

SITUATIONAL ASSESSMENT OF SEXUAL HEALTH AMONG MALES WHO HAVE SEX WITH MALES AND THEIR SEXUAL PARTNERS IN PUNE, INDIA, 2002

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A Summary of the findings

India is a male dominated society where the social and public spaces are primarily male and masculine. As a homosocial and homoaffectionalist society, sexual boundaries between males can be readily crossed and may often become sexual acts. Whereas some of these acts can perhaps be called homosexual (within the context of local identities based upon female gender identification - also self-labelled as *kothis*) in that a sexual sense of self is operating within a framework of gender sex roles and desires, the majority of male to male sexual encounters should be seen within a context of semen discharge.

Beyond this of course are those with specific male to male desires, and in this context, three significant, but differing, identities emerge. That of a *kothi*-identified man, a gay-identified man, or a *panthi*. But the *panthi* is not really an identity as such. Rather it is the name given to "real" men that *kothis* access.

The Situational Assessment consisted of interviewing 252 MSM through questionnaires, with 50 of these men further interviewed in-depth through open-ended questions. Two Focus Group Discussions were also held with a number of MSM, and a range of site visits made for observational analysis. All participants were above 18 years of age.

Kothi-identified men appeared to be significantly more sexually active than gay-identified men in this study, with higher rates of anal and oral sex (average more than 4 times for the former and 3 times for the later). At the same time, the majority of *kothis* met their partners in public sites, whereas gay-identified men tended to meet their partners in private spaces.

Significant levels of unprotected anal sex existed. Actual knowledge about HIV transmission was extremely confused, with around 87% giving correct information about anal penetration risks and a slightly higher percentage in regard to vaginal sex and at the same time almost equal percentage of respondents also got caught in the tricky questions too which shows lack of appropriate knowledge. Yet condom use for anal sex was much lower ranging 30% to 70%.

All self-identified male sex workers in the Assessment were also identifying as *kothis*, while the vast majority who were paid for sex (a much higher figure with many not identifying as a sex workers) were *kothi*-identified too.

In terms of possible symptoms of STIs, there appeared to be a high levels of anal bleeding, itching and burning sensations around the anus, pain while urinating, and other symptoms, with high levels of non-treatment for these symptoms.

Sexual health issues for males (and females) through the primacy of male sexual behaviours, particularly male to male sexual behaviours, should be seen as a major and urgent concern. The fact that nearly all (to be generous) of the STI treatment services do 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 many of the NGOs, STI clinics, donor agencies and other institutions regarding the constructions of male to male sexual behaviours and the frameworks of MSM 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 Pune among agencies and individuals, this was framed within a Western construction of sexuality. But in an Indian sociocultural context such constructions do not "fit", and can actually lead to an increase in the invisibility of the behaviours. It perhaps maybe necessary to separate

behaviour from identities, and in developing appropriate responses, focus on both risk behaviours (for the 'penetrating partner') as well as "at risk groups" (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 Pune, but is much more complicated than the so called heterosexual/homosexual divide.

The MSM Context in Pune

In terms of the numbers of MSM, while for some MSM there are frameworks of male to male desire, identities and visibility which may make it easier to quantify numbers, for the majority who sexually access these males and whose desires are around discharge rather than gender, and who perceive themselves as 'manly' and 'normal men', it is almost impossible to quantify. *Kothis* are much more visible than gay-identified men due to their public gender performance, particularly when *kothis* are in groups in public spaces.

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

- For many men involved in male to male sex, MSM is not a sexual identity but a behaviour based on desire for discharge.
- Most MSM behaviours are not contextualised within a heterosexual - homosexual paradigm but within a gender framework and role-play, where a feminine gender performance signifies the role taken in a sexual act.
- This gendered framework is constructed within a *kothi/panthi* dynamic, where the *kothi* perceives himself and his desire for other males in the context of feminine gender roles in India, i.e. the "penetrated" partner. *Kothis* identify as feminine males, constructing their social roles, mannerisms and behaviours in ways that attract what they call *panthis* - "real men".
- In this context many *kothis* are visible in a range of public environments and neighbourhoods, but *panthis* are not, for they could potentially be any "manly" male.
- This does not mean that Pune does not have any gay-identified men as it is understood in the West. It does. But these men are primarily English speaking, usually middle / upper class, and a minority amongst men who have sex with men. Gay-identified men are much less visible in public arenas because of their identity construction is not based on gender desire.
- Nor does it mean that *kothis* do not penetrate, or that *panthis* are not penetrated. Some do cross over these gender roles. But such crossover is secret (*gupti*), and is not discussed with friends. Such gender role crossovers are seen as even more shameful. Similarly for a *kothi* to admit to having sex with another *kothi* is also considered shameful, and crosses the "incest" boundaries, i.e. *kothis* will state that they perceive each other as "sisters". A new term being used by *kothis* for such sexual encounters when know is "lesbian".
- There are several *kothi* dynamics:
 - *satla* (or sari) *kothi* - a *kothi* who cross-dresses
 - *dhandha kothi* - a *kothi* sex worker
 - *kothis* have the own words and language, a derivative of the *hijra* language
 - *Panthis*, or "real" men, do not see themselves as homosexuals or less masculine because of their sexual involvement with *kothis*. They penetrate *kothis* who are not "real men" - they are *kothis*. Their personal sense of manliness is safe.
- In other words we have a spectrum of masculinities.
- 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 *kothis* or those deemed less "manly", i.e. young males and adolescents.
- With this gendered dynamic it may be possible to physical count the number of *kothis* at a range of public sites, but this doesn't address the so-called *gupti kothis* - the ones who are secret. Nor does this address the number of "manly" partners these *kothis* access
- Beside the *kothi* frameworks, there is 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, sex within male only spaces. Such behaviours

are not identity-based where desire is based on same-biological 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. What appears to exist in Pune, like the rest of South Asia is a core personal identity in terms of gender role, marital status and class. Identities are not based on sexual object choices.
- Gay identities have evolved (and are evolving) from the globalising of Western lesbian and gay frameworks. In Pune such gay-identified men were primarily English speaking, middle and upper class, with extensive contacts with Western gay culture and/or emergent gay groups across India through the internet.
- Gay relationships are usually based on a personal sexual identity, a mutuality, friendship and exchangeable sexual acts - they are companionate relationships formed within a same sex/same gender dynamic. What this means is that gay men are sexually and emotional attracted to other men. They identify as men.
- *Kothi* relationships are based on gender roles - a "husband and wife" relationship. *Kothis* are not friends with their *panthis*, but "wife". This is a relationship based on same sex/different gender identification dynamic. *Kothis* make friends with other *kothis* with whom they "never" have sex with. For *kothis* this would be like having sex with their sister.
- *Kothis* are attracted to *panthis*. *Kothis* perceive themselves as *kothis*, not "real men. The focus of desire is in terms of penetration.
- Many men who sexually access *kothis* do so for semen discharge, not because he other person is a male.
- Male to male sexual desire should be contextualised differently from male to male sexual behaviour

Gay identities and organisations

From all the anecdotal information, there appears to be fewer gay-identified men amongst the MSM networks in Pune than *kothis*. Gay men appeared to be from the middle and upper class, English speaking groups in the city.

There are two small gay networks in Pune. One has developed a social support group with an AIDS awareness focus, the other primarily is seen as a social party group. Each group has about 10 to 20 members who regular attend their meetings and parties. It was observed that these groups hold their meetings in English. There is, however, a considerable class, education and income divide between gay-identified men and *kothis* and their partners. This expressed itself with low social mixing, even when sharing the same site, verbal abuse and stigmatising of the *kothi*.

Relationships between the gay groups and with educated *kothis* were usually termed as "friendly", but each network was seen as irreconcilably different and separate. In several discussions *kothis* expressed an uncomfortableness with gay-identified men because of a lack of their English skills, and their class and economic differences. They also often felt marginalised and "looked down upon" by gay-identified men, particularly those *kothis* from low-income sectors. The sexual networks and "cruising" areas often differed, and any socialising and mixing between them was very rare. The divide in language, identities and actual risky behaviours was considered significant enough to make an effective 'joint' strategy covering both these dynamics unworkable.

