

Naz Foundation International

Short Report for The World Bank, Pakistan

**PAKISTAN ENHANCED HIV/AIDS PROGRAM:
SOCIAL ASSESSMENT AND MAPPING OF MEN WHO HAVE SEX WITH MEN (MSM) IN
LAHORE, PAKISTAN**

Implementing Agencies

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Introduction

In terms of HIV/AIDS Pakistan may be deemed a low prevalence country, all the factors that produce high risk of HIV infection are prevalent. Since transmission of HIV is primarily sexual, it is important to look at all male sexual practices and evaluate the level of risks that are being taken.

It is known that anal sex represents the highest form of risk taking sexual behaviour, in particular for the penetrated sexual partner. Further it cannot be assumed that the patterns of male to male sexual encounters fall into the 'heterosexual/homosexual' binary division that is often assumed.

This report explores the dynamics and constructions of male to male sexual encounters¹ in Lahore, Pakistan, and evaluates risk taking behaviours in terms of STI/HIV transmission, current sexual health service delivery, and the social assessment and mapping of male to male sex in the city.

It is also noted that the term men who have sex with men was inadequate as a descriptive term of the situation in terms of male to male sexual behaviours, and was not particularly useful in conducting the Assessment. Accessibility was a key consideration, and it was considered necessary to identify MSM within self-descriptive categories, one gendered (*zenanas*) and one occupational (*malishias*). Both these networks access males/men from across the social spectrum, are involved in male sex work, and are very sexually active. *Zenanas* are seen as feminised males who are penetrated, while *malishias* are seen within the category 'men' and are perceived to only penetrate.

The Assessment

The Social Assessment consisted of interviewing 200 MSM through questionnaires, with a further 20 MSM interviewed in-depth through open-ended questions. Two Focus Group Discussions were also held, and a range of site visits made for observational analysis. All participants were above 18 years of age. In the main, the Assessment accessed those most easily recognised, the *zenanas* and *malishia* networks.

In conducting the Assessment, potential interviewees were contacted through peer networks, where training had been given to a group of *zenanas* and *malishias* to act as peer researchers. The majority of *zenanas* and *malishias*/customers met their partners in public sites.

A group of *zenanas* and *malishias* were recruited through Vision's networks for training in peer interviewing techniques and the questionnaire to be used in the Assessment. A total of 18 interviewers were finally selected from a group of 25 workshop participants to conduct the interviews.

¹ I am using the term male in the context of male to male sex in its biological sense in that many males involved are not legally defined as adult men, while some males do not define or perceive themselves as men emotionally and at times mentally, i.e. many self-identified *zenanas* perceive themselves as females in a male body.

Demographic Profile of Respondents

201 participants completed questionnaires, and 20 were accessed for taped interviews.

The men ranged in age from 18 to mid-forties, of which 15% were between 18-22, and 29% were between the ages of 22 - 27. 27% of the respondents were married.

55% of respondents reported that they were unemployed, 6% identified as male sex workers while 14% stated they were *malishias*. 20% stated they were dancers while 13% stated they were in business.

8% reported a monthly income below 2000 Rps while 48% reported incomes between 2000 to 5000 Rps. 44% reported incomes above 5000 Rps per month.

In terms of education, 11% reported no formal education, 27% reported completing 12 years.

39% of respondents labelled themselves as *zenanas*, and 36% were identified as *giryas*. 10% stated they were *malishias* while 8% stated they were *chavas*, and 6% as *khusras*.

While 100% of respondents stated they had sex with a male in the previous month, 42% also stated that they had sex with female also. 68% reported being in a relationship with a male, while 18% reported being married and also in a relationship with a male, and a further 12% reported being married and sexually active outside of marriage.

Summary

Pakistan is a male dominated society where the social and public spaces are primarily male. As a homosocial and homoaffectionalist society, sexual boundaries between males can often be crossed in appropriate spaces and become sexualised acts. Further significant levels of males perform gendered roles as feminised males and can be accessed by those defined as “real men”. Male to male sexual behaviours does exist in Lahore at substantial levels.

Most of these behaviours do not exist within a social context of a heterosexual/homosexual oppositional binary as exclusive categories. Rather there appears to be an inclusive behaviour which involves a substantial level of men/males operating within a wide variety of categories and/or networks, which involves at times, gendered self-identities, ‘body heat’ leading to a perceived urgent need for semen discharge, ready and easy accessibility to male sexual partners, and the social contexts of gender segregation, social policing of females, delayed marriage, and concepts of masculinity and femininity.

The frameworks of male to male sex, often substantially divergent and exclusive, involve males who self- identify as *zenanas*², males/men who take on the penetrating role in male to male sex (known as *giryas* by *zenanas*) accessing *zenanas*, *hijras*, and at times, adolescent males. These males are usually perceived by *giryas* as feminised males/females which enables the *giryas* to maintain his sense of manliness. Other dynamics include males who access other males for discharge and/or desire to be penetrated, males who desire male to male sex and do not gender themselves and usually indulge in mutual sexual activity - ‘giving and taking’, friends have sex with friends for mutual pleasure, and males in all male institutions.

² Zenana is the term used by males who perceive themselves as “a woman in a man’s body”, who are socialised within networks of other *zenanas*, and often act out this perception in terms of feminised behaviours involving body language, make-up, cross- dressing, and take the penetrated role in male to male sex.

These networks of differing MSM contexts may at times inter-penetrate, where individuals may shift along differing networks, but usually they are mutually exclusive. In other words there are complex dynamics and diffusion in relation to male to male sex in Lahore.

The most visible of these networks are those involving *zenanas* and *hijras* because of their public performative role which is a part of their self-identification, and those of *malishias* as male sex workers alongside their massage trade because of their occupational visibility.

It was this visibility and ready accessibility that contoured the Social Assessment Study in Lahore in terms of which dynamic of MSM were interviewed. It should therefore be clearly recognised that this Assessment does not tell the whole story of male to male sex in Lahore.

Male to male sex work is a significant factor in Lahore. A broad range of frameworks exist here. *Hijras*, *zenanas*, *malishias*, and other males, will sell sex because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they will also have a regular partner - a *pukka dost*.

There are also self-identified gay men in Lahore, but none were accessed by the Assessment because of their high invisibility, if not denial. Such gay-identified men are English speaking men from the upper-middle and elite classes. They network amongst each other, or through the internet, and they access partners from their personal networks. Sometimes they will access *malishias* too.

It needs to be recognised that the act of a male being anally penetrated by another male is highly stigmatised and those who are perceived to be recipients are usually treated with contempt. A *giryas* or *malishia* or any man/male who is sexually penetrated, orally or anally, will make extensive efforts to hide his desire and/or practice both from the public as well as from *zenanas* and others in their sexual networks to avoid such stigmatisation. Accessing such information is extremely difficult because of the intensive levels of denial that asking such questions generate. However, private discussions with a range of individuals indicate that such practices are not uncommon, but invisible. It should also be recognised that a similar crossing of “gendered” boundaries exist amongst *zenanas*. It is not unknown for some *zenanas* to also penetrate other males.

While there were substantial networks of *zenanas* of all gradations - from the very feminised and cross-dressing type to those who had moustaches and dress in shirt and trousers - their sexual partners could well be any masculinised male. *Malishias* were not only being accessed by men for masturbation and discharge as part of the massage process, they were also being accessed by males across the economic and class spectrum for penetrative sex. Many of these *malishias* were also being accessed for sex by women.

There are other networks of male to male sex, not only in a range of male only institutions, or between young male friends in neighbourhoods, but also between older men and adolescent boys. These frameworks can be seen within contexts of

- a. desire for a specific sexual act, i.e. anal sex
- b. ‘body heat’ that requires discharge
- c. mutual desire for male to male sex
- d. desire for adolescent boys known in the historical literature as “beardless youths”

Accessing sexual partners is not considered difficult by most of the people interviewed. There are many spaces in Lahore (50 specific locations were identified in the mapping exercise) where *zenanas* would go to meet potential *giryas*, often marketing sexual availability through

their feminised social behaviours. Many 'real men' also go to these sites, not only to meet such accessible males, but often for quite legitimate purposes, where they can get caught up "in the heat of the moment" and access *zenanas* there at the time.

What is clearly seen is that language, behaviour, and identity was to a large extent gendered, within a hidden context of polymorphous behaviours, and that behaviour and sexual practice were more significant markers for the majority of males than a specific sexual identity. In a way we could say that there were limited numbers of MSM with specific sexual identities, but significant levels with a gendered identity or perceived 'body needs' which shaped sexual practices.

One more point needs to be made. Relationships between the various networks (I use this term advisedly rather than groups) were often self-stigmatising, tense and sometimes abusive because of the social construct of penetration being seen as equivalent to feminising. Gender 'politics' and relationships, come to the fore. Thus *malishias* may abuse *zenanas* because of their feminisation, *zenanas* will abuse *chavas* because they also are penetrated, *giryas* abuse *zenanas*, and substantial tensions exist between *hijras* and *zenanas*, since *zenanas* are not castrated. These tensions can explode into verbal and physical abuse at times.

The issue of female sexual health is also highly pertinent. Cultural tradition makes marriage socially compulsory. Many MSM, of whatever framework, were married or going to be married, even those who identified as *zenanas*. Many sex partners would also be married or going to be married.

In summary what we can say about male to male behaviours in Lahore is that:

- For many males involved in male to male sex, male to male sexual behaviours does not involve a homosexual identity, but is within a sexual/gendered identity (man/not man), as well as an act, a behaviour.
- Such behaviours are not contextualised within a heterosexual - homosexual paradigm but within a gendered framework and role play, where a feminine gender performance signifies the preferred role taken in the sexual act.
- This gendered framework is constructed within a *zenana/girya* dynamic, where the *zenana* perceives himself and his desire for other males in the context of gender roles in Pakistan, i.e. the "penetrated" partner. *Zenanas* identify as feminised males, constructing their social roles, mannerisms and behaviours in ways which attract what they call *giryas* - "real men".
- In this context many *zenanas* are visible in a range of public environments and neighbourhoods, but *giryas* are not, for they could potentially be any "manly" male.
- This does not mean that Lahore does not have any gay-identified men as it is understood in the West. It does, but the Assessment team members were not able access any.
- Nor does it mean that other dynamics of male to male sex do not occur in Lahore. They do - from discharge sex between male friends, *malishias* and their clients, sex as play, between males in all male institutions, and so on.
- Nor does it mean that *zenanas* never penetrate, or that *giryas* are never penetrated. Some do cross
- Over these gendered sex roles. But such cross-over is seen as a very secretive behaviour, and is not
- Usually shared with *zenan/girya* friends. Such gender role cross-overs are seen as even more shameful.
- Similarly for a *zenana* to admit to having sex with another *zenana* is also considered shameful, and crosses the "incest" boundaries, i.e. *zenanas* will state that they perceive each other as "sisters".

- *Giryas*, or “real” men, do not see themselves as homosexuals or less masculine because of their sexual involvement with *zenanas*/adolescents. They penetrate *zenanas* who are not “real men” - they are *zenanas*. Their personal sense of manliness is safe.
- In a range of discussions it was clearly recognised that cross-gender sexual behaviours did exist, that some *giryas*-identified men were penetrated, and that some *zenanas* do also penetrate. These behaviours may not only arise from desire, they may also be financially motivated in the case of sex work.
- In other words there is a spectrum of masculinities and genders.
- In a culture that excludes females from public spaces, that socially polices females and controls their access by males, and where sexual behaviours are based on gender identification rather than sexual identity, it is possible that for many “manly” males, sexual access will be with *zenanas* or those deemed less “manly”, i.e. young males and adolescents.
- With this gendered dynamic it may be possible to physically count the number of *zenanas* at a range of public sites, but this doesn’t address the so-called *secret zenanas*. Nor does this address the number of “manly” partners these *zenanas* access.
- Beside the *zenana/malishia* frameworks, there is also another dynamic of male to male sexual behaviours, which because of a shame-based culture cannot be readily accessed. This includes inter-family male to male sex, sex between friends, and sex in male only spaces. Such behaviours are not identity-based. Here desire is based not so much on same gender/same sex, but rather on immediacy, “body heat” and felt “discharge” needs.
- Such behaviours could be significantly high since there is a limited social construction of heterosexuality - perhaps we can call this behaviourally heterosexual” - and where sexual access to females is very limited. In Lahore what appears is a core personal identity in terms of gender role, marital status and class. Identities are not based on sexual object choices.
- Another framework also exists in which same sex/same gender frames sexual encounters, but this seems to be more based around trans-generational patterns.
- In this context, adolescents are seen as less “manly”.
- *Zenana/girya* relationships are based on gender roles - a “husband and wife” relationship. *Zenanas* are not friends with their *girya*, but “wife”. This is a relationship based on same sex/different gender identification dynamic. *Zenanas* make friends with other *zenanas* with whom they “never” have sex with. For *zenanas* this would be like having sex with their sister.
- Male to male sexual desire should be contextualised differently from male to male sexual behaviour.
- Apart from the limited mobilising that Vision has been responsible for, no organising exists amongst *zenanas* across Lahore. There are localised social networks in specific sites and among different groups.
- Social and economic class was a significant factor in terms of relationships and maintaining invisibility, where those from middle class backgrounds would most definitely not socialise with those from lower-income backgrounds. But *zenana*-identified males from these backgrounds were much more visible.

MSM contexts in Lahore

To attempt to use the term men who have sex with men as a bounded framework in the context of Pakistan would not be valid. Nor should they be seen as an exclusive category of people, defined by a specific occupation or activity, unlike perhaps female sex workers and IDUs, or even truck drivers and slum dwellers, categories used in Pakistan by NGOs and others. To do so leads to a greater invisibility of differing contexts of male to male sexual behaviours, expressed in an often bewildering variety and range of personal identities, behaviours, gender identifications and practices, which defy such a simple categorisation.

What seems to exist are a range of masculinities and genders with differing contextualisation of a range of sexual behaviours, partner choices, perceived sexual needs, and desires.

While for some MSM there are frameworks of specific male to male desire (based on object choice), identities and visibility which may make it easier to access and quantify numbers, for others who sexually access these males and whose desires are around discharge rather than gender/sex roles, and who perceive themselves as 'manly' and 'normal men', it is almost impossible to quantify. Access would probably be easier through their *zenana* or *malishia* partners than directly.

Further, in the broader context perhaps we should be talking about male to male sexual behaviours rather than men who have sex with men (MSM) for the word "men" can be problematic.

