

# **male to male sexualities and sexual behaviours in South Asia**

## **a training manual for developing sexual and reproductive health programmes**

**for policy makers, management, and programme staff  
working in the field of HIV/AIDS prevention and control**

**Naz Foundation International**

*providing technical, financial and institutional support to men who have sex with  
men sexual health interventions, groups and networks in south asia*

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Naz Foundation International  
Palingswick House, 241 King Street  
London W6 9LP, UK  
tel: +44 20 8563 0191  
fax: +44 20 8741 9841  
email: london@nfi.net  
website: www.nfi.net

Regional Liaison Office  
Naz Foundation International  
9 Gulzar Colony  
New Berry Lane  
Lucknow 226 001, India  
tel: +91 (0) 522 2205781/2205782  
fax: +91 (0) 522 2205783  
email: lucknow@nfi.net

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Naz Foundation International is an agency specialising in the sexual and reproductive health of males who have sex with males and their sexual partners in South Asia.

It conducts feasibility studies; risk and needs assessments; provides technical assistance in the development of beneficiary-led non-government agencies to provide sexual health services for males who have sex with males; advocates on their behalf; develops and conducts training programmes exploring sexualities, sexual behaviours and sexual health issues as they pertain to male to male sexual behaviours and their impact upon male and female sexual health; helps develop policy; and addresses human rights concerns.

This manual has arisen from the extensive work that Naz Foundation International has done with males who have sex with males in a range of cities in South Asia. Without the support of the hundreds of males who have participated in risk and needs assessments, sexual health projects, interviews, and meetings, this manual would not have been possible.

I would like to express my gratitude to all these hundreds of individuals, without whose patience, honesty, openness, and friendship, who patiently told me and others involved in our work, their stories in parks, tea-stalls, street corners, restaurants, rikshaws, and hotel lobbies. I would also like to thank those individuals who took up the challenge to develop appropriate service responses to the expressed needs of males who have sex with males, for whom this manual is written.

Further thanks must also go to all the participants of the Naz Foundation International/UNAIDS consultation meeting held in Almaty, Kazakstan, 24th - 26th March, 1997, for representatives from governmental organisations working on HIV/AIDS prevention issues from the Central Asia Republics. Entitled Sexualities, Sexual Behaviours and Sexual Health, the concepts and structures of this 3 day training course were first successfully tested at this meeting.

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## **SETTING THE CONTEXT**

## Introduction

In the socio-cultural frameworks of South Asia, the issue of male to male sexual behaviours and their impact upon the reproductive and sexual health for both males and females has profound implications for any effective control and management of STDs and HIV infections. But because of cultural, religious, and social reasons, these behaviours are to a great extent invisible, often difficult to access, and not framed within heterosexual and/or homosexual dichotomised constructions. Male sexual behaviours in South Asia appears to be much more polymorphous than the simplified reductionisms of heterosexual/homosexual identities would indicate, whilst anal sex between males and females, and between males and males, is much more common than has been assumed.

Anecdotal and direct research by Naz Foundation and its partner agencies in a number of South Asian countries, as well as newspaper reports, magazine articles, and surveys, as well as work done by a number of gay identified groups/organisations, indicate significant levels of males who have sex with males in South Asia, both in urban and rural areas, as well as the existence of substantial levels of male commercial sex workers in urban areas. With this are the high levels of sexual activity and multiple sexual partners by these males, significant levels of sexual access to females by many of these males, including their wives, low levels of condom use and safer sex practices, with the concomitant high risks for HIV and STD transmission from these males to their sexual partners. Further many young males (both pre-adolescent and adolescent) are also involved in these activities. These behaviours are exacerbated by multi-gender constructions and segregation, economic and age and gender power differentials, adult male ownership of social spaces, low levels of knowledge of STDs/HIV, and adult male sexual privileges, and gendering of penetrated males.

At the same time male to male transmission of STDs and HIV will be largely invisible because of the low levels of testing by males, the lack of anal and oral STD testing in many clinics, and because such behaviours are denied by the males and females themselves, as well as by the societies in which they live.

This invisibility of male to male sexual behaviours is further exacerbated by the claim that transmission of HIV in South Asia is based on “heterosexual” intercourse, i.e. vaginal sex, which allows government, non-government, international and donor agencies to ignore the possibilities of widespread anal transmission of STDs/HIV. Whilst it is recognised that substantial levels of STD/HIV infections in South Asia are caused by vaginal sex, it also needs to be clearly and openly recognised that with the public and social denial of anal sex behaviours between males and between males and females, its significant role in STI/HIV transmission is grossly underplayed, if not denied completely. Such focusing on vaginal sex as the sole (almost) route often ends up victimising females (particularly female sex workers) as the source of infection and disease, whilst it also often denies the male role in STD/HIV transmission. At the same time such a process, by invisibilising the role that anal sex plays in transmitting STDs/HIV, ensures that significant levels of sexually active males sees such sexual behaviour as a safer option. “They have never said that unprotected anal sex can be dangerous, so I have always thought of it as a safer option,” as one person reported to Naz Foundation.

All current research into constructions of male to male sexualities and sexual behaviours in South Asia indicate that they do not fit the patterns of heterosexual/homosexual behaviours so common in HIV literature. There is no such clear cut dividing line. Sexual identities of South Asian males do not fit this Western pattern, and this creates further invisibility of sexual behaviour patterns. Many males who have anal sex with other males also have vaginal and anal sex with females. Many males who have sex with males are married. Early sexual encounters by many males are often with another male. But a major consequence of a heterosexual/homosexual labelling of the AIDS epidemic has meant that if there is any discussion on sexual transmission, males who have sex with males become subsumed within a category of “gay” or homosexual”. This further marginalises and invisibilises the behaviour. Of course there are gay-identified males in South Asia. But they are overwhelmingly outnumbered by non-gay identified males who have sex with males, whether such males define themselves as khoti ( a gendered, feminised identity), panthi/giriya (a label given to “real men” by khotis), hijras (who often are defined as “ a third- gender”, a male body with a women’s soul, a hermaphrodite, a eunuch, a castrated male, a transvestite, a transsexual, or some such label- but it should be remembered that for the large part, hijras are biologically male and before they are castrated are functionally sexually males), double-deckers ( a male who penetrates and is penetrated), or just have sex with other males for maasti or discharge. It becomes an urgent necessity to discover the true patterns of male sexual behaviours, as well as to recognise that anal sexual behaviours is a very common phenomena, if any effective approaches to HIV management and control is to be conducted in South Asia. After all unprotected anal sex is the most risky form of sexual behaviour in terms of transmission of STDs and HIV!

The consequences of unrecognised epidemiological patterns of STD/HIV transmission, whether through denial or invisibility, in regard to the management and control of the AIDS epidemic should be clearly understood. The impact upon the epidemiological, social and economic frameworks need not be overstated where these have been discussed in other forums over the last 10 years. Clearly at the family level, such behaviours, should they lead to STD/HIV infections, have a devastating impact upon its economic welfare. At the social level, the economic impact upon the country is also clearly recognised.

Because of social stigmatisation, invisibility and denial, there are almost no STD/HIV services in South Asia focused on the issues of males who have sex with males and/or anal sex behaviours. Sexual health information and services are focused on so-called “heterosexual” behaviours, i.e. vaginal sex, and ignore the high levels of anal sex, irrespective of the gender of the sexual partner.

At the same time there has been almost no effective and appropriate research conducted on the sexual health issues arising from male to male sexual behaviours, nor on any risk and needs assessments amongst such males, nor any effective and appropriate education and awareness programmes, or sexual health promotion campaigns targeting male to male behaviours. The situation needs urgent clarification if South Asia is to have any realistic hope in enabling the control and prevention of STDs and HIV, and reduce the risks of increasing numbers of people living with AIDS in the region.

What does exist? Humsafer Trust in Bombay working primarily amongst gay-identified men and their partners under the sterling leadership of Ashok Row Kavi. Sahodaran in Madras. Naz Foundation (India) Trust in New Delhi which is now working amongst gay-identified men, male commercial sex workers, street males who are sexually active with other males, and other networks of males who have sex with males. Praajak in Calcutta, which is working amongst males who have sex with males, Bandhu Social Welfare Society in Dhaka working amongst civil and professional khoti, panthis and also rikshaw drivers, hotel boys and truck drivers who also have sex with other males. There is work evolving through Friends India in Lucknow and Sahodaran in Madras with increasing support from Naz Foundation, GAY in Bangalore, and other groups in a number of other cities in India. In Sri Lanka, Companions on a Journey have begun developing a sexual health and advocacy programme primarily amongst gay identified males.

These few projects in a population level of over 1.4 billion people in South Asia! And apart from the number of local gay groups trying to develop a framework of sexual health promotion amongst their constituents, Companions on a Journey, and Humsafar Trust, all the others have evolved out the work of Naz Foundation. What about Pakistan and Nepal? What about male sex workers? Street males? Male domestic servants? Hostels, male only institutions? Males who have sex with males and who are intravenous drug users? Sexual abuse of males in families and by neighbours? Male dorms? Male Gulf workers from South and West Asia? Male refugees who have sex with males? Male to male sexual behaviours arising from traditional and religious beliefs? Male gift sex amongst tea shop boys, hotel boys, rikshaw drivers, truck drivers, construction workers, businessmen who travel, business men who don't travel, male factory workers, male teachers, tutors, .....

### **Vulnerable Groups**

The majority of males who have sex with males will also have sex with females, many of them their wives. Because the level of unprotected sex in the male to male sexual networks is very high, such behaviours increase the vulnerability of females, in particular married women in terms of their reproductive and sexual health. Further, social and cultural structures such as homoaffectionalism amongst males in South Asian societies, the "apprenticeship" models in working environments, gender segregation, delayed marriages, and the high levels of poverty and unemployment, indicate the vulnerability of young males to STD and HIV transmission from sexual encounters with other males.

### **The Need**

There is a clear need to understand the dynamics of male sexual behaviour patterns both in urban and rural settings, to provide effective information towards developing appropriate strategies for reducing the levels of risky sexual practices amongst them. This not only includes sexual behaviour research amongst males who have sex with males, but also exploring methodologies for encouraging safer sex practices amongst them, as well as ensuring that appropriate sexual health services and products are easily accessible to them.

However, it is clear that because of the issues of denial, invisibility and stigmatisation, the frameworks utilised in such work would have to include the beneficiaries of such work as agents of change. This means that the development of research, the production and distribution of sexual health products and the availability of sexual health services must be peer-led.

There is an urgent need to educate people about the risks of unprotected anal sex as much as has been given to vaginal sex. There needs to be linguistically appropriate education materials about STDs and HIV where anal sex is the route of transmission. There needs to be greater accessibility to appropriate condoms suitable for anal sex and appropriately packaged sachets of water-base lubricant, readily and easily available. There needs to be education and sensitising work done amongst STD clinicians and doctors. There needs to be a greater recognition amongst government and non-government agencies working in the field of reproductive and sexual health about the levels of anal sex behaviours, and they should be encouraged and empowered to include such issues into their work and education materials.

## Sexuality and sexual health in South Asia

The debate concerning the development of effective prevention programmes in regard to STDs and HIV/AIDS in South Asia, has become an issue of deep urgency for these countries. But unless these programmes are specifically appropriate to the cultural frameworks of South Asia in which sexual behaviours occur then they will be ineffective, and may actually lead to the opposite effect.

To begin to consider developing appropriate strategies and programmes, we must explore the dynamics of gender constructions, sexuality, sexual behaviours and sexual health within these cultures. For if we do not construct the debate effectively, if we cannot clearly define the parameters of what we mean by the term “sexuality”, if we do not understand the cultural frameworks within which sexual behaviours arise and operate, then we will not be able to develop effective prevention methods.

India already has an STD, Hepatitis B and HIV/AIDS epidemic. The ability of South Asian governments to cope with the health care needs of people living with AIDS is already compromised by the strains placed upon health delivery systems that currently exist. Primary, secondary and tertiary care are stretched beyond their capacity to deliver effective sexual health promotion and care because of funding shortages, other priorities, denial, invisibility of issues, economic pressures, fear, sexism, sexophobia, homophobia, and ignorance.

It is currently estimated by the World Health Organisation and others that there are some 1.5 - 4 million people living with HIV infection in South Asia. Further, within the next decade, this figure is likely to reach up to 20 million such infections. The Harvard AIDS Institute’s estimates are even higher, some 40 million infections. South Asia has the fastest rate of increase of HIV infection in the world, and by 2020 will have more people living with HIV/AIDS than the combined numbers of the rest of the world (if not before). While currently, it is estimated that one in four reported STD infections in the world is given by an Indian.

The main route of transmission in South Asia appears to be penetrative sexual behaviour. Whilst WHO estimates are defined within heterosexual/homosexual dichotomies, stating that 70% of all transmission is through heterosexual intercourse, such use of this terminology can be challenged in the context of sexual dynamics and behaviours within South Asia.

Within the context of South Asian cultures, the terminological use of heterosexual and homosexual frameworks do not exist in the sense they are understood in the West. The diametric oppositional frameworks of this terminology creates an artificial understanding that has no specific relevance to the actuality of people’s lives. Therefore, we cannot realistically say that there is a heterosexual or homosexual transmission. All we can say is that there is sexual transmission within a specific behavioural basis, i.e. vaginal or anal intercourse. What this means is that while sexual behaviours exist across the range of human sexual behaviours, they cannot be fitted into an identity based structure which the terminology of “heterosexual” and “homosexual” implies.

The fluidity of South Asian male’s sexual experience, the framework of sexual invisibility, gender segregation, South Asian homosociability, male ownership of public space, South Asian shame cultures, sexual invisibility, community “izzat”, compulsory marriage and procreation, the current lack of personal identity-based sexual behaviours, South Asian gender constructions, male and female roles as frameworks of adulthood, and so on have a central impact on actual sexual behaviours that are not clearly defined within the terms “heterosexual” or “homosexual”. Similarly actual sexual practices and with which gender they are practised, are not clearly defined either by these terms.

### *The impact on women’s sexual and reproductive health HAS to be seen within this context.*

In other words, determining male sexual practices in the larger context as well as the personal, is an essential component of any women’s reproductive and sexual health strategy.

To develop appropriate strategies for addressing these issues, we therefore need to understand the dynamics of sexuality, the constructions of gender, the psycho-social frameworks of sexual behaviours and the contexts in which they exist. And these must be developed and understood within appropriate cultural frameworks. Unfortunately, in the development of HIV and STD prevention and outreach programmes within South Asia, sexuality, identities, and sexual behaviours have been conceptualised within Western understandings and constructions. In the context of these programmes, we can almost say that our gender constructions, sexual behaviours and identities have once again been colonised through the casual adoption of a specific understandings and conceptualisations of human behaviour that have arisen through Western cultures. Not that these Western constructions are invalid, but they are inappropriate within the South Asian cultures.

The whole discourse of sexuality and sexual behaviours, and thus prevention strategies, arises from Western constructions of individuality, personal identities and sexualities. Gender identities, sexual roles and thus personal identities, arise within the context of a psycho-social and historical dynamic. Perceptions of who we are, what we are and what we do will therefore have different meanings within different cultures.

The urgent necessities that have arisen from the rapid spread of HIV infection and the lack of any specific “cure” for AIDS, has meant that the only strategy available to governments is prevention. There are really only two specific methods of prevention:

- a. “Don’t do it!”
- b. “Do it safely!”

The first approach regarding sexual behaviours is often the one most favoured because of its tone of high morality. Both governmental and non-governmental agencies, particularly in developing countries in utilising this approach have stated recourse to a perceived historical dynamic and corrupt Western influences. In other words, risky sexual practices have arisen in our cultures because of the influence of the West. The other part of this strategy is to utilise specific religious and scriptural texts to support the “don’t do it” strategy.

Neither of these approaches will work. Firstly because there is a denial of sexual histories within our countries, and in a perverse way, this denial, and often suppression of such histories, arise within a Western context as part of their “guilt” cultural frameworks. Thus Indian officials can say that there is no homosexual behaviours, or there is no extramarital sex, or premarital sex, or if they do exist it is at very small levels. The actual evidence states dramatically otherwise. While the use of religious and scriptural texts as the mechanism of prevention denies actual human behaviour, and the histories of these religions and their social interactions in the cultures which sustain them. After all professing to be a Hindu, Muslim, Christian, Sikh, Buddhist, etc. has not stopped behaviours which have been deemed against the specific tenants of these religions. And, of course what about those who have no specific religious faith? The truth of the matter is that South Asian cultures, based on the dramatic differences between public and private spaces and framed within concepts of shame and honour, lead to risky behaviours and particularly sexual behaviours to be psycho-socially invisible. Public messages around culture, religion, anti-West, etc. will not have the desired effect because they ignore the constructions of sexual behaviours. Or why do people do what they do? How? When? Where? Whom?

Sexual behaviours do not arise into practice out of nowhere. They have a context, a history based both on time and place, they arise from frameworks of desire which also have a construction based upon cultural and social dynamics.

For example, in a culture where girls and women are “policed” in terms of their behaviour, particularly sexual, where female virginity is prized, where family and community duty and honour is centrally important, where males own the social spaces, where marriage and procreation is seen as compulsory, where adulthood is defined by these parameters, a culture which is particularly homosocial, where income levels are low, where sexual access to women is therefore marginalised, limited, and sometimes costly, where sexual behaviours are not so much constructed around personal identities but rather around penetrator and penetrated, a culture where non-penetrative sex is not seen as sex but as *maasti* - “play”, who is the most sexually available object?

The denial of histories of gender constructions, sexualities and sexual behaviours by various discourses of both Western and South Asian origin have had a central impact in understanding the conceptualisation of gender identities and sexuality in South Asia. No Indian research institution has dealt with this denial. Instead they have only perpetuated the invisibility of these histories. Further, the current construction of sexuality arising from Western discourses is often ahistoric and the only sexuality that is seen as relevant is that of penetrative heterosexuality. Perversely, any other form is categorised as *deviant and Western*.

This reduces the rich histories of sexualities to an oppositional dichotomy between concepts of heterosexuality and homosexuality which are a consequence of certain Western historical frameworks and understandings of sexuality.

Further, the construction of patriarchal social systems, the enforcement of compulsory marriage, procreative necessity of boy children, and the frameworks through which sexual behaviour and desire manifest themselves over the centuries, has created a pattern of destruction, marginalisation and denial concerning alternate sexualities and their histories. A dominant sexuality has historically emerged which has claimed precedence over all others as a system of social control which enables male power to take on a singular social role.

Alternate histories which often existed as traditions of the periphery are being lost at various levels due to the dominance of procreative ideologies at the rural level and the overwhelming construction of any tradition from solely a procreative heterosexual basis. Older alternate mythologies and histories are manipulated, deformed, and mutilated to suit rural male patriarchal ideologies which leads to women being the repository of tradition but not its interpreters. This creates rural economies where there is a gender segregation of labour, boy children as rural capital, and control of land, economic and cultural resources by men which are recreated within urban spaces. This also leads to the construction of desire and sexuality only from the standpoint of the rural patrilineal male which is then romanticised by various urban discourses as traditional authenticity. In other words denial of alternate sexualities and matrilineal traditions are perpetuated both from within and without.

Further with the impact of various forms of colonialism, dating from Vedic times, monotheism, orientalism, various forms of nationalism, fundamentalism, orthodoxy, etc., have all contributed to the destruction of much localised alternate traditions, whether of dance, theatre, literature, visual art, songs and lifestyles. This has meant an almost complete invisibility of alternate sexualities. Rather than a pluralistic vision emerging, only procreative and penetrative sexuality is seen as socially acceptable. Traditions expressive of sexual diversity are seen as *dirty, deviant and perverted, and the work of evil, over sexual, devouring women*.

This overwhelming denial and silencing of histories and cultures of sexualities means that the only framework available is that which has emerged in the Western countries. Though these can be useful as comparative tools, they cannot be the main basis of understanding the complex psychosexual social matrix of South Asia.