While there have been some concerted efforts by one individual to attempt to bring these networks together, it has been to little avail. This individual has been active in both gay and certain *kothi* networks. This person provided invaluable assistance in the training programme as well as the Assessment.

No *kothi* organisation or group existed before Udaan.

Situational Identities

Such beliefs and practices led the majority of 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 *kothis* with other *kothis*, or to draw the attention of potential male sexual partners.

Situational identities acted as a device to invisibilise identity choices, desire and behaviours, maintain social and family stability, and reduce levels of potential harassment and violence (of which none was observed by the Investigator).

Social Contexts

India, while rapidly developing, is still mainly bounded by traditional and conservative value systems expressed through religious and cultural norms and expectations.

With a population of some 4 million people, there is a growing urbanisation, which has led to significant levels of rural young men migrating to the city in search of employment as often as excitement.

Pune also has a strong Muslim culture. It is believed by many in the city that this history has evolved a more tolerant attitude towards male to male sex practices, as long as it was not too visible to become a "public nuisance". This is believed to have led to what appears to be a low profile of police harassment in the various "cruising" sites, and a higher degree of openness amongst the *kothis*. *Kothis* in the assessment spoke little of police harassment, and what did exist was usually about police accessing sex and money from the *kothis*.

The *kothi social* and sexual networks seemed to be extensive and spread across Pune. *Kothis* appeared to feel more secure in a public expression of themselves at these sites than this Investigator had found in many other cities in India. Despite this sense of security, shame still configured a *kothi's* sense of self. Such levels of shame reduced the ability of *kothis* to purchase condoms at local shops or attend STD treatment centres.

Sociocultural frameworks of male to male sexual availability

Apart from male to male desire in terms of the sociocultural frameworks, both contemporary and traditional, that appears 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.
- To remain unmarried is seen as strange, if not an aberration. 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 India, frame women as not equal to males, as inferior vessels of male honour, to be sexually controlled, if she is allowed any form of sexuality. Sex with one's wife is often seen as a duty, rather than as pleasure. The statement "I do duty to my wife" is quite common, meaning I have sex with my wife. Also asking one's wife to perform certain sexual acts, such as oral sex or anal sex becomes shameful. She is the vessel of one's children.
- 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.

- Indian culture focuses on public shame rather than personal guilt as frameworks of social control. It should be recognised that fulfilment of social, religious and family duty is central to an Indian. Here duty is seen as a public duty, to be visibly performed. Thus the sense of shame and dishonour arises from a public (community) perception about visible personal behaviours.
- Concepts of sexuality, sexual behaviours and sexual identities are bound up within concepts of gender roles (the penetrated and the penetrator, masculine and feminine, male and female) and semen discharge. Such a framework will often lead to high frequency of sexual partners.
- For some males who sexually penetrate (the *panthi*), the gender of the sexual partner can often be irrelevant. What matters is to discharge.
- Because India culture is homosocial and homoaffectional, both in public and private, it is not uncommon for two or more males to share a bed. This makes opportunities for sexual encounters much easier. Very often this takes place in the dark, under the blanket, when partners can disassociate themselves from the act - "it was in my sleep".

All the evidence points to significant numbers of males engaged in sexual encounters with other males, from adolescents to much older men, from close relatives to the domestic servant, from the rickshaw driver to the businessman, from the rag-picker to the shop-keeper. 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 prior to marriage or as part of the sexual repertoire over their sexually active life.

Mapping

The movement of *kothis* and *kothi* sex workers, as well as gay-identified men from the Pune were free-flowing and an effervescent search for sexual partners as well as meetings with friends.

Forty sites where men can meet other men for sex were identified in the Pune. They included parks, bus-stands, railway stations, auto-taxi stands, public toilets, cemeteries, specific streets, bazaars, market places, shopping centres, 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, guesthouses, lodges and hostels, as well as personal homes, where after meeting the partners the men would go for private sex.

Discussions in the workshop and Focus Groups generated guestimates of	
male sex workers:	2,500
<i>kothis</i>	15,000
partners of <i>kothis</i> /male sex workers	100,000

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

In terms of the sexual partners (*panthis*) of *kothis* and male sex workers no figure could be generated. This was because *kothis* kept on referring to their belief that all men are potential *panthis*.

The Investigator at 6 public environments made a physical count. A total of 300 male sex workers were identified with 1000 *kothis*, and approximately 1500 *panthi*-type males. Assessment team members provided assistance with the counts. At one site in Pune the count indicated 60 *kothis*, 40 *kothi* sex workers, and well over 120 possible *panthis* on a Saturday evening between 6.00pm - 9.00pm.

Many of these sites were active during both the day and evening times. For example at the site mentioned above, during weekday afternoons, school and college boys would use the site.

Support and friendship systems

For *kothis* key support and friendship systems were provided by other *kothis*. For gay men, this was other gay men.

In Indian 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.

But *kothis* see men as potential *panthis*, and often treat them as such. It was seen as rare for a *kothi* to develop a non-sexual friendship with a "real man".

In a situational context *kothis* will perform as a "normal" male in other public contexts and in the home, and thus will develop friendships with other neighbourhood males and relatives keeping his identity choice and sexual behaviour secret. But even in this arena, *kothis* spoke of sex with friends, with these male friends. But never, never with another *kothi*.

Support systems tended to be expressed within a narrow arena of friendship networks, usually in a public environment, although sometimes *kothis* will visit other *kothis* at their homes, particularly so when that *kothi* has a room to himself. Here again this space can often become sexualised, as *kothi* friends will bring their *panthis* to access the privacy of the space.

Poverty and sex work

The majority of *kothis* are from low-income groups. Literacy levels are low as are the number of years of education.

A significant number of *kothis* from low income groups, unemployed, or low-paid, turn to sex work to generate extra income.

The study was able to access only *kothi* sex workers, although discussions with members of the gay groups, *kothis*, and others indicated that was a smaller network of middle class male sex workers who were available at a significantly higher price than *kothi* sex workers and expressed masculine male behaviours.

While *kothi* sex workers usually played the penetrated role, either in oral or anal sex encounters, these middle class sex workers would play either penetrated or penetrating role and would also access female sex workers or and/other women.

Motivations also differed somewhat. For *kothi* sex workers the issue was very much to deal with poverty and the need to financially support their families. For the middle class sex worker the motivation appeared to be the self, extra gifts, increase their own consumer purchasing power, or making potential useful contacts, or even for educational purposes, i.e. college costs.

Psychosexual issues

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

This led to a variety of myths, beliefs and practices that were accepted as true and helpful. A considerable tension existed regarding masturbation as a source of body and mental weakness, that reduce the virility and functioning of the penis, if not producing damage of one sort or another. Members of the Assessment team as well as the Investigator were constantly asked about medical treatment for nocturnal emissions, masturbation, penile sizes and shapes. Many of these men used "quack" remedies from street vendors for their perceived weaknesses.

At the same time, the lack of knowledge of their own and female bodies led to a range of risky practices, such as anal bleeding, produced through dry and rapid penetrative acts.

Reproduction also carried its own myths and beliefs, where several men just had no idea how babies are conceived, develop in the womb, or born.

Gender

It was the belief of the Investigator (and validated in the discussion groups and interviews) that the accepted gender bi-polarity of male and female is not so clearly divided in Indian society. In terms of males who have sex with males there appears to be a range of masculinities, a spectrum of possibilities, where at one end are *kothis*, then gay men (who *kothis* often defined as *gupti kothis* - or secret *kothis*) and then what *kothis* define as "real men", *panthis*. *Kothis* are not men believing that they are women, or even that they want to become women. They appear to see themselves as feminine males, and less "manly" than *panthis*. While they identify with the feminine, much of the identification is around performance as a means to attract these "real men" as sexual partners.

However it cannot be taken as a given that because *kothis* 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 *kothis* 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

The Assessment did not request specific information on religious affiliation, although the issue was raised in the Focus Group Discussions and in some of the tape-recorded interviews by participants themselves.

Kothis expressed significant concerns about what their religion said about male to male sexual behaviours. No one knew of any specific statement in either Hindu or Islamic texts referring to male to male sex. There was a general consensus from these discussions that both religions condemned such behaviours. This further exacerbated the feeling of shame.