Contemporary research on sexualities and genders have clearly shown that bipolar categories, such as 'man' or 'woman' or 'heterosexual' or 'homosexual', are not useful to describe the range of identities, desires and practices" (personal discussion with Carol Jenkins, Care Bangladesh, 1999) existing in Pakistan generally and Lahore specifically. The terms "gay" or "homosexual" are too contextualised by a specific history, geography, language, and culture to have any significant usefulness in a different culture from their source. In this we should be talking about sexualities, genders, and at the least, homosexualities and heterosexualities, and about behavioural constructions. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the South Asian context.

Even the word bisexual, often used to label those who have sex with both men and women, is not a useful category in differing cultures. At the same time, the term "men who have sex with men" is also beginning to lose whatever usefulness it may have had once, as this too has become a bounded category. What does the word "men" mean in this context? What does the word "sex" mean? This was clearly seen in Lahore during a range of discussions, where some of those who do not identify as *zenana* are beginning to use this term to give expression to their personal desires and behaviours, while definitions of 'man' and 'sex' also varied considerably.

Whereas some of the male to male sexual acts could perhaps be called 'homosexual' (within the context of a local sexuality based upon a feminised gender identification - also self-labelled as *zenanas*) in that a sexual sense of self is operating within a framework of gendered sex roles and desires, a significant majority of the male sexual partners of these *zenanas* could be seen within a context of semen discharge. These sexual partners of *zenanas* are called *giriya*s by them. But it should also be recognised that within a gendered construct of male to male sex and desire, there are *giriya*s who form emotional and sexual relationships with *zenanas* (such *giriya*s are called *pukka dost*). These *giriya*s do not see themselves (nor are they perceived as such) as homosexuals, but rather as real men, defined by their supposedly exclusive penetrating role that they take in the sexual encounter with a *zenana*.

Self-identities amongst MSM in Lahore varied across a spectrum of divergent categories and masculinities, from *hijras* to *zenanas* to *chavas* (who are penetrated and also penetrate) to *giryas* (who supposedly only penetrate). Within this were also sub-categories, particularly among *zenanas*, indicating finer distinctions of behaviour, dress and mannerisms, whether they were castrated or not, and so on. For many *zenanas*, this is a socialising and socialised role, where they can recognise each other even though they maybe strangers, where ready friendships are easily facilitated, and where a "new" *zenana* with emergent desires (and often not so emergent) will be be-friended by an "older" *zenanas* and learn the characteristics, roles, behaviours (including sexual), mannerisms and language. It is this *zenana* framework which is the most visible framework among MSM in Lahore.

However, not all male to male sexual encounters in Lahore fall into the *zenana/girya* framework, where gender sexual roles are acted out and define the self-identities of the sexual partners. Other constructs, desires, and patterns of sexual encounters exist, framing a complex, open-ended, and extremely porous 'group', or 'networks' of MSM. In fact the word 'group' is highly suspect, in that in term does not fully frame the actual behavioural practices of males across Lahore society. The word 'group' implies an exclusive practice of a number of men/males, but this is not the reality. While *hijras* and public *zenanas* may be considered a group in that their behavioural characteristics make them significantly visible, their partners are not, and can be defined as the general male population whose public behaviour is 'manly' according to the socio-cultural definitions in Pakistan. In fact, we should also recognise that the term men who have sex with men is highly problematic as well, since too often it is perceived as a term with identity connotations, rather than just a behavioural practice, i.e. prison populations, all male institutions, and so on can also be defined as men who have sex with men, since such behaviours are prevalent in such institutions.

In Western terminology, men are divided into oppositional categories: heterosexual **or** homosexual, terms that were invented in the 19th century within a lexical and reductionist framework where a person's behaviour would define his sense of self. You were either a homosexual or you were a heterosexual. Within this oppositional framework, the homosexual was defined as subordinate and less worthy than a heterosexual. And at some cognisant level the homosexual was deemed effeminate, more womanly-like, and the penetrated (or the 'passive') partner. It was only in the 20th century that the penetrating (or 'active') partner was also deemed to be homosexual. Such distinctions are not valid in Pakistan.

There of course is a proviso. Among the elite - the middle and upper social classes - where education and language is highly Westernised, with access to the internet, English language, books and magazines, a sense of homosexuality has developed as a person's primary characteristic, with the adopted language of sexual politics- gay **or** straight. In Lahore, there are men who have developed a gay sensibility and a personal gay identity within the confines of Pakistani culture and social practice. This precludes the "coming - out" process that is seen as a central component of Western gay identities. In other words there are men who perceive themselves as gay, but find themselves too vulnerable to come-out as gay. They are 'closeted'. The reasons for such 'passing', or 'hiding', are of course obvious. This Assessment did not access any gay-identified men.

Several differing networks, definitions, and sexual ideologies were identified in the study. These included:

- a. **Hijras** who are for the most biological males, usually fully castrated, and sometimes sell sex to 'real men'. They form a specific community and follow specific relationship rules with each other, and within "guru-led families". The Assessment did not access *hijras*.

b. **Zenanas**, who are also biological males, are not castrated, and usually perceive themselves as “a woman in a man’s body”. They may or may not feminise their social behaviours in public spaces, will often wear make-up, dress in feminine clothes, and take on the female sexual role as the penetrated partner. Some of them (but certainly not all) are highly visible in certain public spaces by their feminised gestures and body language - usually quite exaggerated - their cross-dressing (both partial and fully) at melas and other functions where they perform as dancers, and for some of them, their availability as male sex workers. Such behaviours can be seen as a ‘public performance’ acting out the role of *zenana* to attract ‘manly’ clients and sexual partners. But it should be recognised that some *zenanas* will also sexually penetrate, but such behaviours are denied.

Other males may call themselves *zenanas*, but their public behaviours and performance are not readily recognised as *zenana* behaviour. However in what they deem as ‘safe spaces’ and/or with other public *zenanas*, their behaviour will shift towards such feminised behaviours and practices. In some ways, perhaps we can call this situational identities.

It should be noted that, like *hijras*, *zenanas* have a language of their own, secret and not accessed by the general public. The *zenana* terminologies and language can be seen as a derivative of the language used by *hijras*, and they term this *farsi*.

It is interesting to note that the terms and phrases used by *zenanas* in Lahore are also used across the sub-continent, whether in Dhaka in Bangladesh, or Chennai in India, with some local variations. But a *zenana* from Lahore can be understood by a *zenana* (also known as a *koti*) in Chennai or Dhaka, or Delhi.

c. **Chavas** are usually young men who look and behave as ordinary males, and whose sexual practice is usually mutual. In other words they will penetrate and be penetrated, orally and anally. This means that they can have sex with a *zenana* as well as a *giryas* and between themselves. *Zenanas* express difficulties with this framework because it lies outside the context of a gendered sex act.

d. **Giryas**, the name given by *zenanas* to ‘real men’ who are seen as potential penetrating sex partners in the gendered framework. In a sense all ‘manly’ men are perceived as potential *giryas* by *zenanas*. A *giryas* who forms a relationship with a *zenana* is also known as a *pukka dost*.

e. **College Boys** are linked with *chavas*, in that they will often take both the penetrating and the penetrated sex role. *College boys* are usually dressed in shirt/pants, and are seen as more educated and come from middle-class families and perform as “normal” males.

f. **Malishias** are different from the above in that this is an occupational term rather than a term defining sexual practice or identity. It is believed that most *malishias* will also offer sex to their customers as well as a massage, and the Assessment did indicate that a substantial number of *malishias* do so. The perception is that *malishias* only take the penetrating role in sex acts, and that they will have sex with both men and women.

There are of course other networks of male to male sex in a range of male only institutions, or between young male friends in neighbourhoods, and also between an older man and an adolescent boy. These frameworks can be seen within contexts of

- a. desire for a specific sexual act, i.e. anal sex
- b. ‘body heat’ that requires discharge
- c. mutual desire for male to male sex

It further needs to be recognised that the act of a male being anally penetrated by another male is highly stigmatised and those who are perceived to be recipients are usually treated with contempt. A *giryas* or *malishias* or any man/male who is sexually penetrated, orally or anally, will make extensive efforts to hide his desire and/or practice both from the public as well as from *zenanas* and others in their sexual networks to avoid such stigmatisation. Accessing such information is extremely difficult because of the intensive levels of denial that asking such questions generate. However, private discussions with a range of individuals indicate that such practices are common, but invisible.

Accessing sexual partners is not considered difficult by those interviewed. There are many spaces in Lahore (50 specific locations were identified in a mapping exercise) where *zenanas* could go to meet potential *giryas*, often marketing sexual availability through their feminised social behaviours. Many 'real men' also go to these sites, not only to meet such accessible *zenanas*, but also for quite legitimate purposes, where they get caught up "in the heat of the moment" and access *zenana* t at the time. But because of the visibility of many *zenanas*, and their performative role, it is considered quite possible to access *giryas* for sex anywhere.

Malishias are also highly visible at a range of sites, clanging their bottles to advertise their presence, or standing by the roadside/pavement. It was noticed that not only passers-by were accessing their massage service (and often what is termed 'hand-relief', or where invisibility was assured, oral and/or anal penetration by the *malishia* - or even allowing themselves to be penetrated in secretive conditions), but many also have regular customers who will take them to local hotels or their own homes for massage and sex. And these were not only customers from the same social/economic status. They include men and women from middle-class backgrounds who can afford to have a car.

What is clearly seen is that language, behaviour, and identity was to a large extent gendered, within a hidden context of polymorphous behaviours, and that behaviour and sexual practice were the more significant markers than a specific sexual identity. In a way we could say that there were limited numbers of MSM with specific sexual identities, but significant levels with a gender identity which shaped their perceived sexual practices, and even a greater number of males who access youth and/or feminised males.

One more point needs to be made. Relationships between various networks (I use this term advisedly rather than groups) were often self-stigmatising, tense and sometimes abusive because of the social construct of penetration being seen as equivalent to feminising and stigmatising. 'Gender politics' and relationships come to the fore. Thus *malishias* may abuse *zenanas* because of their feminisation, *zenanas* will sometimes call *chavas zenanas* because they are also at times penetrated, *giryas* abuse *zenanas*, and substantial tensions exist between *hijras* and *zenanas*, since *zenanas* are not castrated. These tensions can at times explode into verbal and physical abuse.

As part of their public feminine gender performance, some *zenanas* will take oral contraceptives (many can't afford, or can't access, hormone injections) as a means of developing breasts, stating that *giryas* like to "squeeze" their breasts as a part of their sexual practice. From the range of discussions, taking oral contraceptives by these males is a significant activity, not so much as a means to become more like women, but as a tool to attract *giryas* as sexual partners.

Sociocultural, religious and family pressures ensure that the majority of *zenanas* will eventually marry and produce children, no matter how long they attempt to delay this process. The choice is often stark. Stay with your family, or leave! And with no social welfare system available, there is a perception of no choice. This intense pressure produces a range of psychological

effects, sometimes depression, perhaps fear of non-performance with their wives, and always a constant search for a "real man" who will "marry" them and look after them.

For *giryas*, marriage and children are key identity markers of manliness.

Many of the *zenanas* from low income groups become sex workers as a source of generating and income. Not that all may identify as sex workers. This income is to support their families and themselves.

Not all male sex workers are *zenana*-identified. Many *malishias* also sell sex as an additional source of income, while *chavas/college boys* will also sell sex.

But while poverty was a determinant of sexual behaviour for many male sex workers, it was clear from the discussions and interviews that pleasure and discharge was also involved.

Giryas are less clearly defined, being males of all ages and types, married and unmarried, across the spectrum of income and employment, who, at least at times, enjoy sex with other males, stating they could not access females, and they could not control their "body heat" and "needed to discharge". There was a strong sense of immediacy, urgency, opportunity and availability to their sexual behaviours with the *zenanas*.

This, of course, does not mean that many *giryas* don't also desire other males. But usually this desire is usually contextualised within a gendered pattern of 'penetrator' or 'penetrated'. And of course all *giryas* will either be married or will get married eventually, fulfilling the social, religious and family expectations for all men in Bangladesh culture. At the same time, some *giryas* who publicly performs as a 'manly' man will also get penetrated.

Beyond this "public" framework of identities, desires, and behaviours is a context even more invisibilised, an issue also relevant to HIV prevention. An unknown number of males/men experience male-to-male sex while young, often before male-to-female sex and often with family relatives such as cousins or uncles, or even with friends. Such behaviours will often continue into adulthood and sometimes beyond marriage. These behaviours are outside the "public environments" taking place in neighbourhoods, private homes, hostels, guest houses, hotels, and a range of vendor shops and other private places. Here the contexts may well play out a gendered framework, but often it is where access, immediacy and opportunity play a significant role in the prevalence of this behaviour. Very often both of the partners involved in the sexual activity do not express a sexualised identity, but rather speak of need and urgency, "the heat of the moment", or "I did it in my sleep", if they discuss this at all.

Some may well find that their experience of sex with men resonates with their own sexual desires and gender role preferences, and should they meet with *zenanas*, develop their own *zenana* identity. Others give no voice or name to their experiences, and may well stop upon marriage, or continue in their neighbourhoods with local *zenanas* and other males.

This does not imply that these sexual roles are limited to what they publicly speak of, i.e. "active" or "passive" since it is known that sexual acts and roles may well shift and change where space and time permit. Behind closed doors and under the blanket much more diverse behaviours may exist, where the *zenana* may well penetrate what was perceived previously as a *giryas*.

A *zenana* identity is very much around performance, both public and private, of declaring one's sexual interest and preference. It is a socialising role, a framework to meet similar individuals and share common desires, feelings and behaviours. It is also a mechanism of self-recognition and recognising others. To be socially excluded is devastating. Sexual behaviour is a

component of identity, and if behaviour falls outside the identity parameters and it becomes known to others, then the person can fall outside the socialising role.

Thus, such "cross-gendered" behaviours are seen by *zenanas* and by the so-called *giryas* as even more shameful, and both would consistently deny involvement in such behaviours. Where this occurs, the behaviour tends to be kept even more secret than those that "fit" the prescribed gendered sex role.

Secrecy and shame control the frameworks of visibility and denial in regard to behaviours deemed outside the social and cultural norm. Not talking about sex and sexual behaviours is one way of not only invisibilising such behaviours and practices, but also of marginalising them as a peripheral phenomena, particularly in regard to male to male sexual encounters. At the same time such secrecy enables maintaining a socially acceptable public role.

This form of social control is constructed by traditional and religious concepts of honour and shame. Honour, not so much as what is deemed to be personally honourable, but in terms of one's standing in the community and family. Honour as a possession, not a quality. Shame, not so much as what may be deemed as wrongful (or even sinful), but by behaviour and conduct which brings shame to the family and/or community as a whole. These two intersecting frameworks arise out of understandings of value systems around what is public and what is private. What is visible and what is invisible.

Public behaviour, behaviour which is visible, is bound within a context of family duty, honour and obligation (both familial and religious). In this context any behaviour which is visible to the community (and/or family) falls within the scope of public behaviour and therefore falls within concepts of honour and shame.