The world view as expressed in South Asia, has been formed by the central concepts of Vedic Brahmanism, Islam, Christianity and also of Ayurvedic and Western medicalisation of the body and sexuality. Male and female roles have been strictly defined, and any public transgressions of these roles is severely punished through stigmatisation, social exclusion, exile, physical abuse and even death.

The resultant psycho-social constructions of sexualities, the denial of different expressions of sexualities, the sociopolitical control

of sexualities, has resulted in a cultural development that demands compulsory marriage and procreation, that gives no validity and social space for autonomous women, that demeans unmarried individuals, particularly single women and that only confers adulthood and thus social status and responsibility to married people.

Sexual behaviour takes the place of sexuality. Women's sexual behaviour becomes controlled and marginalised, if not denied. Male sexual behaviour becomes self-absorbed, and is reduced to one of discharge rather than based upon a desire for the other person. Sex behaviour becomes depersonalised. Sexuality has no construction. The sex act becomes brutalised whether it is between male and female or male and male. For women who desire other women, there is no social space for such a development. Concepts of personal choice, of privacy, become lost. There can be no development of individuality.

Desires have a history, both personal and social, as well as political, in the way they are expressed and manifested. They do not cease to exist as these histories are changed and reformulated. Nor do they cease to exist if such histories are denied or made invisible. But desires are constructed to fit in with the social constructions.

As a consequence, the contemporary South Asian situation with regard to sexualities and their physical expression, indicate a brutalised sexual behaviour, shown by the significant levels of vaginal and anal tearing; of an almost indiscriminate sexual activity by men without regard to the gender of the sexual partner which is not defined by any form of identity, but rather by the concept of availability and discharge; by the levels of severe sexual repressions which leads towards moments of brutalised sexual release.

But because of this terrible silencing and denial of these histories from various ideologies, an almost total exile situation has emerged. In trying to resist this exile a closeted and schizophrenic state of being has emerged where the person tries to assimilate into society through marriage and having children, yet expressing alternate sexual desires in purdah, in darkness, shame and in silence.

Within the context of the current concerns (if not panic) about sexual health in South Asia, in particular, rape, cervical cancer, STDs, Hepatitis B and C and HIV infection, as well as the alarming increases in sexual dysfunctions amongst women and men, it becomes an urgent necessity to explore the issues outlined above, to formulate strategies that make visible these alternate histories, that deconstruct the frameworks of contemporary sexuality, and to reconstruct them in the light of the historical discoveries being made.

If we are to move towards societies that enable all people to express their best, that gives people the opportunity to develop personhood, that enables people to make choices about their sexuality and sexual/emotional desires, that empowers people to make positive decisions about their own sexual health and others, then this whole voyage of discovery becomes a social imperative. It is only through such positive choices that any effective prevention programmes can be developed, that women's sexual health be addressed appropriately.

### Summary

Within South Asian cultures, personal identities are not based upon the sense of self, but rather of an extended family. This consists of our siblings, our biological parents, uncles, aunts, brother and sister-in-laws, all their resultant children, and so on. In other words, who we are arises from where we are in the extended family network. The person has a family and a community identity in which the sense of personal identity is subsumed. The focus of the self is not upon individuality but upon kinship. Our languages clearly express this, in that we have terminologies for all these relationships.

Within our cultures there are specific understanding of malehood and femalehood. These are defined by duties and obligations to the marriage partner, family and community, The man is not a man until he is married. The woman is not a woman until she is married and with her first child (often this could mean a boy-child). To be a single person after a certain age is seen as shameful, a dishonour to the family, often an aberration or sickness. Marriage is often seen as a "cure" for loneliness.

South Asian languages do not have specific expressions for homosexuality, heterosexuality, bisexuality as nouns or as adjectives. What exist are terms that express differing forms of sexual behaviours but these terms are often abusive and male dominated and refer to specific acts of penetration. In the context of these terms, the viewpoint is very much embedded within what is malehood and femalehood. Sexual behaviours are within constructions of what is deemed appropriate behaviour for men and women. In these constructions, who does the penetrating in a sexual act becomes important for self-definition.

Sexual behaviour therefore is not an expression of a personal identity. Rather it often becomes one of opportunity, accessibility and personal desire for sexual discharge. The phrase "body tension" is an expression of this discharge.

In terms of the cultural frameworks that construct South Asian sexual behaviours, the following points need to be remembered:

1. Marriage is considered a duty and family obligation, not one based upon personal desire and choice.
2. Marriage is also seen as compulsory.
3. To be single is seen as an aberration. Cultural beliefs dictate that a person is not an adult until married.
4. The central objective of marriage is the production of children, specifically male children.
5. Sexual pleasure based upon desire, or lust, for one's wife is sometimes considered shameful. The Wife holds a special place

in this regard. She is the Mother. A place of honour, for it is she who is charged with the responsibility of upholding family tradition, and the rearing of children. Sex with one's wife is often seen as a duty.

6. This leads to a concept of sexual pleasure being permissible outside of the marriage context.
7. Since there is no identity structure around the gender choice for sexual pleasure, what matters is more to do with the sense of malehood and concepts of masculinity.
8. Thus, concepts of identity revolve around ideas of penetration. The penetrator is still "manly", the penetrated is "not a man".
9. Further what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.
10. Gender segregation, female virginity, loss of honour, and so on often make it easier to access other males for sex than females.
11. Such accessibility is also made easier because of the extended family systems, and the homosociability of South Asian cultures.
12. The sense of shame and dishonour arises from a public (community) perception about personal behaviour and the need to fulfil one's (public) duty.
13. Since the concept of sexuality and sexual behaviours is bound up within concepts of sexual discharge, this often leads to frequent sexual partners, rather than forming continuous sexual liaisons with a single person.
14. Often the gender of the sexual partner may be irrelevant.
15. This can be expressed by the statement "The person has a relationship with his wife, but has sex with others".
16. Women are much more supervised and policed by family and community, than men.
17. This makes it somewhat difficult for women to carry out socially illicit sexual encounters/relationships.
18. The penalties for women are of a much greater intensity.
19. It is easier for women to access other women than men.
20. Within these contexts, women's sexual and reproductive health is to a large extent dependent upon male sexual behaviours and the methodologies of their practice. Their constructions are framed by space, time, availability, gender roles, personal desires, opportunity and so on.

## Culture, sexualities, and identities

*males who have sex with males in India*

Prem (1) is 26, married with a young son. He works in a large family business in Calcutta, where his family are prominent members of Calcutta society. He has fond memories of his first sexual experience with another boy at the age of 13. He has continued to have sex with other men, even after his marriage, albeit less frequently because of the lack of opportunity. His sexual interactions with other men have always been fleeting, “pick-ups”. He has never wanted to form a relationship with another man because this would increase the risks of discovery for him. Such a discovery would be disastrous for him in terms of his family and his social standing. He would prefer not to be married. He doesn’t love his wife, but feels he performs his husbandly duties adequately.

Islam is an auto-rickshaw driver in Pune where he lives in one of the small shanty villages on the outskirts of the industrial area. He is married with four children. He says that sometimes he just has to go out and find a man to have sex with it, although he is happy with his wife. This usually happens about once every two months, and he feels that he can’t control his desire for this. He finds men at the many contact points around the city. He doesn’t call himself a homosexual; the word gay he doesn’t understand, not having access to English. Nor does he see anything wrong in what he does. He is just “messaging about”. The terms homosexual or bisexual cannot refer to him he believes because he is happily married with children. He remembers his first sexual experience with his uncle back in his home village. He was 12.

Arjit, 19 years old is a student in New Delhi university studying English literature, and is from a well-to-do family in the Diplomatic Service. He calls himself gay, and would like to “come out” to his family, but he is deeply concerned about their possible reaction and rejection of him. They might cut him out of the family and he would lose everything! He has always known about himself ever since he can remember, always attracted to other boys. His first experience with another boy was when he was 11. Now he visits the various “gay” haunts around New Delhi where he can find “plenty of action”.

Ranjan is a male prostitute, a young man of 16 who plies his “business” in Central Madras near the railway station. He has done this since he was 13, when he had run away from home because of the beatings of his father. He never wants to go back home. He says that he enjoys his “work” because it gives him a lot of money, even though sometimes his clients are rough. He is saving money to buy a small business. He doesn’t call himself a homosexual, even though he enjoys the sex. It is only business.

Mohammed, 42, is married with three children and works in a hotel in Pune. He visits a local female prostitute once a month after pay day. He also has sex with some of the male guests and other staff at the hotel. He says, “I am always ‘hot’. I want a girl, but they’re too expensive. So when I am hot and I don’t have enough money, then I know several men who I can have *maasti* (2) with. A lot of my friends do this.”

Arun lives with his lover Kamal near a railway station in Bombay. They have lived together as lovers for the last five years. Both work as municipal sweepers. That is how they met. Both have had sex with other men prior to their meeting. They say they want to stay together as lovers. They don’t consider themselves as different. They know many men who enjoy sex with other men. They don’t play husband and wife roles, thinking it rather silly as both are men. Neither read or speak English. They both left school at 13.

In the field of developing HIV/AIDS prevention strategies, discussions on heterosexuality, bisexuality and homosexuality, “straight” or “gay”, appear to form clear cut distinctions in terms of sexual behaviours which are often conflated with sexual identities (3). The lesbian and gay “movement” has been globalised (4) while in India several gay and lesbian groups have been established, such as Bombay Dost, Sakhi, G.A.Y, Counsel Club, Friends India (5). Many cities have well established social/sexual networks of lesbians and/or gay men. Whilst for men as “owners” of public spaces, almost all major urban areas will have well defined “cruising areas”, where casual sexual partners can easily be obtained.

Within these groups, formed more often than not by those from the English speaking middle classes, Western terms are used almost exclusively, and the context of discussions relate to Western understandings of gay identities, gay rights, gay lifestyles. You may hear a term such as *hamjinsi* or *samlaingik* (6) but these are contemporary transliterations of the word homosexual. You may also hear the phrase “he is a gay” or “he has gay sex” or “he likes “homosex”, but these refer to sexual acts more than a sense of personal identity.

Who is gay in an Indian context? What is a gay? Who is a homosexual? In a recent survey amongst truck drivers in North Pakistan, some 72% admitted they had sex with other males, whilst 76% stated they had sex with female sex workers (7). Are these 72% gay? Homosexual? There is sufficient anecdotal evidence to indicate that in the other countries of the subcontinent similar levels of male to male sexual behaviours exist as a part of a broader sexual repertoire. Are these males bisexuals? Do the use of these terms carry the same meaning and significance as they do say in New York, London, Sydney?

In the context of developing and delivering sexual health services for males who have sex with other males, the questions become extremely relevant, for any answers given will determine the shape and content of the delivery of such services.

In working with sexual health issues in India and listening to the polemics of UNAIDS representatives, international donor agencies, the Indian medical profession, and many Western and Indian gay men, the often unthought through assumption is that same-gender sexual behaviours must mean the person is a homosexual, or gay, while male to female sexual behaviour must mean that the person is a heterosexual. In this construct, procreative “heterosexuality” is seen as normative and “normal”, the rest is perverse and foreign.

However these constructs seem to have very little contemporary or historical validity in India (and even to some extent in the West). This reductionist ideology is a recent invention from the 19th century which has consequently acted to reduce the rich diversity of alternate sexualities (8). Closer analysis of these debates seems to me to indicate a confusion between sexual behaviours, genders, self-identity formation, and cross-cultural validity, and within such confusion there may well be elements of neo-colonialism, racism and Western imperialism (9).

I am not arguing that there are no women or men with lesbian or gay identities in India. This is patently untrue. However, what I am putting forward is that too often language and terminology are used inadequately outside their cultural context in which that language is used. In India, over 80% of the population have no access to English! So transcribing Western terms easily become host to misunderstandings, inappropriate terminology, and in consequence, (particularly with reference to HIV/AIDS work), Indians can often state that there is no indigenous homosexuality (10). This easily leads to the proposition that there is no, or very little, “homosexual” behaviour, which therefore means there is no need to invest in HIV prevention programmes for males who have sex with males (11). It is clear then that we need to explore what is “homosexuality” and what is “homosexual behaviour” as distinct territories.

This exploration is particularly urgent in India, with its increasing rate of HIV infection, towards ensuring appropriate and adequate access to sexual health services, and addressing human rights violations. While we need to recognise that behaviours and identities in India are constructed within differing cultural frameworks, but also acknowledge that contemporary Western understandings of lesbian and gay identities are beginning to be imagined, emerge and develop amongst some men and women. But in what form? For whom? In what context? And in what language?

These debates have involved a growing number of Indians (and other South Asians) who, in living in Western countries, have “come out” as self-identified lesbians, gay men and bisexuals and have formed specific self-help and support organisations, such as Trikone in the States, Khush in Canada and Shakti in the UK (12). The question can then be posed as to whether these Diasporic lesbian and gay organisations act (or acted) as instigators of a development of a “queer” India.

Trikone, a lesbian and gay magazine for South Asians, was first published in the United States in 1986 and Shakti Khabar in the UK in 1989. Bombay Dost began publishing in India in 1990. Members of lesbian and gay Diasporic groups with their frequent journeys “back home”, carry with them their newly wrought identities and a passionate discourse on lesbian and gay rights, lifestyles and identities to their fellow Indians still having to live under the hegemony of Indian traditions and cultural values. These discourses are of course most often conducted in English, and those Indians privileged enough to access these discourses may then try to attempt to fit them into their lives, amidst the arranged marriages, children, and joint and extended family systems (13).

This of course is a generalisation. There are major exceptions, and two courageous people spring to mind, two who have fought against these traditions and cultural values. I am of course speaking of Ashok Row Kavi and Giti Thadani, who have spoken in public many times about lesbian and gay issues, who have worked tirelessly to address the concerns of emerging identities and helped establish a public arena where lesbians and gay men in India can articulate issues of identities. They are now being joined by a growing band of women and men who are willing to challenge “the system”. However it still needs to be recognised that the very often these groups, networks, organisations and individuals are privileged to be a part of an English speaking, urban elite, who have more options and choices than for the vast majority of those whose same sex desires and acts have to be bounded within tradition, custom and culture and who will often not have the language to articulate their sense of desire and difference (14).

It was very interesting to hear a good friend of mine, Dede Oetomo, a gay activist in Indonesia, speaking at the Vancouver International AIDS Conference in July 1996 and commenting at one of the sessions that perhaps “importing” Western constructions of gay identities into Indonesia was creating a social tension and a public sense of homophobia, whereby local homoaffectionalist (15) and homosocial (16) structures were being destroyed for the fear of being labelled “gay”.

The debate on sexualities and identities may even at times be perceived as a form of sexual neo-colonialism whereby Indian discourses on sexuality and identity by professionals, laypersons, “straights” or “gays”, have been “invaded” by Western sexual ideologies, and where indigenous histories and cultures are further invisibilised. And what we as Diasporic Indian “lesbians” and “gay men” often do is to try to fit Indian sexual and cultural histories as well as contemporary behaviours and identities into a Western sexuality discourse. Thus we have the discourses on Indian “queer” histories (17). This often means that we urgently seek “evidence” for a lesbian and gay history within India itself to validate ourselves as lesbians and gay men of Indian origin living outside of India. The politics of ethnicity and racism in the West often forces those of us in the Diaspora to seek self-justification not only amongst the larger numbers of white lesbians and gay men, but also within our own communities. This may often be the rationale for the formation of groups such as Trikone, Khush and Shakti. Labelled the Other in our countries of residence by our colour, culture and country of origin, whether by “straight” or “gay” society, we seek admittance into a self-affirming social club, to be with Others who are like us both in terms of colour and identity (18).

Indian histories are replete with such “evidence”. Mughal (15th century onwards) paintings and poetry are often explicitly homoerotic, men with men, women with women. There is an abundance of Hindu temple carvings and iconography that show same-sex sexual behaviours (19). Konark, Khajuraho and other sites can become places of pilgrimage for the Diasporic Indian lesbian or gay man. The finger points. Here is the evidence. Yes there were lesbians and gay men in our past. But how much of this is valid? As contemporary self-identified Indian lesbians or gay men (whatever those terms mean to us personally), we shouldn’t need self validation based on a presumptive past. Our existence is our own validation, however we may label ourselves.

It seems to me that the basis of this lies in the conflation of sexual behaviour with a sexual identity. A conflation between a sense of

self and how the self acts in the world. Western discourses on sexuality appear to have placed sexual desire and a sexual sense of self as the centre of a personal self. This perhaps arises from the historical development of the concepts of individuality, the rights of the individual, the individual as a distinct entity separate and separated from his/her family, kinship group and social milieu and the medicalisation of sexual behaviours.

For the majority of males who have sex with males in India these notions of sexuality are considerably less significant than the often clear distinctions between concepts of “active” and “passive”, of concepts of “discharge” (20) or “pleasure and desire”, of even “real sex” (in marriage between husband and wife, where sex is defined by procreation and duty) and *maasti*. It is very common for both “active” and “passive” male partners to engage in sexual relations with women, to be married with children as well as having sex with other men. This does not mean that all same-sex relationships fall into this characteristic of “active” and “passive” role/stereotype activity. Much same-sex sexual activity is around non-penetrative varieties, mutually indulged in frameworks of friendship and sexual play, whilst in other situations urgent sexual discharge and sexual “need” (21) is the significant factor. Indeed same-sex sexual behaviour may play a relatively insignificant role in the construction of an identity. Being a husband, a father, a wife, or mother, often carries greater weight.

None of these frameworks are fully synonymous with the Western lesbian or gay constructions. Whilst most “active” partners in male same-sex interactions do not consider themselves either as homosexuals, gays, or even bisexuals, male “passive” partners in sexual contexts with other males most often see themselves as “feminised” men, as “not-men”, but only in this context. What they do does not have a central significance as to who they perceive themselves to be which tends to be around family and marriage.

In a range of discussions with males who visit “cruising” sites for sex in a number of Indian cities, a constant refrain was the sense that their sense of self in the “cruising” site was differently constructed than that outside the site. As one English speaking person in Calcutta told me “Look, inside the park I am a gay. Once I leave the park and go onto the streets that changes. Outside the park, I am a good Hindu, a married man with a good family.” Identities here shift, change and shape themselves according to context, place, social situation, need and desire. There was no sense of continuity, but one of fluidity (22).

Here the act of sexual penetration (or of being penetrated) is not so much a definer of identity, but one of phallic power. The “penetrator” maintains a sense of “manliness”, while the “penetrated” will be seen as a “not-man”. In the contemporary debates in India, to a large extent homosexuality is defined as “not man”, as being sexually penetrated. There is an assumption that exclusive anal intercourse is the behavioural definition of homosexuality and that the exclusive vaginal intercourse is the definer of heterosexuality. Of course what is forgotten that non-penetrative sex plays a substantial role in same-sex sexual behaviours and that many women are also anally penetrated by men.

In India (and in other countries of the subcontinent) a specific social, religious and culturally based group the *hijras* (23), have often been defined as eunuchs, transsexuals, transvestites, and even as “passive” homosexuals. Of course none of these identity descriptions are particularly valid. *Hijras* have strong religious, social and cultural roles in Indian societies where such roles are defined as “not man” and “not woman”, but a “third gender”. While sexual desire, poverty, pre-adolescent sexual penetration by older men and so on all play roles in a developing a *hijra* identity, the framework is too complex to be reduced to the terms transvestite, transsexual or homosexual.

Similarly, the whole region of Asia has had a history of the sexual/gender construction of post-pubertal boys. Young boys, who are not “men”, nor are they women who often are not sexually available in gender segregated societies, have been historically defined as sexual objects to be desired and penetrated by men. The “beardless youths” of much Arab and Mughal literature reflects such a construction and practice, a practice that still continues to this day to some extent (24).

In India a person’s position in the joint and extended family, marriage and children, are central to social definition and personal identity. Such a family network consists of siblings, biological parents, uncles, aunts, brother and sister-in-laws, all their resultant children, and so on. In other words, who we are arises from where we are in the extended family network and what family obligations and duties that creates. The person has a family and a community identity in which personal identity is subsumed. The focus of the self is not upon individuality but upon kinship. Concepts of individuality, of a personal self separated from others, are weak. And in the context of identities and behaviours they all have a central impact on the social constructions of actual sexual behaviours.