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

Social, religious, cultural and political tensions do exist between the Muslim and Hindu communities, largely framed by considerations, such as the India/Pakistan conflicts, India/Pakistan cricket matches, terrorism, as well as differences in perceived educational and employment opportunities, and some of the broader, all-India, political developments.

Both Hindus and Muslims expressed similar sentiments about family and social expectations, of performing as men, fulfilling duties, maintaining family honour, of marrying and producing children, particularly sons. Choice of marriage partner was still seen as a parental duty and separation from the family as not an option.

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.

Marriage

In India, 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.

The majority of *kothis* and their sex partners in this Assessment accepted the social necessity of compulsory marriage, while some were already married. There appeared to be fatalism operating here, and a sense of not being able to challenge family and society's strictures. For the gay men accessed by this Assessment, in the main they stated they would not get married, but when this was followed through, most stated they may have to get married to satisfy their family's wishes.

AIDS prevention

There was no systematic prevention work taking place amongst MSM in Pune, apart from the small scale, and limited intervention of the members of the gay group amongst gay men in a couple of their cruising sites. Social meetings were focused on gay issues and social gatherings/parties. This work did not reach out to *kothis*.

Sexual Activities

Kothis, at least those assessed in this Assessment, appear to be much more sexual active, with significantly higher levels of anal and oral sex compared with gay-identified men. On average *kothi*-identified men were having 4 times more anal sex and 3 times more oral sex as gay men were in the previous month.

In the previous month there were 1879 reported sex acts, during which condoms were used for only 8%.

In this period, 195 respondents reported 1365 receptive acts and 302 insertive acts, and only 74% of respondents reported using condoms. At the same time, 158 respondents reported oral sex, of which 147 were receptive and 525 were insertive. Only 51% respondents used condoms for oral sex.

A total number of 1879 partners were reported for the previous month, of which 41% were strangers, 2% were male sex workers, 24% were paying male clients, and 20% were considered friends.

Sex partners were met in parks (10%), streets (22%), railway stations (27%), hotels/guest houses (1%), toilets/*mutri* (12%) and a range of other places such as bus stations/truck stand (3%), bazaar (3%) and bars/clubs.

Where people actually did sex varied from public spaces (70%), to private homes (20%), and in hotels, guesthouses or hostels (3%).

In terms of the ages of the last sex partner, 23% were between 18-21 and 41% were between 25-30.

Regarding the marital status of the respondents' last five sex partners, 24% stated they were unmarried, 17% did not know, and the remainder stated that at least one of the partners was married.

Condoms and lubricant

Only 74% of respondents reported using condoms for anal sex, and 51% for oral sex.

Of those who reported obtaining condoms, 48% said they purchased them from pharmacies, 62% said they got theirs from the local MSM project Udaan, and 25% got them from their sexual partners. The primary brands used were Jaroor, Nirodh, Kamasutra, Deluxe and Kohinoor.

In terms of not using condoms, 46% said they do not carry condom every time, 79% as not satisfying, never used (47%), shameful to buy (27%), not sick (66%), main partner faithful (91%).

When asked if they had condoms with them at the moment, 50% said yes.

Only 37% respondents stated they used lubricant all the time, with the primary lubricant being saliva (70%), while 74% also using oil-based products and only 19% using KY jelly.

Being paid for sex

39% of respondents reported that they had been paid for sex in the previous month, but only 63% (of them who reported) identified as sex workers. 21% of these reported had more than 15 paid sex encounters each in this period. The majority of paid sex was for receptive anal sex, 64 of these respondents reporting 718 such acts, and 64% reporting insertive anal sex acts. Similarly, 44% of respondents reported 160 receptive sex, and 15% of respondents reporting 42 oral insertive acts.

With regard to condom use, 6% of these respondents stated they never used condoms for the last 5 paid sex acts, while 57% said that they used condoms for all 5 paid acts. In terms of who initiated condom usage, it was either the partner (23%) or the respondent (77%).

78% of these respondents reported an income of below Rs. 50 for their last paid sex, while 22% reported an income of between Rs. 51-100.

Paying for sex

13% respondents reported paying for sex with another male. 63% reported paying about 3 times a month, 21% paying an average of 5 times a month, while 5% reported paying above 50 times in a month.

50% of these respondents paid to anally penetrate, while only 29% paid to be anally penetrated. 38% paid for oral sex where they inserted.

Out of a total of 362 paid sex acts, 33% were covered by a condom. There were 240 anal sex acts paid for, so this means that only for 33% of anal sex acts were condoms used.

Average age of the male sex worker being accessed was between 18 -24.

Female Partners

Wives

78% of married respondents reported sex with their wives. Significant variance in terms of frequency of sex was reported with 9% stating that they had sex with their wives every day to 52% reporting sex only 1 to 5 times a month. Average was about 6 times a month. 3% of these respondents reported anal sex with their wives, 5% reported oral sex, while all reported vaginal sex. Only 22% respondents reported using a condom for vaginal sex, and none used condoms for anal sex.

Other females

10% of respondents reported having sex with females (not wives) of which 8% of these reported anal sex acts, 10% reporting oral sex, and 58% reporting vaginal sex. 62% of these

respondents reported paying for sex. Only 35% reported using condoms all the time, while 17% stated they never used condoms and 48% said they used condoms some of the time.

Sexual health

34% of total respondents reported some symptom of which 46% stated they experienced pain during sex. But 14% reported itchy rash on genitals, while 1% stated they had pus or discharge from their penis, 18% reported bleeding on defecating, 15% itching or burning around their anus, 15% reporting pain while urinating, and 5% reported genital sores. Most of them reported multiple symptoms.

Those who stated that they had been paid for sex (39% of the total respondents) reported higher levels of symptoms.

Treatment

Regarding treatment, 54% were doing nothing, 9% went to a medicine shops, 28% went to a private doctor, 21% went to a hospital, and 22% went to a street quack, friend or relative. There were similar levels for when respondents had previous symptoms

HIV/AIDS knowledge and self-assessment

90% of respondents had heard of AIDS. AIDS as a "dangerous disease" was stated by 24% of respondents, or some derivative of this. But 2% did not have any idea (right or wrong) of what HIV/AIDS meant.

Mostly respondents had heard of HIV/AIDS from friends (47%), posters (52%), newspapers (37%), radio (57%), Udaan (50%), and doctor (49%).

In terms of personal risk assessment, 31% of respondents stated they did not know, while 19% believed they were at high risk.

In terms of HIV infection routes, 69% said yes for oral sex, sexual contact with a woman (83%), vaginal sex without a condom (93%), anal sex without a condom (88%), and sharing needles (95%). This means that approximately two-thirds of respondents were correct in regard to the main routes of infection but they were also unsure of other types of sexual contacts.

In terms of prevention, 45% stated always using condoms, while 19% stated they did not know. In regard to what safer sex means, 20% reported not knowing what this was and 53% said this meant always using a condom. 8% said this meant have sex with a "faithful" partner.

Risk reduction

With regard to risk reduction strategies, 34% of respondents believed using a condom for anal or vaginal sex would reduce risk, and 66% believed that non-penetration was also a risk reduction strategy. 69% also believed that reducing sex partners was another risk reduction strategy.

Despite this level of knowledge, only 30% of respondents reported using condoms.

Informing your partner

When asked about informing their partners should they experience symptoms of STIs or come to know they have HIV/AIDS, 60% of respondents stated they would inform their male partners, but only 46% stated they would inform their female partners, and 68% said they would inform their wives.

HIV antibody testing

40% of respondents (93 respondents) reported having an HIV anti-body test, of which 4 was positive. Although, only 73 respondents opted for this question out of 93 who informed of going for the test. 20 respondents opted not to respond which was respected by Udaan.

Preventive counselling

68% of respondents reported being counselled on how to prevent STI/HIV infection,

Drug use

1% of respondents reported injecting drug use, while 5% reported their sex partners injected drugs.

Seeking Help with Concerns about STI/HIV

In answering this question, 67% stated they would go to a local MSM project, but 31% said they could go to a government hospital, 44% could go to an AIDS NGO, and 41% would go to a private doctor.

Sexual behaviours and impact on sexual health concerns: a summary

The *kothi/panthi* framework of male to male sex is the predominant pattern in Pune. As seen above indications are of high levels of unprotected anal sex, 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.

