets are other sites which are used to pick up partners. But males also pick up partners at gyms, swimming pools, cinema halls, neighbourhood clubs, school/colleges and offices.

Cruising is an activity centred on looking for males to have sex with. However, socialisation with friends from one cruising area is also an important part of the cruising lifestyle for many males. Some form of sexual contact with one another is often a bond between the males in cruising social networks.

Thus sex becomes both an act reserved for anonymous contact with some males, and as an expression of social solidarity with others. This bonding is generally to a group rather than to one person in particular. Male couples are rare in Calcutta. It is common amongst MSM to deride those who develop 'love relationships'. Of the few couples we know of, none report that they are monogamous.

Sexual scattering can thus be conceived of as endogamous (within the social group) and exogamous (outside the social group). This analysis suggests that there are two principle sexual milieu to be targeted by an intervention, requiring distinct health promotion messages.

It also means that outreach activities aimed at awareness generation in particular must be extended beyond cruising sites, where a substantial number of MSM meet their sex partners e.g. schools, colleges, clubs etc.

8. Locations of sex acts between males.

In focus groups we employed mapping exercises asking males to identify the different locations where they actually have sex.

For reasons of confidentiality named places are not given here. However, we include a list of generic places, along with figures drawn from our questionnaire survey indicating the popularity of different spots.

The following percentages of males reported having sex in the following places:

Partners house	81%
Parks	70%
Own house	59%
Toilets	40%
Bus/ tram depot	36%
Hotels	32%
Relative house	28%
Swimming pools/gyms	24%
Cinema Halls	20%
Clubs	15%
Car/Taxi	10%
Hostels	8%

Those who stated having group sex (54%) the figures were as follows:

Friends house	25%
Parks	15%
Own House	15%
Hotels	11%

Schools, hostels, toilets, clubs and swimming pools were other sites mentioned by respondents.

Among NCC, a comparison of preferred/possible locations for sexual acts is as follows:

	NCC LIG	NCCUIG/MIG
Parks	94%	59%
Partners Place	69%	86%
Own Houses	44%	72%

Poorly lit, hurried, anonymous encounters in parks are bound to be unsafe. This would specially put LIG males at greater risk when compared to MIG males. With a very large proportion of MIG males having sex in private (and possibly threat-free) spaces it might be easier for them to adopt safer practices while having sex.

Among college/university students 67% reported having sex within college or university campus itself.

The contrast between married and unmarried MSM with respect to the location for sexual acts is also significant.

	Married	Unmarried
Parks	59%	71%
Own houses	71%	59%

In general married males in contrast to unmarried males tended to have less no of public environments like toilets, bus/tram depots, clubs and cinema halls. This characteristic should facilitate married males to adopt safer practices in comparison to unmarried males.

Locations for sexual acts also vary according to their commercial nature.

	MSS	NCC
Parks	80%	66%
Bus/Tram Depots	46%	32%
Partners Places	78%	82%
own Houses	38%	66%

Having sex at the client's place, rather than at once own place, effectively reduces the negotiating power for MSS with regard to safer sexual practices. The power dynamics between the sex workers and clients thus gets lopsided in favour of the latter.

Our discussions with NCC reveal that a higher percentage of people having sex at their partners place is a result of a general lack of space to have sex for males who might be sharing rooms with other family members. This often results in creation of *theks* in the homes of those NCC who either live singly or those who have the good privilege of having a private room, low levels of family surveillance or very few family members these *theks* are often used by other NCC to have sex or social get together. Group sex is common in these *theks* which are also a contact point between cruisers and non-cruising MSM.

Group sex is a risk enhancing behaviour, increasing the chances of contact with HIV/STD's The popularity of group sex can be related to group bonding, group socialising predominate between males we work with rather than individual sexual bonding.

Clearly there are a wide variety of places where males have sex with each other. The majority of these are public environments which suggests potential for locating health educational message (i.e. posters) in some of these spots, and for outreach work in specified sex sites.

However, it is also significant that a large percentage of sex acts are taking place in private places, meaning that the localities where males meet and socialise with their partners are also important intervention sites.

Outreach must thus target both pre-sex and actual sex localities, employing special strategies for each type of area and group addressed.