Family, social and cultural pressures for marriage and children are intense and unavoidable. In that sense “a procreative sexuality” can be seen as a social compulsion, as a familial and community duty. Where there may be men who would prefer to form sexual relationships and partnerships with other men they would still feel obliged to marry and produce children to honour family and community obligations (25). Such men will look outside the marriage for sexual and emotional fulfilment (26). Similarly in other contexts, with marital sex seen as duty, sex outside marriage (for men!) becomes a source of pleasure and discharge (27). The fluidity of many South Asian male’s sexual experience and behaviour reflect the socio-cultural frameworks in which they live.

Sexual invisibility, gender segregation, joint and extended families, homosocial and homoaffectionalist culture, male ownership of public space, shame cultures, community “izzat” or honour, compulsory marriage and procreation, gender constructions where male and female roles are based upon duty and obligations as much as upon biology, where adulthood is as much defined by duty as well as age, and so on, frame Indian cultures and therefore identities.

Further, there are also specific understandings of malehood and femalehood. These are to some extent defined by sociocultural duties and obligations to the marriage partner, family and community, A man is not an adult man until he is married, a woman not until she is married and with her first child (often this could mean a boy-child). To be a single person after a certain age is seen as

shameful, bringing dishonour to the family, and is often seen as an aberration or sickness. Marriage is the “cure” for aloneness (28).

Indian languages do not have specific expressions for homosexuality, heterosexuality, bisexuality, either as nouns or as adjectives in the contexts that they are understood in the West. What exists are terms that express differing forms of sexual behaviours that are gendered, or those that speak of specific sexual behaviours (29), but these terms are often abusive and male dominated, referring to specific acts of penetration. Sexual behaviours are within constructions of what is deemed appropriate penetrative or penetrated behaviour for men and women. In these constructions, who does the penetrating in a sexual act becomes important for male self-definition.

Sexual behaviour therefore is not necessarily an expression of a personal identity. Rather, for many men, it often becomes one of duty, opportunity, accessibility, cost, and a self-absorbed need for sexual discharge. The phrases “body tension” or “body heat” is an expression of this discharge (30).

Such contemporary frameworks do not preclude differing frameworks of sexual ideologies in the histories of Indian cultures. The subcontinent has experienced many differing invasions from pre-Vedic times through the Muslim invasions to the British Raj, bringing with them their own constructions and frameworks of identities. All of these have had a major impact upon constructions of ideologies of gender, sexualities and sexual behaviours in India. The denial of differing histories by various discourses of both Western and Indian origin have given rise to a contemporary construction of sexuality which is ahistoric and where a “procreative and penetrative” sexual ideology is the only “sexuality” that is seen as relevant. Perversely, any other form is categorised as deviant and Western. *This dominant sexual* ideology has claimed precedence over all others as a system of social control which enables male power to take on a singular and patronising social role.

At the same time the construction of patriarchal social systems, the enforcement of compulsory marriage and the procreative necessity of boy children has created a pattern of destruction, marginalisation and denial concerning alternate frameworks of sexualities and their histories in India.

Alternate histories existing as traditions of the periphery are being lost at various levels due to the dominance of procreative ideologies at the rural level and the overwhelming construction of any tradition from solely a procreative and marital basis. Older alternate mythologies and histories are manipulated, deformed, and mutilated to suit rural male patriarchal ideologies which leads to women being the repository of tradition but not its interpreters. This creates rural economies where there is gender segregation of labour, boy children as rural capital, and control of land, economic and cultural resources by men which are recreated within urban spaces. This leads to the construction of discharge, desire and a “sexual ideology” only from the standpoint of the rural patrilineal male which is then romanticised by various urban discourses as traditional authenticity. In other words denial of alternate sexualities and matrilineal traditions are perpetuated both from within and without. Sex is then either defined as penetrative and gendered or outside of this, and to maintain fictions of male power, sex becomes deconstructed into play or discharge in times of “body tension” and sexual urgency, when sexual arousal occurs during play or body contact, or when opportunities are created for sexual contact in the dark, under the blanket, in shared beds. Such opportunities are very frequent, where shared households have shared beds due to lack of space and privacy. In such an environment there is an acceptance of males sharing beds, of male to male affectionalism, both public and private. This means that significant levels of male to male sexual behaviour occurs within family environments and networks, between male relatives and friends. But this is not real sex! This is *maasti*, easily invisibilised and denied. In this context, the focus of future obligations means that the object of desire is still a woman, but because she is unobtainable, another male will do.

This is not to deny expressions of romantic and passionate love amongst males. Intense friendships between males in a homosocial and homoaffectionalist culture create boundaries that are easily crossed in sexual play. But the goal will still remain. Marriage and children.

Sexual behaviour then takes the place of sexuality. Male sexual behaviour becomes self-absorbed, and is reduced to one of discharge, to the act itself, rather than based upon a desire for the other person. Sexual behaviour becomes depersonalised. In this the sex act becomes brutalised whether it is between male and female or male and male. (31). Sexual behaviour becomes indiscriminate, where high levels of severe sexual repression lead to sessions of brutalised and urgent sexual release (32). Concepts of personal choice, of privacy, become lost. There can be no development of individuality (33).

For men who have sex with men whose sense of desire and self articulates a yearning for a “lifestyle” or some sort of safe “identity” that expresses “gayness” (34) but where there is no social, psychological or cultural space to resist a closeted and schizophrenic state of being, has emerged where the person tries to assimilate into society through marriage and having children, yet expressing alternate sexual desires in darkness, shame and in silence.

Amongst the educated middle classes there is a small, but growing movement whose sense of a personal identity separate from family, kin group and community are sufficiently emergent to begin to create new forms of identities that enable them to express a sexual identity. Many of these may well call themselves lesbians, gay men, homosexuals, bisexuals and even heterosexuals.

In the main, these evolving, or emerging, identities are arising with the growth of urban, industrialised and commercial cultures, with the rising sense of individuality, privacy and private space, with the development of nuclear family lifestyles, the expansion of education, and the power of the English-speaking middle-classes with access to Western literature and therefore of other choices. Individuals and groups meet, socialise, discuss and debate (usually in English) the issues of sexual identities and “coming out”. Gay activism in India is growing, challenging national constitutions and legal frameworks to decriminalise homosexuality which were left over from the British Raj. But the real question will be whether these emerging identities will reflect (or perhaps imitate)

Western constructions and attempt to live these out within Indian cultures (35), or whether differing identities will be constructed. We await a paper from the future.

### Notes

1. The stories related at the beginning of the essay have come from an ongoing collection of personal stories related to the author over the last four years during training workshops, research and casual meetings. Names have been changed.
2. *maasti* a Hindi term which means mischief and often has sexual overtones when it used between young men.
3. Sexual identity - the belief that one's sexuality and sexual preference creates a sexual identity, that is you are lesbian or gay because you sexually desire those of the same gender. You identify with your sexual desire as the core of your sense of self.
4. See any International Lesbian and Gay Association (ILGA) report!
5. Groups in India include, Bombay Dost, Friends India, Counsel Club, Sakhi, Humrahi, Praajak.
6. *Hamjinci* is an urdu word whilst *samlaingik* is a Hindi term. Both terms approximately mean a man who desires other men.
7. See *AIDS Analysis -Asia*, Vol. 2 No. 4, July 1996, page 6
8. See *Foucault's History of Sexuality Volume 1*, English version, Allen Lane, 1978, Weeks' *Sexuality*, Routledge 1986, Katz's *The Invention of Heterosexuality*, Dutton, 1995, Herdt's Introduction to *Third Sex Third Gender*, Zone Books, 1994.
9. See Khan, *Making Visible The Invisible*, Naz Foundation report, 1996 and Hyam's *Empire and Sexuality - the British experience*, Manchester University Press, 1990.
10. At a number of HIV/AIDS meetings in India and internationally, a range of professionals have stated that "there are no homosexuals in India", that "the level of homosexual behaviour is very small" that "homosexuality is a Western import brought in by the British Raj", and so on. At a meeting in December 1995 in Colombo, Sri Lanka, a consultant for UNDP who had visited Madras and Bombay as part of report comparing HIV/AIDS non-governmental agencies, publicly stated that there were only 3000 homosexuals/gay men in Bombay (population approximately 13 million) and some 1500 homosexuals in Madras (population some 3-5 million)!
11. See *AIDS Analysis Asia*, Vol. 2 No. 4, July 1996, page 15
12. See below
13. See *Lotus of Another Colour* edited by Rakesh Ratti, Alyson Publications, 1993
14. George Orwell "The human mind cannot think a thought unless the words to express the thought exists" 1984. See also Spencer's *Man Made Language*, Routledge, 1980  
*Contexts - race, culture and sexuality* - A Naz Report, 1994
15. homoaffectionalism - in the sense that I use the word here means social acceptance to the public display of male to male, or female to female physical affection. See Hardman's *Homoaffectionalism -from Gilgamesh to the present*, GLB Publishers, 1993
16. homosocial - similarly I use the term homosocial to mean a social framework of strong male bonding or female bonding, and gender segregation of social spaces.  
  
For example in India, it is very common to see two women or two males holding hands, or putting arms around each other, of sharing beds, sleeping together, and so on. At the same time, the public space is socially owned by males. Sufficient anecdotal evidence exists in the work that I have done to indicate the boundary line between homoaffectionalism and homosexual behaviours, particularly "under the blanket" in the shared spaces. See Khan's chapter *Under The Blanket* in *Bisexualities and AIDS*, edited by Peter Aggleton, Taylor and Francis, 1996.
17. An attempt to organise a "Queer Trip of India" in 1994 was made by a diasporic group of South Asians living in San Francisco. A t-shirt with the slogan "India - The Queer View" was produced as a part of the gay and lesbian film festival tour of India. Visits would be made to a number of cities meeting up with local lesbian/gay groups and there would be the usual tourist visits to temple sites where there were known to be iconography and statutes of same-gender couplings. Apart from the choice of the word queer", was interestingly enough the choice of colour of the t-shirt -saffron - which carries religious connotations relating to Hinduism. Whilst this may not seem to be significant, in the light of the current political and religious debates in India at that time (and still going on to some extent) there had been riots in a number of India cities between Hindus and Muslims. For many Muslims in India, saffron carries with it political overtones of the BJP (a nationalist party based on recovering so-called Hindu values) and prejudice against minorities.
18. See Khan's *Contexts - race, culture and sexuality* , a Naz Report, 1994.

19. See Thadani's *Sakhiyani*, Casell, 1996
20. The language of sexuality while apparently simple is in reality complex. Words such as sexuality, sex, sexual orientation, and so on, are often used indiscriminately and synonymously. There are a multitude of definition, so in order to appreciate the context in which I use these words, here the meanings I have given to these words.

### Sexuality

who you are and how you perceive yourself in the context of sexual desire, gender identity and sense of self with specific cultural contexts,

### Sexual Behaviour

what you do sexually with yourself or with another person, for example in many interviews with men who have sex with men in India, a common factor was that a significant number of these men sexually desire women, but have sex with a male. Whilst similar numbers of males have related that what they sexually desire is the sexual act itself, not the person to whom they are performing the sexual act with. This I have labelled "discharge sex". What they feel is a sexual urgency that needs immediate release. Factors other than sexual desire play a role in the sexual partner choice.

21. I have argued consistently, based on my experiences working with Naz Foundation, that one of the factors shaping gay-identified South Asian lives in the UK was the social and cultural shaping of self-identities. As people of colour, as Indians, Pakistanis, or Bangladeshis, there was a multiple framework of identities which shifted and changed according to context and space. As I stated in one lecture I was presenting in the UK, "I am firstly an Indian male amongst Indians, a South Asian amongst South Asians, a gay man amongst gay men, a black person within the general society. Who I present to myself and to the outside world will depend who I am with. None of these identities are central to my sense of self. Each reflects a different need and context". From personal notes.
22. Many truck auto-rickshaw and taxi drivers have stated that their bodies get "hot" from the engines and this produces a need for sexual release to cool their bodies down. They state that they get "body tension" which produces mental tension.
23. Males with a social, religious and cultural identity within which, these males dress up as women, are often religiously castrated as a sacrifice of malehood to the goddess Renuka Devi and/or Yellama. There are also Mulsim hijras, which may have their own rituals. They are often seen on the streets in Mumbai, Varansi, New Delhi and others aggressively begging. Some will also act as sex workers. They will often be called to the birth of male son or to a wedding where the belief is that their blessings will bring prosperity and good luck. See Nanda, *Neither man nor woman - Hijras of India*, Wadsworth, 1990. There has also been recent developments with some hijras where there is less emphasis on religious and ceremonial castration. The hijra phenomena, whilst originating in a feudal, landed and rural class, has become more of an urban phenomenon. where less are castrated, many work as sex workers, and where uncastrated hijras have sometimes been asked to penetrate their male clients! These hijras will still associate themselves with religious and social hijra festivals.
24. See *Boy love in the Urdu Ghazal*, Tariq Rahman, Paedika, Summer 1989, Vol 2, No.1  
*The irresistible beauty of boys - Middle-Eastern attitudes about boy-love*, Maarten Schild, Paedika, Winter 1988, No 3  
*Bacabozlik - Boylove, folksong and literature in Central Asia*. Ingeborg Baldauf, Paedika, Autumn 1990, Vol 2, No.2.
25. "In the end I got married. It was the only way to get back to my family. My parents continuously harassed me for three years, as did my uncles and aunts. Marriage is everything. And if I didn't obey my parents and accepted their choice, where would I be?" Statement made to the author by a self-identified gay man in Bombay.
26. In talking with an unmarried workshop participant in Orissa, he stated that when he fucks a male he thinks of it as "practice" for when he eventually gets married. His body is "hot" and he believes it is much better to "fuck" than to masturbate. Indian beliefs on masturbation state that each drop of semen is equivalent to 40 drops of blood. To masturbate is to weaken the body. How this configures with penetrative sex is not clear. See Khan, *KHUSH report*, Naz Foundation, 1990
27. "I can't tell my wife about myself. It would destroy my family and her. I can't have a divorce because of the shame it would bring to our families. I go out maybe several times a month, pick up some guy for quick sex in the park or toilet". See Khan, *KHUSH report*, Naz Foundation, 1990.
28. The parental line "but who will look after you when you are old?" is a common statement told by many married men who have sex with men.
29. Such words as *khusra* or *gandu*, both terms meaning a "not man" who is penetrated by a man. The term for Hindi for anal sex is *gand marna* which approximately means to beat the arse.
30. See Note 22.
31. In a survey amongst a group of 35 males who have sex with males in Calcutta, the average time for a penetrative act from insertion to discharge was between 3-5 minutes. The comment was made by one such participant that "there is no time for foreplay. They just shove it and pull out." Khan, personal notes.

32. At a particular truck stop in Bombay, several young men have reported that on average they experience more than five acts of penetration by truck drivers in any given night. Khan, personal notes.  
  
Several truck drivers have also reported that when they are on the road they “need” at least four to five sexual encounters per night to release their tension. Khan personal notes
33. “Privacy, what privacy? I share a room with my three older brothers, and I have had sex with all of them. The other room is where my parents and grand parents sleep. There is no lock on the door. In the hallway, my uncle and aunt sleep. Its like this everywhere in India”. A personal comment to the author in New Delhi.
34. “ I was married at 11 and I finally had sex with my wife when I was 16 years old. I had no choice, my family arranged everything. I first had sex with my school teacher when I was 12 and this continued until I was 16 when I left . I have always longed for a man to be with, you know, who will care for me. But how can I find such a man? How can I leave my wife and children. What am I? I don’t know. I just know what I feel sometimes when I see a handsome man (translated from Hindi). Khan, personal notes.
35. To develop concepts of individuality and individual choice as is understood in the West means to deconstruct India concepts of joint and extended families, arranged marriages and compulsory reproduction, of significant changes in Hindu belief systems, and so on. All this would lead to significant cultural shifts.

# Males who have sex with males in South Asia

## Introduction

It is often asked “how many MSM are there in India, in Bangladesh, in Pakistan?”, usually by Western donors, consultants, and representatives of many AIDS NGOs.

The question appears to be reasonable on the surface, but it actually represents a misconception in terms of the social construction of MSM behaviours and identities.

The way the question is phrased generates a conception of MSM as an exclusive group, an identity rather than a behaviour. But, even more contentiously, the question itself cannot be properly answered with any adequate response or accuracy. In this context we should really be talking about male to male sexual behaviours rather than specifically men who have sex with men.

The issue of MSM is much more complex, diverse and often counter-intuitive.

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

- \* For many males involved in male to male sex, MSM is not about a sexual identity but most often a behaviour arising from a feminine gender identification, or a perceived “manly” discharge need. Such behaviours are not contextualised within a heterosexual - homosexual oppositional paradigm
- \* It appears to be that a significant level of MSM behaviours in South Asia is contextualised within a gendered framework - where a feminised gender performance frames the kothi.
- \* 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 gender roles in South Asia, i.e. the “penetrated” partner. Kothis construct their social roles, mannerisms and behaviours in ways which attract what they call panthis - “real men”, identifying as feminised males. In this context these kothis are usually the visible MSM in a range of public environments and neighbourhoods, but panthis are not, for they could potentially be any “manly” male
- \* These “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.
- \* Kothis see any male that is sexually penetrated as another kothi, whether they identify as gay, bisexual, or whatever. To kothi-identified males such identities represent a form of “closetness”.
- \* In other words there is 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 physically 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 in arenas other than the public spaces of parks, railway stations, and so on.
- \* 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, 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 South Asia is a core identity in terms of gender role, marital status and class.
- \* Gay relationships are 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
- \* Kothi relationships, however, 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.
- \* This does not mean that kothis do not penetrate or that panthis are not penetrated. They do, but these behaviours are seen as crossing the gender barrier and are considered even more shameful. They are kept even more secret. And while kothis have a term for such behaviours - do-parathas, double-deckers, dubli, and so on, generally such individuals are looked upon with scorn. A panthi who is penetrated is called a gupti kothi, while a kothi who is known to penetrate another male is seen as not a real kothi.

\* male sexual desire for another male should therefore be contextualised differently from male to male sexual behaviour.

### The MSM Context in South Asia

Men who have sex with men (MSM) should not 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 South Asia by donor agencies, NGOs and National AIDS Programmes. In South Asia, MSM can exist in a broad (often bewildering) variety of identities, behaviours, and practices. What seems to exist are a range of masculinities with differing contextualisation of a range of sexual behaviours, partner choices and desires.

Contemporary research on sexuality and gender have clearly shown that bipolar categories, such as man or woman as gender categories, and heterosexual or homosexual as sexual categories, are “not useful to describe the range of identities, desires and practices” (personal discussion with Dr. Carol Jenkins, Care Bangladesh, 1999) existing in South Asia. The terms “gay” or “homosexual” are also too constricted 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. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the South Asian content.

Beyond all this are the gender categories of man or woman. Self-identities amongst MSM in South Asia vary across the spectrum of divergent categories, where those most public in the expression of same-sex desire, usually identify themselves as a different gender category which is feminised, expressing themselves in feminine language, sometimes through dress, make-up and mannerisms, and who also have access to their own specific “secret” language (ulti - a derivative of the hijra language) which is unavailable to the majority population. These individuals call themselves kothi, but this is a socialising and socialised role, where a “new” kothi with emergent sexual desires for other males (and often not so emergent, but in full force) will make friends with “older” kothis and learn the characteristics, roles, behaviours (including sexual), mannerisms and language. And it is this kothi framework which appears to dominate the MSM contexts in South Asia, in terms of the poor and low and middle income sectors which represent over 70% of the population.