Darkness and privacy creates invisibility. Bushes, trees, dark construction sites, badly lit alleyways, behind houses, under blankets, any place where space is available for mutual sex encounters and where darkness reigns. Darkness invisibilises behaviours creating deniability. It is in the dark that most male to male sex occurs.

Situational Identities and context

Within the context of Pakistan, in a country which is perceived to be a highly religious and conservative, the beliefs and practices lead some participants in this study to act out situational identities. That is, within the family home and neighbourhood they will perform as young (or not so young) men, while in specific environments perform as *zenanas* with other *zenanas*, or to draw the attention of potential male sexual partners. In this context, facial hair (i.e. possession of a moustache) acts as a 'manly' marker. Some *zenana* identified males would also have a moustache and could this blend in (along with *malishias* and *chavas*) with the surrounding 'manly' environment.

At the same time, many others who were not a part of the public sex environment, would totally invisibilise their desires through marriage or 'proper' social and religious behaviour within family, community, and mosque.

The cross-over from one to another can be remarkably swift and immediate. Crossing a road and entering a "cruising" site the actions and mannerisms would change immediately. When this was discussed, it was stated that this was for safety and security in the general society, to keep their desires and behaviours secret from family and friends, and to ensure invisibility on the streets away from what were perceived as safe areas, i.e. "cruising" sites.

Access to medical treatment was also problematic because of the quality and cost of treatment. Sickness of one sort or another seemed to be prevalent, from skin rashes, stomach upsets, and various other physical ailments.

Zenana social and sexual networks seemed to be mainly localised around specific sites where they would go regularly. Similarly with *malishia* networks. Yet these networks were also extensive across Lahore. At least fifty main meeting places were identified.

Shame in this context was about breaking social, religious and family norms, of being outside of socially acceptable behaviours. Social, religious and family expectations were strongly expressed in the workshop, interviews and discussion groups. The sense of not being able to fulfil these expectations created the context of shame felt. This feeling of shame also strongly factored risky behaviours and practices as well as treatment seeking, particularly those from low income groups.

At several sites police activity created significant issues in terms of abuse, harassment, and sometimes violence. But several *zenanas* spoke of having sex with a range of police officers, sometimes on demand, and also of police officers demanding money.

Public environment sex was very rapid, leading to discharge in a few minutes. Such a methodology involving anal penetration led to several *zenanas* speaking of anal bleeding and pain. Combined with a lack of sexual knowledge, low condom usage, low access to treatment, no access to an appropriate water-based lubricant, this type of sexual practice created high risks for STI/HIV transmission.

Sociocultural frameworks of male to male sexual availability

Why is male to male sex so significantly high in Lahore, as elsewhere in South Asia? Various socio-cultural factors affect this, not least being that Pakistan could be deemed an emergent heterosexual society where sexual encounters are bounded within a framework of man/not-man.

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

- Marriage is considered a social and religious duty and a family obligation, not one based upon personal desire and choice. It is therefore seen as compulsory and a social necessity. Marriages were usually arranged by families, and not through choice.
- To remain unmarried is seen as bringing shame to the family. Cultural and religious beliefs dictate that a male achieves social responsibility and thus personhood upon marriage.
- Marriage may often be delayed till the male is in his late twenties or early thirties, because of the economic costs as well as perhaps for a lack of interest and desire.
- 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.
- In this context sex is seen as reproductive. Sociocultural traditions in Pakistan, frame women as not equal to men, 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. 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.
- This often leads to a concept of sexual pleasure for men as only available outside of marriage. Others would be asked to perform sex acts that could not be asked of a wife.
- Here what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.

- 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 and much less accessible.
- Concepts of sexuality, sexual behaviours and sexual identities are bound up within concepts of gender roles (the penetrated and the penetrator) and semen discharge. Such a framework will often lead MSM to high frequency of sexual partners.
- For some males who sexually penetrate (the *giryā*), the gender of the sexual partner can often be irrelevant. What matters is to discharge.
- Because Pakistan culture is homosocial and homoaffectional, both in public and private, it is not uncommon for two or more males to be physically affectionate with each other and at times to share a bed. This creates opportunities for sexual encounters as much easier, and generates invisibility. Very often this takes place in the dark, under the blanket, when partners can disassociate themselves from the act - "I don't know what I did". This can also lead to significant degree of familial sex, i.e. uncles, cousins, and so on.

These characteristics of Pakistan culture, which also include over-crowding in urban areas, poverty, males sharing spaces, a substantial number of males below the age of thirty and unmarried, difficulties in sexually accessing females, lack of privacy which can also be costly, 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).

This same framework exists in contemporary Bangladesh, 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 young adolescents to much older men, from relatives to the domestic servant, from the rickshaw driver to the businessman. Many will engage in these behaviours sporadically, or over relatively brief periods of time. 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 sexually 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 in Lahore. 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. They will also be framed within the context of gender/sex roles. Thus *zenanas* will speak of their *pukka dost* - their 'husband'. Or deep and abiding male to male friendships will develop.

Pakistan public spaces are supremely male. The street, the bus stand, the park, the railway or bus station, the mazar, 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 sector also a part of these networks. Whether just for sexual release, money, or actual desire for sex with other males is a difficult question to answer. These include rickshaw drivers, barbers, room service and housekeeping males in hotels, waiters and table boys at restaurants, shop assistants. The framework is ubiquitous. In Lahore 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.

But perhaps we should accept that often Pakistan male sexualities are amorphous, opportunistic, spatially bound, discharge oriented, time-based, as well as those based upon same sex desire and love, but framed within concepts of differing genders.

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 its existence, or to contextualise it only within the limited heterosexual/homosexual paradigm, will ensure that no such programme will successfully contain the spread of AIDS.

See, Khan, Badruddin: Sex, Longing & Not Belonging - a gay Muslim's quest for love and meaning, Floating Lotus, 1997

Mapping

The movement of *zenanas*, *zenana* sex workers, and *malishias* across Lahore appeared to be limited and fixed to particular sites. Some *zenanas*, those who could afford the transport costs, would move from one site to another in a constant search for partners. Friendships however, also existed across sites.

The mapping exercise was undertaken as part of the situational needs assessment of men who have sex with men (MSM) in the city of Lahore. This mapping was done over a period of 3 weeks.

Objectives:

The objectives of the mapping exercise were following:

- Approximate estimates of men who have sex with men in the city of Lahore (those who are accessible and visible at cruising sites and pick up points)
- Approximate estimate of sub identities within the larger MSM group such as *Zenanas/Kotis/Moorats, Khusras, Giryra/Mard/Pucca dost, Chavas, Lifters, Masseurs, Ghomar, Mummy Daddy, College boys*, etc.
- Residential concentration of these groups in the city of Lahore
- Occupational concentration of these groups such as cruising sites, pick up points, social spaces etc.
- Approximate estimates of spaces used by MSM for cruising, pick up and sex
- Approximate estimates of health care facilities accessible and accessed by these groups for their health care.

Methodology:

- Municipal mapping of the city was used for determining the names and numbers of shrines, parks, bridges, bus stations, railway stations and shopping areas of Lahore city.
- Project mapping of Vision was used as a guideline to identify the MSM concentrated areas (residentially as well as occupationally) on the larger city map.

Three teams were formed, each team consisting of 3 MSM from the Assessment Team and a resource person from Vision. Each respondent was interviewed separately by Vision's resource person as a key informant. This was done to validate the already identified spaces generally used by MSM in the city of Lahore for living, cruising, pick up and sex. Each team selected random sites to visit and observe the activity at different hours of afternoon and evening as well as different days of week.

Findings

Shrines as cruising areas and pick up points

Out of more than one hundred large and small shrines, there are some seventeen main shrines in Lahore that are mostly used by MSM as cruising areas. Three of these seventeen are used by MSM on any given night for cruising, remaining fourteen are one night a week i.e. Thursday, cruising spots. However, all seventeen become cruising spots for MSM on the lunar 11th of each month.

The numbers of MSM present at such shrines would vary both according to the size of the shrine and its following. The three mentioned above have a big following and are spread out on large pieces of land too.

The MSM populations frequenting these shrines are *Zenanas, Khusras, Double ralas, Ghomars, Chavas, College boys, Masseurs and Giryas*.

Health facilities around these shrines:

The most used health facilities by the MSM are around one of the biggest and well known shrines in Lahore. Following are the numbers of these health facilities within 2 mile radius of this shrine:

Sanyasi	8
Pansari	12+
Private hospitals	1
Government hospitals	2
Hakeems	3
Doctors	5+
Pharmacies	20+

Parks as cruising areas, pick up points and sexual spaces

Out of several there are three main parks in Lahore that were identified as MSM cruising areas, pick up points and to some extent sexual space by the community representatives.

One is a very old historical park that after sunset has areas that are not too well lighted. Reportedly these areas are very convenient for oral sex, masturbation and discharge through body rubbing.

Observations through on-site visit by the mapping team revealed that the park was frequented by families and did have areas that had bushes and were dark. There was evidence of men sitting in couples in those areas or just lying down close to each other but at the same time there were opposite sex couples too sharing the same space. Thus, the park being used for oral sex, masturbation and discharge through body rubbing was a strong probability. However, there is vigilance in the park. Armed guards are patrolling the park after sunset. Therefore anything more than discharge through the above mentioned means may not be possible. Since the park closes down at 8pm in the winters and 10pm in the summers, it is

during the summer months that the park is more used as a cruising, pick up and a sexual space.

The second park is close to a major MSM cruising area in the city. It is a well spread out park adjoining the main bus station of Lahore. It is again a park that closes down at night time. The timings are different in summer months and it is in the summer months that this park is a major sexual space for massage boys. In summer evenings men get their bodies pressed by masseurs in this park. Discharge during the massage is common. Masseurs are the only population visible in the park as it is a park that is well lighted, and frequented by families from the walled cities. It is a spread out park without any trees. There are bushes but they are also properly manicured and are not too tall.

The third park is close to the main railway station of Lahore. This park is smaller in size but a very convenient cruising area and a pick up point. It is in close proximity of cheap hotels. Generally men meet and pick up men from this park. There is a large visibility of small boys in this park especially after sunset. These boys often have oil bottles for massage in their hands or are roaming around with wooden boxes for polishing shoes.

The team observed a high volume of interaction between these young boys and older men and eventually the older men being followed by these boys from the park.

There are other MSM populations such as *zenanas*, *chavas* and masseurs in this park too, however any sexual activity except discharge through massage is not possible in this park as it is very small and has no tree or bush in it. This park was categorised as a major pick up point by the MSM population.

Health facilities around the parks:

The first park has following health facilities within one mile radius:

Government teaching hospital	1
Pharmacies	8

The second park is within one miles radius of the health facilities mentioned above.

The third park has following health facilities within one mile radius:

Hakeem	1
Private doctor (male)	1
Private doctor (female)	1
Pharmacies	4
Homeopath doctors	3

Bus Station

The main bus station of Lahore city is also considered a cruising spot. It is also a space for sexual activity. The team observed that there were lots of empty buses parked at night time and could provided convenient space for any kind of sexual activity. Reportedly penetrative sex inside the empty buses is quite frequent. There were a noticeable number of masseurs, *zenanas* and *chavas* at the bus station when the mapping team visited the site on three different days and time.

Health facilities around the bus station:

The health facilities mentioned in 4.2 are within one mile radius of the bus station.

Railway station

The main railway station is also reported as a sex space. The team observed that there were plenty of empty trains parked at the station. The compartments were dark and provided a safe space for all kind of sexual activity. The MSM community members in the team reported a high frequency of sexual experience in the dark compartments. However the only visible population was that of masseurs at the more distant and deserted platforms during all the three visits of the team.

Health facilities around the railway station

The health facilities mentioned in 4.4 for the third park are within half a mile radius of the railway station.

Bridges

A canal goes through the city of Lahore and on both sides of the canal are roads for traffic. Each intersection has a bridge. Three different bridges (intersections) on this canal are known to be famous MSM pick up points. The MSM populations that use the intersection for getting picked up are Masseurs, *zenanas*, *ghomar*, *chavas*, *college boys*.

Health care facilities close to the bridges

Each bridge has at least one major hospital and several pharmacies within two mile radius.

Shopping areas as cruising spots and pick up points:

There are at least three upscale shopping areas that are considered good for cruising and getting picked up by MSM. In all three shopping areas there is a noticeable visibility of *zenanas*, masseurs, *chavas*, *giryas* and *college boys* at night time.

Health care facilities close to the shopping areas

There is at least one major hospital and several pharmacies close to each shopping centre.

Conclusion

28 well known MSM cruising sites, pick up points and spaces used for sexual activity were identified. Apart from these team members also identified other sites, including some neighbourhoods that normally are used for getting picked up. There were at least five neighbourhoods that were identified by the team members but while visiting the team did not find any evidence of such activity in these neighbourhoods. Similarly the majority of sites identified were not visited because of the time scale.

As an observed estimate, approximately 1500 *zenanas*, 1000 masseurs, 3000 *chavas* and nearly 2000 other MSM was reported by the key informants in their separate interviews. However it should not be presumed that this is the total MSM in Lahore. Partners of these MSM were not counted, nor the whole range of sites visited.

However, during the training workshop, a further twenty 24 sites were also identified, where males can meet other males for sex were identified in the Lahore area. They included parks, bus-stands and stations, the railway station, auto-taxi and rickshaw stands, mazars, specific streets, bazaars, market places, shopping centres, tea gardens, under bridges, any area where a measure of anonymity and access to males was possible. While sexual activities did take place in many of these sites, much also took place in construction sites, guest houses, lodges and hostels, as well as personal homes, where after meeting the partners would go for more private sex.

But at the same time, *zenanai*-cruising goes on in restaurants, tea-shops, hostels, shops, even during the day time, and the *malishias* can be seen in a wide variety of locations.

Discussions in the workshop generated guestimates of	
male sex workers	3,000
<i>zenanas</i>	25,000
partners of <i>zenanas</i>	100,000
<i>malishias</i>	5,000
partners of <i>malishias</i>	50,000
<i>chavas/college boys</i>	5,000

These figures could be higher or lower. Their accuracy could not be verified.

Support and friendship systems

For *zenanas*, their key support and friendship system were other *zenanas* (likewise with *maliashias*). This also expressed the gendered framework in which the majority of *zenanas* identified with. A 'sisterhood' appeared to exist. At the same time a level of competition existed between *zenanas*, which at times could lead to bitter disputes, although it was stated that these rarely lasted long.

In Pakistan cultural systems, men and women rarely make friendships. The public arena is male dominated. And male to male friendships are expressed in the public domain. The home is a private space, where friends can attend, but privacy is lacking. Pakistan homes are crowded spaces, where rooms are shared always - unless you happen to be rich enough for privacy.