There was a significant difference in the issues between gay-identified men and *kothi/panthis* in the Assessment, where *kothis* were primarily penetrated orally and anally, while gay men tended towards more equally in terms of penetration or being penetrated. There were lower numbers of partners for gay men, as well as earlier treatment for STI symptoms.

It was noted that saliva was the common lubricant used for penetration, but that a significant number of assessment participants also reported using oil-based lubricant as an aid to penetration, even with condoms. Only those who could afford it would use KY jelly, a water-based lubricant, and these were primarily gay-identified men, as well as those *kothis* who knew about KY jelly and who could afford the price.

While the majority of assessment participants had heard of HIV/AIDS, and at the same time personal risk assessment indicating that a large minority knew that they were at risk from STI/HIV infection, specific knowledge of HIV transmission was mixed and confused for a large minority, primarily *kothi*-identified males.

There was a clear gender-based division about partner notification where female partners of MSM were less likely to be informed of their partner's status than male partners.

From the range of interviews and the focus group discussions, there was a range of anecdotal reports of early sexual activities of many *kothis*, who often started their sexual life before the age of fourteen, and whose first sexual partner was usually a male relative such as a cousin or uncle.

Also being reported was a much broader context of male to male sex than only a *kothi/panthi* or gay dynamic, and involved significant levels of males. Such sex encounters were 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, madrassas, 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 offices 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 were *kothi*-identified and primarily involved in anal sex as the receptive partner. The majority was unemployed and/or poor. A significant number were illiterate or poorly educated.

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 *panthis* accessing males will also access females for sex, particularly female sex workers.

It is also clear that there are some distinct differences in regard to sexual health issues for gay-identified men and for *kothi*-identified males. It is also 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.

BCC Materials

No appropriate BCC materials for MSM existed in Pune. The local gay group conducting the small scale intervention was using a leaflet (produced by another agency working with female sex workers) which spoke of vaginal sex but only mentioned anal sex once, which asked men to practice partner reduction or abstinence, and which talked of water-based lubricant without indicating where appropriate resources could be obtained. The intervention observed by the Investigator was conducted by one person in a large site, with only 20 leaflets distributed, each with four condoms. This was amongst gay-identified men only at that site.

STI treatment

Discussions with five doctors willing to treat anal sex issues were limited. These doctors had been identified by the Local Focus Person as those to whom some of the gay-identified men and *kothis* would go. However, the lack of understanding of MSM frameworks and behaviours, as well as anal issues was clearly obvious. This included both private and government doctors. Most *kothis* did not access doctors but asked friends, "quacks", or received anti-biotics from pharmacies for "problems".

There is concern regarding the suitability or appropriateness of these doctors and clinics, particularly in terms of acceptance of *kothi* and/or gay identities, as well as the stigmatisation of anal sex practices.

Two gay doctors with some experience of STI treatment were identified and brought to the attention of the Assessment Team members so that they could refer individuals.

NGO and Donor response

Discussions by both the consultant and by this Investigator with a number of local NGOs working on HIV/AIDS issues, the State AIDS Control Society, International donor agencies indicated a high degree of support for an intervention amongst MSM in Pune.

Conclusions

In exploring male to male sex in Pune this report highlights the following issues (in no specific order):

- There are significant levels of males who have sex with males where a *kothi/panthi* dynamic was the most prevalent framework of MSM in the city
- Some gay identity and organising does exist but this was very limited and middle class-based
- High rates of anal sex exist between males particularly *kothis/panthis* with lower rates for gay-identified men
- Significant levels of male commercial sex work exists in Pune, where MSWs were primarily *kothi*-identified males
- High levels of partner change amongst *kothi*-identified males, less so among gay-identified males
- High rates reported of possible STI symptoms
- Low levels of appropriate health seeking behaviours
- Inadequate appropriate STI treatment services regarding anal transmission of STIs
- No appropriate condoms available suitable for anal sex
- No affordable, accessible and appropriately packaged water-based lubricant available
- Many males who have sex with males begin their sexual activities in early adolescence, where their first sex partner is usually a male relative
- There are no appropriate education resources dealing with male to male sexual behaviours and/or anal sex
- Levels of appropriate knowledge of STIs/HIV/AIDS amongst males who have sex with males, particularly amongst gay-identified men
- Low levels of condom usage
- Many males who have sex with males will be married and many will get married
- Gay identified men on the other hand usually find sex partners among other gay-identified men,
- *Kothis* sexually access many different men across
- They have extensive social networks with other *kothis*.
- They usually come from poor, marginalised and socially excluded communities.

If appropriate support and technical assistance is given, it is possible to develop a community building strategy amongst *kothis*, and use this emergent community as a means of education and prevention intervention amongst *kothis* and their partners, where *kothis* can be mobilised on behalf of improving sexual health among MSM generally.

However it should also be recognised that *kothis* do not have the experience, knowledge, or skills to develop, implement and sustain their own sexual health intervention without considerable initial and on-going technical assistance.

Primary recommendations

- Funding provided towards developing a *kothi*-led sexual health intervention amongst MSM in Pune
- Technical assistance and support provided to *kothis* to develop community-building strategies in Pune and to mobilise the resultant emergent community
- Such technical assistance should also include skills and capacity building
- Appropriate condoms for anal sex and sachets of water-based lubricant should be made available at affordable prices for the *kothi* MSM project to distribute
- it will probably be necessary that initial distribution be free towards building a users habit before social marketing is developed
- It is an urgent necessity that at STI treatment service be accessible to MSM which is confidential, accepting and of high quality
- It is necessary to ensure that the STI service provider has acceptable and appropriate knowledge of MSM issues and concerns, and of anal STIs and problems.

- Enabling and empowering a *kothi*-led project to host its own clinic service should be considered as a priority
- A drop-in centre should be strategically located in Pune to ensure maximum impact, outreach and support towards effective community-building and mobilising
- Training and sensitisation programmes should be provided for local STI treatment centres, HIV/AIDS and sexual health NGOs and development agencies, as well as government services dealing with MSM issues
- Appropriate and relevant BCC materials should be urgently developed for *kothis* and their partners using their own terminology, and distributed by themselves.
- The concept of peer education, community-building, and beneficiary led services is central to any effective and sustainable intervention strategy and this should be supported by any donor

World Health Organisation definition of sexual health

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

METHODOLOGY

Cities in this study had been selected for situational assessments based on population, evidence of increasing levels of HIV (though the evidence is very poor due to the lack of effective surveillance centres), and significant known levels of MSM and male sex worker networks identified through anecdotal materials and through the knowledge of Naz Foundation International (NFI) and its partner MSM sexual health projects.

The initial phase consisted of networking in the target cities to identify appropriate MSM networks through contacts already established by NFI and its partner agencies

This enabled the recruitment of an appropriate Local Focus Person (LFP) who had access to these networks, as well as being a part of them. It was an important principle for this study that all participants in the Assessment would be MSM themselves and from the same networks that were being assessed.

The LFP recruited 15 other individuals from these networks who were interested and willing to participate in the training workshop as well as conduct the assessment.

Prior to the workshop participants and friends were invited to a Social Meeting where food and refreshments were provided. This meeting was used as a socialising space for Assessment participants to get to know each other as well as introduce the project.

A 6-day training programme was conducted for these 15 participants and the LFP. The training programme consisted of:

- i. Issues relating to sex, sexual behaviours and sexuality in South Asia
- ii. Increasing knowledge of the male and female body and psycho-sexual issues relevant amongst males in South Asia
- iii. Discussions on MSM in the context of Pune, which included mapping the city for specific MSM public locations
- iv. Sexual health issues, including STI/HIV transmission and prevention
- v. Methodologies to be used in the Assessment
 - a. use of the questionnaire
 - b. focus group discussions
 - c. taped interviews
 - d. a range of site observations conducted by the Investigator

The workshop was presented in English/Hindi by the Investigators and translated into Marathi as an on-going process by the Local Focus Person. All documents were also translated and printed in local languages.

Following the workshop, an Assessment Team was formed with 10 of the participants. The remaining 5 were not suitable, based on levels of literacy and skills required for the study.

A further one-day session was provided for this team to enhance their research and interviewing skills.

Two hundred fifty two survey questionnaires and two focus group discussions were conducted. The discussions generated by the workshop was also taken as a third and on-going six day focus group discussion - this was not the original intention but the quality of information raised during the workshop was too invaluable to ignore.