Kothis see themselves as the feminine in a masculine/feminine sexual partnership, and play out the perceived gender role in the culture. Most kothis feel relatively comfortable with their choice, although expressing a varying degree of shame in terms of the shame-based culture of India. Those men who access these kothis for sex, and sometimes for sexual relationships and partnerships, are seen as “real men” by the kothis, men who play the “dominant”, “active” and “penetrating” role. Such men do not see themselves as “homosexuals”, since the people they have sex with are not “men”, but feminised males, kothis. They do not have a sexual identity term for themselves, but practice a sexual behaviour, very often based on “discharge” and “body heat”. They see themselves as manly men. The label panthi is used by kothis to describe them, meaning a “real man”, a man who will penetrate them, and who most likely will also have sex with women. Many kothis speak of all men as potential panthis, accessible to them as sexual partners, accessible, not based on male to male desire, but because of what was perceived as an urgent need for sexual discharge.

As part of their public gender performance, many low income group kothis take oral contraceptives (many can’t afford, or can’t access, hormone injections) as a means of developing breasts, stating that panthis 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 as a means to become more like women, but as a tool to attract panthis as sexual partners.

Sociocultural, religious and family pressure ensure that the majority of kothis 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, a depression and fear of non-performance with their wives, to a constant search for a “real man” who will “marry” them and look after them. In the discussions several kothis stated that they will even sometimes use female sex workers “for practice”.

Some of the kothis from low income groups become sex workers as a source of generating income. Usually this income was to support their family. But it should be noted that not all male sex workers are kothis, and not all kothis are sex workers.

Panthis are less clearly defined, being men of all ages and types, married and unmarried, across the spectrum of income and employment, who, at least at times, enjoy sex with other men or stated 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 kothis.

And of course all panthis will either be married or will get married eventually, fulfilling the social, religious and family expectations for all men in South Asian cultures.

But beyond this “public” framework of identities, desires, and behaviours is a context even more invisibilised, an issue also relevant to HIV prevention. An unknown proportion of males 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 are outside the “public environments” taking place in neighbourhoods, private homes, hostels, guest houses, hotels, and a range of vendors shops and other private places. Here the contexts may well play out a kothi/panthi framework, but often it is where access, immediacy and opportunity play a significant role in 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”.

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

Kothis by their very number, “nature” and practices have access to a broad range of other males whom they access for sex, and can be seen as an entry point to the dominant framework of men who have sex with males in Bangladesh and India.

Perhaps where the term “behaviourally homosexual has been used by UNAIDS and others, we should use the term “behavioural heterosexual” as well to get even a glimpse of the range of masculinities, male sexual behaviours, genders, identities, and the multiplicity of male to male sexual frameworks.

### *Situational identities*

Such beliefs and practices lead many kothis to act out what could be called situational identities. That is, within the family home and neighbourhood they will perform as young (or not so young) men, while in specific environments, they will perform as kothis with other kothis, or to draw the attention of potential “manly” male sexual partners. This behaviour often involves an exaggerated sway of the hips, loose wrist actions, eye movements, touching the mouth with a finger, use of *ulti* and so on. These gestures demonstrate sexual availability to the panthis.

Situational identities act as a device to invisibilise identity choices, desire and behaviours, maintain social and family stability, and reduce levels of tension, potential harassment, and violence. This also means that the kothi identity has a significant level of performance as part of it. This has been clearly borne out in a range of the discussions where several kothi-identified males stated that they performed as a kothi with other kothis to be able to be a part of a social network that accepted them, rather than because of their sexual behaviour and identity choice, i.e. they saw themselves as men with both “active” and “passive” sexual encounters.

### *Support and friendship systems*

For kothis their key support and friendship systems are provided by other kothis and their own families. This also expresses the gendered framework with which the majority of kothis identify with, as well as the living out situational identities.

In South Asian 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 is seen as rare for a kothi to develop a non-sexual friendship with a “man”. Kothis expressed the desire to “find a husband”, but even in this context kothis recognised that this “husband” will get married and live with his wife.

In a situational context kothis will perform as men 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 sometimes speak 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 kothi 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.

Kothis who have strong bonded relationships, will often call each other in feminine relationship terms, such as sister, aunty, mother, and so on.

Here there are several lateral and vertical relationships based on female family structures, which requires acknowledgement, but sometimes it also generates “sibling” rivalry and discord over access to apparel, make-up, appearances, and potential sex partners. Kothis will always turn to other kothis for moral, emotional and financial support where the family could not, or would not provide this.

### *Family*

Joint and extended familial links are strongly held together by custom, tradition, belief, practice and economic need. Their value lie 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.

### *Marriage*

In South Asia, 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 marriage is 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. To have no children can be seen as a curse.

But such marriages are not usually based on mutual friendship, desire and love. Extremely few of married MSM have informed their wives about their extra-marital behaviour with other males, or for that fact, other woman. They believe that all they need to do is to function adequately as husbands in terms of economic support for their wives and engage in sexual intercourse in order to have children. Marriage is considered a duty and sex with one’s wife 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”.

### ***Psychosexual issues***

Sex education is largely absent. Knowledge of the male and female bodies, of reproduction, of the sex organs, is almost non-existent.

This leads to a variety of myths, beliefs and practices which are accepted as true and helpful. A considerable tension exists 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. Constantly questions are asked about medical treatment for nocturnal emissions, masturbation, penile sizes and shapes. Many men use “quack” remedies from street vendors for their perceived weaknesses.

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

Reproduction also carries its own myths and beliefs, where many young males have no idea how babies are born, or even formed.

### ***Gender***

In terms of men who have sex with men there appears to be a range of masculinities, a spectrum of possibilities, where at one end are hijras, then kothis and then what kothis define as “real men”, panthis. Kothis are not men believing they are women, or even want to become women. They appear to see themselves as “less than men”. but “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.

Male and female gender roles are strictly divided through sexual positions, appearance and dress, mannerisms, and work functions. These roles are hierarchical and oppositional. Women are “passive”, “servile”, “domiciled”, wife and mother. Kothis, through their gender identification are also supposed to “passive”, “servile”, “domiciled” and “wife” to their panthis. Many kothis speak of “finding a husband”, seeking for a “real man” with an “akka likam” (meaning a big penis).

But there are often intense contradictions here. Kothis in a public space (like hijras) can be extremely voluble, sexually assertive (it is often the kothi who usually approach the panthi in the cruising sites), and will often dominate the sex act, even though he is being penetrated. And it should be recognised that many kothis also play the role of husband and father with their wives.

It cannot be taken as a given that because kothis identify with the feminine, that they only take the receptive role in the sex act, and use feminine terms for each other, that they are passive. There is much diversity in all of this.

But it should be recognised that because kothis play out the socially accepted gender roles, that their self-definitions, language and behaviours sustains a patriarchal framework of gendered relationships and sexual behaviours, this increases their risk of STI/HIV infection and transmission.

## Issues of concern: male to male sex

South Asia consists of male dominated societies where the social and public spaces are primarily male owned. As homosocial and homoaffectionalist societies, sexual boundaries between males are often easily crossed to become sexual acts, especially in the dark, hidden away. Whereas some of these acts can perhaps be called homosexual (within the context of local identities based upon penetration), in that a sexual sense of self is operating based upon a desire for anal penetration by another male, this appears to be a minority framework (however significant that minority may be). But it appears that a majority of sexual activity between males should be seen as opportunistic and discharged based.

In a range of studies conducted by Naz Foundation, a majority of males questioned were either married or would get married. Apparently there was no significant evidence that marriage actually substantially decreased the levels of male to male sexual activity. Several males that this was discussed with stated that when they got married they believed they would stop, but because they received little sexual satisfaction from their wives, they continued. Partly this was because they felt they couldn't ask their wives to perform certain sexual acts, and partly because sexual opportunities with their wives were not always available because of social conditions, such as appropriate accommodation, religious and cultural customs, joint families, and so on. For them, male to male sex was not a matter of sexual orientation or identity. It was to do with sexual need and tension.

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

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

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

The characteristics of South Asian cultures, such as arranged marriages, joint and extended families, community identities rather than personal identities, socially policed females, also include the extreme overcrowding, poverty, males sharing spaces, a substantial number of males below the age of thirty and unmarried, low sexual access to females, lack of privacy, and low incomes, create conditions which frame male to male sexual behaviours, and in a sense encourage its differing manifestations.

Age can also play a significant role in terms of penetration. As Michael Rocke states in his book *Forbidden Friendships - homosexuality and male culture in Renaissance Florence*:

"the restriction of the 'womanly role' to adolescents actually permitted all mature men to engage in sex without jeopardising their 'manly' identity". (page 13, Oxford University Press, 1996). The same framework exists to some extent in India, whilst Mughal history is replete of "boy love". Here young males - boys - can almost be considered as a gender in its own right; not man - not woman.

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

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

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

All this does not imply that loving bonds between males does not exist. It does. Intense emotional and sexual relationships do exist, but these will be framed by the cultural necessity of marriage and children. Very few males are able to escape this cultural necessity. There are frameworks for desire for a specific gender, i.e. males who specifically desire other males and seek other males for sex (and sometimes love). These males will often frame their relationship as "husband and wife", a giriya with a khoti (with a very few exceptions of mutuality and equal. Public spaces are supremely male. The street, the bus stand, the park, the railway or bus station,

these are the arenas of contact. Such publicness leads to quick sex, penetrative or otherwise, in the darkness of parks, behind bushes, in alleyways.

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

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

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

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

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

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

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

In exploring male to male sex in South Asia the following issues (in no specific order) should be highlighted:

1. Significant levels of males who have sex with males
2. These behaviours are invisible because of secrecy, shamefulness and denial
3. High rates of anal sex between males and between males and females
4. Significant levels of male commercial sex work
5. High rates of STD symptoms
6. Low levels of health seeking behaviours
7. Nonexistent or totally inadequate STD treatment services regarding anal transmission of STDs
8. No appropriate condoms and water-based lubricants available suitable for anal sex
9. Many males who have sex with males having pre-pubescent sexual encounters, where often the first sexual partner was a male relative
10. For many males involved in male to male sex, there is no specific identity construction

11. Those who evolve an identity based upon anal penetration call themselves khotis and label their sexual partners as giriya/panthis (or equivalent local terms)
12. Shame and dishonour create the conditions for secrecy, lies and shamefulness around male to male sex
13. No previous work has been done on sexual health promotion amongst males who have sex with males
14. No appropriate education resources dealing with male to male sexual behaviours and/or anal sex is available
15. Poor knowledge of STDs/HIV/AIDS amongst males who have sex with males
16. Low levels of condom usage
17. Many males who have sex with males will be married and many will get married
18. There are no agencies providing sexual health promotion services for males who have sex with males
19. Female partners (including wives) of males who have sex with males are very vulnerable to their sexual practices
20. The South Asian legal codes prohibits non-reproductive sex (defined as 'carnal intercourse')

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



## **The Training Programme**



# The training programme

The intention of this manual is to present a three day workshop which explores a range of issues around male to male sexualities, sexual behaviours and sexual health in a cultural context. We will be looking at the reality of such behaviours, and from that, develop models of education and prevention. We will also be specifically looking at male sexual behaviours and their impact upon women's sexual and reproductive health, and will explore all ranges of sexual behaviours rather than focus on the terminologies of "heterosexuality" and "homosexuality".

This workshop explores local traditions, customs and cultural constructions of sexual behaviours and desire. From such explorations we are able to look at how the HIV epidemic can be patterned within specific contexts. We are able to look at the difference between guilt and shame, between public statements and private practices, at the hidden patterns of sexual behaviours, particularly men who have sex with men.

The framework and analysis arises from socio-cultural patterns of a range of societies within Asia, who share similar dynamics around shame, "compulsory marriage and procreation", gender roles and segregation, traditional values and their impact upon on sexual behaviours. It allows us to access sexual networks, and explore risky behaviours in a supportive environment.

## Aims

1. To clarify our understanding of STDs/HIV and sexual and reproductive health arising from male to male sexual behaviours within a South Asian context.
2. To explore male sexual behaviours in South Asia, the socio-cultural contexts in which they take place, and develop appropriate sexual and reproductive health strategies to prevent and control the spread of STIs and HIV/AIDS amongst both males and females, that arise from such behaviours

## Participants

This training programme is designed for representatives from National AIDS Programmes, its range of institutions, AIDS organisations at State and local level, policy makers and programme managers from government and non-government institutions and reproductive and sexual health agencies.

## Methodology

In a series of working groups, participants will share, dialogue, discuss, and evaluate the personal, psycho-social, medical, political and religious impact of HIV/AIDS and the education, prevention, and support services available for males who have sex with males, with particular attention being paid to the development of community-based AIDS service organisations.

Participants will discuss the impact upon the management and control of STDs/HIV in relation to male to male sexual behaviours, and the socio-cultural frameworks within South Asia of such behaviours. They will also discuss the suitability and applicability of current HIV/AIDS education, prevention programmes, and services, and their relevance to the sexual and social health needs of males who have sex with males and explored the development of appropriate services through governmental support of community based organisations towards implementing and delivering such services.

Issues to be explored include psycho-social dynamics of male to male sex, provision of appropriate HIV/AIDS education and prevention, behaviours leading to possible HIV/STD transmission, and empowering behavioural communities to develop their own community-based AIDS service organisations providing appropriate sexual health services.

Identifying gaps and shortcomings in current service provision, exchanging visions of ideal standards and religious values, and exploring appropriate methodologies for service delivery, the workshop will develop a series of recommendations on good practice, appropriate education, and prevention strategies. These recommendations will guide government and non-governmental agencies in developing policies and practices in these areas.

The workshop focuses on a growing recognition that male to male sexual behaviours can play a significant, often hidden, role in the epidemic, and which needs to be appropriately addressed. It recognises that in developing such strategies, beneficiary-led community-based organisations dealing with males who have sex with males can often be more effective than any governmental approach.

## Scope

1. To bring together representatives from National AIDS Programmes and sexual health services within towards developing models of good practice for promoting sexual health amongst males who have sex with males.
2. To enable discussions and the sharing of skills, knowledge and information towards ensuring that STIs/HIV/AIDS can be effectively managed and that the AIDS epidemic can be controlled amongst males who have sex with other males.
3. To explore culturally appropriate frameworks of HIV education, prevention and care, particularly in terms of sexual health, taking into account issues of sensitivity, denial and shame and the political, social and religious concerns that sexual behaviour issues generate.
4. To promote the development of appropriate community-based strategies for prevention and control of STIs/HIV amongst males who have sex with other males.

## Training notes

- Objective:** towards ensuring that effective STD/HIV control and management programmes are developed that take into account all forms of risky sexual practices
- Aims:** explore reproductive and sexual health concerns arising from male to male sexual behaviours in .....
- explore different possible strategies for reducing the risks of STD/HIV transmission arising from male to male sexual behaviours
- Develop an appropriate response to STD/HIV transmission arising from male to male sexual behaviours
- For:** government and non-government agencies working in the field of reproductive and sexual health, and STD/HIV/AIDS prevention programmes

## Agenda

- Day One: exploring STD/HIV transmission issues arising from male sexual behaviours within the socio-cultural context of South Asia
- Day Two: exploring different strategies for intervention and management of STDs/HIV/AIDS for males who have sex with males
- Day Three: develop a specific strategic response to reduce the risks of STD/HIV transmission arising from male to male sexual behaviours

Each day will end with a list of issues and needs, with the final day leading to a series of recommendations for action.

Facilitators must be trained in the process before they can be utilised in facilitating this programme. They should have a comprehensive knowledge of the issues involved, particularly in terms of the dynamics of male to male sexualities and sexual behaviours in the cultural contexts of South Asia.

## The working group process

This training programme uses a working group process to discuss the issues and arrive at appropriate solutions.

If the number of participants is greater than 12, then 2 working groups will be formed, each with its own facilitator and recorder.

Each day there will be a series of issues to discuss within a specific framework which we are entitling the Working Group Process.

In this Process participants are urged to explore the topics of the day, developing a listing of issues and needs. On the final day, recommendations of action will be developed.

At the end of each day, participants will all come together to share the information from each working group, and generate common list.

The Process being used is felt to be the most effective in achieving the goals of the training programme through:

sharing of experience and expertise  
learning  
formulating ideas and agendas that can be utilised

In this Process, participants are encouraged to give vent to, and express their subjective views, criticisms, fears, hopes, fantasies and visions, in a space that is safe, empowering and confidential. A highly energetic and emotional process results in the preparation of a set of very concrete recommendations, aiming to develop and/or improve the performance of STD/HIV/AIDS education and prevention programmes in the context of male to male sexual behaviours.

There are three phases to the Process:

### 1. Critique Phase

in which the participants use their knowledge and experience of the present with its shortcomings and formulate problem areas or themes within the context of the discussion topics

#### 1.1 Critical Keywords

In a brain-storming exercise, explore issues identified and list critical words/themes

#### 1.2 Critical Themes

Keywords or consensus are obtained and then prioritized.

### 2. The Utopian Phase

discussions to enable the participants to express visions and utopian solutions to the problems, aiming to stimulate innovative and creative thinking and problem solutions

#### 2.1 Utopian Models

The task is to imagine how people could respond to the needs identified in the Critique Phase under unlimited financial, political and social conditions and what the ideal situation could be like under such circumstances

### 3. The Realisation Phase

in which participants are helped to extract practical solutions from the Utopian ones. This is done by a process of evaluation, strategy development and action planning.

#### Facilitator

This person's job is to take the group members through the Working Group Process within the subject areas identified. There should be an equal opportunity for each person in the group to have their say, to make their point and to challenge others within the rules of conduct identified.

The facilitator's role is not to teach but to enable others to state their ideas, concepts and feelings. The facilitator acts as a guide, not a leader.

At the end of the Working Group's day, the facilitator should attempt to summarise the day's activities and come with a series of bulletin points with a range of recommendations.

#### Reporter

The reporter's role is to take notes of the day's proceedings, and to minute the summary as well as the recommendations. These must be handed in to the Conference Secretariat after the Working Group Process Day.

The reporter will also present the summary at the next day's plenary session. Each Working Group Reporter will have five minutes for this presentation.

## Preparing for the workshop

### *Equipment needs*

The workshop requires  
 flip-chart paper and stand  
 marker pens  
 name tags  
 pocket folders for participants, each of which include:  
     workshop agenda  
     writing pen  
     writing pad  
 overhead projector and screen  
 sticky tape (which does not damage the walls of the workshop space)  
 blank postcards ( 6 times that of the number of participants)  
 assessment questionnaires (translated)  
 evaluation form (translated)  
 overhead documents  
 certificates of completion

### *Refreshments and lunch arrangements*

During a full day of training, lunch should be arranged for the participants, with a morning and afternoon refreshment break of tea/ coffee/soft drinks/snacks. Refreshments might also be considered prior to the start of a full day session.

To have a successful workshop, careful planning must be undertaken. A checklist is provided below.

1.     Establish Objectives for the workshop
  - develop training objectives (see Learning Process)
  - determine number of participants
  - assess training needs
  - develop a detailed budget
  - identify workshop facilitator
  - check on availability, subject knowledge, skills and abilities
  
2.     Arrange Logistics
  - decide on date and location of workshop
  - determine costs per participant for bursaries, food, transportation, materials, etc.
  
3.     Review Curriculum
  - check manual
  - determine resources to be used
  
4.     Prepare Materials and Equipment
  - prepare handouts - translate where necessary
  - arrange overheads, slides, newsprint/poster paper, tape, newsprint/poster paper, marker pens (water-based), pens, etc.
  - arrange slide and overhead projector, etc. as needed
  - ensure refreshments/meals are available on the day

# The learning process

## *Facilitating participation*

For this process to produce an effective and cohesive group, trainers must ensure that all participants are encouraged to take part in the workshop. However, they should not be pressurised to do so.

Where participants cannot read any notes or documents which are handed out to them, or are written on flip chart paper, or are shown on overheads, trainers must pair them with those who can read.

## *Humour and explicitness*

Humour is an essential component of the training process, since much of the contents may raise many fears and personal concerns which can produce stress. Humour should be that of the group, and facilitators need to have a good understanding of the background of the participants, be at ease with differing sexualities and sexual behaviours, and not show any form of discrimination. Trainers should have a good and “earthy” sense of humour, be compassionate and understanding, and be flexible and patient.