Zenanas see "real" men as potential *giryas*, and treat them as such. Rarely would a *zenana* develop a non-sexual friendship with such a man. *Zenanas* expressed the desire to "find a husband", or just to find sex, but even in this context *zenanas* recognised that this "husband" will get married and live with his real wife. At the same time many *zenanas* would also see other *zenanas* at the same site as a sexual competitor.

In a situational context the majority of *zenanas* will perform as "regular" males in other public contexts and in the home, and thus will develop friendships with other neighbourhood males and relatives keeping his identity choices and sexual behaviours secret. But even in this arena, *zenanas* often spoke of sex with friends, these male friends - but never with another *zenana*. When this was discussed, the sense of shame was palpable.

Thus it is clearly seen that support systems tended to be expressed in a narrow arena, usually in a public environment, although sometimes *zenanas* will visit other *zenanas* at their homes, particularly so when that *zenana* has a room to himself. Here again this space becomes sexualised as *zenana* friends will bring their *giryas* to access the privacy of the space.

Groups of *zenanas* who had strong bonded relationships with each, would often called each other by feminine names and relationships, such as sister, aunty, mother, and so on.

Within this were several lateral and vertical relationships based on female Pakistani family structures, which required acknowledgement, as well as "sibling" rivalry and discord over apparel, make-up, appearance, and potential sex partners.

Zenanas would always turn to other *zenana* for moral, emotional and financial support.

Several *zenanas* reported relationships with their *pucca dost*, framed by a 'marriage' and recognised partnership within the *zenana* networks. These emotional and sexual partnerships could last several years, but appeared to exist with a range of tensions, and at times considerable violence. In fact violence was quite common in the lives of *zenanas*, and included violence from the main partner, to violence from police and local thugs, to a considerable degree of group rape.

Poverty and sex work

Poverty, lack of employment, as well as low-paid employment, along with the increasing costs of living, poor educational levels, has a significant impact upon levels of male sex work. The need to support self and family contextualised the significant level of male sex work, whether they were living with their families, or whether they send funds to their families who may well be living in a village or another town. Many of those interviewed while *zenana*-identified, also were male sex workers. Some also use *zenana* performance as a means of attracting clients. Alongside these sex workers, were *malishias* who also sold sex for further income. Other frameworks of male sex work exist, from *chava/college boys*, to hotel staff and others.

For many, sex work not only brought pleasure, but also an income. However, significant issues exist in terms of power differentials between sex worker and client, and the whole issue of gender and attitudes towards feminised males by clients which often leads to violence. Condom use negotiation is very difficult in these circumstances.

Another source of income for *zenanas* who cross-dressed, were in entertaining men through dance and singing at special gatherings and melas. Here, the *zenana*, dressed as a female, would dance, either folk and/or film, in erotic and sexually provocative styles, for a fee. Several *zenana* would go together and perform at these functions. After the entertainment, members of the audience would access these *zenanas* for paid sex as well.

Poverty also affects the ability to access medical treatment for any illness or disease.

Psychosexual issues

Sex education was absent amongst the vast majority of the participants in the Assessment. Knowledge of male and female bodies, of reproduction, of the sex organs was almost non-existent.

What knowledge participants had was gained from friends, or very rarely, from books where the person was literate. Pornographic videos were also available.

This ignorance led to a wide variety of myths, beliefs and practices which were accepted as true and helpful. Many of these beliefs and practices were dangerous in themselves. Creams, unguents, antiseptic liquids were seen as methods to protect a person from STIs.

A considerable psychological tension existed regarding masturbation as a source of body and mental weakness, that reduces the virility and functioning of the penis and reduced manliness, if not producing damage of one sort or another. Issues around shape, size, premature ejaculation, sexual abilities, strength, nightfall, and so on, were constant cause for concern. Many of these men used "quack" remedies from street vendors to 'cure' their perceived weaknesses. This also included issues around "night discharge" which was seen as a medical condition.

Such myths and beliefs strongly affect self-esteem and empowerment.

Gender

In Muslim societies, the male-female opposition is clearly delineated, and social and religious expectations define expected gender and sex roles. Such beliefs arise from, and are supported by, Quranic and Hadith injunctions. Concepts of maleness and manliness are clearly articulated.

However, in Pakistan this fixed bi-polarity is not always so clearly expressed as we would understand in the West, particularly where a society is so gender divided that women as

sexual beings are invisibilised and denied, and often inaccessible. There was space for divergent expressions of maleness.

With an ancient South Asian tradition of feminised males as part of a range of visible masculinities, cultural mechanisms exist where these frameworks of masculinities can be tolerated, if not socially acceptable, as long as there is a sense of invisibilising attendant with them. That is, as long as there is no direct challenge to the gender division and expected role play, such divergent masculinities can be contained. Such a challenge would be seen as destroying the fabric of society.

To be seen to promoting homosexuality - or a gay culture - creates a condition of *fitna*, as in this situation, the concept of **men** being penetrated, or acting outside their ordained gender (manly) role, is perceived as social destructive. But where the male is adolescent, or feminised, and the man is only penetrating such males, then this is less social destructiveness. The gender division is maintained. The penetrated partner is not a "real" man. Manliness is defined around "active" and "passive" or "penetrating" and being "penetrated". The penetrated male, like the adolescent or youth, is not a man by definition. No threat therefore exists to the specific gender divide. And with this, as long as fictive relationships are maintained, the man gets married and produces children, he follows public social customs and rules, then what he does in privacy is invisible and can be ignored.

Such a framework maintains patriarchal culture and as long as "real men" maintain their gender role. as long as there is no publicness, then social order is maintained. Concepts of gender is central here where the penetrating "manly" male is not defined as a homosexual even if such a man sexually and emotional desires other males, regularly acts out his desires, or even "marries" the "penetrated" partner. He has to be seen as performing the "manly" role. Here also marriage and children are key components for a "manly" identity. Marriage and reproduction are not only necessary and essential to maintain the fabric of family and society, they also represent key indicators of manly masculinity. If a male is married and performs his husbandly duty with his wife, then he is a man. If he has children, particularly a son, then he is more manly. He is now a social person, an adult male able to make adult decisions and take on adult social responsibilities.

To be unmarried, to have no son, is to be somewhat "feminised" within such a cultural framework. In such a case the person is "less of a man".

In these cultures developing a sexual identity is problematic. We can even say that Pakistan is not as yet primarily a heterosexual society! While "men" are "behaviourally heterosexual" and some will be "behaviourally homosexual", the sense of identity focuses on marriage, children and position in the joint and extended family. For those who are *zenana*-identified, identity will be both in this context as well as in feminised gender identification.

Thus in terms of males who have sex with males in Pakistan there appears to be a range of masculinities, a spectrum of possibilities, where at one end are *hijras* and *zenanas*, and then what *zenanas* define as "real men", *giryas*. *Zenanas* are not-men believing they are women in a man's body, or even want to become women. They appear to see themselves as "less than men" while "more than women". While they identify with the feminine, much of the identification is around performance as a means to attract these "real men" as sexual partners. Lahore is no exception.

However it cannot be taken as a given that because *zenanas* identify with the feminine, or that they may take the receptive role in the sex act, and use feminine terms for each other, that they are always "passive". There is much diversity in all of this.

It should be recognised that the fact that *zenanas* play out the socially accepted gender roles, that their self-definitions, language and behaviours sustains a patriarchal framework of gender relationships and sexual behaviours, and that this has a strong likelihood of increasing their risk of STI/HIV infection and transmission.

Religion

Pakistan has very strong Muslim religious beliefs, traditions and practices. Islam is central to Pakistan society.

Here I am not attempting to define Islam in Pakistan in terms of specific and particular beliefs, traditions, and practices. What I wish to briefly to do is to locate Islam within the cultural context of Pakistan, the interaction of religion and sociocultural dynamics. For example, Muslims in Pakistan, while having a similar faith as Muslims in Saudi Arabia, will often have very different customs and traditions, which will also be different from Muslims in Indonesia. This is because of different languages, different histories, different geographies, different traditions and so on. Further while Islam is sometimes seen as monolithic, it is not. Islam has several different branches. Each will have their own localised traditions and customs partly based on historical and cultural factors, of the particular locality, and partly based upon their singular interpretation of the religious texts.

What needs to be clearly understood is that religion, culture, tradition and social practice are not isolated from each other, nor do they represent the same thing, but are interwoven in complex dynamics. While Islam in Pakistan may specify particular and specific social practices, beliefs and attitudes, very often cultural traditions and customs will outweigh these religious beliefs and statements. What matters is interpretation, social customs and historical traditions. But who does the interpretation? Where interpretation of religious texts interpenetrate cultural beliefs and customs, then very often these customs and practices will take on a sanctity that never existed in the original sacred text.

It should also be remembered that in contrast to the way that Christianity is viewed and practised, where it is seen as very much a matter of personal choice and individual response, Islam relates to how a community functions as a whole. Religious and secular life centres in the mosque. Islam is a faith of community.

This does not mean that there isn't an intense personal belief and practice for many people. The private *namaz* often has deep meaning. Religious belief can provide personal solace, meaning and context to one's life. But with all this goes the daily observances, the food a person eats, his or her relationships with others and the family, interactions with his community and community structures, religious celebrations and festivals. These are all interlinked and interdependent. This is the visible side, the proof of one's religious observance and community participation. Private and public are co-joined.

Religion becomes an obligation to the community, a duty to the community. Not to accept this duty can bring shame and dishonour to the family and to the community. Thus we can say that community participation, more than a personal belief, has a greater relevance. It relates a lot more to what you are seen to do than what you actually do. Participation involves submission to the daily rituals, customs and traditions that surround a specific religious belief. It is public acceptance rather than a private knowing.

All those interviewed professed affiliation to Islam and accepted their specific religious traditions. None could conceive of anything else.

Yet these respondents found ways to balance their sexual practices, identities and desires within the context of being a Muslim. Whilst many of those who identified as *zenana* would

speak of shame, guilt, and dishonour, they also believed that what they were, who they were, and what they did, was between themselves and God. Religious belief was still important to them and a central part of their self definition.

Islam contextualised the peoples' lives. What they eat, how they dress, what they say, and what they do. Islamic injunctions regarding male to male sex also configures MSM's lives, the fear, sometimes inadequacy, the shame, the fear of the after-life and punishment, as well as the sense of guilt.

Religious, social and family expectations followed a seamless context in which conduct, behaviour and expectations arose for all men to follow. *Zenanas* felt strongly marginalised in terms of their desires, hopes and aspirations.

Family

Joint and extended familial links are strongly held together by custom, tradition, belief, practice and economic need. Their value lies in providing a form of social security and welfare in a society that has neither. The elders are supported, as often are the unemployed, the unmarried, the range of children, the disabled. It is considered a moral duty for the family to stay together in this mutual support system, whether the staying together is physical or psychological. For example, leaving a small town or village to migrate to a major city for work, the individual will often stay with an extended family member already in that city.

Such extended family systems can be a liberating experience in terms of the social conditions of individual members. To rely on the family for such support, emotional, physical, or financial, relieves much of the burden for sustaining the self. But as a consequence, the concept of individuality becomes lost. Personal choice and desire becomes subsumed within family choice and desire. Marriage, children and duty to parents is the focus.

However, many *zenanas* reported considerable tensions, violence, and disavowal from their families because of their sense of feminised identity. Many *zenanas* run away from home, because of this, moving to Lahore as an escape from such familial violence and the expressed need to find freedom to be themselves. Similarly, for others, an escape from family violence configures in their decisions to run away.

Despite this, participants still expressed strong family attachments, and some would keep close links with their families.

Such tensions add to the psychological problems and disempowerment that many *zenanas* and *malishias* felt. Added to this was the sense of shame that some felt because of their occupation and/or sense of self-identity. These further created splits between themselves and their families.

Marriage

In Pakistan, marriage is a social, cultural and religious necessity, a central issue within people's lives and a mainstay of family and community life. It should be seen as a socially and religiously compulsory duty towards maintaining family and community bonds. Marital status signifies adulthood, social responsibility and the achievement of personhood.

Traditionally, marriages are arranged between two extended families. Such arrangements are based around economic and inter-family connections. In urban environments there may be a matter of choice and concepts of "love marriage" are growing in the middle classes, but ultimately many see marriage as no choice. As Herdt states in his book *Same Sex Cultures*, "full personhood is not achievable until people have married and produced children" (p5).

To remain unmarried is often seen by the family and others as an aberration, a sickness, bringing shame and dishonour upon the family, creating social and family disorder. And to have no children can be seen as a curse.

But marriage is not based on mutual friendship, desire and love. None of the married men in this Assessment have informed their wives about their extra-marital behaviour with other males, or for that fact, other woman. They believed that all they need to do is to function adequately as husbands in terms of economic support for their wives and engaging in sexual intercourse in order to have children. Marriage was considered a duty and sex as a means to have children.

The wife is seen as the bearer and mother of his children, not as a friend and lover. Marriages are not seen as companionate and egalitarian. And because of the dominant male ideology and male social spaces, a male should be seen spending more times with other males, otherwise he would be seen as being weak and perhaps "womanly".

The vast majority of *zenanas* and their sex partners in this Assessment accepted the social necessity of compulsory marriage, while some were already married. There appeared to be a fatalism operating here, and a sense of not being able to challenge family and society's strictures.

Sexual Activities

MSM in Lahore, at least those assessed in this Assessment, appear to be significantly sexually active with multiple sexual partners as the norm, along with anal sex practice. In the previous month the 200 respondents reported some 3388 sex partners between them.

During this time, 75% of respondents had more than 7 partners in the previous month, with 15% reporting partner levels of 21 or more. 5% of respondents reported more than 51 partners each.

In this period, 1912 anal receptive acts and 282 anal insertive acts were reported.

While 79% reported using condoms, this was highly irregular, with only 55% of the reported insertive acts and 11% of the receptive acts were condom covered.

Of the 3388 reported sex partners for the previous month, 58% were strangers, 16% were friends, while 14% were stated as customers.

Sex partners were met on the street (49%), private homes (21%), and public spaces (24%). These included parks, public toilets, railway station, truck depot, neighbourhoods, bazaars, cinema halls and tea stalls/restaurants.

Where people actual did sex varied from public spaces (33%), to private homes (37%), in cars (11%), and in hotels, guest houses or hostels (16%).

In terms of the ages of the last sex partner, 26% was below 21 and 48% were between 22-30.

Regarding the marital status of the respondents last five sex partners, 25% stated they were unmarried, 26% did not know, and the remainder stated that at least one of the partners was married.

Condom and lubricant use

The data clearly shows that while most respondents have experience of condoms (79%), their use was highly irregular (only 17% of anal sex acts were covered in the previous month).

