A cultural approach to HIV/AIDS prevention and care: A handbook for India

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ISST has had long experience of research in the area of health and in the recent past has been involved in research on HIV/AIDS. By the time UNESCO came up with the proposal on '*A Cultural Approach to HIV/AIDS prevention and care: A Handbook for India*' ISST was already into various issues related to HIV/AIDS. It would be unfair to suggest that the present report takes into account the entire gamut of cultural diversities prevalent in India in the context of HIV/AIDS. The study that was carried out from August 2000 to January 2001 was a short time for such a vast theme. Within the time frame, field studies were conducted in different parts of India and secondary data was reviewed.

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Glossary of local terms

Arogya	Free from disease
Ayurveda	Indian system of medicine
Babu	Used as a north and east Indian Hindu courtesy title,
Charpai	String cot
Dhanda	Business (in this context it means sex work)
Dosti	Friendship
Gotra	Clan
Jati	Caste
Khel	Play
Kismat	Fate
Mahila mandal	Local women's group
Masti	Fun
Mela	Fair
Panchayati raj	Local self governance
Paraya dhan	Someone else's property
Patita	Fallen woman
Pradhan	Community leader
Purdah	The Hindu or Muslim system of keeping women secluded
Sarvodaya	People's movement in mid-twentieth century
Siddha	Indigenous system of medicine
Swasthya	Health
Taluk	Administrative jurisdiction within a district
Unani	Greek system of medicine

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDU	Intravenous Drug User
IUD	Intra Uterine Devices
MSM	Men having sex with men
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organisation
PHC	Primary Health Centre
PLWH/A	People living with HIV/AIDS
RMP	Registered Medical Practitioner
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNESCO	United Nations Educational and Cultural Organisation
UNICEF	United Nations Children's Fund

I. Introduction

It is said that in India language changes every five miles. There are eighteen official languages and hundreds of dialects. India is largely a rural country and its economy is still primarily agricultural. Approximately 75 per cent of the population of one billion reside in rural areas. The political entity is divided into 35 states and union territories that are further divided into districts. Some of these states are larger than many European countries. Each state has a different language and script, with numerous dialects within that. The people belong to diverse ethnic groups. India's sprawling landscape ranges from mountains and large plains to deserts and the peninsular coasts. In addition, India has had a long history of successive waves of settlers and invaders, which has had its impact on this vast and culturally diverse subcontinent.

A cultural approach to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) care and prevention has to deal with a whole complex of issues. It has to take into account the diversity in religion, languages, values and social laws that are part of people's lives in India. This handbook takes up some of the issues that comprise the cultural matrix that has relevance to the HIV/AIDS epidemic.

Background and extent of the epidemic

In the beginning of the millenium, an estimated 3.7 million adults and children were living with HIV in India. With such a huge population, even low prevalence rates mean a huge number of people live with the virus. The largest number of HIV positive individuals is estimated to be residing in India. The first HIV positive case in India was reported from Chennai in 1986. The major concentration of AIDS cases then gradually extended to 3 states – Maharashtra, Tamil Nadu and later to Manipur. The situation at present is worse with HIV cases spread across states. At the end of 1999, an estimated 1.3 million women were living with HIV in India. Due to high levels of under-reporting, and due to the secrecy surrounding the infection, the exact number of HIV cases in many states is not known. The epidemic is highly diverse across states, while some states show less cases of HIV infection, others have reached a high adult HIV prevalence of two per cent and above in the general population.

In India eighty per cent of the infections are said to occur from the sexual route, the rest occur through intravenous drug use, blood transfusions and through transmissions from mother to child. In the recent years, the pattern of the spread of HIV has undergone a change. It is no longer confined to urban areas, and has spread to rural areas as well. In the earlier years of the epidemic, HIV was largely prevalent among individuals practicing 'high-risk' behaviour and unsafe sex, with multiple sexual partners, mostly sex workers, truckers, homosexuals, and intravenous drug users. Now, the epidemic is spreading in the general population. There are a growing number of orphans and widows who are living with the virus.

Rationale for a cultural approach

The preamble to the Mexico Declaration of Cultural Policies of the UNESCO, dated 1982, defines culture as 'a set of distinctive spiritual and material, intellectual and emotional characteristics', which defines a society or social group. 'Culture' in this sense 'encompasses ways of life, the fundamental rights of the person, value systems and beliefs.'