Participants will utilise explicit sexual language, since several of the exercises encourage this. Facilitators must feel comfortable with this, and be willing themselves to express such terms where appropriate.

## *Learning objectives*

These are identified as:

1. Correct knowledge gained on STD/HIV/AIDS and methods of transmission by all participants
2. Able to use condoms effectively
3. Understanding the impact of male sexual behaviours upon male and female reproductive health
4. Understanding what safer sex means and methods of practice
5. An understanding of sexualities and the full range of male to male sexual behaviours within a local context
6. Good communication skills developed
7. Be able to work as part of a team

## ***EFFECTIVE LEARNING ACTIVITIES***

People have different ways they like to learn, but everyone needs certain things including:

- a. **RESPECT**  
the learner needs to feel heard, honoured and respected as a person for more than what he knows or doesn't know; democratic social arrangements promote better, more human experiences
- b. **IMMEDIACY**  
taking something from a previous experience and relating it to something that will come after; the learner should be able to identify how he can use his knowledge and skills, and attitudes in the exercise of learning what is being taught.
- c. **EXPERIENCE**  
the learner gets to do something and can see how what he is learning has something to do with his own life experience; cooperative enterprise where people share their expertise

What makes a learning experience good?

1. **USEFULNESS**  
making a difference, use information in decision making, personally affected by the consequences of what is learned, working with real people dealing with problems, affects what I do
2. **DOING**  
practical exposure, opportunity to practice procedures, did something practical and experienced the outcomes

3. **COMFORTABLENESS AND SAFETY**  
comfortable and safe environment, confidentiality, easy exchange of information, non-threatening, no pretence, treated as an adult, allowed to share, good interactions between learners and facilitators, treated equally
4. **DESIRE TO LEARN**  
like what I learnt, freedom to choose what I learnt
5. **SHARING**  
worked with others who are like me, worked with others with more experience, worked things out together
6. **EMPOWERED**  
did something that made me feel proud, overcame challenging tasks, felt more able to make decisions, in control

#### **WHAT NOT TO DO**

1. a manner that is unfriendly
2. did not care about answers
3. no discussion allowed
4. no flexibility
5. lacking of humour
6. feeling ashamed
7. speaking too fast
8. telling people they are wrong
9. information and instructions too confusing
10. talked about things inappropriate to the situation
11. made learners feel stupid
12. no opportunity to share knowledge and experience

# Ways of learning - ways of teaching

## Teacher Centred

### Resources for learning

- \* teacher in a traditional course

### Required conditions

- \* willingness to be dependent
- \* assumes students have no knowledge on the subject
- \* respect for authority
- \* commitment to learning as a means to an end
- \* competitive relationship with fellow students

### Required skills

- \* ability to listen uncritically
- \* ability to retain information
- \* ability to take notes
- \* ability to predict exam questions

## Learner Centred

### Resources for learning

- \* printed materials and experts

### Required conditions

- \* intellectual curiosity, spirit of inquiry
- \* knowledge of resources available
- \* health skepticism towards authority
- \* standard to measure success
- \* commitment to learning

### Required skills

- \* ability to ask questions
- \* ability to find answers in printed materials
- \* ability to scan quickly
- \* ability to decide if something “works” (logic)
- \* ability to review information to produce answers to questions

It is recommended that facilitators use the Learner Centred approach

## Remember

People generally remember:

- \* 10% of what they read
- \* 50% of what they see and hear
- \* 90% of what they say as they do a thing

People learn best when they are actively involved in the learning process.



## **THE WORKSHOP**

# Workshop Agenda

- Day One**                    **STI/HIV/AIDS, culture and male sexual behaviours**  
welcome  
outline of training programme  
ground rules  
personal sensibilities  
knowledge and attitudes  
transmission of STI/HIV  
male sexual behaviours and anal sex  
male to male sexual behaviours: desire or semen discharge?  
socio-cultural frameworks of male to male sex  
who is at risk?  
problems, concerns and issues  
behaviour change  
identifying needs for sexual health promotion
- Day Two**                    **Strategies for intervention and management of STD/HIV/AIDS for MSM**  
welcome  
feedback from day one  
risky groups or risky behaviours?  
frameworks for prevention  
don't do it strategy  
do it safely strategy  
government response  
organisation frameworks  
self-help organisations and government  
ngos versus shos  
relationships between government and shos
- Day Three**                **Developing a response**  
welcome  
feedback from day two  
responsibility of the sho  
education and prevention  
changing sexual practices  
methodologies for government agencies  
methodologies for MSM SHOs  
community  
designing an MSM sexual health promotion project  
project development recommendations for action  
evaluation and closing

**Day One STI/HIV/AIDS, culture, and male sexual behaviours**

## Day One: STI/HIV/AIDS, culture, and male sexual behaviours

### 9.00am Welcome and introductions

#### Registration

When participants come into the training space, ensure that each person is given a name-tag, and a workshop folder containing the workshop agenda, writing pad, pen, and necessary documents.

The Facilitator will introduce himself, and ask all participants to introduce themselves, stating who they are, what organisation they belong to, and why they are attending the workshop.

*Time: 15 minutes*

### 9.15am Outline of the training programme

#### Facilitator presentation

#### Purpose

Participants obtain a clear understanding of the programme and its purpose

*Time: 15 minutes*

#### FACILITATOR NOTES

Process for day one

Discussions will focus on:

1. HIV: primary transmission  
sexual: vaginal/anal/oral
2. sexual behaviours  
vaginal/anal/oral  
  
males who have sex with females  
males who have sex with males  
males who have sex with both females and males
3. cultural frameworks of male sexual behaviours

Discussions and group work will flow from:

1 - 2 - 3 - 2 - 1

The issue will be male sexual behaviours and their impact upon male/female sexual health

with a focus on male to male sexual health

### 9.30am Ground rules

#### Group Discussion

Explain what is meant by ground rules, and what purposes they serve. Ask the participants to list the ground rules that they should adopt during the course of this training programme to ensure that it runs smoothly and cooperatively. Write down these rules on a large sheet of poster paper. After completion place these ground rules in a position which is highly visible to all participants.

*Time: 15 minutes*

#### **FACILITATOR NOTES**

Ground Rules should include:

- |   |   |
|---|---|
| confidentiality                               | discussions during the training programme may reveal personal attitudes and concerns, as well as differences of opinion; this should be respected |
| openness                                      | discussions will be about sex and sexual behaviours - we should feel comfortable and safe enough to openly discuss these issues                   |
| respect for differing opinions and behaviours |   |
| non-judgemental                               |   |
| no abuse                                      |   |
| time-keeping                                  |   |
| no interrupting                               |   |

Discuss and form a common set of rules. Suggest additions if necessary.

Keep the list on a wall in the training room throughout the programme.

It is used as a reminder in case of any infractions. Facilitator should go through rules before the start of the workshop each day.

#### **9.45am Personal sensibilities**

##### *Group discussion*

In this training programme, we are discussing STDs and HIV transmission. This means that participants will need to address the issues of sexual behaviours, and this means discussing sex.

For the training programme to achieve its goals, there needs to be open discussions regarding the range of sexual behaviours, including those highly stigmatised, where denial and shame operate to make these issues invisible.

Ask the participants how they personally feel about talking about sex.

Then ask them how they personally feel about anal and oral sex issues and males who have sex with males.

Explain to them that in this training programme you hope to clearly demonstrate that male to male sex is not uncommon in South Asian countries, that it is structured differently from a heterosexual/homosexual framework, and that anal sex is also significant sexual behaviour, both between males and between males and females. This means addressing shame, denial and invisibility.

Further, stress that if we are truly concerned about the spread of STDs and HIV/AIDS then we must address all behaviours in non-judgemental ways, if we are to develop effective strategies for the control and prevention of STDs/HIV/AIDS.

Record all important points on poster board. Review these points and ask for feedback from the participants.

*Time: 15 minutes*

#### **Purpose**

*To enable participants to confront their own fears and shame in dealing with highly stigmatised sexual behaviours, and to recognise that these need to be dealt with if any effective strategies to control and prevent the spread of STDs/HIV/AIDS*

#### **FACILITATOR NOTES**

There are a range of games that highlight these issues and make visible inner tensions. The Facilitator may wish to use one.

**10.00am Knowledge and attitudes*****What do we think we know***

Give each participant a copy of the knowledge and attitudes questionnaire ( a sample questionnaire with appropriate answers is in the annex of this manual) and ask them to complete it.

Explain that it is important to first discover the levels of accurate knowledge, and the sort of attitudes participants have about HIV and AIDS.

Tell the participants that there are several “tricky” questions, so they should read them very carefully. If they cannot answer a question, then just say “I don’t know” in response.

*Time: 15 minutes*

Following this period, the facilitator should go through all the questions, using the answers provided. Participants are asked to compare their own answers to those given.

*Time: 45 minutes*

Once the answers have been completed, the facilitator should collect all the completed questionnaires for later analysis.

**Purpose**

*To explore what participants know of HIV/AIDS and their personal attitudes towards HIV/AIDS related issues*

**FACILITATOR NOTES**

Several questions in the questionnaire, HIV and AIDS are deliberately made synonymous. The idea behind this is to ensure that participants understand their difference. Ensure that this is clearly understood during the question/response period.

**11.00am break****FACILITATOR NOTES**

Following the refreshment break, if there are more than 12 participants in the training programme, then the facilitator should form two working groups, each facilitator being responsible for one of these groups. Inform the participants that they will be staying in these particular working groups for the rest of the training programme.

Each group should also select a recorder who will write comments on poster board, and report back the discussions to the plenary session at the end of the day.

Ensure that the groups have sufficient poster paper and marker pens each day.

**11.20am Transmission of STDs/HIV**

Separate the participants into Working Groups. Each working group to briefly discuss the routes of STD/HIV transmission

Facilitator points out that some 70%+ of transmission of HIV is through unprotected sexual intercourse.

Discuss the relationship of STDs and HIV transmission, particularly in the context of increased risks for HIV infection when either partner has STDs. Then ask participants to list sexual activities in terms of no risk/low risk/high risk. Add to this list if necessary. (See page 38)

Ensure that any incorrect information is corrected with explanations.

Finally acknowledge that the most risky sexual practices are unprotected:  
vaginal sex (sometimes known as genital sex)  
anal sex

Discuss why unprotected anal sex is more risky than unprotected vaginal sex.

## LOW RISK AND HIGH RISK SEXUAL ACTIVITIES

<b>SAFEST - NO RISK</b> (no exchange of semen, vaginal secretions or blood)	<b>SAFER - LOW RISK</b> (most likely there would be no exchange of semen, vaginal secretions, or blood)	<b>UNSAFE - HIGH RISK</b> (almost certain exchange of semen, vaginal secretions, or blood)
touching	oral sex (where the person sucking another's penis does not have bleeding gums or open sores in or around the mouth)	anal sex without a condom
hugging		vaginal sex without a condom
massage		immediate sharing objects inserted into the anus/or vagina
kissing (unless the kiss is very hard and draws blood, or either partner has open sores or infections around the mouth)	You can reduce the risk factor by not ejaculating into the mouth by not brushing your teeth before oral sex by using a condom	any activity that allows blood-to-blood contact
masturbation (alone or with partner)	if doing oral sex to a woman you can reduce the risks by: using a latex barrier over the vagina not doing oral sex during the women's menstruation)	
body rubbing		
licking the body (clean skin: no oral contact with genitals or any open sores)	anal sex with a condom ( as long as the condom is used properly and doesn't break you can reduce the risks of breakage by proper use and the use of water-based lubrication)	
"dirty" talking	vaginal sex with a condom ( as long as the condom is used properly and doesn't break you can reduce the risks of breakage by proper use and the use of water-based lubrication)	
bathing together		
thigh sex (where there are no genital/anal infections, open sores in the genital/anal area)		

Through drawn images on poster board indicate that:

- A. anal walls delicate and thinner  
single celled  
blood vessels closer to the surface
- B. easier to cause lesions and bleeding
- C. vaginal walls multi-celled and more elastic  
more resistant to damage
- D. both dependent upon how the penetration is done, with or without lubrication.

Also in terms of anal sex, if the:

penetrated partner	HIV infected:	approximately 50% risk
penetrator partner	HIV infected:	approximately 95% + risk

These risks increase with STD symptoms

State that in South Asia just about all STD treatment and STD/HIV prevention programmes ONLY deal with vaginal transmissions.

This means there could easily be a hidden epidemic.

*Time: 40 minutes*

#### **Purpose**

*To ensure that participants clearly understand that by preventing STD and HIV transmission through penetrative sexual intercourse leads to the most significant reduction in HIV/AIDS*

*To ensure that participants recognise that anal sex is a contributing factor to the spread of STDs/HIV to both males and females*

#### **12.00 noon Male sexual behaviours and anal sex**

**Question:** *who does anal sex?*

- A. males - with females
- B. males - with males

Ask participants to discuss this issue.

*Time: 15 minutes*

#### **Purpose**

*To ensure participants understand that anal sex is both a male to male sexual practice as well as a male to female practice.*

#### **FACILITATOR NOTES**

There may be a great deal of resistance to admitting that

- a. anal sex behaviours exist
- b. that males have anal sex with females

The facilitator, at this point, should argue about this resistance, but suggest to the participants, that perhaps, at this point, we should just accept the possibility of these behaviours.

It should also be pointed out that in terms of anal sex:  
whilst some males will do this with their wives, most would prefer not  
- ashamed to ask their wives  
and, similar with female sex workers

**12.15pm. Male to male sexual behaviours : Desire or semen discharge?**

**Question:** *why the term males and not men?*

Discuss

**FACILITATOR NOTES**

MSM: MALES WHO HAVE SEX WITH MALES

The term men who have sex with men ignores the different cultural constructions of manhood, adulthood, differing gendered identities.

It is often treated as an identity term of an exclusive group, rather than a behavioural term that is inclusive.

It means:

any male who has a sexual encounter with another male, whether regularly, frequently, or infrequently, for whatever reason.

**Question:** *What is reproductive sex?  
What is recreational sex?*

Discuss the difference. What does this difference mean to sexual practices?

**FACILITATOR NOTES**

In an Orissa workshop.

Husband: "I do duty to my wife"

Wife: "I do work with my husband"

**Question:** *Does premarital sex exist?  
Does extramarital sex exist?  
At what levels?*

Discuss

**Question:** *who is doing male to male sex?*

Facilitator lists the following and then asks the above question.

Homosexual

bisexual

heterosexual

Participants will most probably pick the first two. Ask participants to define these three terms. Are they behavioural terms or identity terms?

**Question:** *What is a homosexual?  
What does he do?  
What sexual role does he play?*

Repeat these questions with regard to the term bisexual and heterosexual.

**Question:** *Are these divisions valid?*

Discuss

statement: from assessments conducted in South Asia, we cannot divide identities/behaviour so neatly.

See page 51

### Who is involved in male to male sex?

In a number of workshops conducted by Naz Foundation in India and Bangladesh amongst males who have sex with males the participants were asked to identify from personal experience, who was engaged in male to male sexual activity . They listed:

teachers with students	with brothers
uncles with nephews	cousins
neighbours	with domestic servants
between domestic servants	between friends
“elder brothers”. i.e. boy scouts,	students
residential school hostels	rickshaw drivers
truck drivers with helpers/others	taxi drivers
construction labourers	police/armed services
amongst bus/launch/train passengers	security guards
male sex workers with clients	expatriates
doctors	foreigners
hotel staff amongst themselves	
and with customers	
landlord with tenant	students in hostels
street children with each other	
and with others	
private tutors with their students	
school teachers with students	
amongst prisoners and prison staff	
in orphanages	in Madrassi schools
in boarding schools	
between shopkeepers and staff,	
i.e. restaurants/tea shops	
beggars	businessmen
actors	dancers
hijras with males	gay identified men
you can add to the list	

Indicate that the behaviours are not so much defined by the identity terms but rather by the act of penetration itself:

active - passive  
penetrator - penetrated

#### FACILITATOR NOTES

**BUT:** such divisions are also not so rigid either. The active partner may not have a sexual identity, but may also be anally penetrated, although this would be too stigmatising to admit.

the penetrated partner often acquires an identity based on penetration called KHOTI. May also penetrate other males, and will penetrate his wife.

**NOTE:** many males who have sex with males will also be married  
many will also have sex with other females

#### **Question:** *Why do males have sex with other males?*

The Facilitator then asks participants to list the reasons why males will practice anal sex, both as insertors and insertees. Add to list if necessary. See page 43.

Then show participants pages 44 -45 and discuss.

Record all important points and review them at the end of the session, asking for feedback from the participants

*Time: 75 minutes*

#### **Purpose**

*To ensure that participants understand that male to male sex crosses all sections of society, that it involves a range of reasons beyond just desire for another male, and that it is a significant sexual behaviour in society.*

#### FACILITATOR NOTES

A high degree of resistance to acknowledging the breadth of male to male sexual behaviours will be experienced during this session. Anecdotal materials and reference to the range of surveys conducted by Naz Foundation may be appropriate here.

Further to this, it may be advisable to bring into the session a local male sex worker and/or a local khoti who can aid in the discussions.

Facilitator should identify such a person(s) prior to the training programme.

Anecdotes:

1. "I prefer anal sex because the anus is tighter than the vagina"  
man in New Delhi
2. "I can't ask my wife, so I go to boys instead"  
man in Dhaka
3. "Sex with women is dangerous now, that's why I do with boys"  
man in Lucknow

**1.30pm Lunch**

**2.30pm Socio-cultural frameworks of male to male sexual behaviours**

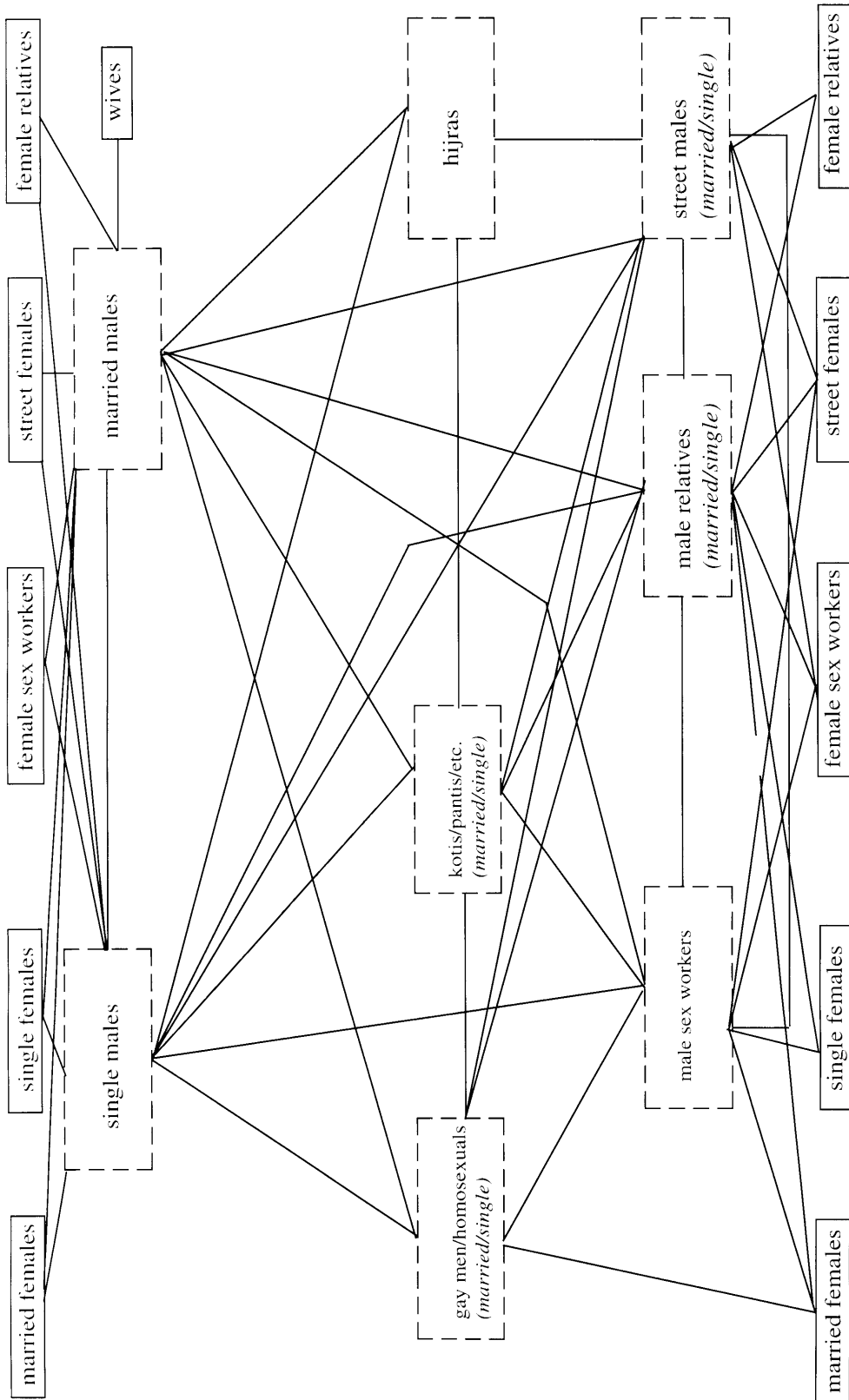
Explain to the participants, that sexual practices and desires are not isolated events but come into being through a range of social and cultural frameworks.