Respondents did have knowledge of where to get condoms. Medical stores (53%), friends (24%), sexual partners (32%), and paan shops (13%), were the most common access points.

Accessing condoms in terms of availability and cost was not an issue. However, in a multiple choice questions seeking to discover the reasons why condoms were not being used, 84% stated that they did not carry condoms with them, 79% stated that they did not enjoy anal sex when their partner uses a condom, 45% stated that they have never used condoms, 21% reported that buying condoms was too shameful. Some 67% of respondents also said that there was no need to use condoms as they were not sick while 23% stated that their partners were not sick. Only 15% of respondents were carrying condoms with them at the time of the interview (85% were not). Only 8% reported that condoms were not easy to use.

Asked if any lubricant was used for anal sex, 80% reported positively, but 85% reported oil-based products, and 70% saliva as their lubricant.

Sex Work

Being paid for sex

57% of respondents reported that they had been paid for sex in the previous month, but only 6% identified as sex workers. 33% of these reported more than 16 paid sex encounters in this period. The majority of paid sex was for receptive anal sex (61% of total acts) - that is the sex worker is penetrated, 14% for anal insertive, 17% for oral receptive, and 0.8% for oral insertive.

With regard to condom use, 58% of these respondents stated that condoms were used sometimes during the last 5 paid sex acts, while no respondents reported regular condom use, and 42% stated they had never used a condom. When condoms were used, 64% respondents stated that they initiated condom use.

60% of respondents stated they were paid above 200 Rps for the last paid sex.

Paying for sex

48% respondents reported paying for sex with another male. 25% of these reported paying more than 7 times in the previous month. This was primarily for anal sex. 63% of the paid acts were for receptive anal sex, while the remainder was for insertive acts. In terms of oral sex, only 1 respondent reported being paid twice for receptive oral sex.

67% of respondents who paid for sex stated they never used condoms, while 15% stated they used condoms most of the times, and 22% only some of the time. There was no regular use of condoms.

40% of partners paid for sex were below the age of 22.

Female Partners

27% of respondents reported being married, of which 86% reported having sex with their wives between 1 to 5 times in the previous month, while 14% reported having sex with their wives more than 6 times in the same period. 15% of respondents also reported having sex with women who were not their wives in the previous month of which 47% reported having sex with at least 2 women in this period. 8 respondents reported having anal sex with their female partners. In regard to condom use in sex with other women (last five partners), 67% reported no condom use, and only 5% reported condom use all five times.

Sexual health

There were significant levels of poor understanding of what health means among the *malishias*, where health was linked with religious practices and exercise, and links were not

made to disease prevention. At the same time, participants linked disease to STIs which could only be contracted through male-female sex. In regard to *zenana* concepts of health these were linked to physical appearance.

93% of the respondents reported current symptoms, of which 16% stated they experienced pain during sex. 34% reported itchy rash on genitals, while 11% stated they had pus or discharge from their penis, 24% reported pain or bleeding on defecating and 10% reported pus or discharge in their stools, 20% itching or burning around their anus, 27% reporting pain while urinating, and 34% reported and itchy rash on genital. Many reported multiple symptoms.

Treatment

Regarding treatment for current symptoms, 9% were doing nothing, 20% went to a pharmacy, 71% went to a private doctor, 15% went to a hospital, and 48% went to a street 'doctor', friend, relative or other clinic. Several respondents went to several places.

Regarding treatment access when respondents had previous symptoms, 29% did nothing, 16% went to a pharmacy, 61% went to a private doctor, 31% went to a hospital, while the remainder went to a street 'doctor', friend, relative or other clinic. Several respondents went to several places.

HIV/AIDS knowledge and self-assessment

95% of respondents had heard of AIDS. AIDS as a "dangerous disease" which cannot be treated or cured was stated by 77% of respondents, or some derivative of this.

Mostly respondents had heard of HIV/AIDS from the radio or television, (77%/84%), 75% heard from a doctor, and 22% from friends. 9% had head of AIDS from sex partners.

from friends (39%), posters (11%), newspapers (40%), radio (42%), sex partners (26%), and either from a doctor or hospital (30%).

In terms of personal risk assessment, 79% of respondents stated they did not know, while 14% believed they were at a small to medium risk. 7% stated that they had a high risk.

94% stated needle sharing as a route of HIV infection, 93% agreed that HIV can be passed through unprotected penetrative sex with another man and 87% agreed that not using a condom when having penetrative sex with a woman would be risky. 66% of respondents also stated that oral sex was also risky for HIV infection.

This means that in terms of accurate knowledge of HIV/AIDS and transmission routes respondents were clearly knowledgeable. Yet the data on condom use indicates that knowledge had not informed behaviour change. However some 14% of respondents were also unclear regarding masturbation, thigh sex and body rubbing as routes of infection. Rimming as a route of HIV was stated by 81% and deep kissing by 53%.

When asked about ways to prevent being infected with HIV, 53% stated condom use, 5% by being faithful to one partner, 7% by having sex with clean people, and 26% stated that they did not know.

59% of respondents had heard of the term "safer sex", of which 51% stated this meant using condoms always, 3% sex with clean people, but 42% did not know what the term meant.

Risk reduction

With regard to risk reduction strategies, 40% had no idea, 66% of respondents believed using a condom for anal or vaginal sex would reduce risk. Non-penetrative sex was mentioned by 58%, and 72% also stated reducing the number of sex partners.

Informing your partner

When asked about informing their partners should they experience symptoms of STIs or come to know they have HIV/AIDS, 66% of respondents stated they would inform their male partners, 35% stated they would inform their female partners, and 72% said they would inform their wives. Whether this would actually occur is another matter.

Injecting drug use

3% of respondents stated they had injected drugs in the previous year, while 4% stated that their sex partner had injected drugs.

Sexual behaviours and impact on sexual health concerns: a summary

As seen above, indications are of high levels of unprotected anal sex, high levels of anal sex compared to oral sex, high levels of multiple partners, significant levels of possible symptoms of STIs, and a significant degree of untreated symptoms. Along with this was poor knowledge of concepts of health, infection and the body. What knowledge existed of STIs was through personal experience.

Awareness and knowledge of HIV/AIDS was high, but this did not translate into safer sex practices.

In terms of possible symptoms of STIs, there appears to be significant levels of anal bleeding, itching and burning sensations around the anus, pain while urinating, and other symptoms leading to increased vulnerability in terms of STI/HIV infection, with high levels of inappropriate treatment for these symptoms.

While a majority of assessment participants had heard of AIDS, few perceived themselves at any significant risk from infection. Specific knowledge on HIV/AIDS was confused.

The concept of partner notification was very poor where most people stated that they would not inform their partners if they had HIV/AIDS or an STI.

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 the STI treatment services in Lahore did not address anal transmission of STIs, is a cause for deep concern.

Appropriate service delivery of STI testing, treatment, care and counselling will 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 issues raised in this report.

The lack of understanding and knowledge of local NGOs, STD clinics, and other institutions regarding the local constructions of male to male sexual behaviours and the frameworks of behaviours and/or identities create many barriers to the development of appropriate and effective intervention services.

While it appeared that there was a certain degree of acceptance of MSM existence in Lahore amongst some agencies and individuals in both a local context as well as that framed within a Western construction of sexuality, these agencies were unable to access networks, or develop community-based and peer-led programmes. Shame and stigmatisation framed potential approaches to education and prevention.

It perhaps may be necessary in some contexts to separate behaviours from identities also. In developing appropriate responses, there may well be a need to focus on both risk behaviours (for the 'penetrating partner') as well as "at risk" *zenanas* (for the penetrated partner) as two distinct frameworks. It would be difficult to incorporate both within one intervention strategy. Sexual behaviours between males is certainly not a practice of only a small minority in Lahore, but is much more complicated than the so called heterosexual/homosexual divide would indicate.

As indicated above, the *zenana/girya* framework of male to male sex is the predominant visible pattern in Lahore. Alongside this are also the *malishias*. The Assessment indicated high levels of unprotected anal sex, with much higher levels of anal sex compared to oral sex, high levels of multiple partners, significant levels of possible symptoms of STIs, and a significant degree of

untreated symptoms. Oral sex was seen to be 'dirty', in that many participants stating that the mouth was used to speak the Quran, and therefore could not be 'defiled'.

While the majority of assessment participants had heard of AIDS, HIV was a different matter. Their understanding of what AIDS means and methods of infection was very poor, while personal risk assessments indicated that very few thought of themselves at risk from infection. Even when participants indicated some understanding of risk and HIV infection, a fatalistic attitude was taken. "Today is today, who knows what tomorrow will bring."

For several participants, sex with females was more dangerous, while for some condoms were used for cleanliness. Disease was linked with what was perceived as unhealthy looking bodies, excessive discharge, and too much 'heat'. At the same time partner notification in terms of passing on STI/HIV infection did not seem to be of great concern, or the fear of discovery was too great for such action to be taken.

In the interviews and focus group discussions it became clear that many *zenanas* appear to start their sexual activities at an early age. There are a range of sociocultural reasons for this, around space, availability and opportunity, along with power imbalances, male only spaces, and lack of access to females. Historical concepts around "beardless youths" also configured the trans-generational sexual encounters, along with male on male rape, and sexual violence.

What remains significant is that many *zenanas* start their sexual histories in early adolescence, including sex work. Adolescent sexualities and sexual behaviours are an urgent issue of concern.

During these discussions and interviews it also became clear that there were other frameworks of male to male sex outside of a *zenana/girya* dynamic and the *malishias* frameworks. Participants indicated male to male sex was going on in hotels amongst hotel staff and between hotel staff and guests, amongst street children, and street children and others, within a range of all male institutions such as boarding schools, madarsa, military establishments, hostels, prisons and so on. All sorts of males from across the spectrum of age, class and occupation were described as being involved in male to male sex, from police officers to beggars, from rich businessmen to movie extras, from rag pickers to truck drivers.

At the same time, the discussions generated a whole range of reasons why males have sex with males, from male to male desires, to "women don't do oral or anal sex", from protecting a girl's virginity to maintaining one's chastity, from "body heat" to "the anus is tighter than the vagina".

Most male sex workers in the assessment were *zenana*-identified and primarily involved in anal sex as the receptive partner. The majority come from low income groups, unemployed and poor. A significant number were illiterate or poorly educated, with low levels of knowledge of STI/HIV/AIDS. But *malishias* were also involved in sex work primarily as the penetrating partners, with their clients being both male and female. Chavas also sold sex, being the penetrating partner or being penetrated.

Many MSM will also be married, usually by the time they are in their late twenties, whether they are *zenanas* or *giryas*. It was clear from the interviews and discussions that marriage is a central issue in the lives of MSM. A familial and social necessity, all of those accessed who were not already married believed that they would have to get married, whether it was their choice or not.

In such a situation where condom use was low, where anal sex was a common and regular practice, and where multiple partners was also common, the possibilities of STI/HIV

transmission is high both between males and between MSM and any female partners they have.

Many *giryas* accessing males will also access females for sex, particularly female sex workers. This also included *malishias*, as well as *chavas*.

A large number of assessment participants were reporting a range of symptoms that could be related to various infections including STIs. Yet a significant number were not seeking treatment, either currently or when previously symptomatic. It is clear that the levels of risk for STI and HIV infection and transmission are considerable, and that this risk also affects female partners of MSM as well as male.

Stigmatisation, harassment and violence

Male to male sex, particularly, but not only, *zenanas* and *hijras*, are highly stigmatised. There is considerable harassment and violence by local police, thugs, and often sexual partners, clients or otherwise. Family members and regular sexual partners (*pariks*) may also be a problem. *Malishias* are also at risk from police and client violence and harassment. *Zenanas* are particularly at risk because gender boundaries are usually being crossed. Here the general perception appears to be that such people should be treated harshly. They are extremely vulnerable to human rights abuses on a regular basis.

Such attitudes are not only at the lower levels of institutions, whether they are government, non-government, statutory authorities, agencies, social services, and local communities. They also affect higher level officials in all these organisations. This includes the legal enforcement agencies, the judiciary, NGOs, business, donors, and members of the general population.

This harassment can be extensive, but does not appear to be systemic or state sponsored, rather it is localised. It is causal, opportunistic and irregular, **but** frequent. It can arise because of money (blackmail), alcohol, shame, even religious sensibilities, or the need of police officials to show they “are doing something”. In terms of clients and partners, shame after the act, or alcohol, or even what can be termed “systemic gender violence”, will often play a role, which reflects the whole gender encounter in Pakistan, where male on female violence is extensive. *Zenanas*, as “female-like”, fall into this framework.

During the course of this study, two *zenanas* were harassed and arrested as they were conducting the questionnaire survey. It was only through direct intervention by the Local Consultant through his personal networks amongst police officials that these individuals were released. During this time, periodic raids were being conducted at a range of sites being accessed for the study as a means to “clear these places that are infested (sic) by these undesirable elements”. As a result, these raids were blamed on the survey being conducted by other MSM at these sites increasing levels of distrust.

At the same time, many of these men also use the sexual services provided by *zenanas* and other male sex workers. Local police often know the homes of these young men because of this, and when orders are given to “clean up the streets”, many are arrested and are abused. Blackmail is not uncommon, as is violence, humiliation and theft also. Humiliation is usually of the form of stripping, shaving of heads, and anal or oral rape. Often other objects can also be used in such rape.

This police action during the time of the study had an impact upon the levels of trust that had been developed by the NGO working with the MSM at these sites, and a considerable amount of energy and time had to be invested to re-build this trust. One advantage in this process was the visibility of the MSM involved in the survey actually being seen in an empowering situation –

that is, it was they who were conducting the survey, and doing something outside of the constructed sexual roles.

One significant lesson has been learnt from the experience of conducting this study. It is essential for all agencies, at all levels, whether government, NGO, clinic, donor, or other institution, working in the field of STI/HIV/AIDS prevention and sexual health promotion, to coordinate and liaise with each other when something like this is taking place through the government's approval. Small NGOs, those working with stigmatised and socially marginalised groups are highly vulnerable themselves, and require the advocacy and support of larger institutions, along with government bodies.

This means that there is an urgent need for a significant investment in advocacy and sensitisation training of staff and institutions at all levels, on the issues and needs, not only of MSM and their diversity, but also in terms of the needs for an effective collaborative strategy for HIV/AIDS prevention. Effective advocacy cannot rely only upon the networks of a key individual involved in prevention activities, who happens to have had personal links with the local police and/or judiciary. Such advocacy does not change anything. To do so requires concerted actions by all involved in HIV/AIDS prevention work, at all levels, if MSM sexual health programmes are going to have a sustainable impact.