T. Scarlett Epstein, defines culture as inclusive of behavioural norms of the society and an inventory of solutions. She suggests that the "success of developmental projects depends on changes in social behaviour that are often deeply rooted in traditional cultural norms, without an understanding of which it is unlikely that necessary and socially desirable behavioural changes can be expected to take place." (Epstein, 1999)

The acknowledgement of the cultural dimensions of development would, therefore, amount to the need for grounding the theory and practice of development within a cultural approach, at the level of 'strategy, institutional action, programmes, projects or field work.' (UNESCO, 2000).

Broad epidemiological patterns of the incidence and prevalence of HIV conceal the considerable local, regional and cultural variances in social practice and sexual behaviour in India. It is quite likely that HIV prevention programmes based on epidemiological patterns have had little impact on the spread of the virus. Current programmes of prevention that are targeted to specific social 'high-risk' groups such as sex workers, truck drivers, intravenous drug users (IDUs) may for these reasons miss out on the vulnerability of others who may be equally at risk.

A recent study conducted by ISST on "G*ender Dimensions of HIV/AIDS*' (2000) also corroborates the fact that the prevailing socio-cultural features have significant implications on the spread of the HIV epidemic in India. Cultural practices and codes play a very significant role in relation to HIV/AIDS in India – both positive and negative. For example, early age of marriage for the girl in many parts of India makes her biologically more vulnerable. Cultural restrictions on discussion about sexual matters result in perpetuation of ignorance, often leading to preventable vulnerabilities. Having relations with multiple sexual partners for men, is ignored by society as part of maleness and a necessary initiation into sex, which leads to high-risk behaviour. On the other hand, there is the institution of the family. The Indian family can play a significant role in prevention, and it provides the essential support base for the HIV positive members, irrespective of the social ostracism they might be facing. Similarly, the traditional value systems could form the basis of more effective methods of prevention and care. Cultural influences on institutional care need to be examined as well. Past experiences of AIDS control and prevention projects highlight that care and prevention efforts are more likely to be sustained if they are integrated into the existing community structures. Programmes need to be in stages in the change continuum, so as to understand the needs of the target group, which might ensure the requisite behaviour change.

Objective of the study

This study has been undertaken to provide the basic structure of a handbook for the prevention and care of HIV/AIDS in India, in a manner that is sensitive to the cultural diversities in the country and their crucial significance in formulating institutional preventive and care-giving strategies.

The study seeks to understand the cultural factors that help or hinder the preventive and care-giving aspects of HIV/AIDS within the different cultural contexts.

Methodology

Various methods of qualitative research have been used for the study. These are:

I. **Desk-Based Research** - The study is based on available secondary information on cultural attitudes towards sexual behaviour, gender relations and life-threatening infections.

II. **Field Studies** - The desk-based research is supplemented with data collected by the ISST team in relevant cultural practices and norms in selected communities in different parts of India.

Following methods have been followed to collect data from the fields:

- Case Studies- Interviews and life histories of individuals have been recorded with a view to understand the whole process of socialisation of the individuals in their respective environments with emphasis on their attitudes, way of life, culture of sex, family relations and acceptance within the community.

- Focus Group Discussions- The discussions were held with selected communities and groups with the objective to learn more about their cultural beliefs, attitudes, their treatment-seeking behaviour and their attitudes towards life threatening illness.

- Key Informants Interview- Institutional caregivers, NGO personnel, opinion leaders were interviewed so that more insight could be gained into the behaviour of the community, the kind of ongoing prevention programmes and its impact if any on the community.

Keeping in view the cultural diversity of the country and the time frame, attempt has been made to focus on various communities from different regions including some with special cultural features. The sample is selected from both mainstream communities and people outside the popular mainstream culture including culturally distinct ethnic groups. Four locations/communities has been selected from all over the country:

- Selected communities in **Delhi**: local people and the migrants
- Culturally distinct ethnic groups. e.g., Bedias of Bharatpur, **Rajasthan**
- Men who have Sex with Men (MSM) community and Street Children in **Calcutta**
- Devadasi community of Bellary district, **Karnataka**

The selection of locations and community groups for the study is indicative but not representative of the culturally diverse scenario in India. The selection has been made after the consultations with the advisory committee and the Delhi office of UNESCO after a review of the ground conditions and considerations of logistics.

In Delhi, the discussions were held with adolescent girls and married women from both settled and migrant communities. Focus Group Discussions were also held with migrant male workers and adolescent boys from the lower-income groups and lower middle income groups.