One can see from this list of people's professions and occupations which respondents had stated that they had sex with, it is clear that male to male sexual encounters are not some small marginalised behaviours within selected social and occupational groups but rather appears to ubiquitous and part of the male social space.

At the same time, the question was asked as to "why do males have sex with males from your personal experience?", the answers included:

personal desire  
sexual pleasure  
females don't do anal/oral sex  
males are easily available for sex  
anus is tighter than vagina  
males are more available than females  
nobody is suspicious if we mix with other males  
females are more socially controlled  
sexual adventure and curiosity  
sexual play  
no chance to be friendly with girls  
females unavailable  
meeting physical needs  
males can sleep in the same bed without a problem  
to be aloof from girls  
girls virginity must be protected  
no chance of getting a girl pregnant  
easier to seduce boys than girls  
easier to get along with males than females  
no financial involvement  
no marriage involvement  
living together with other males  
poverty leading to selling sex  
attraction to other males  
migration and separation from wife  
maintaining chastity

**MAPPING MALE TO MALE SEX IN SOUTH ASIA**



**Question:** What the socio-cultural frameworks in South Asia that control sexual behaviours?

Discuss. Ask participants to list these. Give an example. Add to the list if necessary.

#### FACILITATOR NOTES

The following issues should be highlighted in this discussion

- a. no discussion on sex
- b. knowledge through friends (usually incorrect)
- c. private practice versus public statement
- d. shame - guilt  
note differences: shame - arise from honour and public perception  
guilt - arises from a sense of sin

this leads to: WHAT I SAY I DO

WHAT I REALLY DO - SECRETLY

- e. gender segregation/separation
- f. maintaining female virginity - family honour
- g. male homosociability and homoaffectionalism - explain these terms
- h. vaginal sex seen as "real sex"  
anal sex seen as "play"
- i. no stigmatisation of active males
- k. historical traditions/customs
- l. sexual desire
- m. lack of opportunity of vaginal sex/opportunity of male sex
- n. poverty

End discussion on : male to male sex exists in unknown numbers

involves NOT only homosexuals/gay men

## **Culture, sexualities and sexual behaviours**

South Asian frame works of sexual behaviours

the following points need to be remembered:

1. Marriage is considered a duty and family obligation, not one based upon personal desire and choice.
2. Marriage is also seen as compulsory.
3. To be single is seen as an aberration. Cultural beliefs dictate that a person is not an adult until married.
4. The central objective of marriage is the production of children, specifically male children.
5. Sexual pleasure based upon desire, or lust, for one's wife is sometimes considered shameful. The Wife holds a special place in this regard. She is the Mother. A place of honour, for it is she who is charged with the responsibility of upholding family tradition, and the rearing of children. Sex with one's wife is often seen as a duty.
6. This leads to a concept of sexual pleasure being permissible outside of the marriage context.
7. Since there is no identity structure around the gender choice for sexual pleasure, what matters is more to do with the sense of malehood and concepts of masculinity.
8. Thus, concepts of identity revolve around ideas of penetration. The penetrator is still "manly", the penetrated is "not a man".
9. Further what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.
10. Gender segregation, female virginity, loss of honour, and so on often make it easier to access other males for sex than females.
11. Such accessibility is also made easier because of the extended family systems, and the homosociability of South Asian cultures.
12. The sense of shame and dishonour arises from a public (community) perception about personal behaviour and the need to fulfil one's (public) duty.
13. Since the concept of sexuality and sexual behaviours is bound up within concepts of sexual discharge, this often leads to frequent sexual partners, rather than forming continuous sexual liaisons with a single person.
14. Often the gender of the sexual partner is irrelevant.
15. This can be expressed by the statement "The person has a relationship with his wife, but has sex with others".
16. Women are much more supervised and policed by family and community, than men.
17. This makes it somewhat difficult for women to carry out socially illicit sexual encounters/relationships.
18. The penalties for women are of a much greater intensity.
19. It is easier for women to access other women than men.
20. Within these contexts, women's sexual and reproductive health is to a large extent dependent upon male sexual behaviours and the methodologies of their practice. Their constructions are framed by space, time, availability, gender roles, personal desires, opportunity and so on.

The facilitator is advised to read the following Naz Foundation International publications:

*Sex, secrecy and shamefulness*

developing a sexual health response to the needs of males who have sex with males in Dhaka, Bangladesh, 1997

*Perspectives on males who have sex with males in India and Bangladesh, 1997*

*Making visible the invisible*

sexuality and sexual health in South Asia - a focus on male sexual behaviours, 1996

**FACILITATOR NOTES**

In South Asia, identities are familial/community - not personal

Based upon:

- a. family structure and position in the family  
family: joint and extended  
even if physically living as a nuclear family  
  
example: in English, one word for cousin  
in South Asian languages many words, depending on EXACT relationship
- b. Marriage/children: adulthood  
  
Example: " I am a husband/wife/son/daughter
- c. Strict bi-polar gender: men/women
- d. Status: age/class/work/clan  
position in family  
gender  
marital status  
possession of children
- e. clan/caste
- f. children: motherhood  
fatherhood  
(sons - daughters)
- g. urban/rural
- h. educated/non-educated
- i. religion/region
- j. language
- k. occupation

These are community identities

The facilitator then should point out that the terms

Gay - homosexual - bisexual

are personal. These are individual identities

In the context of penetrated males, they may acquire a gender identity:  
khoti in terms of the sexual spaces they operate in.

In South Asia, however, these terms tend to only operate in specific spaces where males meet other males for sex.

But for the majority of males - they do not have these identities.

In South Asian cultures, family and community identities are more relevant.

End with the question: So who does anal sex?:

non - identified males and their partners  
khotis and their partners  
(some of these khotis may also be male sex workers)  
homosexuals and their partners  
gay men and their partners  
hijras

Time: 60 minutes

### Purpose

To ensure that participants understand that in South Asia, male to male sex is not defined by the terms gay, homosexual, or bisexual, but are framed by socio-cultural factors and gendered identities

### 3.30pm Who is at risk?

**Question:** *who is primarily at risk from anal sex, amongst males who have sex with males?*

Discuss

“passive” partner: stigmatised  
feminised and gendered as not male/not female: a khoti  
also some may well be male sex workers

Hijras:

“active” partner: often not stigmatised  
and still seen as male  
also at risk

Also at risk are  
wives and other female/male partners

children and youth

Example: married man with children. But is also passive male in anal sex  
What identity?

See pages 44-45, and also 50

Time: 20 minutes

### Purpose

To ensure that participants understand the frameworks of male to male sex in South Asian cultures

#### FACILITATOR NOTES

Cannot always clearly separate.

Three frameworks

- a. males who are sexually penetrated: male sex workers  
other males  
both may identify as khotis  
tend towards specific sites but not always
- b. the males who penetrate them  
tend to be at specific sites, but not always
- c. other dynamics of male to male sex  
all male institutions  
within joint and extended families  
neighbourhoods  
within occupational groups

### 3.50pm break

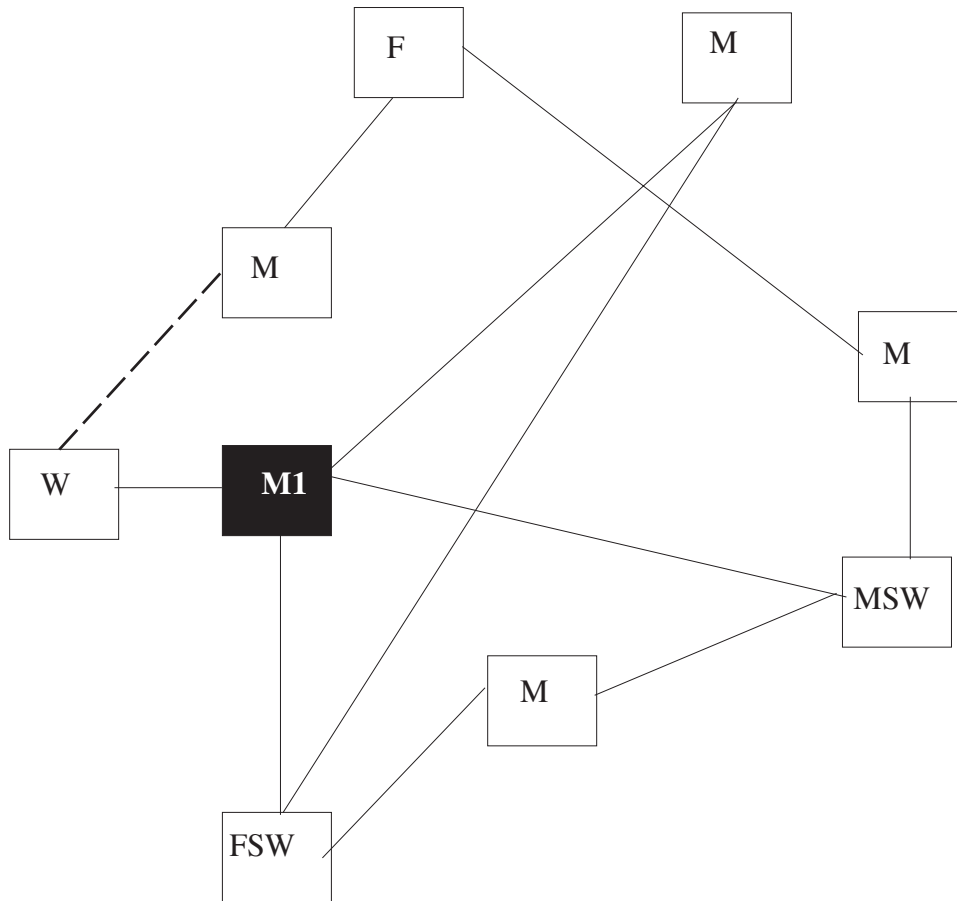
### 4.10pm Problems, concerns, and issues

**Question:** *in terms of male to male sex and STD/HIV prevention, what are the issues?*

Discuss

Time: 50 minutes

### POSSIBLE TRANSMISSION FLOW CHART



M1      Key married males  
M        Male  
W        Wife  
F        Female  
FSW     Female sex worker  
MSW     Male sex worker

**Purpose**

To identify a range of issues concerning male to male sexual behaviours and STD/HIV prevention

**FACILITATOR NOTES**

What are the issues - problems - concerns

- a. acknowledgement of MSM
- b. historical acknowledgement  
MSM not imported
- c. anal sex seen as very risky without protection
- d. public versus private domains
- e. public - no discussion  
private - doing
- f. labels - identities  
not risk groups  
but risk behaviours
- g. lack of education and knowledge
- h. lack of appropriate sexual health resources  
condoms and lubricants  
quality  
price  
distribution/access  
quantity  
choice
- i. appropriate STD/HIV testing and treatment and counselling service  
acknowledgement of issues  
attitude of service providers  
confidentiality  
discrimination  
harassment  
legal  
human rights abuse
- j. development of skills  
capacity building  
training
- k. lack of good, informed sex education
- l. religious frameworks
- m. economic conditions
- n. NGO development  
lack of NGOs
- o. NGO - GO collaboration/partnership
- p. legal/judicial issues
- q. fear - stigmatisation - denial
- r. stereotypes
- s. government taking responsibility
- t. infrastructure development
- u. how to: educate/prevent  
appropriate methodologies
- v. how to: maintain/modify behaviour towards safer sex

**5.00pm. Behaviour change**

**Question:** *what are the primary motivators for sustaining behaviour change?*

Discuss

Use page 52 for this discussion

*Time: 15 minutes*

**Purpose**

To ensure that participants understand that enabling behaviour change is much more than just giving information

**CHANGING BEHAVIOURS REQUIRES**

**KNOWLEDGE**

**DESIRE**

**WILL**

**SKILL**

**POWER**

what I feel

**DESIRE**

what I believe

**THINK**

what I do

**BEHAVIOUR**

**CONSEQUENCES**

**5.15pm Identifying needs for sexual health promotion**

**Question:** *what are the needs for developing STD/HIV prevention programmes for MSM*

Discuss

*Time: 45 minutes*

**Purpose**

*To ensure that participants can identify sexual health promotion needs arising from male to male sexual behaviours*

**FACILITATOR NOTES**

1. providing appropriate sex education:  
incorporating all forms of behaviours  
knowledge: gender  
                  sexualities  
                  transmission  
                  safer sex  
                  de-stigmatisation  
literate/non-literate  
formal/informal  
peer education:            what is peer education?

2. develop appropriate prevention strategies
  - a. immediate                           behaviour change
  - b. short term                           maintenance
  - c. long term                            maintenance

CHOICES    -    ENCOURAGE    -    EMPOWER

**FOUR ISSUES**

1. government education/mass media
  2. strong NGOs/grass roots activity
  3. constant reinforcement/peer pressure
  4. appropriate treatment/ support services
3. legal issues  
The law, judiciary, and police  
human rights  
advocacy  
laws and regulations that impede to be amended
4. NGO Development
    - a. people
    - b. investment
    - c. independence
    - d. networking
    - e. information/skills sharing
    - f. capacity building
    - g. technical assistance
    - h. safety/security

NGO skills needed
5. training for government institutions
  6. training for non-government, national, international and local institutions
  7. appropriate testing, treatment and counselling services  
accessible, confidential, anonymous, free
  8. Financial investment in sexual health  
“investment for the future”

**FACILITATOR NOTES continued**

9. Employment opportunities
10. Access to technical expertise: appropriate
11. Sharing of skills, knowledge and information

6.00pm      Close

**Day Two Strategies for intervention and management of  
STDs/HIV/AIDS for males who have sex with males**



## Day Two      Strategies for intervention and management of STDs/HIV/AIDS for males who have sex with males

### 9.00am      Welcome

#### *Registration*

As participants come into the workshop space, complete the daily registration form. Ensure that each participants has their name tag, note pad, and pen.

*Time: 15 minutes*

### 9.15am      Feedback from day one

#### *Discussion*

Ask participants to give their impressions of the previous day, what they learnt, what difficulties they may have experienced, and any questions they may have.

*Time: 30 minutes*

#### **Purpose**

*To ensure that participants have retained knowledge gained from the previous day, and have a clear understanding of the issues that arose*

#### **FACILITATOR NOTES**

Briefly go through the previous day's discussions. Ask participants what they had gained from these discussions. Ensure that all questions are answered patiently. Re-visit any topics if necessary. Use humour wherever possible.

### 9.45am      Risky groups or risky behaviours?

**Question:**      *Should we look at risky groups or risky behaviours?*

Discuss the context of males who have sex with males in South Asia.

List on chart paper

homosexuals

gay men

transvestites

bisexuals

hijras

males who have sex with males

khoti

panthi (local equivalent)

**Question:**      *What is the difference between risky groups and risky behaviours?*

**Question:**      *Identity or behaviour?*

Discuss. List all important points and review with feedback from the participants

*Time: 30 minutes*

**Purpose**

To ensure that participants fully understand that effective STD/HIV prevention programmes need to be cognisant of both those who practice risky behaviours (usually those who penetrate - however frequently or infrequently) as well as those who belong to shared behavioural groups and networks (i.e. male sex workers, khotis)

**FACILITATOR NOTES**

From previous day show list of those involved in MSM

military personnel  
teachers  
students  
hotel staff  
etc.

also            gay men  
                  homosexuals  
                  other identities: active/passive

Indicate MSM -    all levels of society  
                          invisible

Need to look at both    a.    risky behaviours  
                                  b.    behavioural groups/networks

To often males who have sex with males are lumped into one behavioural and/or identity group. However such a construction is not valid in South Asia.

Participants need to be aware that males who penetrate other males more often than not, do not have a sexual identity, and their approach is one of opportunism and availability. Approaches to STD/ HIV prevention would need to address the risks of anal sex.

On the other hand, significant proportion of males who are penetrated develop a gender/sexual identity - khotis. This includes the majority of male sex workers.

Many of these individuals already participate in socialising networks that operate from a range of public sites. As such these networks could be likened to shared behavioural groups. Lose affiliations, friendships, and socialising occurs within these networks. Prevention would need to look at community development and mobilisation within such networks.

**10.15am      Frameworks for prevention**

There are only two broad frameworks

- A.    DON'T DO IT  
      includes:  
      a.    stick to one partner  
      b.    reduce number of partners  
      c.    stop the behaviour
- B.    DO IT SAFELY  
      focuses on safer sex: risk reduction  
      early STD treatment

Write these on poster board. Ask the participants define and to discuss each one in turn.

List all the important points, and review with feedback from the participants.

*Time: 30 minutes*

**Purpose**

To gain a clear understanding of the two different frameworks, and to recognise how all prevention strategies fit either of these two

**FACILITATOR NOTES**

Ask participants to document a range of education and prevention strategies that they are aware. Analysis and break them down into components and see which of the two frameworks they fit.

**10.45am Don't do it strategy**

THIS CAN BE DEFINED AS A DETERRENT STRATEGY

USE OF FEAR AND PUNISHMENT TO ATTEMPT TO CONTROL BEHAVIOUR

Write these two statements on a poster board. Discuss what these two statements mean. List all important points and review with participant feedback.

**Question 1:** *What steps would be needed to be taken to implement such a strategy?*

Discuss and list all important points, review and ask participants for feedback.

**Question 2:** *Why would this strategy be used?*

Discuss and list all important points, review and ask participants for feedback.

THE "DON'T DO IT STRATEGY" COULD BE SEEN AS A PUBLIC OR MASS STRATEGY

It tells people what to do and requires a threat and punishment for behavioural control.

**Question 3:** *What would the social consequence of this strategy be?*

Discuss and list all important points, review and ask participants for feedback.

**Question 4:** *Will this strategy achieve its goal to prevent STD/HIV transmission amongst males who have sex with males?*

- a. why will it achieve this goal?
- b. why will it not achieve this goal?

Discuss. List all important points, review, and ask for feedback from participants.

**Question 5:** *Can fear change behaviour and maintain behaviour change over a long period of time?*

**Question 6:** *Can you stop/change sexual behaviours through deterrence/punishment?*

Discuss. List all important points, review with participant feedback.