At the same time, legal support will be required, not only for individual NGOs who may be caught in the trap of "promoting illegal, immoral, or obscene behaviours" because of their prevention literature, or outreach activities which are a part of government health policy, but also for the primary stakeholders in such service delivery, who may well be victimised and arrested individually. This legal support would include:

- funding for any legal costs incurred in terms of baseless arrest and trials, say hiring of a lawyer
- reviewing, amending, and or repealing acts within the Pakistan Penal Code, as well as local city ordinances, regulations and statutes which impede effective sexual health promotion, such as Section 377 of the PPC which speaks of "carnal intercourse against the order of nature"
- supporting legal challenges to such acts, ordinance, regulations and statutes
- other *hidden* costs which are often required by certain individuals and agencies

Condom and lubricant use

Anal sex is the predominant sexual practice among MSM in Lahore. It is also recognised that anal sex is the most high risk sexual activity in terms of HIV/STI transmission.

The pattern of MSM sexual behaviours in Lahore indicates that – in terms of those accessed for the study – male to male sexual encounters were primarily gendered. Two distinct groups emerged. Those who are primarily the penetrated partner, usually *zenanas* (and *hijras* although they were not a part of this study), and those who will penetrate and be penetrated, including *malishias*, *college boys*, and *chavas*. The high level of sexual partners is also a significant issue, along with the fact that many *zenanas*, and others, also have a regular partner (*parik*), and are also accessing (or being accessed by) female sexual partners, not only because *malishias* were also being picked up by women for sex, but also because marriage is a central fact in Pakistani culture.

Several other factors in terms of risk determination need to be addressed. Firstly, much of male to male sex takes place in public environments, such as parks, alleyways, building sites, etc., since private spaces are not readily available. This means that time is of the essence to reduce the risks of discovery. Taking time to put on a condom increases the risk of being seen by others.

Secondly the methodology of *how* penetrative sex is being practised (whether it is anal or vaginal it appears). Discussions with a range of MSM of differing labelling indicated that the act of anal penetration was rapid with violent thrusting actions, which would have a high risk for anal tissue damage (currently 16% reported pain, 10% reported anal pus discharge, and 10% reported anal bleeding).

Along with these rapid and often violent penetrative actions, another factor reported anecdotally was the “early” ejaculations of many men. The actual penetrative act was reported as usually within 3 – 5 minutes. There was no “foreplay”, no sense of “love-making”, just the act of penetration. This “early ejaculation” also was cited as a reason to avoid condom use, because the likelihood of ejaculation while putting on a condom, was perceived to be high.

There does not appear to be a consistent habit of buying and carrying condoms and their use was infrequent (while 79% reported condom use in the previous month, only 17% of anal sex acts were covered by condoms). For regularity to occur would require planning and forethought. But sexual encounters for many were not specifically planned, rather it was opportunistic. Likewise condom use also appeared to be opportunistic, if they were available at that moment - maybe. One factor that affects this of course is the high risk of local police discovering that a person may have condoms on them. This could then be used as an excuse for an arrest, or at the least being taken to the local jail, where there are significant possibilities of sexual abuse by police (as reported by some MSM), physical violence, or verbal abuse at the least. Another reported issue was that some respondents experienced shame purchasing a condom from a shop. The seller would know what it was for.

At the same time, many *zenanas* (and other MSM, including *malishias* - and this would also include *hijras*) have extremely low self-esteem and lack self-worth. Apart from factors such as low educational skills, poverty, and a lack of power, is the fact of their gendered behaviours and sexual choices. Such behaviours are highly stigmatised often leading to violence and social exclusion, not only from their families and friends, but also from neighbourhood and society. So many other issues intrude in making “choices” for risk reduction. Basic living needs are often central concerns in their lives, food, shelter, clothing, and significantly, to be loved and to love.

For many *zenanas*, love was contextualised within frameworks of partner violence, where such violence was seen as a demonstration of care. At the same time for many *giryas* (the penetrating male – who does not have a sexual identity other than being a man), the act of doing sex with a *zenana* or other male is often followed by an act of verbal and/or physical abuse. For most *giryas*, sex is seen primarily as a vehicle for discharge, while sex with another male is not only shameful, but also against his faith. Violence and abuse is thus directed at the Other. In such an environment, negotiating condom use was seen as a non-starter. Power and social differentials were considered too great.

Respondents were aware of condoms, and where to get them. Cost itself was not seen as a significant factor, but rather:

- condoms being associated with family planning
- condoms being promoted for sex with women and not for male to male sex
- difficulties of condom use in public sex environments
- shame in purchasing a condom
- low self-esteem
- lack of power to persuade partners to use condoms
- a range of male psychosexual issues
- a sense of uncomfortableness in their use
- a desire for “skin to skin”
- the sociocultural environment itself, all discourage condom use

- stigmatisation and abuse
- human rights abuse and police harassment
- concepts of masculinity
- and of course, no habit of condom use developed generally

Beyond this of course is the skill to use condoms properly. Workshops conducted with *zenanas* and *malishias* in Lahore indicated that knowledge of proper condom use was low. Only 20% of workshop participants knew how to put a condom on properly. It is most likely that this figure would be considerably lower for their penetrating partners who come from the general male population. It should also be remembered that much male to male sexual practice (and this would be true general in terms of male to female sex) is done in the dark, or under a blanket, but certainly with clothes on. Such practices add to the difficulties in putting on a condom. Much training on condom use does not address the issue of darkness, of blankets, of clothing, of the realities of sexual practices.

These concerns in promoting regular condom use will all need to be addressed in any effective MSM sexual health strategy. Some of them can be addressed through a combination of a variety of methods which include:

- utilising gate-keepers and “leaders” within MSM networks to promote condoms
- ensuring that in condom promotion strategies (whatever target ‘group’), anal sex is addressed
- on-site distribution of condoms
- use of additional key message other than disease prevention, which can often promote additional stigmatisation, such as cleanliness – keeping the anus and penis clean
- constant reinforcement of the condom messages
- developing peer and group pressure
- fear of death and dying
- advocacy support with local police
- address harassment and violence by local thugs
- provide programmes that develop self-esteem and empowerment
- provide condom use education and practice programmes
- distribution of low cost (if not free) condoms initially to encourage develop a condom use habit
- provide on-site psychosexual counselling

Other areas would require concerted and collaborative social actions which address gender(ed) inequality, gender(ed) violence, issues that address constructions of masculinity, and so on.

The use of appropriate lubricant is an urgent requirement as a part of any risk reduction strategy, not only in terms of reducing possible anal tissue damage, but also reducing the risk of condom damage (brought on by improper use of condoms, as well as the method of doing penetration). Condoms and lubricant need to be promoted together for anal sex (and one suspects, for vaginal sex). However in Pakistan, no appropriately packaged, low cost, and easily accessible water-based lubricant is available. What is currently used is saliva (with its own risks of a range of possible bacterial infections) or oil-based products (which damage condoms).

All these issues need to be adequately and appropriately addressed, if there is any hope in ensuring that MSM in Pakistan have access to effective sexual health promotion services, and if sustainable risk reduction strategies are to be accepted as normative behaviours by MSM themselves (*see A Way Forward below*).

BCC resources

A range of local, national, and regional BCC materials, including brochures, posters, and training resources, were reviewed for content, style, and meaningfulness, by a range of respondents and members of the research team. These included resources produced by:

- Family Planning Association of Pakistan
- All Women Advancement for Resource Development, Peshawar
- Sindh AIDS Programme
- UNAIDS, Pakistan
- Community Support Concern, Lahore
- National AIDS Programme
- Unicef, Pakistan

Resources from India and Bangladesh were also reviewed as were those from John Hopkins University, Global Health Council, WHO, and UNAIDS, and Naz Foundation International.

None of these materials addressed male to male sex, or anal sex (apart from the NFI leaflets). Some of the materials used Urdu, but many (including NFI's) did not, and even when Urdu was used, imagery and language were seen to be more appropriate for the educated middle and upper classes. For example, one poster showed a high profile pop star giving out an HIV prevention message. *Zenanas* and *malishias* who reviewed the poster did not appear to identify with the image. For them a female star would have been more appropriate.

Another poster showed an image that was interpreted by members of the research team, workshop participants, and other MSM, as a picture of the faces of a man and a woman encircled by the international “do not do” sign in red. The female face was identified as a prostitute because of the nose pin in the image, which in female sex work signifies a woman who is not a virgin. This was then taken to mean that men should not do sex with prostitutes. Along with this image, the messages stated that

- Condoms saves you from AIDS
- Condoms saves from death
- Get blood from a healthy relative

There was no apparent connection between image and sex, or even the messages and sex as a risky activity. The observer would have to know what the image meant first to make a possible connection. The question for those who did understand the international symbol was, “don’t do what?” There was no indication as to how “condoms saves one from AIDS” or “death”, nor in what way was this relevant to MSM. Further, the definition of “healthy people” to the reviewers was being fair, with red cheeks and well built.

Other brochures and posters were also problematic in regard to being significantly meaningful to MSM. None (apart from the NFI leaflets) dealt explicitly with the facts of HIV infection in terms of sexual encounters or which sexual acts were risky (particularly worrisome since it is unprotected anal and vaginal sexual encounters which lead to the majority of HIV infections). None had images which a broad range of MSM could clearly identify with, while some images were seen as offensive to women, such as a poster which showed a woman wearing a *dupatta* sitting on an unrolled condom with a male by her side. This was considered offensive because a condom was perceived as a dirty and shameful object. While this poster did have useful information in that it mentioned “sticking to one life partner”, and, “be careful in sexual contact – use condom”, for those who were illiterate, it was inadequate. The messages had to be read out to them.

Other resources spoke of sexual promiscuity, or at times, a focus on razors, barbers, dentists, and other low risk activities. Many times the Urdu terms being used were more appropriate for the educated middle classes. But most messages focused on morality, condemnation, and were accusatory. For example, in one poster, the phrase “immoral and unnatural lifestyle can

result in AIDS” was used. In others, “Use caution”, “Observe the Islamic lifestyle”, “....protect our country from this shame”.

Another significant issue was the catchall word ‘sex’ without any definition of what sexual act, which implies that all sexual practices is risky. The hidden context was that this ‘sex’ was penetrative vaginal sex, while the messages being given out were to do with, faithful marriages, having sex outside marriage is dangerous, using clean needles, and to be a good Muslim. What relevance do these messages have for MSM in all their diversity?

An interesting observation had been made in the training workshops, in that there was no clear understanding of what ‘sex’ is. For some workshop participants ‘sex’ is what you do with your wife. The rest is ‘play’. For others it was only vaginal sex. Such understandings create misunderstandings and tensions between the message and the observer, without substantial input by an outsider to explain context and meaning.

Predominately then, the perception was that these prevention messages did not address MSM themselves or their sexual practices, and that they tended to victimise marginalised people, and were often too euphemistic to understand where meanings were implicit rather than explicit, and required external interpretation, or a certain degree of education and literacy to connect image, message, and understanding.

Because of this lack of clarity, simplicity, and appropriateness, feedback from MSM indicated that some men believed anal sex was risk free in terms of STI/HIV infection and therefore safe to do without protection. Some men also used this as their rationale for having sex with other males.

With no connection being established between image, message and understanding, no impact was being achieved. Understanding arose with the intervention of another who could contextualise the material within the person’s life and sexual practices. In other words, the BCC materials were inadequate as “stand alone” tools for HIV/STI education and prevention for those most highly at risk, those males who practice anal sex with other males and their sexual partners.

This writer clearly recognises that the socio-religious-cultural dynamics in Pakistan make it extremely contentious, if not impossible, to provide appropriate sexual health information to certain “at-risk groups”, such as MSM and *hijras*. Provision of appropriate BCC resources for distribution in public environments would be highly problematic because of the levels of stigmatisation, marginalisation, and harassment of MSM. Certainly many NGOs (*see below*) would feel uncomfortable in talking about MSM and/or anal sex positively in their literature, while for any government programme to do so will be seen by the general public and religious bodies as condoning such men and such behaviours. This could easily lead to significant increase in the levels of attacks on the government and its implementing agencies.

Public displays and distribution, then, of appropriate materials that speak of MSM, that address the issue of anal sex as a high risk activity, that does not stigmatise, that promote condoms for anal sex, may not be political or socially possible.

Fundamentally there are only two methods for promoting safer sex:

- Don’t do it
- Do it safely

For the Pakistan government, accepting the current socio-religious reality, its only choice is the “don’t do it” strategy. Similarly for many NGOs working in AIDS prevention and who have a moralistic approach to sex, particularly in regard to MSM, this would be seen as their only

choice. Promotion of morality however, increases law enforcement, stigmatisation and harassment, which would tend to drive MSM even more underground than they already are, as well as increase the risks of ever more violence as well as HIV/STI infection.

However, if an appropriate NGO can be developed that works closely with MSM, which is seen as being meaningful and belonging to them, which can be trusted by them, and which also has direct access to the range of MSM networks, then it would be possible to implement a pragmatic strategy of STI/HIV risk reduction programmes with appropriate BCC materials as one tool among many. Firstly it needs to be understood and accepted that using BCC materials only, will not build a sustainable risk reduction programme for MSM. Apart from designing, producing, and distributing BCC materials that are meaningful to those receiving them, to have any sustainable impact, they should be part of an of a broader education and support programme that addresses the range of issues that MSM face, such as stigmatisation, harassment, and violence, their lack of empowerment, as well as their social exclusion.

It also needs to be clearly recognised that MSM do not form a singular, homogeneous, closed group of males in only specific localities. The term MSM represents not only males with specific identities, such as *zenanas*, *chavas*, and *college boys*, but also include many who are in a profession, i.e. *malishias*, as well as a broad range of other males from the general male population, who do not have an identity as such, but who may (or may not) desire other males, or just have sex with other males for discharge. This will necessitate developing a range of outreach and support programmes which will include different types of BCC materials developed for different environments, whether public or private, with images, language and content carefully constructed to provide meaningful information and impact, without generating an increase in stigmatisation, violence and harassment against them.

Such resources will need to recognise different levels of education and literacy, with clear and recognisable imagery, and with simple messages that are directly relevant to MSM behaviours, practices, attitudes, and contexts. They would need to be in formats that can be easily carried and invisibilised, for example pocket leaflets, and would have to be designed in terms of content for different locations, whether indoors, or outdoors. At the same time significant advocacy work would need to be done amongst local police, judiciary, and other institutions.

BCC means “behaviour change communication”, which means that such education and information resources must also be backed up by other appropriate communication resources which sustain the information being provided. This can be achieved through developing appropriate and sympathetic clinical services, safe socialising spaces, and community-building strategies that promote peer education and support.