The Assessment Team was supervised by the Local Focus Person. The LFP was supervised by Naz Foundation International through the Project Manager.

Potential participants were approached by the members of the Assessment Team at a range of sites and asked if they would be willing to be interviewed. These participants were part of the Assessment Team members' own networks.

It should be noted that since the Assessment Team members in the main were *kothi* -identified, the majority of respondents come from their own networks and were *kothi*-identified themselves.

Members of the Assessment Team also invited 30 interviewees (from both questionnaire and taped pools) to participate in 2 Focus Group Discussions, each group consisting of 15 participants and facilitated by the Investigator and the Local Focus Person acting as translator.

At all levels, participants were assured of anonymity and confidentiality, where no identifying characteristics would be collected. All participants were 18 years and above.

Following the questionnaire and taped interviews, as well as the focus group discussions, participants were given information on STIs/HIV/AIDS, safer sex and condom use, and condoms were distributed.

The survey questionnaire consisted of 63 questions on

- socio-demographic information
- sexual behaviours and practices
- partner numbers and recruitment
- sex work
- condom usage
- possible STD symptoms and treatment seeking
- HIV/AIDS knowledge

The questionnaire was translated from English into Hindi/Marathi with special care being taken to use the local colloquial terms normally used by potential participants.

The two Focus Group Discussions were on the issues and needs of MSM with a focus on sexual health concerns, including STIs/HIV/AIDS. Other issues discussed were:

- situational and/or self-identities
- support systems
- health seeking behaviours
- social roles and expectations
- MSM mapping of the city
- existent access to STD treatment services
- family and marriage issues
- sex work

The Investigator also visited six of the main public sites in Pune where men can meet other men for sex on. One-on-one discussions also took place at each of these sites with a number of MSM

facilitated by the Local Focus Person, following an assurance of anonymity and confidentiality, and an explanation of purpose.

There were also several personal discussions and two group discussions with one gay group in Pune during their regular meetings.

SAMPLING

As noted above, access to the MSM networks for data collection and interviews was through the personal networks of members of the Assessment Team.

This was because members of the team as well as the Principle Investigator believed (based on prior experience), that with the nature of the questions to be asked, and because of the MSM living in a social context of shame and invisibility, accessing a random MSM sample would be difficult, if not impossible.

Thus, sampling was based on personal networks and friendship, and was a non-random, non-probability sample. It was not intended to develop a behavioural study, but to reflect the levels of understanding, risks and behaviours within certain MSM networks known to the Principal Investigator, the Local Focus Person and members of the Assessment Team.

However, the choices of the Assessment Team was determined by:

- Local Focus Person access to networks
- a willingness and desire to become involved
- the time to do so
- an ability to be open about their own sexual desires, identities and behaviours
- MSM

While the Investigator had discussed the Assessment Project with the two gay groups in the city on his first initiatory visit, only one gay-identified man agreed to be a part of the training programme and Assessment Team. All others of the 15-member group were self-identified *kothis*. This meant that the members of the assessment team accessed MSM they knew or through people they knew, and since members of the team were *kothi*-identified, these were also *kothis*.

It was not possible to bring *panthis* together for a group discussion (see MSM context below). However the discussion groups held a mixture of *kothis* from different occupational groups, gay men and male sex workers.

This selection process limited access to a number of possible networks and ensured that the Situational Assessment was a non-probability, non-random sample. However, while the majority accessed were self-identified *kothis* with a number of *kothi* sex workers, it was felt that it is this network that expressed the higher risk for STI/HIV transmission, as well as often the lowest income, and the largest number of members.

Size of sample population

- 252 completed questionnaires completed either on or near site or at the Local Focus Persons home
- 30 involved in focus group discussions two discussion groups of 15 held in a rented accommodation

Because of the self-identities of the workshop participants, who in the main labelled themselves as *kothis* (there was one gay-identified participant as well), the majority of the interviewees were other *kothis*.

While this process gives information on the sexual behaviours and practices of *kothis* and their *panthi* partners, it could not perhaps provide adequate information on the level of male to male behaviours in Pune or the numbers of MSM. Estimates of the number of "public" (meaning visible by demeanour, behaviour and use of public meeting places) *kothis* and male sex workers

were made by the Assessment Team members as well as the Investigator in terms of his field visits, but these can only remain as guestimates. No claim is being made in terms of accuracy, but these guesses are made by those involved in the networks themselves.

DATA ANALYSIS

A code number identified the survey questionnaires. Completed questionnaires were kept in a locked cupboard until all had been done. The Local Focus Person did necessary translation into English. Following this the questionnaires were analysed using special software designed by Bamon Development Consultants, a professional group in New Delhi.

Field observation notes were written as summaries and included discussions with individuals at the sites, numbers present, behaviours observed, geographical details, and so. The Principal Investigator was supported by the Local Focus Person who took him to the specific sites, acted as translator while facilitating meetings between him and a range of individuals.

ANNEX 1

Workshop Agenda

- Day One:** **Setting the context**
what is sex?
sexual behaviours
learning about sex
sexual stereotypes
cultural and social expectations
labelling
stigmatisation, denial and invisibility
- Day Two:** **The sexual body**
feedback from day one
knowing your own body
knowing a woman's body
talking sex
the practice of sex
- Day Three:** **Males who have sex with males**
feedback from day two
what is your sexual experience and history?
desire of semen discharge?
local structures of male to male sex in....
male sex work
mapping the city
women and wives
- Day Four:** **Sexual health: part one**
feedback from day three
what is sexual health?
knowledge and attitudes
what are STDs?
what is HIV and AIDS?
STD/HIV transmission
spreading the virus
who is vulnerable?
- Day Five:** **Sexual health: part two**
feedback from day four
what are risk behaviours?
personal risk analysis
personal and social impact of STDs/HIV
changing sexual practice
practising safer sex
all about condoms and lubricant
psychosexual issues
- Day Six:** **The assessment**
feedback from day five
assessment methodologies
the questionnaire
the taped interview
focus groups
observational analysis
evaluation and closing

ANNEX 2

Pune Data

1. YOURSELF

Q. 1 Age of the respondents (N=252)

Age	Respondents	%
18 - 21	52	20.64
22 - 30	141	55.95
31 - 40	49	19.44
Above 40	10	3.97

Q. 2 Marital status of the respondents (N=252)

Category	Respondents	%
Married	74	29.37
Unmarried	178	70.63
Not married but in a relationship with a male	158	62.70
Married & in a relationship with a male	66	26.19
Active outside marriage	66	26.19
Others	33	13.10

Q. 3 Currently employed? (N=242)

Category	Respondents	%
Yes	133	54.96
No	109	45.04

Q. 4 Occupation of the respondents (N=198)

Category	Respondents	%
Salesman	2	1.01
Unemployed	2	1.01
Private	29	14.65
CSW	2	1.01
Job	27	13.64
Student	30	15.15
Private Service	20	10.10
Pvt. Ltd.	3	1.52
Mangtai	9	4.55
Tailor	2	1.01
Male Sex Worker	7	3.54
Business	23	11.62
Shopkeeper	3	1.52
Room Boys	2	1.01
Government Job	5	2.53
Driver	3	1.52
Painter	3	1.52
Teacher	2	1.01
Others	24	12.12

Q. 5 Monthly income of respondents (N=171)

Category	Respondents	%
Below 1000 Rupees	9	5.26
1000 To 2000	50	29.24
2000 To 5000	79	46.20
5000 To 10,000	27	15.79
Above 10,000 Rupees	6	3.51

Q. 6 Self sexual labeling by respondents (N=252)

Category	Respondents	%
Kothi	106	42.06
Panthi	41	16.27
Double - Decker	44	17.46
Heterosexual	14	5.56
Homosexual	21	8.33
Gay	22	8.73
Others	4	1.59

2. SEXUAL ACTIVITY WITH OTHER MALES

Q. 7. Sexual activities with males (N=228)

Category	
No. of males have had sex in last week	578
No. of males have had sex in last month	1879
No. of respondents used condom for sex	128
No. of males used condom for sex in last week	390
No. of males used condom for sex in last month	150