9. Sex acts engaged in.

The following percentages of males reported having ever engaged in the following sex acts and other males:

Deep kissing	80%
Giving oral sex (taking penis into mouth)	80%
Mutual masturbation	78%
Receiving oral sex (putting penis into mouth)	74%
Inter femoral sex	73%
Giver anal sex (inserting penis into anus)	55%
Receiving anal sex (taking penis into anus)	45%
Rimming (analingus)	22%

Safer sex acts come at the top of the scale indicating potential for promoting these in a sexual health intervention. However, anal sex is practised by an average of half the males we work with. This is a significant figure, especially in consideration that all these acts, as shown above, are likely to be unprotected.

Within particular target groups however, there are significant differences in sexual behaviour.

A comparison between the overall frequency of different sex acts between males who sell sex and non-commercial cruisers is given below:

SEX ACTS	MSS	NCC
Giving oral sex	88%	77%
Receiving anal sex	73%	35%
Deep Kissing	69%	84%
Mutual masturbation	65%	82%
Inter femoral sex	54%	80%
Receiving oral sex	54%	81%
Giving anal sex	46%	58%
Rimming (analingus)	42%	15%

It is very clear from the table that risky sexual acts from the point of view of STD/HIV infection giving oral sex or rimming are much more popular among MSS in contrast to NCC.

On the other hand comparatively safer acts like deep kissing, mutual masturbation and interfemoral sex, top the popularity list for NCC. Receiving anal sex or rimming is significantly low for comparable figures among MSS.

In fact while only 11% of the MSS said they never indulged in anal sex whether receptive or penetrative) almost thrice the number (32%) of the NCC said the same thing.

Among NCC, there are equally interesting differences between males from middle income group and for lower income groups.

SEX ACTS	MIG	LIG.
Deep kissing	95%	44%
Mutual masturbation	90%	56%
Inter femoral sex	88%	50%
Receiving oral sex	91%	41%
Giving oral sex	74%	87%
Receiving anal sex	26%	69%
Giving anal sex	64%	37%
Rimming	14%	18%

The differences between MIG and LIG males are glaring. The overwhelming popularity of safer sexual practices among MIG males confronts dramatically with the moderate attraction they hold for LIG males.

LIG males reported playing the receptive (and risky) roles in sex is much larger in number than MIG males. This is somewhat difficult to explain. It could be that MIG males often hide the fact that they also play a receptive sexual role as the stigma of “effeminacy” is attached to it. Even considering some shading on the part of MIG males, LIG males seem to be particularly at risk because of their preferences.

Correlations can also be drawn between distribution of some sexual behaviours and religion identity as will be clear from the following table:

SEX ACTS	HINDUS	MUSLIMS
Deep kissing	93%	25%
Mutual masturbation	84%	50%
Inter femoral sex	82%	40%
Receiving oral sex	78%	55%
Giving oral sex	80%	80%
Receiving anal sex	36%	70%
Giving anal sex	55%	50%
Rimming	28%	5%

While giving oral sex and giving anal sex were equally popular, significant differences existed between communities with regard to other practices.

While 31% of the Hindus reported that they never indulged in anal sex, the figure was 10% among Muslims. However, a widely prevalent myth that Muslims never play the receptive role during anal sex was proved wrong with 70% Muslims reporting that they have played the “passive” role in comparison to only 36% of the Hindus.

These differences between Hindus and Muslims seem to have a cultural basis as it was prevalent among both middle income and lower income groups. Hindus preferred deep kissing, mutual masturbation and inter femoral sex much more compared to Muslims

There is not much difference between sexual practices of married and unmarried MSM who don’t cruise commercially, except around penetrative behaviour.

SEX ACTS	MARRIED MALES	UNMARRIED MALES
Giving anal sex	79%	53%
Receiving oral sex	100%	77%

This means that a married male is much likely to take the insertive role during sexual penetration. Unmarried males therefore can be seen to be at relatively higher risk than married males.

10. Sex with females

It is wrong to assume that males who have sex with males only have sex with males 47% of our survey sample report having sex with female sex partners in the last year. A little more than 1/3rd of this figure were married.