In Calcutta, two interviews and a focus group discussion were conducted with the MSM community. Two focus group discussions and three interviews with street children were organised.

Visits were made to the Bedia community in Rajasthan and the Devadasi community in Karnataka for data on sex workers. Two focus groups and several discussions were conducted with sex workers and other members from both Bedia and neighbouring communities in Bharatpur district of Rajasthan. In Bellary district of Karnataka, three Focus Group Discussions were held with the female members of Devadasi community. Another FGD was conducted with the non Devadasi communities in the same area.

In Delhi, one discussion was conducted with ex-drug users and two key informant interviews were held with activists rehabilitating drug users.

The structure of the Handbook

The present report has been defined as a first step towards preparing a handbook for care and prevention of HIV/AIDS based on a cultural approach to the problem. Clearly this is a huge task and the current study, as noted above, marks only the beginning of the process. Given the complexity of the cultural scene in India, the report has been conceived as consisting of components at three levels of aggregation.

There are five sections. This introductory section is followed by Section II, which provides the macro perspective and an analysis of the general cultural practices and norms of relevance in the Indian society.

Section III presents the insights derived from the field-based studies that covered a spectrum of the population. At one end are the special groups who have been identified as groups of high-risk behaviour in the National AIDS Control Programme, such as sex workers. Two groups belonging to this category that have been studied here are the Devadasi community in Karnataka and the Bedia Community in Rajasthan. At the other end are the select mainstream groups, such as the adolescent boys, married women and

migrant labourers interviewed in Delhi. In between are the groups who do not follow mainstream cultural practices and yet, by dint of their sheer numbers, have large areas of interaction with mainstream population, with implications for the spread of HIV/AIDS. Two examples of such structures reported in this document are MSMs and street children, both from West Bengal.

Section IV draws upon the macro perspective to derive some culturally conditioned beliefs and practices that are of relevance for the care and prevention of HIV/AIDS.

Section V is the conclusion.

II. Socio-cultural Context: A Macro Perspective

Social Organization

Family and Kinship

A discussion on the cultural approaches to prevention and care of HIV/AIDS in India needs to begin with the family. Family is the basic unit of social organization. This is where the socialization process begins, where behaviours and roles are taught and, gender norms are defined. Moreover, the family provides a support structure to the affected individual and thus assumes greater importance in the absence of state-sponsored welfare. It is also important to examine the family's role with reference to the spread of HIV/AIDS because of the modes and pattern of spread. Sexual activity is the mode of transmission in nearly 75% of the cases and the infection is spreading very rapidly amongst monogamous single partner married women who have been considered till now as a lower risk category. Hence, it is necessary to examine the family structure in India, and the implications they have for HIV transmission and care of the infected.

The family in India has to be viewed in terms of the larger kinship system of which it is a part. Even the Indian nuclear family exists in a network of formal and informal ties with other families. It needs to be stressed that there is no single model of the family and kinship structure in India. The different family structures have emerged from different types of lineage systems, patterns of residence and the types of marriage practised by various communities in the country. The different systems have been influenced also by religious ideology, patterns of production, social divisions in the society, ecology and environment, various behavioural norms and cultural constructions of man and woman. Different family and kinship systems bestow different types of rights and entitlements on individuals on the basis of sex, age and marital status. This often determines the right of membership in a family, and access to family resources, division of labour and gender relations.

The most common family structure in India is that of patrilineal descent (succession and inheritance passes from father to son) with patri-virilocal residence (woman after marriage lives with her husband in his fathers house). This system is culturally ideal and has had a strong influence on the values and beliefs, and on gender constructions. Females and males have different status in patrilineal societies. This is reinforced by the fact that men carry the lineage forward, while women move out to become part of their marital homes. Inheritance laws of all religious groups in India are strongly patrilineal whereby the male members of the family are entitled to inherit property by excluding the female members partially or completely. Patrilineal joint families are prevalent, mostly among communities engaged in trade and those who own land. Joint family may exist without property. Smaller joint families are found among traders, artisans, agriculturists and even urban service classes. In the absence of property the joint family functions collectively to pool resources and labour.