Further to all of this, is the understanding that many males involved in male to male sexual behaviours do not belong to any MSM network or group, but live within the general male population and identify with the sensibility of a “manly male”. These males will have sex with *zenanas*, *malishias*, *college boys* and *chavas*, as well as *hijras*, but see their sense of masculinity sustained by their being the penetrating partner. Such targeted resources will of course not reach these males. In this context, other non-MSM NGOs will need to ensure that as part of the sexual and reproductive health education strategies, anal sex risks are also addressed.

NGOs and Donor response

Discussions by the Local Consultant with a range of NGOs working on HIV/AIDS who, in some cases, also held a small component or activity or an activity indirectly linked to MSM, as well as the Provincial AIDS Programme were held. While all expressed a willingness to working with MSM and HIV/AIDS issues it was clear that, in the main:

- specific knowledge of MSM issues and contexts in Pakistan was lacking,
- direct access to different networks of MSM was not available
- technical expertise for working with MSM and empowering them to develop an MSM CBO was not available
- a significant gap in empathic understanding of the contexts of MSM lives, such as *zenanas*, *chavas*, and *malishias*
- this may have been due to the prevalent social attitudes towards MSM and male to male sexual practices, as much as to the absence of any “out” MSM within knowledge and understanding of MSM networks in these organisations
- and for some, a lack of sensitisation of the specific issues and concerns for, and of, MSM.

In some cases, discriminatory attitudes, such as ridiculing, sexual harassment, and stigmatising, abuse of power, as well as disbelief were observed by the Local Consultant. For example, in one situation with a local NGO where a space had been hired for a workshop to train a group of *zenanas* in street theatre, certain male members of the NGO staff tried to force one of the workshop participants to “dance” for them. In another case, one NGO, used local police to force about 20 *zenanas* and bring them to their office so that they would be there when their donor arrived. The NGO representative in this case also stated that he “had to take a shower because they smelled so bad and I feel the smell has taken over me”.

In another case, local representatives from an international donor agency were conducting a field visit. One of the representatives publicly stated his disapproval of the gendered self-identity expressions of a *zenana*, nor would he accept that person’s statements in regard to his life story, such as ‘his’ sexual abuse by a mullah at an early age, or of the police harassment he had experienced.

Many representatives of NGOs, donors and government institutions see MSM in Pakistan within a heterosexual/homosexual polarised dichotomy, and do not understand the reality of the complexity, diversity, and sociality of MSM identities and behaviours in the region. Often this lack of knowledge generates confusions so that *zenanas* and other types of MSM are clustered into one homogeneous group and identified as *hijras*. Such a misunderstandings, if applied to developing services, who certainly further marginalise and invisibilise many MSM networks, where distinct networks and groups require different services and methodologies of delivering those services.

Insensitivity among some was a key issue.

Clinical services were also problematic because doctors often do not have the appropriate STI management skills to deal with anal symptoms, or had the levels of empathy, understanding and confidentiality, which would empower and enable MSM to access such services.

While it is fair to say that some of these attitudes and behaviours arise from a lack of knowledge and understanding, issues that can be addressed with intensive sensitisation training programmes, for others stigmatising socio-cultural attitudes were strongly prevalent, in the same way that attitudes towards female sex workers, or even women in general, exist. It can be likened to the intense levels of work that was required to challenge racism in America and Europe, or caste in India, or women’s disempowerment all over the world. Such ingrained attitudes are difficult, not only to challenge, but also to change. A sustained effort would be required.

MSM contexts, issues and concerns have historically been marginalised, if not totally invisibilised, compounded by the socio-religious frameworks in Pakistan. This has meant that the primary focus of all these organisations was around male/female sexual encounters, such

as female sex workers, truck drivers and such like. They have had no real experience of truly working **with** MSM, even for those who stated that they wanted to work with MSM, or at times stated that they did so. It was clear that these agencies had no workable access to MSM networks, nor encouraged them to develop their own sexual health programmes.

To an extent suspicions were aroused that some NGOs in talking about MSM in an “enlightened” way, was being seen as “political correct” in an international arena, but this was done without the necessary empathy, understanding and knowledge behind their statements. It was an “added-on” value to a project.

As far as could be determined, there was no effective work being done amongst MSM (or *hijras*) apart from one project. No lessons had been learnt because, in reality, no questions had been asked. If anything, based on observational analysis, staff from some of the agencies reviewed, perpetuated stigmatising attitudes and beliefs.

There are genuine issues of concern based on experiences of a number of MSM and Local Consultant.

Responses to some of their experiences and interactions varied from the abusive to dismay, and in some cases, fear of discovery, fear of police and fear of their family. There was lack of trust, of disbelief in what they say, and at times, an anger because of the feelings of stigmatisation and exclusion. As one *zenana* stated: “...how would you feel if someone tells you that you must stop what you are doing, that you are a bad person...when he also says he is from an NGO who is trying to help us?”

While there was evidence of willingness to learn and work with MSM issues, it is clear that considerable work on sensitisation and understanding will need to be done. While it is essential to work with local police on this, both at management and constabulary levels, this needs to be also at institutional levels with the National and Provincial AIDS programmes, AIDS NGOs and other agencies, government officials, judiciary, media and community leaders. Donors must also be included, as most donors hire Pakistani staff who may have the same prejudices and beliefs as other members of their society.

As can be seen above, it is also essential to recognise that to rely on existing NGOs to deliver a sexual health service for MSM is not appropriate. This would be a “top-down” approach, and does not encourage developing sustainable behaviour change because of a lack of ownership and trust. Even if these NGOs were able to hire the appropriate MSM staff, this question is still not adequately addressed. The question would still arise regarding which type of MSM for which type and network of MSM, community ownership and participation and levels of MSM empowerment. Beyond this of course would be what surety these NGOs would give that such MSM staff would have the support and power within them to make decisions and operate freely. Another question would be

The need for a low profile MSM sexual health programme because of possible local resistance, as well as ensuring effective and sustainable sexual health promotion programmes would suggest that peer-led and peer-owned methodology would be the most effective approach in order to reach the greatest numbers of MSM in their diversity. Such an approach would also contribute to the sustainability of efforts as self-help initiatives, once established, require fewer external inputs.

Other established NGOs could (following significant training) contribute through advocacy and technical support, which would be difficult for a peer led project in this socio-cultural setting, and at the least certainly, through adopting male to male/anal sex messages within their programs. These NGOs will need to be oriented to the importance of male to male sexual health issues, including how these may be affecting the health of their own beneficiary groups.

MSM accessed by this study did not want to work with any NGO or government agency because they did not trust them. They believed that these institutions did not address the central concerns of their lives, the violence, poverty, lack of educational and employment opportunities, or the very nature of their varied self-identities. What they did trust was the one agency in Lahore which did not work for MSM, but worked with MSM, and which provided emotional support and non-judgemental counselling, which talked with them as ordinary people and not as something different and at a distance, which was empowering MSM to help themselves help others like them

Such an approach is central to developing good working relationships with MSM. It is clearly mandated in all UNAIDS best working practice documents, which speaks of empathetic understanding, local empowerment, community ownership, and self-help as keys to develop a replicable, sustainable sexual health service for MSM, one that is managed by themselves for themselves.

Conclusion

To a significant extent MSM in Lahore do not comprise an easily identifiable or visible target group, apart from those who identify as *zenanas*, *malishias*, or male sex workers who are primarily *zenana*-identified. To insiders, many male sex workers are easy to find, but, unlike female sex workers, relatively invisible in most social spaces. But accessing these males through their own collectivities and networks, a strategy that has been successful in other countries, is not directly applicable here without extensive work and support on community-building and development. At the same time, wives and other female partners of MSM comprise a very vulnerable section and will be particularly difficult to reach. Therefore, for reasons of efficiency, cost-effectiveness, and practicality, a peer-led process of developing MSM collectivities must begin.

Unprotected anal sex is a common practice, placing the majority of MSM at high risk of STIs and HIV infection, especially when poorly lubricated, and not protected by condoms. Anal STIs are not well understood by most doctors and there is no syndromic algorithm for anal infections. Access to clinic services is low, and often such services were inappropriate and unsympathetic to the specific needs of MSM.

Accessing adequate and appropriate STI care is very difficult for the poor and uneducated within these networks. Embarrassment and lack of money, coupled with the providers' ignorance of MSM, their sexual practices, the lack of knowledge of anal symptoms and problems induced by anal sex practices, along with the lack of a syndromic algorithm for anal STIs, adds up to poor treatment and continuing infection.

Anal sex, as it is practised in Lahore, has a high likelihood of producing anal damage. Any blood present during sex increases the risk of acquiring HIV, and this is probably enhanced by the presence of piles.

The considerable level of partner change and sexual networking evident in the Assessment, coupled with the significant levels of reported current anal STI symptoms, demonstrates the potential of this group of men and youth for a concentrated HIV epidemic.

Given their fairly extensive sexual networks and contacts with women, *zenanas*, *malishias*, *chavas* and *college boys*, and their partners, represent a "core networks" for transmission of STI/HIV. Whether their practices are approved of by society or not, they exist substantially, and have a long history of tacit tolerance at times, yet on the margins of society. Specialised services and sensitive outreach programmes will be required to address their needs.

Zenanas sexually access many different men across Lahore. They have extensive social networks with other *zenanas*. If support and technical assistance can be given, it is possible to develop a community building strategy amongst *zenanas*, and use this emergent community as a means of education and prevention intervention amongst *zenanas* and their partners, where *zenanas* can be mobilised on behalf of improving sexual health among MSM generally. A similar approach can be used with *malishias* also.

Investment is required for considerable advocacy work amongst the police, judiciary, government bodies, NGOs and others involved in HIV/AIDS work in Pakistan. This investment would be the provision of appropriate training, skills development, sensitisation, as well as legal changes towards a programme for developing an enabling and empowerment environment to respond positively to the challenges that HIV/AIDS presents to their lives. Such work is an integral part of any sustainable risk reduction strategy.

On-going and adequate financial and technical investment will be needed to ensure a sustained development and delivery of appropriate sexual health strategies among MSM.

Community-based and self-help initiatives have clearly been identified by UNAIDS and the World Bank as the most appropriate framework to implement sexual health strategies for “at risk” groups and networks. A similar approach needs no justification for MSM in Lahore specifically and Pakistan generally. Such initiatives have been shown to work effectively in increasing sustained condom usage, reducing STI/HIV infection risks, and changing risk behaviours in other MSM sexual health programmes evidenced in India and Bangladesh, as well as in other developing countries. This means that specialised, self-help initiatives must be encouraged and support, which means new MSM community-based organisation will need to be developed as an urgent priority.

But it should also be recognised that *zenanas* and *malishias* do not have the experience, knowledge, or skills to develop, implement and sustain an MSM sexual health. Any effective programme on HIV/AIDS/STI prevention will require a considerable and appropriate initial and on-going technical assistance and support. This requires accessing what appropriate technical expertise exists in Pakistan and elsewhere in the region which demonstrate the knowledge, skills and understanding of MSM in Lahore, and in Pakistan for developing primary stakeholder-led projects and organisations, as well as accessing the technical expertise that already exists in Pakistan in terms of institutional development and management. Current NGOs in Lahore and Pakistan need to be encouraged to work closely with these newly emergent MSM CBOs, through ensuring that they too have access to sensitisation training on the issues and needs of MSM.

Newly emergent MSM projects that are developed to respond to the challenges of HIV/AIDS will also need to be supported to enable and empower them to network with each other in terms of information and skills sharing, as well as network with other similar MSM CBOs already existent in the region, who work within similar MSM dynamics. Such networking and sharing will strengthen the skills of these new MSM CBOs by information and resource sharing, and also empower them to gain strength and sense of a larger community.

Finally, it is clear from the study that MSM networks represent a significant and high risk for STI and HIV infections. So far, almost nothing has been done to address these needs. While Pakistan is seen as a low HIV prevalence country, the future is uncertain. At one time, Indonesia (also a Muslim country) was also seen as a low prevalence country, but its situation has changed dramatically in the last couple of years. Unless MSM issues and needs are not urgently addressed soon and appropriately, then this author perceives a disaster awaiting their future, further pain and grief for them.

A Way Ahead

Addressing these issues requires a skilful combination of strategies and methodologies, some of which may be readily implemented, while others may be quite challenging (to say the least). Risk reduction for STI/HIV infection is **not** only about condom BCC materials distribution. Such activities, to be effective, should take place within an appropriate and enabling environment in which risk reduction behaviours can be practiced and sustained.

This requires a framework in which MSM:

- Have knowledge and understanding
- Have the desire to change
- Have the will-power to change
- Have the skills and techniques to practice change
- Have the social power to change

Any effective MSM sexual health programme should demonstrate its capacity to provide such an environment.

Bangladesh and India share similar MSM contexts and dynamics as demonstrated in Lahore (and likewise in other parts of Pakistan). While local terminology may vary, whether it is Dhaka or Chennai, Lahore or Chittagong, Mumabi or Hyderabad, the gendered framework for MSM sexual practices is the most visible. A *zenana* from Lahore visiting a *kothi* from Chennai will be able to recognise and communicate with each other. They share similar behavioural characteristics, utilise similar language terms (*zenana farsi* is similar to *kothi* language). And their sexual practices and preferences are also similar.

One way to address the needs and concerns of sexual health for MSM identified above is that which the author of this report has been involved with in Bangladesh and India. Here, a number of MSM CBOs have been developed which have replicated a sexual health promotion strategy which has demonstrated its effectiveness in building sustainable risk reduction behaviours among their primary stakeholders.

The strategy involves concepts of:

- Community-building and development
- Low cost access to appropriate clinical services
- Primary stakeholder-led agencies
- Self-help strategies and service provision provided by primary stakeholders themselves
- Empowerment and building self-esteem strategies
- Advocacy and addressing human rights concerns
- Provision of safe socialising spaces
- Appropriate, specifically targeted, and meaningful BCC resources

All these are framed with three interlinked service outputs which are:

- Field Services which provide
 - outreach to MSM networks and their sites
 - building trust and friendship through actions of field team members
 - peer support and education
 - referrals to appropriate services
 - on-site counselling and condom/lubricant distribution
 - community-building and development
 - peer pressure for sustainable risk reduction
- In-house subsidised clinical services which provide
 - STI treatment syndromic management

- General health services
- Counselling
- Centre-based services which provide
 - A safe socialising and entertainment space
 - Sexual health education
 - Vocational training and literacy classes
 - Drop-in services
 - Psychosexual counselling
 - Building friendship and trust
 - Sexual health products
 - Community-building and development
 - Peer pressure for sustainable risk reduction

Along with there must also develop strong and mutually trusting relationships with other NGOs in the locality, who in working together, provide an advocacy programme to address the issues of stigmatisation, harassment and violence at all levels in the local community. At the same time, government institutions and national NGOs would need to advocate at provincial and national levels.