Male reported their female sexual partners they have ever had sex with to be:

Girl friends	43%
Wives	34%
Strangers	21%
Females who sell sex	9%

Besides the males reported also to have had sex with cousins, neighbours, other relatives, and colleagues at workplaces.

The pattern of sexual practices with female partners reported by the respondents was as follows:-

Vaginal penetration	85%
Deep kissing	68%
Receiving oral sex	36%
Mutual masturbation	13%
Inter femoral sex	13%
Cunilingus	13%
Giving anal sex	2%

Interviews with married males (94% stated that they had a bisexual orientation) revealed that most of them could not think of having oral sex or inter-femoral sex with their wives. To most of them sex with their wife was a duty to be fulfilled and it largely took the form of vaginal sex. Vaginal sex is a major route for the spread of STD/HIV infection. With married males frequently indulging in multi partner sex with strangers, the risk faced by their wives with regard to STD/HIV infection is serious.

What is alarming is that most married males were not open to basic sex education of STD and HIV/AIDS awareness for their wives and children, though they expressed deep concern and fears about infecting their wives in FGD's . Almost all of them cherish being a father and were wary of any awareness campaign targeted at their families as that could lead to "unnecessary tensions" or "exposure"

Most of them refused to take home health promotion materials because they didn't want to arouse suspicious. For most married males harmonising their "personal" or "married" life was an urgent problem for which they required professional help.

Given that our sample was largely of unmarried males under thirty we estimate that an even greater potential risk to females sexual health is presented by male to male sex than these statistics indicate as many of our cohort not yet having sex with female may do so in future.

In focus groups, most young unmarried males we worked with indicated that they expected to marry, but they would like to continue having sex with males. This aspect of lifestyle means that the network of sexual risk to be considered in any health intervention on male to male sexual behaviour must consider both the males presented and future female partners as part of the target population

Street children

Our additional research with street boys was limited, consisting of two focus groups. Some participants spoke of the hierarchy of power between street boys, which has a sexual expression. Older boys force or seduce younger boys into engaging in anal sex, mutual masturbation, oral sex, and inter-femoral sex. Some boys enjoy this as it is their only form of intimacy, and also establishes protective relationships with elders.

Sex between boys and girls is also common amongst street children

11. Condom and Lubricant usage and use of Alcohol/Drugs

The most important observation regarding risks involved in actual sex acts amongst our target population is that condom use is all but non-existent.

Our survey of 100 males revealed that:

58% never use condoms for any sexual activity.

36% Sometimes use condoms

4% mostly use condoms

2% always use condoms.

All 36% of the sometimes users said they had used condoms just once or twice. Thus there is effectively no condom use amongst 94% of our sample.

All average of 50% of our survey cohort report practising anal sex in either insertive or receiving roles. Almost all, if not all, of these acts are likely to be unsafe.

Also 39% of our sample engage in vaginal sex with females. This too is most likely to be unsafe.

Reason given by males for not using condoms include:

I don't have time

It's no fun with condoms

I don't have anal sex

Loss of feeling and pleasure

I've no disease

Condoms are for married people

Condoms are murder (meaning a form of contraception)

Married males have “sometimes” used condoms with their wives, but only as a birth-control measure. They have never thought of using condoms with their male partners. The role of condoms as a barrier to infection was unheard of not only among married males but generally across all groups of MSM.

59% of males use saliva as a lubricant.

49% use cream.

40% use oil.

29% use vaseline.

24% use no lubricant.

1% uses K.Y. jelly.

Therefore any intervention work on promoting condom use must also contain messages on appropriate lubricant use.

Another factor possibly exacerbating the risk in sexual contact between males is oral hygiene. This is particularly so given the popularity of oral sex. Although the chances of acquiring HIV through oral sex is minimal, risk becomes a potential factor if the person sucking the penis has bleeding gums or ulcers in the mouth.

Of our sample 30% report presently having bleeding gums, and 12% mouth ulceration

Risk is enhanced if ejaculation into the mouth occurs. A number of males we spoke to during outreach and focus groups desired this. Males spoke of swallowing their partners semen as a way to absorb energy and strength. In some cases males felt that by swallowing semen they would enhance their own masculinity.

Alcohol use at the time of sexual activity is another variable in risk behaviour, potentially inhibiting persons from engaging in more risk behaviours.