Along with patrilineal descent, matrilinity (where inheritance and succession is passed in the female line from mother to daughter) is also practised in a few communities. Matriliny is confined to a few pockets of the country as compared to the wide spread of patriliny across regions and religions. Matrilineal communities are found today in the south-western part of India and in the north-eastern areas. The type of residence followed in matrilineal communities varies. While some are uxorilocal (husband stays in wife's home), others may be visiting husbands, whereas a few have neo-local residence (the couple sets up a new home) and others follow virilocal residence.

Women in matrilineal communities have a higher status than those in patrilineal communities. An important difference between matrilineal and patrilineal communities in India is that in matrilineal communities, men as well as women retain their rights to property, while in patrilineal communities women are excluded from rights in property. In terms of the HIV epidemic, women in patrilineal societies have very little access to resources when they themselves or their families are affected. Even those women, whose marital or natal families own property or are engaged in trade, do not have independent access to resources. Theoretically, women in matrilineal communities are better placed as they have access to property. However, how much of this translates into actual control over their property is a different question.

Caste System

The family has to be viewed in the context of the caste system in India. The caste system is a distinctive feature of Hindu society. It refers to division of society into numerous hierarchically placed hereditary caste groups. The castes are endogamous (marry within the caste group) and accept cooked food only from members of their own castes or those above them in the social hierarchy. Each of these castes is associated with a traditional occupation that is passed down the generations. While the caste system is a social division of Hindu society, caste like divisions are also found in other religious groups.

Integral to the caste system are the notions of purity and pollution. This ideology categorises castes, occupations, tasks, food, bodily emissions as pure or polluting elements. All bodily emissions are considered defiling. Similarly, those castes associated with funerals, cleaning toilets, removing carcasses, etc., are also considered polluting. As occupations are traditionally associated with certain castes, people of other castes do not like to undertake tasks that are considered polluting. In the past hundred years though, many changes have come about in the caste system. Marriage with persons of other castes is becoming acceptable especially in the urban areas and there is a gradual lessening of notions regarding purity and pollution.

The hierarchical caste system in India is a crucial socio-economic as well as cultural dimension. One of the main features of rural India is the presence of numerous, strong, land-owning castes who enjoy high status and wield power over other castes, in particular scheduled castes, landless labourers and numerous small serving castes. Dominant castes also have a tradition of resorting to violence when they find it necessary to enforce their rights over land or other human beings. It has been said by sociologists that anyone who

wants to change or improve living conditions in rural areas in any way has to deal with leaders of the dominant caste as they control access to the people.

Marriage

In India arranged marriages are the norm. The idea of choosing one's spouse is scandalising for many and is viewed by elders as connoting loose behaviour. Courtship if at all, is practised mostly by the urban, educated middle and upper class. Marriage in India is not just an alliance between two individuals rather, an alliance between families.

Marriage in India is a universal institution. For Hindus, marriage is an essential religious duty. Marriage alliance amongst Hindus is determined by various factors. First of all it has to be within the same caste group (*jati*) but outside the lineage and *gotra*.

The Hindu Marriage Act of 1955 made monogamy the rule for all Hindus. Previously every Hindu man was allowed many wives, though in practice only a very small percentage, mostly the very wealthy and powerful traders and warriors practised polygamy. Very often inability to have a child or to have a son was the reason for taking a second wife. Very few communities practise polyandry. Some communities living in the Himalayas and a few other castes in north India and in south are known to practice polyandry. Most of these communities practise fraternal polyandry where the husbands are brothers. Monogamy is rapidly becoming a socially preferred norm even among these communities. For Christians, religion forbids a man from taking more than one wife. Muslims men are permitted to take four wives as long as all are treated as equal. However, the actual incidence of polygamy is very low. Christians and Muslims are also divided into caste like groups based on perceived racial and cultural differences, region, and the Hindu castes from which they converted. These criteria play an important role in spouse selection.

In northern India, village exogamy is also practised. In peninsular India there is a preference for cross-cousin marriage where the girl marries her father's sister's son. Some communities also practice marriages with other relatives such as with the maternal uncle or the mother's brother's son.

For all patrilineal families, marriage is important as a means of social security in old age. The son is looked upon as the one who will provide security during old age. A girl is married and sent to her husband's house, while the son will bring his wife home and look after his parents.

Marriage is regarded as the destiny of all women in India. Though there is no religious compulsion to get women married in Islam and Christianity, as in Hinduism, it is deemed necessary for all women. Men in India are also under societal pressure to get married though not of the same kind as women. Marriage confers on both men and women the status of an adult.