It is suggested that in each city a sexual health programme developed similar to the one outlined above along with the financial and advocacy support required.

There are two approaches for a national development programme which can be explored. The first would be to develop several independent MSM CBOs, one for each city, where each is mentored and supported by an appropriate local NGO to provide technical assistance, advocacy support and “shelter” to the emergent MSM CBO. Further to this, each of these MSM CBOs would be networked with each other for mutual support and information sharing through regular provincial and national MSM meetings and workshops.

The other approach would be to develop a national MSM agency linked to an appropriate technical assistance provider, which would establish a series of autonomous local MSM sexual health branch projects, each with its own local Steering Committee. Each of these local branches would also liaise and work with other local HIV/AIDS and sexual health NGOs developing partnerships and collaborative work in shared concerns.

In either case, appropriate MSM staff at management and field level in each city will need to be identified and trained, and infrastructures will need to be developed for each sexual health projects. This not only includes the physical space, equipment and resources along with staffing, but also the range of institutional needs such as appropriate policies, management tools, monitoring and reporting tools, and guidelines.

Such approaches outlined above, can help towards ensuring that the spread of HIV infection in Pakistan can be controlled. But it will require a sustained commitment from the government of Pakistan, its agencies working in the field of HIV/AIDS prevention and sexual health, donors and NGOs to work together and support the sexual and human rights of those who currently are highly stigmatised and socially excluded, and who should be trusted and empowered to develop a response to their own sexual health needs.

Recommendations

As has been stated, male to male sexual behaviours exist at significant levels in Lahore as well as in any other city/town in Pakistan. Significant risks exist for the spread of HIV/AIDS, not only among MSM themselves but also into the general society because of the gendered dynamics of male to male sex, so that the penetrating partner does not identify as a homosexual and will usually have female partners as well, and the fact of marriage as a key social institution among all Pakistani men.

While MSM behaviours and those involved are highly stigmatised creating conditions of invisibility and denial, there are only two options that any government has in order to promote HIV/AIDS/STI reduction. Either it can promote a moral stance of abstinence, or it can promote a pragmatic stance of risk reduction.

Evidence from across the world clearly indicates that taking the moral high ground, or issuing of threats, does not reduce HIV. If anything it drives the behaviours even further underground and makes promoting behaviour change even more difficult.

Further, experience has shown that the most effective approach to reduce risks is one based on peer education and support, providing community-based frameworks to deliver services. In this case, that of MSM being empowered to develop, manage and deliver their own services. A self-help, community-based approach.

Currently, the situation in Lahore, and elsewhere in Pakistan, is that MSM do not form a community, but rather are framed by differing identities, networks and small social groups based at particular sites. Community building and development will be a key requirement for developing a sexual health response to the needs of MSM, and the risks of HIV/AIDS/STIs in Lahore specifically, and Pakistan generally.

In the light of these comments it is recommended that a reading of the NFI Briefing Paper 3: The Kothi Framework - developing a sexual health response to men who have sex with men is required. The recommendations outlined below have also been made.

1. *Developing an appropriate MSM sexual health service*

- 1.1 Investment in the sexual health of MSM should be considered a priority, and should be significant and sustained over time. Sustainable behaviour change amongst these networks will not occur in short period, but will take years. Short term, or annual funding can actually create even more problems than solve, providing an environment of hope which cannot be sustained.
- 1.2 Appropriate technical, institutional and financial support should be given to empower and develop an MSM CBO in Lahore to provide sexual health promotion and care services for its constituents. Staff at all levels should be drawn from the MSM networks, and provided skills training with capacity building to manage their own institution. On-going technical support will be essential, particularly in the areas of management, monitoring and evaluation, as well as report writing.
- 1.3 However, due to the nature and level of stigmatisation and harassment of MSM, the actual institutional structures will need to be carefully thought through. It may be necessary to “shelter” such a CBO within an appropriate NGO (if such exists) to provide a measure of security to such an MSM CBO. This “shelter” agency will in itself need to be fully cognisant of the issues and needs of MSM, as well as provide a confidential, empathic and sensitised space for MSM, and empower autonomy and self-management.

- 1.4 Empowerment is a significant issue in regard to developing a community sensibility among MSM. This involves community-building and development strategies, active involvement of MSM in ownership, management, and service delivery in their own sexual health promotion project, autonomy in decision making, programmes to build self-esteem, and vocational and literacy programmes.

Such an intervention would consist of 3 primary components

- outreach and friendship promotion through field teams of MSM drawn from the networks, promoting sexual health
- drop-in centres providing safe socialising and community-building spaces for at risk MSM, particularly for *zenanas*, *malishias*, and *chavas*
- male sexual health centres providing syndromic management of STIs and medicine at affordable rates with an appropriately trained and sensitised doctor

It has been shown in a range of STI/HIV/AIDS programmes around the world that peer-led interventions have the most impact on building on sustainable risk reduction strategies. NFI's experience in developing some 18 such projects in South Asia also clearly demonstrates this. This means that for an effective implementation, self-help, utilising MSM themselves, and empowering MSM to own and manage their own service is the appropriate strategy for developing an MSM sexual health programme. In the context of the findings of this report, *zenanas* should be used to work with *zenanas*, *malishias* used to work with *malishias*, and *chavas* with *chavas*.

In terms of providing sexual health services to hijras, similar frameworks for service development and delivery are also effective, but it would be essential to develop a separate and independent Hijra programme from an MSM sexual health programme.

- 1.5 Recognising the multi-frameworks of MSM in Lahore it is necessary to ensure that time and space will be managed in such a way that any service can be appropriately accessed by these differing networks of MSM - it is not perceived as possible to utilise the same space/time for say *zenanas* and *malishias* because of the different social constructs. Further, because of the spread and location of many MSM public sites across Lahore, it may be necessary to provide a number of drop-in centres and clinic services at strategic locations. It is suggested that there should be a minimum of 3, with one location acting as the headquarters of the CBO.

- 1.6 Appropriate and relevant BCC materials should be urgently developed for all frameworks of MSM behaviours.

While it is essential to ensure that MSM receive accurate and direct information in regard to their specific sexual health needs, i.e. address anal and oral sexual practices, in ways that are accessible and meaningful, because of the socio-cultural dynamics in Pakistan, the following need to be taken on board:

- local police harassment
- religious sensibilities
- shame and lack of any public discussion on sex
- increasing visibility leading to increasing harassment\
- field staff at risk
- literacy skills
- public environments where MSM meet

It also needs to be clearly recognised that BCC resources on their own do not change behaviour in sustainable ways. Provision of such resources needs to be appropriate to

the environment and methods of delivery, but must also be seen as a component of a larger based strategy on sustaining behaviour change through risk reduction methodologies. Messages must also be appropriate to the dynamics of MSM psycho-social and behavioural constraints and issues.

BCC resources also include a range of activities that build up a sense of community affiliation, self-esteem and empowerment to encourage behaviour change. These include the provision of safe spaces for socialising and community-building, socialising and entertainment meetings, sexual health education groups, vocation and literacy classes, and a range of other activities. These act in concert to provide an environment in which sustainable behaviour change can be encouraged through developing sexual responsibility, and peer-pressure. It requires processes that encourage new sexual habits, such as changing the choice of sexual practice and/or regular condom use.

Such sustained change in risky behaviours requires 5 key components:

- desire to change behaviours
- possessing the will-power to change
- having the skills to utilise change practices, i.e. proper use of condoms, methods of sexual practice to reduce risks
- possessing the information and knowledge
- empowered to practice risk reduction in terms of negotiation with partner

All these components must be addressed appropriately.

- 1.7 The practice of both anal and vaginal sex indicates that significant levels of anal and vaginal damage occur due to “roughness” and “dryness” and “speed and violence of the penetrative thrusts”.

Proper use of appropriate lubrication is an essential practice to reduce such tissue damage. Combined with condoms, risks for STI/HIV are significantly reduced. Access to appropriately packaged and priced sachets of water-based lubricant is an urgent necessity to reduce anal damage and reduce risks.

- 1.8 Current regular use of condoms amongst MSM in Lahore is very low. There is no general habit of using condoms, and sexualised public environments are not conducive to their use.

As a part of a sexual health strategy, condom and lubricant use can be promoted, but the 5 factors above need to be taken on board. At the same time, the strategy should recognise the need to build a habit of using condoms. It will be necessary that initial distribution of condoms and lubricant be free towards building a users habit before social marketing is developed. Issues of distribution, availability and easy accessibility need to be addressed. Price and distribution would need to reflect affordability and accessibility for the poorest at locations where sexual activities take place.

- 1.9 Appropriate STI treatment services are urgently needed providing a confidential, sympathetic, empowering environment to encourage accessibility. Such a service should be an integral part of any MSM sexual health project itself. Provision of such a service should be free or subsidise treatment to address the issues of poverty or lack of immediate disposal income.

Because of the stigmatisation of males who have sex with males, particularly *zenanas* and others who practice anal sex, any MSM community-based agency should be

supported to host their own STD treatment service to ensure confidentiality, safety, acceptance and accessibility.

Further, because so many MSM from low income groups have other health issues of concern, the clinic should be developed as a general health clinic which also addresses these non-STI health concerns. Such an approach will enable such a clinic to play a significant role in developing a community sensibility amongst MSM, particularly if it is a part of a larger project. Outreach teams could then refer their contacts to such a clinic, and follow up following treatment. The clinic will act as a cross-reference point to other programmes which the project delivers. In such a setting confidentiality and empathy are easier to maintain.

This will require ensuring that appropriate and sympathetic doctors are identified with the skills and knowledge to deal with sexual health concerns of MSM, particularly around anal problems and STIs. This may well mean the provision of training for doctors.

Further to this, psycho-sexual counselling will also need to be integrated into the clinical services, along with counselling around HIV/AIDS, STI treatment and management, and safer sex behaviour practices.

In terms of other sexual health service provision for the general public, all STI medical staff should be trained in the issues surrounding anal sex behaviours, whether between males or between males and females, in regard to symptoms, treatment and counselling. Further abuse and harassment at such services by staff must be stopped. All staff should be sensitised to the needs of males who have sex with males, particularly those with stigmatised behaviours and identities. Confidentiality and anonymity must be available in accessing such services.

- 1.10 Psychosocial support programmes need to be part of any on-going sexual health programme for males who have sex with males. These would include telephone lines (“hotlines”) providing free and anonymous advice and information, social support groups, sexual health discussion groups, and other services deemed appropriate and needful by males who have sex with males themselves.
- 1.11 Poverty amongst MSM is also a significant issue which motivates a significant level of male sex work amongst *zenanas*, *malishias* and *chavas*, and which also increases levels of risk taking. It will be essential to address this perhaps through micro-credit schemes, vocational and literacy training, employment opportunities, and such like.
- 1.12 A key component for any effective strategy will be a strong advocacy and legal assistance programme which will advocate on behalf of MSM at political, judicial, legal, medical, and social levels, and work closely with police officials, particularly at the local level. It is essential to address the human rights concerns of all MSM, including *zenanas* and *hijras*.

Effective and supportive relationships with local police will need to be developed and facilitated by the appropriate agency. This will require appropriate sensitisation programmes with the police and other officials.

- 1.13 Training and sensitisation programmes must be given to:
- National AIDS Programme and Provincial AIDS Programmes
 - STI doctors in regard to anal symptoms
 - police, judiciary and media

- other sexual health NGOs
- government institutions
- donors and other agencies

These training programmes should be seen as a part of the work of advocacy and capacity building to provide appropriate and accessible service delivery.

- 1.14 *Giryas* do not define themselves as MSM, nor perceive themselves as “homosexuals”. To many of them, penetrating a *zenana* is like penetrating a woman.

Further because so much male to male anal sex takes place outside "cruising" sites and external to *zenana/girya* dynamics, other NGOs developing sexual health services will need to promote safer sex behaviours that include anal sex in their programmes of education and prevention. These include rickshaw drivers, female sex workers, truck drivers, educational establishments, street children factory workers, overseas workers, prison populations, et al.

- 1.15 Specifically targeted resources should be developed that are aimed at differing social, economic and behavioural groups, including medical staff, family planning clinics, religious teachers, educational staff, factory workers, hotel staff, and so on. This would also mean educating and updating all health and social care workers skills with regard to prevention, care, management, counselling and related issues on HIV/AIDS, including issues on anal sex and males who have sex with males.

- 1.16 In terms of developing MSM sexual health services in other locations in Pakistan a similar strategy of development will need to be utilised in each location. That is:
- conduct situational assessments both in terms of providing base-line data, as well as encourage networking
 - identifying appropriate MSM who can be accessed and empowered through skills building programmes to develop a locally based MSM agency
 - provide technical, financial and institutional support to empower this agency to provide sexual health services to other MSM
 - replicate the model identified above in service delivery

2. The role of the National AIDS Programme and other donors

- 2.1 NAP, the Provincial AIDS Programmes and donors must play a lead role in encouraging and enabling the development of a peer-led community-based AIDS service organisation by investing in, and empowering them, to deliver appropriate STI/HIV prevention and sexual health services for males who have sex with males.

- 2.2 Such an investment in the development of appropriate sexual health services for males who have sex with males would be in the form of:

- 2.2.1 provision of long term financial support
- 2.2.2 provision of, or unhindered access to, technical assistance and financial support
- 2.2.3 access to capacity-building training
- 2.2.4 addressing legal and regulatory constraints which may hinder the development of such peer-led community-based agencies

- 2.3 In order for this to occur, these agencies will need to ensure that they can gain the trust and confidence of males who have sex with males by ensuring confidentiality,

safety, security and anonymity.

- 2.4 NAP, with donor assistance should provide training and awareness programmes to government and non-government agencies providing sexual health services on the social and sexual health needs of males who have sex with males in order to address the lack of knowledge and understanding. Such programmes will provide unbiased information, sensitisation, as well as destigmatise the issue.
- 2.5 Where laws, regulations and policies hinder males who have sex with males to access sexual health services, or discriminate against them through intimidation, fear of harassment, violence, denial or the risk of imprisonment, then these should be amended or repealed to empower such males to access these services. Appropriate NGOs, donors and NAP should advocate for this.
- 2.6 Training of police staff and the judiciary on issues regarding males who have sex with males and sexual health concerns should be provided
- 2.7 Appropriate NGOs should develop and/or support advocacy programmes for males who have sex with males to ensure the human rights of individuals are being respected, and that those who are harassed or violently abused can seek legal redress.
- 2.8 NAP should ensure that all STD services staff, private or government, as well as all sexual health services provided by government and non-government agencies receive appropriate training on ALL frameworks of sexual behaviours which must include anal sex as a practice both between males and between males and females towards improving the quality, accessibility and delivery of these services to all sections of society.