We found 35% of our cohort sometimes drink alcohol at the time of cruising and have sex. This figure was higher amongst males who sell sex at 61%.

Group sex is another risk enhancing behaviour, increasing the chances of contact with HIV or STD's 54% of males we surveyed reported having engaged in multi partner sex acts. This can be related to the group rather than individual sexual bond predominant the males we worked with.

12. Barriers to sexual health for the target population

A principle barrier to sexual health for the males we worked with is lack of information on STD's HIV/AIDS and safer sex.

Without knowledge males are unable to assess risk and protect themselves.

There is no targeted sexual health information for MSM available in Calcutta. Praajak plans to produce such literature as a component of intervention work.

Another barrier is the unavailability in Calcutta (India) of condoms suitable for anal sex. Consequently even if males decide to use condoms there are no brands on the market which will offer appropriate protection.

Limited availability of water based lubricants is another problem. If informed lubricant use is to be promoted this must be backed up by making K.Y jelly or another suitable brand accessible to males.; K.Y which is available in Calcutta is in toothpaste size tubes. Sachet size packets are preferable as these are easier for males to carry in their pockets when out cruising.

Also the total absence of reputable STD facilities in Calcutta where MSM feel able to attend with openness about their sexual behaviours is a barrier to sexual health maintenance.

In the wholistic sense of sexual health obstacles to well being are much broader.

The secret, dual lives most males lead have an important impact on self esteem. In particular many of the married males we spoke to felt a lot of guilt about their sexual behaviour. One man, whose wife had suffered a miscarriage, blamed himself for this, seeing it as a consequence of having had sex with males.

Prejudice and its many manifestations also impacts on the sexual health of males. If MSM are unable to express their desire for other males in a healthy ways then they and the people around them will suffer. With regards to a more clinical definitions. of sexual health, if MSM don't feel good about themselves, as they are less likely to be motivated to protect themselves. Thus the transmission of HIV and STD'S becomes more likely.

13. Constraints that may be faced by an intervention

Prejudice is the main constraint our intervention is likely to face.

External stakeholder interviews conducted during the needs assessment revealed prejudicial attitudes amongst a number of service providers, principally police and medical personnel.

Police officers interviewed by our advocacy officer at Hare St. Taltala, Lake, Tollygunge, Beniapukur and Park Police stations variously described MSM as "unnatural" and "perverted". Such attitudes are manifest in the harassment MSM report at the hands of the police. Many males reported such experiences in one to one conversations with outreach workers and in FGD's.

Additionally police officers we spoke to have poor knowledge of issues around sexual health and HIV/AIDS.

In order for our intervention to improve the total sexual health of the males we work with, we need to establish good relations with the local police. This is important as we need the police to act on the violence and blackmail which MSM experience at the hands of police, park guards and hoodlums including a section of MSS. This violence occurs in cruising sites. and some males have reported being harassed by these people in their neighbourhoods.

Good relations with the police are also needed to ensure the safety of our outreach executives.

Although some senior police personnel we have interviewed have shown some interest in Praajak's work, we believe that tackling the prejudice throughout the police force will be difficult.

Another restraint is presented in the attitudes of medical personnel. Doctors interviewed by our advocacy officer showed little awareness of our sensitivity towards the needs of MSM.

One doctor at S.S.K.M. described MSM as "perverted", another as "diverted". Another doctor at the same clinic, when asked about how he might deal with an STD patient who presented himself as having contracted the infection through sex with a male, said he would scare him so that he wouldn't do such things again.

We found it alarming that doctors showed so little sensitivity to the needs of MSM.

Political and legal attitudes could also be a constraint to our intervention. Sections of the Indian penal code are used to criminalise male to male sexual behaviour. These are:

Section 377, which carries a possible ten year prison sentence to anyone voluntarily has carnal intercourse against the order of nature.'

Sections 269 & 270, which are used to prosecute for acts likely to cause infections.

Section 294, used to prosecute obscene acts in public places.

Consequently it is technically not legal for Praajak to openly promote safer anal sex between males. Such legislature also manifests a lack of political commitment to dismantling homophobia and seriously addressing male to male sexual health issues in an informed way.