The legal age at marriage for boys is 21 years and for girls 18 years however it is not strictly followed. Even today in rural areas and in urban slums most girls are married at

an age much lower than 18 years. A girl's marriage is related to puberty and a desire to control her sexuality. Though the age at first marriage has been going up consistently there are many who still marry below the legal age.

Mean Age at Marriage

Year	Female	Male
1951	15.4	19.9
1961	16.1	22.3
1971	17.1	22.7
1981	17.9	23.3
1994*	19.4	-
1996*	19.4	-

Source: Figures for 1951, 1961, 1971 and 1981 are from singulate mean age of marriage based on Census data; 1994 and 1996 data are the mean age at effective marriage based on the Sample Registration System. (Manpower Profile India Yearbook, 2000)

In almost all communities in India, a very high value is placed on the virginity of the bride at first marriage. After attaining puberty, the girls' movements are under constant supervision lest she acquires the reputation of 'loose character'. A woman's married state is considered auspicious. Marriage is very closely linked to a woman's fertility and sexuality. In fact, a woman's sexuality is expressed through marriage. Subsequent to the marriage, there is also a lot of pressure on the woman to give birth to a son as soon as possible. Her status rises when she gives birth to a son.

At marriage a woman in the patrilineal system joins the husbands kin. Even if a couple sets up a new residence, it is more in the nature of virilocal residence than neolocal residence. Marriage for a woman means not just incorporation into her husband's family but also total subordination to the marital family. The bride is under the control of the mother-in-law in matters relating to everyday activities, household chores, mobility and use of resources. Control over resources and authority is in the hands of the males. The clout a woman wields in her marital family is determined by her age, her husband's order of birth in the family, his status within the family, his economic status and also by the status, influence and support of her own natal family. A young married woman, especially a recently married one is constantly under pressure not to bring discredit to her natal family. Women are also under the threat of being sent away to their natal homes, where they may not be welcome. Coupled with this is the socialisation of girls that instills in them the idea that the natal home is only a temporary home and that their future is in their marital home. Most families view a daughter as someone else's property (*paraya dhan*, bringing up a daughter is like watering your neighbour's tree). Women thus live with a lot of feeling of insecurity in their marital homes.

Thus girls are brought up to believe that marriage is their destiny and they have to put up with whatever *kismat* (fate) has in store for them. They are under the dictates of the marital family. She is very often treated as property of the family. In real terms this means that the married woman has very little control over resources, mobility, leisure time and even her own body.

These values strengthen the gender discrimination in the marital family when someone suffers seriously from any health problems in the family. The wife has to act as the main caregiver in the family, which is her prime duty, even if she herself is ill. In many cases she is deserted by her marital family, if she is unable to put in her share of work. A woman has to bear a lot of stigma as a widow and if the husband dies of AIDS related illness the marital family often sees her as a bad omen. She is often sent back to her natal family and sometimes she is not allowed to take her children.

Widowhood amongst Hindus is strongly associated with inauspiciousness. It was believed that widowhood was brought about due to sins committed in the previous birth. Divorce and widow remarriage, though traditionally forbidden to patrilineal upper caste women, were practised among lower and some middle castes. However, today amongst upper caste widows, remarriage has gained acceptance to some extent, especially in urban areas. A widower on the other hand faces no such difficulties. He can marry any number of times. He is not considered inauspicious. Widow remarriage is practised among other religions though everywhere widow remarriage becomes difficult when the woman has children.

Some castes in the north-western part of India are known to practice leveratic marriage that is slightly different from the typical leverate. The practice in India is for the widow to marry her husband's younger brother, though marriage with husband's elder brother is not unknown. The children born from such a union are considered the married couple's children and not the dead man's as in some parts of Africa. Sorority marriage of a widower with his wife's younger sister occurs in most parts of the country.

The strong institution of marriage with associated strong marriage rules and conventions often results in a situation where individuals have to give in to societal pressure. The rules of marriage such as cousin marriage, leverate and sorority sometimes play a negative role with reference to HIV. Despite knowing their HIV status, individuals are forced to marry under social pressure. On the other hand, widows whose husbands have died of HIV related illnesses but themselves are HIV negative, face a lot of stigma in society and, in spite of the growing acceptance of widow remarriage they find it very difficult to get married again. This is compounded by the fact that women in strong patrilineal systems as it is in India, have very little access to resources.