Q. 8A Anal sex acts in last week (N=149)

Category	
Insertive sex acts	116
Receptive sex acts	441
No. of respondents who used condoms	116
Insertive sex acts with condoms	84
Receptive sex acts with condoms	283

Q. 8B Anal sex acts in last month (N=149)

Category	
Insertive sex acts	302
Receptive sex acts	1365
No. of respondents who used condoms	145
Insertive sex acts with condoms	203
Receptive sex acts with condoms	1033

Q. 9 Oral sex acts to ejaculation in last week (N=158)

Category	
No. of Insertive sex acts	525
No. of Receptive sex acts	147
No. of respondents who used condoms	82
Insertive sex acts with condoms	230
Receptive sex acts with condoms	75

Q. 10 Relationship with sex partners in last month (N=232)

Category	No. of Times
Friends	378
Strangers	771
Neighbors	107
Male Sex Worker	38
Relatives	14
Servants	6
Paying Clients	459
Others	71

Q. 11 Places of meeting with males you had sex with in the last month (N=232)

Category	No. of Times
Bar / Club	15
Street	413
Personal home	111
Park	182
Friend's home	102
Toilets	231
Railway station	502
Guest house	10
Truck stand	29
Neighborhood	74
Health club	2
Bazaar	64
Cinema	28
Hotels	6
Bus Stations	36
Others	64

Q. 12 Places of sex acts (N=230)

Category	No. of times
Your home	207
Friend's home	177
Park / crusting area	384
otel/guest house	45
Hostel	9
Cinema/theatre	54
Bar / club	6
Public toilet	258
In a car	55
In a train	476
Train / bus depot	30
Others	130

Q. 13A Age of last male sex partner (N=163)

Category	Respondents	%
18-21	47	28.83
22-24	29	17.79
25-30	54	33.13
31-40	23	14.11
41-50	10	6.13
Above 50	0	0.00

Q. 13B Age of second last male sex partner (N=119)

Category	Respondents	%
18-21	20	16.81
22-24	17	14.29
25-30	58	48.74
31-40	14	11.76
41-50	9	7.56
Above 50	1	0.84

Q. 14 Last 5 male sex partners' marital status (N=180)

Category	Respondents	%
All were unmarried	43	23.89
1 was unmarried	24	13.33
2 were unmarried	24	13.33
3 were unmarried	24	13.33
4 were unmarried	7	3.89
5 were unmarried	28	15.56
Don't know	30	16.67

Q. 15 Availability of condoms from ... (N=221)

Category	Respondents	%
Pharmacy/medicine shop	106	47.96
Family planning clinic	5	2.26
Shops / Panwallas	24	10.86
MSM projects	138	62.44
Social worker	6	2.71
AIDS NGO	32	14.48
Doctors	12	5.43
Vending machines	25	11.31
Friends	51	23.08
STD clinics	3	1.36
Sexual partners	55	24.89
Others	11	4.98

Q. 16 Brand of condom (N=208)

Category	Respondents	%
Jaroor	131	62.98
Nirodh	124	59.61
Kamasutra	59	28.39
Deluxe	22	10.58
Kohinoor	20	9.62
Durex	7	3.37
Masti	4	1.92
Cow Boy	3	1.44
Moods	2	0.96
Other Brands	5	2.40

Q. 17 Reasons for not using condom (N=93)

Category	Remarks
Don't carry condoms with me	93
Not satisfying	73
Hard to dispose	57
Never used before	44
To shameful to buy/use	25
Don't know where to get condoms	2
Am not sick	61
Partner not sick	55
Not easy to use	46
Main partner is faithful	85
Get more money for sex without condom	11

Q. 18 Do you have a condom now? (N=244)

Category	Respondents	%
Yes	123	50.41
No	121	49.59

Q. 19 Can we see your condoms? (N=230)

Category	Respondents	%
Yes	125	54.35
No	105	45.65

Q. 20 Use of lubricant for anal sex (N=207)

Category	Respondents	%
None of the time	23	11.11
Some of the time	108	52.17
Every of the time	76	36.71

Q. 21 Type of lubricant used for anal sex (N=195)

Category	Respondents	%
Oil	76	38.97
Ghee/Butter	1	0.51
Saliva	137	70.26
Vaseline	53	27.18
KY Jelly	38	19.49
Soap	8	4.10
Others	5	2.56

3. PAID SEX

Q. 22 Have you ever been paid by a man for sex (N=227)

Categories	Respondents	%
Yes	89	39.21
No	138	60.79

Q. 23A No. of times you have been paid by men for sex in last week (N=56)

Category	Respondents	%
1 - 5 times	43	76.79
6 - 10 times	9	16.07
11 - 15 times	0	0.00
More than 15	4	7.14

Q. 23B No. of times you have been paid by men for sex in last month (N=85)

Category	Respondents	%
1 - 5 times	46	54.12
6 - 10 times	16	18.82
11 - 15 times	5	5.88
More than 15	18	21.18

Q. 24A Pattern of paid sex in last week (N=55)

Category	
No. of anal insertive sex acts	27
No. of respondents doing anal insertive sex acts	12
No. of anal receptive sex acts	187
No. of respondents doing anal receptive sex acts	45
No. of oral insertive sex acts	14
No. of respondents doing anal insertive sex acts	7
No. of oral receptive sex acts	47
No. of respondents doing oral receptive sex acts	26
No. of masturbation sex acts	7
No. of respondents doing masturbation	5
No. of other type of sex acts	6
No. respondents doing other type of sex acts	2

Q. 24B Pattern of sex when paid for sex in last month (N=84)

Category	58
No. of anal insertive sex acts	12
No. of respondents doing anal insertive sex acts	718
No. of anal receptive sex acts	64
No. of respondents doing anal receptive sex acts	42
No. of oral insertive sex acts	13
No. of respondents doing oral insertive sex acts	160
No. of respondents doing oral insertive sex acts	37
No. of oral receptive sex acts	14
No. of respondents doing masturbation	6
No. of other type of sex acts	28
No. of respondents doing other type of sex acts	4

Q. 25 No. of times condoms used in last five paid sex acts (N=79)

Category	Respondents	%
Never	5	6.33
Single time	7	8.86
Two times	7	8.86
Three times	11	13.92
Four Times	4	5.06
Five Times	45	56.96

Q. 26 Who initiated condom use? (N=73)

Category	Respondents	%
Your Self	56	76.71
Your Partner	17	23.29

Q. 27 Last time how much were you paid for sex by a man (N=73)

Category	Respondents	%
1 - 10 Rupees	1	1.37
11 - 20	13	17.81
21 - 30	16	21.92
31 - 40	4	5.48
41 - 50	23	31.51
51 - 100	13	17.81
101 - 150	0	0.00
151 - 200	1	1.37
Above 200	2	2.74

Q. 28 Ever paid for sex with another male? (N=208)

Category	Respondents	%
Yes	26	12.50
No	182	87.50

Q. 29 No. of times you paid for sex with a male in last week (N=10)

Category	Respondents
1-3	9
4-6	0
7-10	0
11-15	0
16-20	0
21-25	0
Above 25	1

Q. 29B No. of times you paid for sex with a male in last month (N=19)

Category	Respondents
1 to 3	12
4 to 6	4
7 to 10	2
11 to 15	0
16 to 20	0
21 to 25	0
26 to 30	0
31 to 40	0
41 to 50	0
Above 50	1

Q. 30 Pattern of sex when paid for sex in last month (N=24)

Category	No. of Times
No. of anal insertive sex acts	30
No. of respondents doing anal insertive sex acts	12
No. of anal receptive sex acts	210
No. of respondents doing anal receptive sex acts	7
No. of oral insertive sex acts	110
No. of respondents doing oral insertive sex acts	9
No. of oral receptive sex acts	8
No. of respondents doing oral receptive sex acts	7
No. of masturbation sex acts	4
No. of respondents doing masturbation	4
No. of other type of sex acts	0
No. of respondents doing other type of sex acts	0

Q. 31 No. of times not used condom when paid for sex during this time (N=16)

Category	Respondents
1 - 3	12
4 - 6	2
7 - 10	1
11 - 15	1
Above 15	0

Q. 32 Last time how much did you paid for sex with a male (N=19)

Category	Respondents
1 - 10 Rupees	0
11 - 20	2
21 - 30	4
31 - 40	0
41 - 50	5
51 - 100	4
101 - 150	1
151 - 200	3
Above 200	0