The West Bengal State Government mentions MSM as a target group in its sexual health policy. This stated commitment will need to be followed through with action to assist our work.

Institutional prejudices are manifestations of pervasive denial and prejudice about male to male sexual behaviour in Indian society. This is the most all encompassing constraint our intervention faces. It is this prejudice which means MSM invisibilise their sexual behaviour and social networks, which consequently places many of them out of reach of sexual health interventions.

Praajak has built rapport with many MSM in Calcutta. However, we estimate that as yet we have little contact with a larger percentage of our target population. The inaccessibility of these invisible groups of males is a constraint in our work. However, like all constraints mentioned above, it is one we look upon as a challenge.

15. Local power structures and gatekeepers who affect the lives, health and sexual behaviour of the target population;

There are a number of local based power structures which affect the lives of MSM in Calcutta.

As in all social groups, within networks of MSM there are key individuals who have more social prestige and influence. These males can act as gatekeepers to whole groups of males and can influence other males' sexual practice in the light of information about safer sex.

In our outreach strategies we aim to recruit influential persons within the MSM networks as peer educators.

Park guards are another principal figure in the lives of MSM as they are in position to observe and restrict what goes on in park based cruising areas.

Park guards are often the perpetrators of violence toward MSM. For example, the beginning of our needs assessment period coincided with some particularly violent incidents in the toilet of a central cruising area where cruisers were beaten up by guards.

Such dangers clearly affect the lives the males we work with in terrible ways. Sensitisation of park personnel is an important need we have identified.

Amongst street boys, older boys, who act as leaders in groups, are key figures who affect the lives of other children. They instigate and largely control sexual between boys. Intervention with street children must be aware of the power dynamics which affect children's sexual behaviour and health.

A SUMMARY

Shivananda Khan, Naz Foundation

India is a male dominated society where the social and public spaces are primarily male. As a homosocial and homoaffectionalist society, sexual boundaries between males are easily crossed and often can become sexual acts. Whereas some of these acts can perhaps be called homosexual (within the context of local identities based upon penetration) in that a sexual sense of self is operating based upon a desire for anal penetration by another male, such appears to be a minority framework. The majority of sexual activity between males should be seen as opportunistic discharged based.

The majority of males in this study were married or will get married, but apparently there was no significant evidence that marriage actually substantially decreased the levels of male to male sexual activity. Several males that this was discussed with stated that when they got married they believed they would stop, but because they received little sexual satisfaction from their wives they continued. Partly this was because they felt they couldn't ask their wives to perform certain sexual acts, and partly because sexual opportunities with their wives were not always available because of social conditions, such as appropriate accommodation, religious and cultural customs, joint families, and so on.

Sexual health issues for males and females through the primacy of male sexual behaviours, particularly male to male sexual behaviours, should be seen as a major and urgent concern. The fact that nearly all (to be generous) of the STD treatment services do not address anal transmission of STDs, is a cause for deep concern.

Appropriate service delivery of STD testing, treatment, care and counselling need to be developed as a urgent necessity, in order to formulate strategies that can effectively deal with different sexual behaviours in a confidential and sympathetic manner. Promotion of sexual health amongst males who have sex with males will be particularly challenging, but necessary, because of the frameworks discussed in this report.

The lack of understanding and knowledge by many of the NGOs, donor agencies and other institutions regarding the constructions of male to male sexual behaviours and the frameworks of their identities, creates many barriers to the development of appropriate services. Such lack of knowledge may well be based on denial and homophobia, but much of it is also because these individuals and agencies utilise Western constructions of sexuality to attempt to define such behaviours. In an Indian cultural context such constructions do not "fit", and actually increases the invisibility of the behaviours. It is necessary to separate behaviour from identities, and in developing appropriate responses, focus on risk behaviours to a large extent, rather than only on "risk groups". Sexual behaviours between males is certainly not a minority practice.