As communities and families move up the social hierarchy, they take up some of the lifestyles of the upper classes and castes. Amongst Hindus, it is manifested in withdrawing women from the workforce, increasing rituals and adopting the practice of giving dowry instead of bride price. Amongst Muslims, *purdah* is a mark of status and upward mobility. Whereas in poorer families, necessity prevents segregation. Thus, there is an interesting aspect of greater segregation of women as the family status improves. At the same time, amongst both Muslims and Hindus, women with western education and employment opportunities in the urban upper and middle classes are moving out of segregation.

Sexuality

Sexuality has different meaning for different people in different contexts. Sexuality is a comprehensive concept that encompasses the physical capacity for sexual pleasure as well as personalised and shared social meanings attached to both sexual behaviour and the formation of sexual and gender identities. Sexual behaviour and attitudes are constituted within complex political, social, economic and cultural contexts. Sexuality is understood as a complex social construct that has different meanings within different communities and societies, and one that has diverse expressions within and across age, gender and social class.

An important aspect of sexuality in patrilineal India is the control exercised over women's sexuality. It becomes most evident at menarche. From here on segregation of girls begins. They are withdrawn into the house and a close watch is kept on their movements. Seclusion and segregation are closely linked with ideas of female chastity, modesty and femininity.

As mentioned earlier, a woman's sexuality is mediated through marriage in most communities in India. While there is a premium placed on the virginity of the bride at first marriage, the same is not true for the man. After marriage a woman is expected to be faithful to her husband while digressions by the man are overlooked.

Sexual activity and behaviour is considered to be the man's domain, and a woman is not expected to take the initiative. A woman is not supposed to know about sexual matters or else she is labelled as 'loose' and suspected of infidelity. She should remain 'innocent' and know nothing about her body, contraceptives, and sexuality. Cultural norms do not allow a woman to show desires or question sexual behaviour of her partner. Sexual activity for women is considered a duty for procreation and to fulfil her husband's wishes. A woman who resists or expresses unwillingness to fulfil her husband's desires is threatened with desertion. Thus, a woman is rendered more vulnerable, due to lack of knowledge and lack of control over her body, to sexual violence within marriage and STIs including HIV.

While there is strict control over female sexuality the same is not true for males. There is no pressure on men to remain virgins till marriage, neither is there a big stigma attached to pre-marital sex for men. Studies from all over the country reveal that sexual activity is high among adolescent boys. Between 12-25 per cent of patients at sexually transmitted diseases (STD) clinics are in their teens. The first encounters are mostly with sex-workers or with other boys.

At the same time men with other sexual orientations are under very strong social pressure to get married and procreate. This results in a situation whereby homosexual men are forced into a heterosexual union through marriage and continue with their homosexual activities at the same time.

Socialisation of the man in Indian society, takes a different path than that of the woman. Here the man has to prove his manliness and sexual desire, otherwise he would not be

considered strong. Visiting a sex-worker by a man before marriage is ignored by the society. This acceptance is rooted in a general notion that the man has to be knowledgeable about sex, so as to lead the woman who should be innocent about sex and sexuality. The man is viewed as sexually powerful and a woman as sexually passive.

For any programme to succeed, a deeper understanding of sexuality is necessary to find out people's sexual attitudes and why they behave that way. The whole gamut of kinship structure, systems of marriage, and ideologies about gender and sexuality shape the concept of sexuality within a society, and should therefore be integrated in this process of understanding. Each of these systems structure sexual relations differently, and the differences are compounded when it involves people of different status and with unequal capacities to negotiate for safer sex. These processes and sexual interactions, therefore, have grave and differing consequences for the vulnerability of different groups to HIV.

Health Care

Health Infrastructure and Access to Health Care

The concept of health varies from culture to culture. Standards and concepts of health are geographically, culturally and historically variable, as they change over time in response to changing socio-economic and cultural patterns and also to prevailing systems of health care. In the traditional Indian systems of medicine there are two terms used for health: *arogya*, which signifies recovery from ill health and s*wasthya*, which is not a mere absence of diseases, but a positive state of well-being. The latter is a preferred concept. The definition of s*wasthya* is closer to the WHO definition of health.

The demand for health care is constantly increasing with development and increasing public awareness. In India, three stages of health problems are prevalent:

- health problems associated with underdevelopment
- the diseases of the affluent
- environmental and behavioural threats among all population groups.