Q. 33 Age of last male you paid to have sex with? (N=25)

Category	Respondents
18 - 21	10
22 - 24	6
25 - 30	6
31 - 40	3
Above 40	0

4. SEXUAL ACTIVITY WITH FEMALES

A. Married Males

Q. 34 No. of times you have sex with your wife in the last month (N=58)

Category	Respondents	%
1 - 5	30	51.72
6 - 10	13	22.41
11 - 15	5	8.62
16 - 20	5	8.62
Above 20	5	8.62

Q. 35 Pattern of sex with your wife in the last month (N=64)

Category	
No. of times of vaginal sex act	531
No. of respondents doing vaginal sex	63
No. of times of vaginal sex acts with condom	117
No. of respondents doing vaginal sex with condom	14
No. of times of anal sex act	6
No. of respondents doing anal sex	2
No. of times of anal sex with condom	0
No. of respondents doing anal sex with condom	0
No. of times of oral sex act	8
No. of respondents doing oral sex	3
No. of times of oral sex with condom	0
No. of respondents doing oral sex with condom	0

B. All Males

Q. 36 No. of females (not wife) have you had sex with in the last month ? (N=24)

Category	Respondents
None	0
One	6
Two	9
Three.	2
Four	3
Five	1
Above Five	3

Q. 37 Pattern of sex with females (not wife) in the last month (N=64)

Category	
No. of times of vaginal sex act	128
No. of respondents doing vaginal sex	37
No. of times of vaginal sex acts with condom	43
No. of respondents doing vaginal sex with condom	19
No. of times of anal sex act	3
No. of respondents doing anal sex	2
No. of times of anal sex with condom	2
No. of respondents doing anal sex with condom	1
No. of times of oral sex act	6
No. of respondents doing oral sex	5
No. of times of oral sex with condom	2
No. of respondents doing oral sex with condom	2
No. of times of masturbation	2
No. of respondents doing masturbation	1
No. of times of other sex with act	2
No. of respondents doing other sex act	1
No. of times of other sex with condom	2
No. of respondents doing other sex with condom	1

Q. 38 Relationship with female sex partner to yourself (N=36)

Category	No. of Times
Friends	44
Relatives	7
Strangers	23
Servants	3
Neighbors	15
Female sex workers	38
Others	0

Q. 39 Last 5 female sex partners' marital status (N=23)

Category	Respondents
All unmarried	9
One was married	5
Two were married	4
Three were married	1
Four were married	1
All were married	1
Don't know	2

Q. 40 No. of times condoms used while having sex with last five female sex partners (N=26)

Category	Respondents
No time	5
One time	2
Two times	5
Three times	4
Four times	0
Every time	10

Q. 41 Have you paid for sex with a female in last month? (N=29)

Category	Respondents
Yes	18
No	11

Q. 42 Pattern of sex, when paid for it with 5 last females (N=29)

Category	
No. of respondents who had anal sex	3
No. of times did anal sex acts	5
No. of respondents who had oral sex	3
No. of times did oral sex acts	7
No. of respondents who had vaginal sex	28
No. of times did vaginal sex acts	122
No. of respondents who had masturbation sex	0
No. of times did masturbation	0
No. of respondents who had other type of sex	1
No. of times did other type of sex acts	3

Q. No.43A No. of times condoms used in last five paid sex acts with (N=23)

Category	Respondents
Never	4
Single time	1
Two times	7
Three times	3
Four times	0
Five times	8

Q. No.43B Who initiated condom use? (N=5)

Category	Respondents
Your self	0
Your Partner	5

5. Your Health

Q. 44 Currently having these symptoms (N=85)

Category	Respondents	%
Pain while urinating	13	15.29
Itching or burning around anus	13	15.29
Pus or discharge from penis	1	1.18
Pus or discharge in stools	0	0.00
Pain upon defecation	25	29.41
Bleeding when defecating	15	17.65
Genital sores	4	4.71
Itchy rash on genitals	12	14.12
Blisters or sores inside mouth	26	30.59
Pain during sex	39	45.88
Others	7	8.24

Q. .45 What are you doing to treat these symptoms (N=121)

Category	Respondents	%
Nothing	65	53.72
Medical shop	11	9.09
Private doctor	34	28.10
Hospital	26	21.49
Friends/Relatives	1	0.83
Street 'Quack'	2	1.65
Other clinic	3	2.48
Others	20	16.53

Q. 46 What did you do the last time you had any of these symptoms (N=105)

Category	Respondents	%
Nothing	60	57.14
Medical shop	11	10.18
Private doctor	30	28.57
Hospital	22	20.95
Friends/relatives	0	0.00
Street 'quack'	2	1.91
Other clinic	4	3.81
Others	0	0.00

Q. 47 Ever heard of HIV and/or AIDS? (N=252)

Category	Respondents	%
Yes	228	90.48
No	24	9.52

Q. 48 What have you heard about HIV / AIDS (N=221)

Category	Respondents	%
It's a dangerous disease	32	14.48
It spreads through sex	30	13.57
There is no treatment for it	29	13.12
Don't have sex without condom	26	11.77
Reduces the antibodies of the body	25	11.31
Infected people dies	16	7.24
Good knowledge	15	6.79
Do safe sex	12	5.43
A dangerous viral disease	12	5.43
It's a deadly disease	10	4.53
Don't have sex with infected people	10	4.53
Infects through infected blood	9	4.07
Infects through more sex	7	3.17
HIV causes AIDS	5	2.26
Sex with single partner	5	2.26
Don't Know	5	2.26
Others	16	7.24

Q. 49 Sources of information on HIV/AIDS (N=228)

Category	Respondents	%
Doctor	111	48.68
Radio	129	56.58
Social Worker	25	10.96
NGO	85	37.28
Newspaper	84	36.84
Leaflets	36	15.79
Posters	118	51.57
Hospital	58	25.44
Clinic	39	17.11
Family member	3	1.32
Local MSM projects	113	49.56
Friends	107	46.93
Sex partners	43	18.86
Others	25	10.96

Q. 50 What risk do you personally think you have of getting HIV/AIDS? (N=236)

Category	Respondent	%
Large	22	9.32
Medium	22	9.32
Small	119	50.42
I do not know	73	30.93

Q. 51A You can get HIV from sharing a needle (N=224)

Category	Respondents	%
Yes	212	94.64
No	6	2.68
Not Sure	6	2.68

Q. 51B You can get HIV from being penetrated by a man without a condom (N=224)

Category	Respondents	%
Yes	196	87.50
No	19	8.48
Not Sure	9	4.02

Q. 51C You can get HIV from being penetrated by a man with a condom (N=226)

Category	Respondents	%
Yes	197	87.17
No	19	8.41
Not Sure	10	4.42

Q. 51D You can get HIV from penetrating a woman without a condom (N=223)

Category	Respondents	%
Yes	208	93.27
No	7	3.14
Not Sure	8	3.59

Q. 51E You can get HIV from only having a sexual contact with a woman (N=213)

Category	Respondents	%
Yes	176	82.63
No	23	10.80
Not Sure	14	6.57

Q. 51F You can get HIV from sucking a penis (N=220)

Category	Respondents	%
Yes	151	68.64
No	48	21.82
Not Sure	21	9.55

Q. 51G You can get HIV from swallowing semen (N=223)

Category	Respondents	%
Yes	175	78.48
No	26	11.66
Not Sure	22	9.87

Q. 51H You can get HIV from licking a vagina (N=215)

Category	Respondents	%
Yes	155	72.09
No	32	14.88
Not Sure	28	13.02

Q. 51I You can get HIV from masturbating someone (N=212)

Category	Respondents	%
Yes	23	10.85
No	179	84.43
Not Sure	10	4.72

Q. No. 51J You can get HIV from rubbing bodies (N=212)

Category	Respondents	%
Yes	23	10.85
No	177	83.49
Not Sure	12	5.66

Q. No. 51K You can get HIV from thigh sex (N=213)

Category	Respondents	%
Yes	24	11.27
No	174	81.69
Not Sure	15	7.04

Q. 51L You can get HIV from licking anus (N=217)

Category	Respondents	%
Yes	104	47.93
No	86	39.63
Not Sure	27	12.44

Q. 51M You can get HIV from deep kissing (N=206)

Category	Respondents	%
Yes	56	27.18
No	133	64.56
Not Sure	17	8.25

Q. 52 What ways you can prevent getting or passing HIV (N=229)

Category	Respondents	%
Use condom for sex	103	44.98
Do masturbation	35	15.28
Do thigh sex	22	9.61
Do safe sex	21	9.17
Watch sexy movies	9	3.93
Make the people aware of HIV	8	3.49
Pornography	8	3.49
Don't have more sex	7	3.06
Cyber sex	6	2.62
Sex with single partner	6	2.62
Oral Sex	5	2.18
Do care of yourself	4	1.75
Yes	4	1.75
Use checked blood	3	1.31
Kissing	3	1.31
Reduce the No. of partners	2	0.87
Use new needles	2	0.87
Sexy phone talk	2	0.87
Don't have sex with strangers	2	0.87
Control yourself	2	0.87
Sex with good and healthy people	2	0.87
Don't Know	44	19.21
Others	13	5.68