Socio-cultural frameworks of male to male sexual availability

In terms of the socio-cultural frameworks, both contemporary and traditional, that appear to shape and construct male sexual behaviours in India, the following points need to be remembered:

1. Marriage is considered a social and religious duty and family obligation, not one based upon personal desire and choice. It is therefore seen as compulsory and a social necessity.
2. To remain unmarried is seen as an aberration.. Cultural and religious beliefs dictate that a male achieves social responsibility and thus personhood upon marriage.
3. Marriage is often delayed till the male is in his late twenties or thirties, because of the economic costs.
4. The central objective of marriage is the production of children, specifically male children. Marriage is thus seen not as egalitarian and companionate and based upon mutual friendship, but rather as a source of reproduction of children.

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5. In this context sex is seen as reproductive. Socio-cultural traditions in South Asia, frame women as not equal to males, as inferior vessels of male honour, to be sexually controlled, if she is allowed any form of sexuality. Sex with one's wife is often seen as a duty, rather than as pleasure. The statement "I do duty to my wife" is quite common, meaning I have sex with my wife. Also asking one's wife to perform certain sexual acts, such as oral sex or anal sex becomes shameful. She is the vessel of one's children.
 6. This often lead to a concept of sexual pleasure of men as only available outside of marriage. Others would be asked to perform sex acts that could not be asked of a wife.
 7. Here what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.
 8. Gender segregation, female virginity, loss of honour, and so on often makes it easier to access other males for sex than females in a homosocial and homoaffectionalist society, because women are more policed and socially controlled.
 9. Indian cultures focuses on public shame rather than personal guilt as frameworks of social control. It should be recognised that fulfilment of social, religious and family duty is central to an Indian. Here duty is seen as a public duty, to be visibly performed. Thus the sense of shame and dishonour arises from a public (community) perception about visible personal behaviours.
 10. Concepts of sexuality, sexual behaviours and sexual identities are bound up within concepts of penetration (the penetrated and the penetrator) and semen discharge. Such a framework will often leads to high frequency of sexual partners.
 11. For some males who sexually penetrate, the gender of the sexual partner can be irrelevant. What matters is to penetrate and to discharge.
 12. Because India culture is homosocial and homoaffectional, both in public and private, it is not uncommon for two or more males to share a bed. This makes opportunities for sexual encounters much more easier. Very often this takes place in the dark, under the blanket, when partners can disassociate themselves from the act - "it was in my sleep".

These characteristics of Indian culture, which also include the extreme over-crowding, poverty, males sharing spaces, a substantial number of males below the age of thirty and unmarried, low sexual access to females, lack of privacy, low incomes, create conditions which frame its male to male sexual behaviours, and in a sense encourage its differing manifestations.

Age can also play a significant role in terms of penetration. As Michael Rocke states in his book *Forbidden Friendships - homosexuality and male culture in Renaissance Florence*, "the restriction of the 'womanly role' to adolescents actually permitted all mature men to engage in sex without jeopardising their 'manly' identity". (page 13, Oxford University Press, 1996).

The same framework exists to some extent in India, whilst Mughal history is replete of "boy love".

All the evidence points to significant numbers of males engaged in sexual encounters with other males, from extremely young males to much older, from close relatives to the domestic servant, from the rikshaw driver to the businessman. Many will engage in these behaviours sporadically, or over relatively brief periods of times. Many will also continue this behaviour infrequently over longer periods of time, beyond even their marriage. And many will engage in male to male sex as either an exclusive sexual behaviour or as part of the sexual repertoire over their sexual active life.

To quote Michael Rocke again, "homosexual activity formed part, at one time or another and with varying significance and degree of involvement, of the life experience of many males" and that there was "an absence of conceptual categories based on sexual object choice" (page 15).

Rocke then goes on to say that male to male sex "...did not constitute a separate world or a truly distinctive 'subculture'. Both casual sexual encounters and more durable relationships occurred or evolved in largely familiar everyday social contexts and were tightly insinuated into other forms of male sociability from the camaraderie of gangs of youth or bonds of work and neighbourhood to relations between patrons and clients or the sodaliture of kin and friendship networks (page 115).

All this does not imply that loving bonds between males does not exist. It does. Intense emotional and sexual relationships do exist, but these will be framed by the cultural necessity of marriage and children. Very few males are able to

escape this cultural necessity. There are frameworks for desire for a specific gender, i.e. males who specifically desire other males and seek other males for sex (and sometimes love). These males will often frame their relationship as “husband and wife”, a *giriya* with a *khoti* (with a very few exceptions of mutuality and equal. Indian public spaces are supremely male. The street, the bus stand, the park, the railway or bus station, these are the arenas of contact. Such publicness leads to quick sex, penetrative or otherwise, in the darkness of parks, behind bushes, in alleyways.