*Time: 90 minutes*

*NOTE: serve refreshments during the course of this discussion.*

**Purpose**

*To ensure that participants fully understand that deterrence and punishment creates more problems for prevention of STD/HIV than solves*

**FACILITATOR NOTES**

Some points to include in the discussions

*Question 1: What steps would be needed to implemented?*

- a. abstinence is the message  
“Stop doing it - or else”
  
- a. media campaign to promote message  
message: moral  
fear
  
- b. enforcement of legal codes and regulations  
police  
prison  
religious laws. i.e. Shar’ia  
(so the Muslim religious law for male to male sex is death, whilst in South Asia countries, the civil code for “carnal intercourse” is up to ten years imprisonment - but you have to prove anal penetration actually occurred)
  
- c. school education: moral  
fear
  
- d. increased religious instruction: moral  
fear
  
- e. parental control over their children
  
- f. employment practice: shame  
threat
  
- g. social control: shame

*Question 2: Why would this strategy be used?*

*Question 3: What would the social consequences be?*

- a. easier to do?
- b. social control
- c. promote morality
- d. sustain prejudice
- e. promote religious values
- f. national reputation

Cost of media campaign: frequency  
design  
training

Enforcement of the law/new laws: increased arrests  
increase in judiciary  
police  
courts  
prisons  
more surveillance  
in public  
in prisons  
new laws of control

Consequence: more costs  
more social control  
more social disorder

**FACILITATOR NOTES continued**

Deterrence through school education

training  
technical equipment  
spies  
teacher control  
discipline/dismissal/shame

d. religious instructions

training  
material  
shaming

e. parental control

observation  
disciplines/punishment

f. work place

spies  
more security  
disciplinary measures

*Question 4: Will this strategy achieve its goals?*

*Question 5: Can fear alone change behaviour?*

*Question 6: Can you stop/change behaviour through deterrence?*

There is a difference between public statement and private practice

Who watches the watcher

What happens behind locked doors, in the dark, under the blanket?

Also

Mandatory Testing: needs regular testing of whole population  
not 100% accurate  
extremely costly

corruption

drives risky behaviour underground  
more difficult to access

develops hidden epidemic

**12.00 noon Do it safely strategy**

Using the definition arrived at previously, ask participants to list the key components of such a strategy for males who have sex with males.

Discuss, and list key points. Review and ask participants for feedback.

**Question:** *What would need to be done for this strategy to be implemented?*

Discuss and list key points. Review and ask participants for feedback.

**1.00pm lunch****2.00pm Do it safely strategy (continued)**

Participants continue their discussions from before lunch

*Time: 90 minutes*

**Purpose**

To ensure that participants understand what is involved in a pragmatic approach towards an effective sexual health promotion strategy that incorporates all forms of sexual behaviours, particularly in targeting males who have sex with males

**FACILITATOR NOTES**

Don't do it strategy

Means promoting safer sex activities amongst males who have sex with males and encouraging maintenance of such behaviours

means educating, encouraging and empowering

- a. changes of sexual behaviour to those with less risk
- b. condom/lubricant use

Key components should include

- a. increase access to condoms/lubricants
- b. appropriate condoms for anal sex
- c. social support systems amongst MSM to develop community support for behaviour change
- d. increased access to MSM networks/behaviours
- e. de-stigmatisation of behaviour
- f. community building and empowerment

*Question: What would need to be done for this strategy to be implemented?*

Discussions should include:

1. appropriate services  
who delivers these services?
2. legislative changes  
decriminalisation  
increase safety to increase access to services
3. media campaign  
increase awareness  
de-stigmatise behaviour & HIV/AIDS
4. National AIDS Programme to incorporate MSM issues in strategies
5. research and identity networks and potential peer educators  
who will do the research?  
what research?  
what would happen the results?
6. educational materials appropriate for MSM
7. increased availability of appropriate condoms/lubricants
8. community-based organisational development
9. self-help groups established
10. anonymous telephone counselling
11. training on MSM issues
12. effective collaboration between SHO and:  
GO  
CBO  
social institutions  
research/medical institutions

**FACILITATOR NOTES continued**

13. education
  - family
  - general public
  - schools
  - colleges/universities
  - military
  - police
  - work places
14. sexual health counselling centres
15. destigmatisation programmes
16. human rights promoted
  - discrimination
  - harassment
  - violence
17. voluntary anonymous testing
18. STD services taking into account anal sex

**2.30pm Governmental response**

**Question:** *What is the responsibility of government organisations?*

Discuss. List all important points, review and ask for feedback.

*Time: 30 minutes*

**Purpose**

*To enable participants to clearly define what the government should do, as well as what it is capable of doing*

**FACILITATOR NOTES**

The list should include the following

1. ensuring the health and safety of all its citizens
2. educating its citizens
3. legal support
4. address human rights
5. ensure that all its citizens can be informed and access appropriate services
6. monitoring and surveillance without abusing human rights of its citizens
7. provide social welfare
8. provide education including sex education
9. sexual health products distributed for easy and affordable availability
10. Sexual health treatment and care
  - STD treatment services
11. HIV/AIDS treatment, care and support
12. investment in community based services

**STATEMENT**

*To create a framework which ensures that ALL citizens have access to appropriate information, medical treatment and care and social support according to their needs without hindrance*

**3.00pm Organisation frameworks***Definitions*

NGO: Non-Governmental Organisation  
 CBO: Community-Based Organisation  
 ASO: AIDS Service Organisation  
 CSO: Civil Society Organisation  
 SHO: Self-Help Organisation

List these on poster board and ask participants to define each category of organisation.

Review with feedback from participants.

**Question:** *What are the advantages of an MSM self-help organisation?*

Discuss. List all important points and review with the participants

*Time: 30 minutes*

**Purpose**

*To ensure that participants understand that for effective STD/HIV and sexual health promotion programmes targeting MSM behaviours, the most effective approach is through an MSM self-help organisation.*

*To enable participants to understand the concept of beneficiaries of services acting as providers of those services*

**FACILITATOR NOTES**

Definitions should include

NGO  
 non-governmental  
 not for profit  
 charitable  
 community-based (perhaps)  
 grass roots development (perhaps)  
 independent of state control

COMMUNITY-BASED AIDS SERVICE ORGANISATION  
 non-government  
 charitable  
 community-based and led  
 grass roots  
 independent  
 provides education/prevention/care

SELF-HELP ORGANISATION  
 self - help  
 community-based  
 grass roots  
 provides solidarity/social support  
 addresses sociability  
 human rights  
 sexuality  
 identity  
 beneficiary-led

Note: ALL GAY MEN ARE MSM BUT NOT ALL MSM ARE GAY MEN

1. shared behaviours
2. shared identities



**FACILITATOR NOTES**

Discussions should include:

- a. shame versus acceptances
- b. shared understandings
- c. confidentiality
- d. willingness to be open with others who are similar
- e. socialising and friendship as a methodology
- f. peer pressure to sustain behaviour change

**5.10pm Relationships between Government agencies and SHOs**

**Question:** *What should the relationship between government agencies and SHOs?*

Discuss these relationships. List all important points, and review with participants feedback.

*Time: 20 minutes*

**Purpose**

*To ensure that participants understand that cooperative relationships between government agencies and SHOs provides the most effective framework in which to develop appropriate sexual and reproductive services so that all people can access those services that are appropriate to their needs*

**FACILITATOR NOTES**

Discussions should include:

- a. development of choice
- b. appropriate services targeted to fit needs
- c. not competing
- d. not supplanting
- e. But working together with same intention: to save lives
  - i. helping government to protect its citizens
  - ii. helping people to protect themselves
  - iii. fill in the service gaps
- f. dealing with behaviours/identities that government can do because of political and/or religious reasons

Develops a framework of

SHARED RESPONSIBILITIES

NEED

SHARED RIGHTS

**5.30pm Close**

## **Day Three      Developing a response**

## Day Three    Developing a response

### 9.00am        Welcome

#### *Registration*

As participants come into the workshop space, complete the daily registration form. Ensure that each participants has their name tag, note pad, and pen.

*Time: 15 minutes*

### 9.15am        Feedback from day two

#### *Discussion*

Ask participants to give their impressions of the previous day, what they learnt, what difficulties they may have experienced, and any questions they may have.

*Time: 30 minutes*

#### **Purpose**

*To ensure that participants have retained knowledge gained from the previous day, and have a clear understanding of the issues that arose*

#### **FACILITATOR NOTES**

Briefly go through the previous day's discussions. Ask participants what they had gained from these discussions. Ensure that all questions are answered patiently. Re-visit any topics if necessary. Use humour wherever possible.

### 9.45am        Responsibility of the SHO

*Question: What would define the responsibility of SHO?*

Discuss. List all important points and review with participants' feedback.

*Time: 30 minutes*

#### **Purpose**

*To enable participants to gain a clear understanding of the responsibilities of an SHO*

#### **FACILITATOR NOTES**

Discussions should include:

1. provide appropriate services to its constituents/community
2. outreach work
3. community building
4. counselling and support
5. advocacy
6. access behavioural groups
7. financial responsibility
8. accountability
9. good management
10. challenge discrimination
11. empowerment of its constituents
12. programme effectiveness

Indicate the framework by using maps on pages

**10.15am Education and prevention**

**Question:** *What is the difference between education and prevention?*

Discuss briefly. List all important points. Note: this issue will be looked at more intensively tomorrow.

**Question:** *Does education change behaviour. If so, how? If not, why not?*

Discuss. List all important points.

**Question:** *Can government do prevention. If so, how? If not, why not?*

Discuss. List all important points

Review all these important points and ask for feedback from the participants.

*Time: 45 minutes*

**Purpose**

*To ensure that participants understand concepts of education and/or prevention strategies and their differences*

*For participants to recognise the limitations of government only responses to HIV prevention strategies*

**FACILITATOR NOTES***Education*

increase knowledge  
gives information  
to learn  
“how to”  
teaches  
theoretical  
depends on teaching skills  
accuracy and completeness of information  
can increase awareness of issues and facts  
who teaches? how? where? when? who receives?

*Prevention*

putting into practice what you have learnt  
practical  
promoting safer sex behaviours  
methodologies of practice  
enabling people to put knowledge into practice

Also

1. access to condoms and lubricant
2. peer pressure
3. demonstrate condition
4. solidarity of practice
5. peer support
6. psychological support
7. social support
8. community development/mobilising
9. economic development
10. empowerment
11. befriending - be with you
12. friendship

STD treatment services

2. Access means
  - a. quality
  - b. quantity
  - c. price
  - d. availability: where? when? by whom?
  - e. location

**11.00am**      **break**

**11.20am**      **Changing sexual practices**

**Question:**      *What do you need to be able to change sexual practices towards safer sex, and to be able to maintain that behaviour change?*

Discuss. List all important points and review with participants feed-back.

*Time: 30 minutes*

**Purpose**

*To develop a clear understanding of the issues involved in changing sexual practices towards health seeking behaviours, and to ensure such changes are maintained over the long term.*

**FACILITATOR NOTES**

*Note:              Condoms are for life*

**Means:**              with the current status being that there is no vaccine against HIV and no cure for AIDS (despite the current medical treatments to prolong life for those living with AIDS which are extremely expensive and beyond the means of the vast majority of people in South Asia, and their governments), condoms have to be used ALL THE TIME.

Just one lapse may place that person at risk from infection.

What do you need to change sexual behaviours? See page 68

MAP

Should also include  
appropriate sexual health products  
appropriately accessible  
appropriate treatment services  
support to maintain change

**11.50am**      **Methodologies for government agencies**

**Question:**      *What do government agencies need to do?*

Discuss. List all important points and review with participants' feedback.

*Time: 40 minutes*

**Purpose**

*To enable participants to explore what government agencies would need to do to support sexual health programmes for MSM SHOs*

**CHANGING BEHAVIOURS REQUIRES**

**KNOWLEDGE**

**DESIRE**

**WILL**

**SKILL**

**POWER**

what I feel  
**DESIRE**

what I believe  
**THINK**

what I do  
**BEHAVIOUR**

**CONSEQUENCES**

**FACILITATOR NOTES**

Discussions should include:

1. provide and distribute educational materials
2. invest in sexual health services
  - specialist clinical services
  - treatment and care programmes
  - counselling services
3. provide and distribute condoms/lubricants
4. address human rights concerns by implementing and acting on UNAIDS/UN recommendations, policies and guidelines
5. amend laws and regulations that impede implementing appropriate sexual health programmes
6. support the development of SHOs through provision of
  - a. financial support
  - b. encourage networking
  - c. enable access to technical skills
  - d. enable access to media/ministries
7. collaborate closely with NGOs to develop and implement National AIDS control strategies
8. localise and decentralise sexual health service delivery and decision making
9. collaborate with NGOs to enable them to access closed systems
  - military
  - prisons
  - to increase awareness /practice of safer sex
10. National AIDS Programme to regularly evaluate and monitor ministerial action plans and their implementation and make appropriate recommendations
11. implement an effective anonymous surveillance programme
12. develop a national advisory board to advice NAP coordinator includes CBOs
13. regularly review of NAP strategy for effectiveness
14. upgrade technical skills/knowledge of government officials

**12.30pm Methodologies for MSM - SHOs**

**Question:** *What do MSM SHOs need to do?*

Discuss. List all important points and review with participants' feedback.

*Time: 40 minutes*

**Purpose**

*To enable participants to clearly understand what MSM SHOs would need to provide in order to achieve an effective sexual health promotion service*



**1.10pm**      **lunch**

**2.10pm**      **Community**

**Question:**    **What makes a community?**

Discuss. List all important points, and review with participants' feedback.

*Time: 40 minutes*

**Purpose**

*To enable participants to understand the frameworks of MSM networks and what is needed towards developing community mobilisation*

**FACILITATOR NOTES**

In South Asia, MSM communities as such don't exist. What does exist are socialising and/or sexual networks that are often site specific.

These networks to be targeted to draw MSM into emergent communities where affiliation is based upon behavioural and emotional characteristics as well as on personal friendships

Mobilising networks, encouraging network development, and networking of networks is feasible under current social realities.

Can be developed under a framework of male sexual health programmes

Characteristics of a community are:

- affiliation to a shared consensus
- solidarity as a "community"
- mutual support mechanisms
- social support services
- shared ideologies and social characters
- socialising frameworks
- mutual concerns
- shared needs
- shared rituals

**2.50pm**      **Designing an MSM sexual health promotion project**

Participants are asked to discuss and develop an outline for an MS sexual health project.

Using the questions below, the working group are to list their responses as bulletin points.

Note: the items in italics are for the working group facilitator

1.      What is the overall goal  
*reduce HIV/STD transmission risks*
2.      what is the purpose of the project  
*reduce risks for MSM*
3.      Who is the target  
*MSM - network? Group?*
4.      Where is the target  
*location in terms of sites?*
5.      How will goal be achieved?  
*activities to be taken*
6.      who will do the work?
7.      how will the work be done?

8. Outputs  
*what will the outputs be*
9. Outcomes  
*anticipated outcomes*
10. how will success/failure be measured?
11. who will measure?
12. Costings  
*what will be needed and their costs*

*time allowed for this section: 70 minutes*

#### **4.00pm Discussion on Project Development**

Group (s) is asked to present their discussions. Facilitator critiques the presentation, using concepts identified in the Facilitator Notes.

List all important points. Review with participants' feedback.

*time allowed for this section: 40 minutes*

*Total time: 110 minutes*

*Note: refreshments can be served during this exercise*

#### **Purpose**

*To enable participants to understand the context of developing an MSM sexual health project*

#### **FACILITATOR NOTES**

##### *Project Development*

The following briefly outline the components being used towards developing a sense of community affiliation, of mobilising networks, and networking of networks creating frameworks in which condom usage and STD treatment can be promoted as normative behaviours.

##### 6.1 Outreach/Networking

Using field workers drawn from these khoti networks to be site specific -based developing friendships in that specific site that can be extended beyond the sites through shared characteristics, socialising, support and enabling access to service provision.

Using site-based key informants (although the term informant is problematic, and we would rather use the term "site-buddies") who can provide supportive frameworks to the field worker with their knowledge and insight into specific sites and provide continuity within a site when the field worker is not present.

##### 6.2 Socialising meetings

A range of of-site social groups developed, each facilitated by a Field Worker, drawing upon his own personal, social and field work networks. These groups can act as a space within which personal friendships and bonding can be developed, experiences shared, and common purposes evolve.

##### 6.3 Personal skills development

A range of educational classes offered including literacy, social skills, life skills, health seeking knowledge, vocational skills, income generation skills, and so on.

##### 6.4 Employment and accommodation networks

Using khoti networks to identify employment opportunities and vacant accommodation, as well as emergency housing.

##### 6.5 Savings and Loans Club

Using the Grammen Bank model, encouraging small scale savings and loans amongst the khoti networks.

##### 6.6 Advocacy

Police and maastan harassment are common factors amongst khotis who use public environments as social spaces, for sexual encounters and to sell sex. By developing legal aid services, challenging human rights abuses, and providing counselling and support, a framework of service use and access can be developed which can be seen as a "community service", encouraging affiliation to an "emergent sexual community".

**FACILITATOR NOTES continued**

## 6.7 STD treatment services

Extremely problematic in main stream services because of the stigmatisation of behaviours, khotis have extremely few choices to access appropriate treatment services, particularly around anal sex behaviours. Khoti services providing such appropriate STD treatment services, either as syndromic management, or through direct testing, ensures that khotis will be treated sympathetically, with respect and consideration, and access correct information and treatment.

## 6.8 Condoms and lubricants

Many khotis feel very ashamed to access condoms in regular outlets (particularly if they are young and unmarried), nor do they access family planning clinics. Further South Asia does not have appropriate condoms for anal sex, nor any appropriately and cheaply packaged lubricant. Provision of condoms and lubricants in ways that are affordable and easily accessible through site distribution can increase condom usage.

## 6.9 Needs assessments

Regular surveys of service users, site surveys, and focus group discussions, ensures that assessments are conducted regularly as to how needs are being defined by the khotis. These needs can be felt needs, expressed needs and/or projected needs. These discussions and surveys built up consensus on shared needs, which can also be used towards building a sense of community. Such needs do not necessarily directly relate to STD/HIV/AIDS. However addressing such needs can build a sensing of shared concerns which can be developed as a community sensibility.

Such needs can be:

## 6.9.1 Social needs

- education
- employment
- economic development
- human rights
- family, marriage and children
- vocational skills
- socialising spaces

## 6.9.2 Personal and emotional needs

- sexual abuse and violence
- counselling
- personal hygiene
- friendship
- identity and desire
- emotional support
- empowerment
- personal skills development
- personal health issues

## 6.9.3 Sexual health needs

- appropriate condoms
- appropriate lubricant
- sexual spaces and privacy
- access to appropriate treatment
- psycho-sexual issues
- counselling
- knowledge
- empowerment
- negotiating skills

**FACILITATOR NOTES continued**

## 6.10 Responding to needs

It is essential that the service provision should build upon these needs and find appropriate ways to ensure that these needs are being adequately and appropriately addressed.

Thus, for example:

- 6.10.1 a health service that can look at non-sexual issues and provide appropriate treatment and care, i.e. chest infections, TB, and other potential illnesses
- 6.10.2 an employment agency/network
- 6.10.3 vocational skills development including reading and writing
- 6.10.4 an emergency housing network
- 6.10.5 address poverty issues, such as subsidised medicine and treatment, and access to low interest credit and small savings
- 6.10.6 socialising spaces that allow non-sexual friendships to be developed amongst khotis and non-khoti identified MSM
- 6.10.7 access to legal aid
- 6.10.8 addressing discriminatory laws and regulations
- 6.10.9 addressing police and maastan harassment
- 6.10.10 a sexual health service that is appropriate and sympathetic and easily accessible
- 6.10.11 a non-judgmental service provision irrespective of class, economic group, work affiliation, sexual behaviour/desire and feminisation
- 6.10.12 development of socialising rituals for community bonding, such as dance, music, prayer, songs, food rituals, etc.

The frameworks of all these actions is to create a psychological community that transcends family, locality, origin (where rural or urban), class, economic group, work affiliation. It is a psychological community with shared concerns and needs. It is utilising networks to network and build a community (ies).

**4.40pm Recommendations for action**

Participants are now asked to develop a range of recommendations for action by their government and non-government agencies and action plans

*Time: 60 minutes*

**Purpose**

*To enable participants to develop a framework of action that can be taken on board by their own agencies*

**FACILITATOR NOTES**

The following recommendations were developed at a similar workshop. They can be used as examples, if necessary, or as points of debate.