India has a wide spread health delivery system. Health care is provided by public, private and voluntary bodies. Along with allopathy, other systems of medicines such as *unani*, *ayurvedic*, homeopathy, *siddha*, etc are practised. There are 85 hospital beds and 110 doctors per one lakh population. However there is a very strong urban bias visible in the delivery of health care. 80 percent of the government health care and two thirds of the private practitioners are in urban areas while 70 per cent of the population resides in rural areas. 80 per cent of the doctors are in the private sector and 60 per cent of them practice systems other than allopathy.

There is wide spread network of the government health system all over the country. At the centre, the Ministry has three vertical line departments: the department of Family Welfare concerned with population stabilisation programmes, reproductive and child health; the department of Health, which deals with medical and public health, drugs control, food adulteration, research and education; and the department of Indian Systems

of Medicine and Homeopathy. In rural areas there is one community health centre for every 120,000 population, one Primary Health Centre (PHC) for every 30,000 population, and a sub-centre for a population of 5000. The sub-centre has one female and male multi-purpose worker each and link the community to the health care system. The PHCs are staffed by one trained doctor and a number of paramedics. While the government health system is present in every district, it is grossly inadequate and unevenly distributed.

It was only after the International Conference on Population and Development (ICPD) in Cairo that reproductive health as a concept and ideology was acknowledged. The government tried to integrate the reproductive health services in the PHCs but most government programmes have generally ignored the fact that reproduction takes place through sexual relations, which are conditioned by broader gender relations.

On the curative side, there has been marginal growth of hospitals and PHCs across states, and there is an absence of referral services. In majority of the states, there has been no significant increase in hospitals and beds from the mid-1980s to the early 1990s. The marginal increase is inadequate to meet the growing demand for services. Shortage of medicines and drugs are also rampant. A major failure of the public health system has been the insensitive and impersonal attitude of doctors and other caregivers within the system.

One of the pre-requisites for good health is access to health care. Access to health includes three components: locational access, economic access and social access. Even today, a large number of people in India are unable to access health services due to economic, social and locational reasons. Access is also integrally related to cost of health care. Health services have been extended to PHCs and sub-centres in rural areas, yet this strategy has had only partial success in reaching adequate health services.

There is meagre information on the cost of health care in India and how the extensive public health care delivery system is utilized. The demand for health care is of two types, one for in-hospital treatment and the other for out of hospital treatment. Costs also depend on who provides health care, government or private hospitals. In-patient care requires institutional infrastructure facilities. At the all-India level, 60 per cent of the in-patients get treated at government health care institutions. The proportion is similar in both the urban and rural sectors. Broadly 80 per cent or more of in-patients receive treatment from the public health care system in the less developed states like UP and Orissa while the corresponding proportion is 40-60 per cent in the more developed states like Kerala and Maharashtra. Higher proportion of in-patients being treated by the public care system in the backward states is not an indication of its accessibility or its efficiency. For example, Orissa has 40 beds per lakh population and U.P has 45-50 beds per lakh population. This clearly indicates that government health infrastructure is grossly inadequate in these states. The higher utilization of the public system also reflects the poor development of the private health care system in these states. High levels of poverty and low incomes presumably restrict the demand for private health care. There are some differences in the pattern of utilization of health care facilities between the rural and the

urban sectors. A slightly higher number of in-patients are treated in public hospitals in the urban sector, reflecting their urban locations and easier access.

Dominant forces, often caste-based, present in local society may want health care diverted in a certain direction and might even prevent care from reaching some others.

The burden of home care has always been on the woman. The woman has the least access to health care, due to her low status in the marital family. This is related to both cultural ideas as well as unavailability of health services. The problem compounds due to lack of female doctors whom women can visit. This problem is more acute in the rural areas than in urban centres. In the absence of a female doctor, women find it difficult to get physically examined by the male doctor. Most of the time the male members accompany her to the doctor, and she is unable to communicate her health problems openly. Most of these times, therefore, she resorts to self-medication or traditional curative methods.

Available studies in India indicate that HIV positive women do not receive the same care and support as men. In many cases, the positive married women, whose husbands have died of HIV related illness were either turned out of their marital homes or denied proper health care.

Reproductive Health in India

Reproductive health issues in India and globally have emerged from the women's movement and from a critique of population polices by the women's movement. Reproductive health was brought centre stage by the ICPD in 1994, not just in India but all over the world when the governments of the world agreed to address issues of women's health including reproductive health, education of girls and empowerment of women.