Q. 53 Ever heard of safer sex ? (N=237)

Category	Respondents	%
Yes	189	79.75
No	48	20.25

Q. 54 What have you heard about safer sex (N=198)

Category	Respondents	%
Use condom for sex	104	52.53
Don't get infected by HIV/AIDS	57	28.79
Safe sex	13	6.57
Sex with single faithful partner	15	7.58
Take care of yourself	5	2.53
Don't have sex with strangers	5	2.53
Don't have more sex	2	1.01
Use condoms with strangers	2	1.01
Don't Know	7	3.54
Others	8	4.04

Q. 55A Can you reduce the risk of getting STDs or HIV/AIDS by always using a condom for anal or vaginal sex (N=213)

Category	Respondents	%
Yes	72	33.80
No	113	53.05
Do not know	28	13.15

Q. 55B Can you reduce the risk of getting STDs or HIV/AIDS by only doing non-penetrative sex (N=220)

Category	Respondents	%
Yes	146	66.36
No	47	21.36
Do not know	27	12.27

Q. 55C Can you reduce the risk of getting STDs or HIV/AIDS by reducing the number of sexual partners (N=222)

Category	Respondents	%
Yes	154	69.37
No	45	20.27
Do not know	23	10.36

Q. 56 Can you reduce the risk of getting STDs or HIV/AIDS by other ways (N=23)

Category	Respondents
No	5
Use condom every time	2
We can prevent	5
Do safe sex	3
It can be treated	2
I'll try	1
I don't know	5

Q. 57A Will you tell your male sex partner, if you were experiencing symptoms of STDs / HIV / AIDS (N=230)

Category	Respondents	%
Yes	138	60.00
No	84	36.52
Do not know	8	3.48

Q. 57B Will you tell your female sex partner, if you were experiencing symptoms of STDs/HIV/AIDS? (N=177)

Category	Respondents	%
Yes	82	46.33
No	88	49.72
Do not know	7	3.95

Q. 57C Will you tell your wife, if you were experiencing symptoms of STDs/HIV/AIDS? (N=167)

Category	Respondents	%
Yes	113	67.66
No	45	26.95
Do not know	9	5.39

Q. 58A Have you ever been tested for HIV/AIDS? (N=233)

Category	Respondents	%
Yes	93	39.91
No	140	60.09

Q. 58B HIV Test Results? (N=73)

Category	Respondents	%
Negative	69	94.52
Positive	4	5.48

Q. 58C Place of HIV Test (N=89)

Category	Respondents	%
Hospital	42	47.19
Private Clinic	37	41.57
Other Places	10	11.24

Q. 59 Were you counselled before/after taking the test? (N=120)

Category	Respondents	%
Yes	74	61.67
No	46	38.33

Q. 60A In the last two years have you been counselled on STD\HIV/AIDS? (N=209)

Category	Respondents	%
Yes	141	67.46
No	68	32.54

Q. 60B Where were you counselled on STD/HIV/AIDS? (N=137)

Category	Respondents	%
Udaan	67	48.91
Humsafar Trust	13	9.49
DD store Rehka	8	5.84
Parivartan	2	1.46
Mitramandal	2	1.46
Janjagriti	1	0.73
Roshni	1	0.73
Rajnish Ashram(Osho)	1	0.73
Donbasco	1	0.73
AIDS NGOs	2	1.46
MSM centers	15	10.95
Friends	15	10.95
Doctors	12	8.76
Hospital	8	5.84
School/College	3	2.19

Q. 61A Have you ever injected drugs in the last year? (N=199)

Category	Respondents	%
Yes	2	1.01
No	197	98.99

Q. 61B Has your sex partner ever injected drugs in the last year? (N=194)

Category	Respondents	%
Yes	10	5.15
No	184	94.85

Q. 62 Where would you prefer to go to get help if you were worried about STDs or AIDS? (N=236)

Category	Respondents	%
Government hospital	73	30.93
AIDS NGO	103	43.64
Religion	35	14.83
Private doctor	96	40.68
Local MSM Projects	157	66.53
Other clinic workers	13	5.51
Peer educator	6	2.54
Do not know or other	100	42.37

COMPARATIVE REPORT BETWEEN KOTHI, PANTHI, DOUBLE – DECKER, HETEROSEXUAL, HOMOSEXUAL, GAY & OTHERS For Question No. 7, 8, 47 and 53

Q.7A Sexual activities with males in last week (N=163)

Category	Respondents	No. of sex acts	No. of sex acts with Condom
Kothi	78	375	275
Panthi	22	50	28
Double-decker	29	87	48
Heterosexual	8	17	12
Homosexual	11	26	12
Gay	12	16	13
Other	3	7	2

Q. 7B Sexual activities with males in last month (N=224)

Category	Respondents	No. of sex acts	No. of sex acts with Condom
Kothi	97	1237	914
Panthi	40	199	127
Double-decker	40	283	135
Heterosexual	13	58	25
Homosexual	17	37	30
Gay	17	49	36
Other	4	16	4

Q. 8A Anal sex acts in last week (N=149)

Category	Respondents	No. of sex acts	No. of sex acts with Condom
Kothi-Insertive	7	29	28
Kothi - Receptive	69	324	222
Panthi - Insertive	22	46	28
Panthi - Receptive	1	3	1
Double-decker- Insertive	10	22	12
Double-decker- Receptive	24	85	39
Heterosexual- Insertive	2	5	4
Heterosexual- Receptive	6	11	9
Homosexual - Insertive	5	6	5
Homosexual - Receptive	5	9	5
Gay - Insertive	4	5	5
Gay - Receptive	4	5	3
Other - Insertive	2	3	2
Other - Receptive	1	4	4

Q. 8B Anal sex acts in last Month (N=195)

Category	Respondents	No. of sex acts	No. of sex acts with Condom
Kothi-Insertive	12	51	35
Kothi - Receptive	78	1057	852
Panthi - Insertive	34	167	109
Panthi - Receptive	4	16	13
Double-decker- Insertive	13	43	26
Double-decker- Receptive	33	208	117
Heterosexual- Insertive	3	9	4
Heterosexual- Receptive	9	36	23
Homosexual - Insertive	7	11	10
Homosexual - Receptive	8	19	14
Gay - Insertive	7	15	15
Gay - Receptive	5	20	8
Other - Insertive	2	6	4
Other - Receptive	2	9	6

Q. 47 Ever heard of HIV / AIDS? (N=252)

Category	Respondents
Kothi- Yes	96
Kothi- No	10
Panthi- Yes	35
Panthi- No	6
Double-Decker - Yes	39
Double-Decker - No	5
Heterosexual - Yes	12
Heterosexual - No	2
Homosexual-Yes	20
Homosexual-No	1
Gay-Yes	22
Gay-No	0
Others-Yes	4
Others-No	0

Q. 53 Ever heard of safer sex? (N=237)

Categories	Respondents
Kothi- Yes	69
Kothi- No	28
Panthi- Yes	33
Panthi- No	5
Double-Decker - Yes	35
Double-Decker - No	8
Heterosexual - Yes	12
Heterosexual - No	2
Homosexual-Yes	18
Homosexual-No	3
Gay-Yes	20
Gay-No	1
Others-Yes	2
Others-No	1