1. provide investment towards enabling the development of SHO AIDS Service Organisations through provision of
  - a. finance
  - b. technical support
  - c. access to capacity building training
  - d. address legal issues that may impede NGO development
2. develop close collaboration between GO/SHOs through regular meetings, discussion and sharing information
3. develop a national AIDS Advisory Committee to inform, advise, monitor and evaluate which will include SHOs
4. encourage SHO networking and development of SHO forums, locally, nationally, regionally and internationally
5. increase investment in development of appropriate sexual health services
6. investigate current laws/regulations which impede access to sexual health services and make necessary changes to reduce such impediments
7. in conjunction with NGOs develop and implement national sexual health education programme through a range of institutions addressing all sexual behaviours and STD/HIV/AIDS issues

**FACILITATOR NOTES continued**

8. Encourage and help SHOs to develop community-bases sexual health programmes for males who have sex with males through male sexual health programmes
9. Develop and implement an on-going awareness campaign utilising mass-media
10. increase availability of condoms/lubricants which address issues of concern on quality, quantity, appropriateness, prices, commercial marketing, social marketing and free distribution
11. collaborate with international agencies such as UNAIDS, UNDP through national aids advisory committee to implement agreed polices, recommendations and guidelines locally adapted to address concerns on human rights, service development and accessibility and reduce discrimination.

**5.40pm Evaluation and Closing**

Discuss with the participants how they felt during the course of the training programme. Review their expectations and achievements.

Distribute the evaluation forms to the participants. A sample form appears in the Annex.

Briefly review the purpose of the evaluation form and read the questions to the participants.

Ask each participant to complete the form. Encourage the participants to be as specific and honest as possible.

Tell the participants where to put the completed forms.

Thank all the participants for attending the workshop. Congratulate them for completing the workshop and making the commitment .

Hand out the certificates of completion. See example in the Annex.

Bid the participants farewell.

**Time: 30 minutes**

**FACILITATOR NOTES**

Follow-up discussions should be held with the organising agency in regard to the outcomes of the training programme and possible future training and development

## **ANNEX**

1. HIV/AIDS Questionnaire
2. Notes on the HIV/AIDS Questionnaire
3. Sample evaluation form

## HIV/AIDS Questionnaire

(tick response where appropriate)

1. What is HIV (write in)
  
2. What is AIDS (write in)
  
3. You can catch AIDS?  

true	false	I don't know
------	-------	--------------
  
4. You will get AIDS if you are a :  

prostitute	homosexual	pregnant woman
drug user	haemophiliac	young person
truck driver	other (please state)	
  
5. You can tell if someone has HIV by looking at them:  

true	false	I don't know
------	-------	--------------
  
6. There is a cure for AIDS  

true	false	maybe
------	-------	-------
  
7. AIDS comes from  

Africa	Monkeys	Prostitutes
America	Homosexuals	no one knows
  
8. If you are HIV infected you will develop AIDS:  

true	false	maybe
------	-------	-------

9. You can catch HIV from (please tick response):

	yes	no	maybe
having sex			
kissing			
razors			
blood transfusion			
masturbation			
hugging			
vaginal or anal sex without a condom			
vaginal or anal sex with a condom			
be coughed/sneezed on by a person with AIDS			
being tattooed			
sleeping with a man			
sleeping with a woman			
rimming			
sharing needles			
cunnilingus			
fellatio			
insect bites			
prostitutes			

10. A pregnant woman with HIV will transmit the virus to her unborn baby

yes                      no                      maybe

11. Pregnant women with HIV should have an abortion

yes                      no                      maybe

12. Mothers with HIV should not breast feed their babies

yes                      no                      maybe

- 
13. Having HIV/AIDS means you can't have sex  
true                      false                      maybe
14. Using condoms when having sex will protect you from HIV  
true                      false                      maybe
15. If you have a test for HIV and you test negative this means you have AIDS  
true                      false                      I don't know
16. You can have an AIDS test  
true                      false                      I don't know
17. If you have a test for HIV and you test positive this means you have the virus  
true                      false                      I don't know
18. If you are HIV positive you should tell your  
parents                      doctor                      dentist  
friends                      teacher                      family  
sexual partner                      spouse                      children  
religious leader
19. Having many sexual partners puts you more at risk from catching HIV  
true                      false                      maybe
20. You will not get HIV if you only have one sexual partner  
true                      false                      I don't know
21. Sexually transmitted diseases makes it easier to get HIV  
true                      false                      maybe

22. You can protect yourself from catching HIV by
- stop having sex
  - reading the scriptures
  - staying within our cultures
  - only having non-penetrative sex
  - always using a condom when having sex
  - staying to one sexual partner
  - eating the right foods

This questionnaire and the trainer notes are an amended version from “Working with uncertainty” by Hilary Dixon and Peter Gordon, - A handbook for those involved in training on HIV/AIDS, published by FPA Education Unit, and AIDS Education Unit, Cambridge Health Authority, UK, 1987.

## Notes on the HIV/AIDS Questionnaire

### 1. WHAT IS HIV

Human : you and me - affecting only people

Immunodeficiency: what happens when the body does not fight diseases properly  
a weakened immune system

Virus: an extremely small piece of matter

Descriptions may be given. Check these for validity. Explain each term

### 2. WHAT IS AIDS

Acquired: something you get

Immune: a body systems that protects against disease

Deficiency: a lack of this protection

Syndrome: a group of symptoms and diseases

Descriptions may be given. Check these for validity. Explain each term

### 3. YOU CAN CATCH AIDS: FALSE

You cannot catch AIDS but you can catch HIV, the virus which in some people leads eventually to AIDS. AIDS is a condition, not a disease and is the extreme end of the spectrum of HIV infection. HIV causes AIDS but it does not necessarily lead to AIDS. The majority of people infected can remain well and lead full, active lives.

### 4. YOU WILL GET AIDS IF YOU ARE:

PROSTITUTE	HOMOSEXUAL	PREGNANT WOMEN
DRUG USER	HAEMOPHILIAC	YOUNG PERSON
TRUCK DRIVER		

ANSWER: NONE OF THESE

It is what you do, not what you are that may put you at risk of HIV - or make you a risk to others.  
Discuss. Is HIV/AIDS an issue for everyone?

### 5. YOU CAN TELL IF SOMEONE HAS HIV BY LOOKING AT THEM

ANSWER: FALSE

HIV is the name of the virus. The majority of people infected can remain well and lead full, active lives. When a person becomes ill as a result of HIV this is known as having HIV related illnesses. AIDS can be a consequence.

### 6. THERE IS A CURE FOR AIDS

ANSWER: FALSE

At the present moment, there is no vaccine against HIV and no cure for AIDS. What exists is a range of medical treatments which can slow down the progression of HIV to AIDS. These medicines are very expensive and are not generally available in South Asia.

## 7. AIDS COMES FROM:

AFRICA	MONKEYS	PROSTITUTES
AMERICA	HOMOSEXUALS	NO ONE KNOWS

ANSWER: NOBODY KNOWS

Unless we happen to be epidemiologists or scientists investigating a vaccine or cure, this information is largely irrelevant and often used as an excuse for scapegoating, e.g. gay men, IV drug-users, or for racism.

In any case, new organisms have evolved throughout history, probably through spontaneous mutation; for example, penicillin-resistant gonorrhoea.

What issues has AIDS raised about scapegoating?

Does the sexually transmissible nature of HIV change our perception of it? In what ways?  
What about the term 'innocent victim'?

## 8. IF YOU ARE INFECTED YOU WILL DEVELOP AIDS

ANSWER: MAYBE

With present scientific knowledge we do not know if everyone who is HIV infected will go on to develop AIDS. There are many people who have are HIV infected but have remained well for more than fifteen years. A shorthand way of saying this currently is that approximately 50% of people who are HIV infected will develop AIDS within 10 years. This may be greater in India and surrounding countries for socio-economic conditions.

## 9. YOU CAN CATCH HIV FROM:

HAVING SEX: MAYBE

It all depends whether you are having unprotected sex, that is penetrative sex without using a condom.

What do you mean by the word sex?

KISSING: "NO"

This raises the issues of saliva. Confusion arises out of the fact that scientists have been able to isolate the virus in samples of saliva taken from infected individuals. However, this has occurred under very strict laboratory conditions, and the virus has not been identified in all the samples of saliva tested. It seems most unlikely that the virus is present in saliva in sufficient amounts or in transmissible form for kissing to be considered a risk. Nobody has indisputably been identified as becoming infected with HIV in this way.

If anyone mentions bleeding gums as a risk, what are they doing kissing? Surely it could be quite painful! In normal circumstances wounds bleed outwards, and mingling of blood usually takes place outside of the body. Contact with blood is potentially dangerous anyway, and should always be treated with respect, however the risk is small.

RAZORS: NO

We may need to construct a worst possible scenario in which transmission might occur: for example, cutting oneself deeply with a razor almost instantaneously after it has been used by an infected individual who has also cut himself with it. How realistic is this?

Remember that this is a fragile virus and transmission requires a certain amount of virus. Safety requires good hygiene.

Even this dubious risk could be overcome by:

- a) running the razor under a hot tap
- b) using disposable razors

Would you use a bloody razor or toothbrush used by anyone else without washing it?  
What other infections might you get from a razor?

**BLOOD TRANSFUSIONS: MAYBE**

With the current situation in India and its surrounding countries, whilst officially all blood should be screened for HIV, this may not be so always. Commercial selling of blood has been banned, but this has produced a blood bank crisis. This may mean that commercial blood may well be available on the black-market.

So check what blood you and your relatives will receive should you need an operation.

What precautions can you talk?

**MASTURBATION: NO**

What other words are there for this?

**HUGGING: NO****VAGINAL OR ANAL SEX WITHOUT A CONDOM: "YES**

(See discussion on condoms below.)

What assumptions are being made about the gender by the participants?

Are they men and women, both men?

Does it make a difference whether the sex is anal or vaginal?

Evidence indicates that anal sex is more dangerous than vaginal in terms of transmitting HIV. However both types of intercourse are highly effective modes of transmission.

What words do people really use when they describe sexual intercourse - how do you feel about them? What attitudes might these words convey?

**VAGINAL OR ANAL SEX USING A CONDOM: MAYBE**

This depends on reliability of the condom, lubricant (which should be water-based like KY jelly rather than oil-based such as Vaseline) and the user. People should always use a good quality condom which has an expiry date on the packet. Use before the date has expired. Follow instructions carefully.

What problems do you see in trying to encourage men to use condoms?

What effect do you think the current focus on AIDS and safer sex might be having on young people? What can we learn from the experience of gay men?

How could we help young people?

How are women going to become pregnant?

**BEING SNEEZED ON BY A PERSON WITH AIDS: NO****BEING TATTOOED: NO**

It is wise to deal with this one together with ear piercing, acupuncture, electrolysis and dentists. A worst possible scenario would be infection through a contaminated needle/instrument. However, the virus is unlikely either to live long enough or to be present in large enough quantities to pose a serious threat.

You would be more at risk of Hepatitis B. In any case, if you are in doubt about the professionals you use and their sterilisation or hygiene practices, either challenge them or change them!

For infection to occur a bloody instrument would have to go directly from one person to another immediately after use. In spite of hundreds of accidental injuries with contaminated needles at work, there is no evidence that HIV is a risk to healthcare workers provided they observe the Control of Infection Guidelines issued to them.

**SLEEPING WITH A MAN: NO**

Provided that's all you do with him. However, what about the language people use to describe sex? Does 'sleeping with' imply sex? Are people thinking about a man and a woman or two men? Does it matter?

**SLEEPING WITH A WOMAN: NO**

(See above: sleeping with a man.)

RIMMING: NO

Check out that participants are familiar with this term (which means licking the anus).

Rimming may not be a very effective way of transmitting HIV, but it is certainly a good way of passing on a variety of other infections.

SHARING NEEDLES: YES

If needles are shared with someone who already has the virus it is likely they will inject this directly from the syringe into their bloodstream. However, if the equipment is properly sterilised after each individual has used it this effectively prevents transmission. It is the shared equipment not the drug which is dangerous in terms of HIV transmission.

How do you feel about people who use drugs? What is your stereo-type of the 'junkie'?

CUNNILINGUS: NO TO MAYBE

Check out that participants are familiar with this term which means licking a woman's genitals.

This would seem to be a similar scenario to rimming and fellatio, but for the sake of caution avoid during menstruation. The risk of transmission from vaginal fluids during oral sex is thought to be low because the mouth is not a very effective route of transmission.

FELLATIO: NO TO MAYBE

Depending on whether semen is ingested.

Check out that participants are familiar with this term which means licking or sucking a man's genitals.

Evidence points to oral sex being less of a risk than was first thought. It is seen as a very low risk, but not completely safe. It is wise to avoid pre-ejaculate or semen in the mouth, or swallowing semen.

How realistic is this?

What is the difference between 'safe' and 'safer' sex? How does it relate to oral sex? Would it make, a difference to the safer sex message if oral sex was declared to be low or no risk?

INSECT BITES: NO

The evidence for this comes from the fact that in Central Africa, only babies and sexually active adults get HIV - not children between these ages or old people. If insect bites were a risk the spread would be:

- a) more widespread; and
- b) more evenly distributed throughout the population

What insects might people be concerned about in this country?

PROSTITUTES: NO

This depends on what clients do with them. The fact that they are prostitutes is irrelevant if unprotected penetrative sex (e.g. oral, anal or vaginal) is avoided. It is important to remember that prostitutes may well be experienced in using condoms and in devising adventurous safer sexual activity.

10. A PREGNANT WOMEN WITH HIV WILL TRANSMIT THE VIRUS TO THE UNBORN CHILD

ANSWER: MAYBE

Some statistical evidence from Africa indicates that 30% of pregnant women will transmit HIV to their unborn children

It appears that all babies born to infected mothers have maternal antibody, but an unknown proportion clear this over a period of months. The answer must be, therefore, that we know there certainly is a risk but not the degree of risk.

11. PREGNANT WOMEN WITH HIV SHOULD HAVE AN ABORTION

ANSWER: MAYBE

Pregnancy may be a co-factor in a woman's progression from asymptomatic infection to AIDS therefore termination is an issue for personal consideration. Effective and appropriate counselling should always be offered in such situations.

## 12. MOTHERS WITH HIV SHOULD NOT BREAST FEED THEIR BABIES

ANSWER: MAYBE

HIV does exist in breast milk and can be transmitted to the baby during feeding. But this does not happen in 100% of all cases. The statistics vary from 10% - 30%. Using powdered milk is a possible option but is this true for poor women?

There is evidence from Africa that use of bottle feeding increases malnutrition of babies because of costs. There are also issues in terms of use of polluted water in making the milk preparations.

## 13. HAVING HIV/AIDS MEANS YOU CAN'T HAVE SEX

ANSWER: FALSE

It depends on what sort of sex you will have, whether it is safe, or protected. Many people with HIV/AIDS have a full sexual life by taking suitable precautions or practising safe sex.

## 14. USING CONDOMS WHEN HAVING SEX WILL PROTECT YOU FROM HIV

ANSWER: MAYBE

Condoms are NOT 100% protection against infection. It depends upon quality of the condom and the user's skills and knowledge. If a condom of good quality, is used correctly with liberal application of water-based lubricant, and if penetration is gently, then condoms have a 98% safety record.

## 15. IF YOU HAVE AN HIV TEST AND YOU TEST NEGATIVE, THIS MEANS YOU HAVE AIDS

ANSWER: FALSE

The HIV anti-body test only indicate presence of anti-bodies to HIV. Testing negative means that no such anti-bodies have been detected. It does not mean you don't have the virus. The anti-bodies may exist in such small quantities as to be impossible to test for.

It could mean that you are in the "window period", which is that period in time when you are infected and the period necessary to produce enough anti-bodies to show up in a test. This period could be anything from 6 weeks to 3 months.

## 16. YOU CAN HAVE AN AIDS TEST

ANSWER: FALSE

The test that people take is known as an HIV anti-body test. It tests the bodies reaction to infection from HIV. See above. AIDS is the acronym for a group of systems that result from the virus, HIV.

## 17. IF YOU HAVE A TEST FOR HIV AND YOU TEST POSITIVE, THIS MEANS YOU HAVE THE VIRUS

ANSWER: TRUE

But this will depend on the quality of the test and the technician. There have been cases of "false positives", tests which appear to indicate a false result.

## 18. IF YOU ARE HIV POSITIVE YOU SHOULD TELL YOU:

PARENTS	DOCTOR	DENTIST
FRIENDS	TEACHER	FAMILY
SEXUAL PARTNER	WIFE/HUSBAND	CHILDREN
RELIGIOUS LEADER		

Who you tell depends on your relationships with them. Can you trust them to keep confidentiality. Will they stigmatise you?

In terms of sexual partner this will depend on your relationship and the nature of your sexual activity. Is there or has there been a risk of transmission? However, this may reveal unresolved difficulties of trust and communication, or the fear of rejection, etc.

What advise could you give to someone in this situation? What are the implications?

19. HAVING MANY SEXUAL PARTNERS PUTS YOU AT MORE RISK FROM CATCHING HIV

ANSWER: MAYBE

It all depends on what you do with your sexual partners. If you practice safe sex all the time then you are not at risk no matter how many sexual partners you have.

Practising safer sex reduces the levels of risk considerably.

What is the difference between safe sex and safer sex?

20. YOU WILL NOT GET HIV IF YOU ONLY HAVE ONE SEXUAL PARTNER

ANSWER: MAYBE

This depends on the HIV status of both yourself and your partner and the maintenance of a monogamous relationship.

Can you trust your sexual partner to only have sex with you?

21. SEXUALLY TRANSMITTED DISEASES MAKES IT EASIER TO CATCH HIV FROM YOUR SEXUAL PARTNER

ANSWER: TRUE

Evidence exists that indicate that having a prior history of STD infections increases the likelihood of HIV infection if your sexual partner has HIV. This is because many STD leave lesions which increase possibilities of HIV getting into the bloodstream.

Also having STD weakens the immune system, which enables HIV to increase its ability to develop AIDS in a person.

22. YOU CAN PROTECT YOURSELF FROM CATCHING HIV BY:

STOP HAVING SEX

If you are HIV negative that is - but is this possible for you?

READING THE SCRIPTURES

HIV is to do with what you do sexually. Reading the scriptures might persuade you to change what you do, but in itself is not a preventive measure.

STAYING WITHIN OUR CULTURE

Many prominent individuals in India and elsewhere have made statements that Indian cultures does not have such risk taking sexual behaviours like pre-marital sex, or anal sex, or homosexuality. What do you think?

ONLY HAVING NON-PENETRATIVE SEX

As long as you don't share needles, or that any blood transfusion you get is free from HIV.

EATING THE RIGHT FOODS

This is the same as reading the scriptures. However eating the right foods can help maintain your immune system which can possible help delay the development of AIDS. Or whilst living with AIDS, a good diet can help maintain your body in its fight against AIDS.

# Workshop evaluation

TITLE:

DATE:

AIMS:

## LEARNING OBJECTIVES

By the end of the course participants will have

1. correct and appropriate knowledge on STD/HIV/AIDS
2. a clear understanding of safer sex and its practice
3. a clear understanding of sexual health in the context of males who have sex with males
4. an understanding of the impact of male sexual behaviours upon male and female reproductive and sexual health
5. an understanding of the socio-cultural context in which male sexual behaviours take place

### 1. Did the course meet the objectives to your satisfaction?

Objective	1	YES	PARTLY	NO
	1			
	2			
	3			
	4			

Additional Comments

### 2. How did you find the quality of training? (please circle)

excellent	fair
good	poor

Please comment:

### 3. Have you learnt anything new? What did you learn? Comment

4. *Have you gained new and useful skills? Comment*

5. *Did you feel comfortable with the information presented (please tick)*

Yes

No

Please comment

6. *Were you challenged by the workshop information? In what way?*

yes

no

Please comment

7. *What was the best thing about the workshop?*

8. *What was the worst thing about the workshop?*

9. *Did you find the language difficult? Please comment*

Yes

Some

No

9. What suggestions can you give for improving the workshop

10. *Any other comments.*