Many workers in the service sectors also join in these networks. Whether just for sexual release, money, or actual desire for sex with other males is a difficult question to answer. Taxi-drivers, rickshaw drivers, barbers, room service and housekeeping males in hotels, waiters and table boys at restaurants, shop assistants. The framework is ubiquitous. The glance, the second glance, the smile, the appropriate questions, sometimes “for a few rupees more”, sometimes just *khela*.... In Delhi and Lucknow urban culture, male to male sex does not exist in a few selected areas as in Western cities. It is anywhere, in the right conditions, the right time, the right space.

We could perhaps label male to male sexual frameworks to some extent (and with trepidation) in the following manner:

age stratified
gender structured
status stratified
professional defined
religiously or culturally based
egalitarian and companionate
economically framed
transgenerational
patron-client
situational
opportunistic
discharge based
same sex desire
penetrative

But perhaps we should accept that Indian male sexualities are amorphous, opportunistic, spatially bound, discharge orientated, time-based, as well as those based upon same sex desire and love. We need to move away from the reductionist, scientific, and naming process, and accept a more wholistic approach to the issues.

In doing so we have to recognise that the impact upon any STD/HIV/AIDS prevention and control programme which does not address male to male behaviours will be doomed to failure. To deny their existence will ensure that no such programme will successfully contain the spread of AIDS.

Unfortunately, India primarily focuses on targeted groups and within these targeted groups only on vaginal sex as a transmission route for STDs/HIV. Truck drivers, female commercial sex workers, intravenous drug users (but all their education material is about the risks of shared IV use and nothing on their sexual behaviours). It forgets that males also have sex males as well as with females, that for significant numbers of unmarried males, sex between males is often their only sexual outlet, either desire based or discharge-based. That males also have anal sex with females. It has adopted Eurocentric constructions of identities and sees things in a heterosexual/homosexual framework, and thus misses the majority of male to male sexual behaviours. It continues to invisibilise and deny significant levels of male to male sex.

Further its STD services often denies anal transmission of STDs, where there apparently are no investigations into rectal gonorrhoea. STD clinicians have no training on such issues, where shame and denial will invisibilise these behaviours and make them difficult to access in terms of such services.

In exploring male to male sex in Delhi and Lucknow this report has highlighted the following issues (in no specific order):

1. Significant levels of males who have sex with males
2. These behaviours are invisible because of secrecy, shamefulness and denial
3. High rates of anal sex between males and between males and females
4. Significant levels of male commercial sex work
5. High rates of STD symptoms
6. Low levels of health seeking behaviours

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7. Non-existent or totally inadequate STD treatment services regarding anal transmission of STDs
 8. No appropriate condoms and water-based lubricants available suitable for anal sex
 9. Many males who have sex with males having pre-pubescent sexual encounters, where often the first sexual partner was a male relative
 10. For the majority of males involved in male to male sex there is no specific sexual identity construction
 11. Those who evolve an identity based upon anal penetration call themselves *khotis* and label their sexual partners as *giryas*.
 12. Shame and dishonour create the conditions for secrecy, lies and shamefulness around male to male sex
 13. No previous work has been done on sexual health promotion amongst males who have sex with males
 14. No appropriate education resources dealing with male to male sexual behaviours and/or anal sex is available
 15. Poor knowledge of STDs/HIV/AIDS amongst males who have sex with males
 16. Low levels of condom usage
 17. Many males who have sex with males will be married and many will get married
 18. There are no agencies providing sexual health promotion services for males who have sex with males
 19. Female partners (including wives) of males who have sex with males are very vulnerable to their sexual practices
 20. The Indian legal code prohibits non-reproductive sex (defined as 'carnal intercourse')

The development of a range of preventative strategies that are necessary if there is not to be the huge potential personal, social, cultural and economic impact, is now an urgent necessity. Is India to enter into the next millennium with an uncontrolled spiral of illness and death which it can ill afford, as increasingly individuals, families and communities do not have the capacity to cope?