Reproductive health issues have a special significance for HIV/AIDS in India, as heterosexual transmission is the most common route. It is well established that where heterosexual transmission is the route, HIV spread is more efficacious from man to women than vice versa. Different estimates show the transmission from man to woman is 1.5 to 4 times more efficient than from woman to man for physiological reasons.

It is also well known that the efficacy of transmission increases when one or both partners are suffering from sexually transmitted infections (STIs). Lesion, inflammation or any other damage caused by STI facilitates the transmission of the virus during sexual intercourse. In this regard, women are at a greater risk for both biological and social reasons.

There is no large-scale data available on the incidence of STIs, even though STIs were the third most important group of diseases in the country, next only to malaria and tuberculosis (TB). The data available from sexually transmitted diseases (STD) clinics, even though from a predominantly male population, shows that the incidence is quite high. Women report less at STD clinics due to cultural taboos, restrictions on mobility, non-availability of user-friendly services, lack of resources, lack of support from the male

partner and also because most STIs are asymptomatic in women. The few studies on the incidence of STIs in women have been carried out by NGOs in small community settings show an alarming scenario. One study showed that up to 70% of the women screened in a community were found to have one or more STI.

Studies also show an interesting difference between patterns of STIs between north and south India. A higher number of men reported sex-workers as the source of infection among male patients visiting STD clinics in the South as compared to the North. This has been linked to a greater degree of urbanisation in the south. Studies in northern India show a slightly higher percentage of sex with relatives and friends.

Studies also show that between 40 to 60 per cent of patients visiting STD clinics in various parts of India report having picked up the infection from sex-workers. Sex-workers in cities are known to have, on an average, about seven partners during the course of the night. Studies also show that sex-workers suffer from one to three STIs. But they lack the knowledge about cure and prevention of STIs and are unable to demand condom use from their clients.

The reasons for such a high incidence of STIs are not difficult to understand. There is ignorance among the general population about the causes, early symptoms and even about STIs. Apart from this is the lack of treatment and diagnostic facilities for STIs. The problem is very acute in the rural areas where the government-run primary health system is the only health care available.

Patient attendance at STD clinics are predominantly males from the economically low-income strata, while men from middle and upper strata avoid reporting to STD clinics owing to stigma. Most prefer to go to private practitioners who may neither have specialised training nor diagnostic facilities to deal with STIs, and many also end up with unregistered medical practitioners. Between 30-40 per cent of male patients visiting STD clinics are repeaters. Male patients at STD clinics show a great deal of reluctance to bringing their wives or sexual partners for examination. Amongst women patients visiting STD clinics, there is a high percentage of young married women between 14 – 25 years of age. Unmarried adolescent girls are totally left out of any sort of treatment.

Many women suffer silently due to ignorance and also because they feel that it is normal since most women suffer from the same problems. Another important reason is the ‘culture of silence’ over issues regarding sexuality and reproductive health. There is a strong stigma associated with STIs. The result is that women never speak about these issues for the fear of being labelled as ‘loose’. The more tangible fear is that of being suspected of infidelity by her husband and marital family if it is known that she suffers from any STI irrespective of the fact that she may have contracted it from her husband.

Among women, problems of the reproductive tract also aggravate the situations. Inflammation and trauma caused by frequent and difficult deliveries, intra uterine devices (IUDs**)**, induced abortions, etc. are also the cause of many infections of the reproductive tract. Apart from STIs, sexual trauma, forceful penetration and early age of women

engaging in sexual activity also lead to damage to the vaginal lining and that increases the possibility of transmission of the HIV infection to the women, if her partner is already infected.

Among women, due to biological reasons, many of STIs, which cause lesions/inflammation, may remain asymptomatic or may cause vague, non-specific symptoms and therefore may remain undetected. In addition, for anatomical reasons, diagnosis is a much-complicated process involving internal examination and laboratory tests, which makes diagnosis difficult. Pre-natal and gynaecological clinics in many public hospitals that are more accessible to women do not have diagnostic facilities for STIs. The problem is most acute in rural areas, which lack any sort of heath care leave alone treatment of STIs.

While there is a general lack of health services for the treatment of STIs, the situation is worse in rural parts of the country. The situation is also especially bad for women who find it very difficult to get access to STI treatment. A lack of female doctors, especially in the rural areas compounds the problem.

Poverty and Unemployment

Globally the HIV epidemic is the highest in Africa, which is one of the poorest regions of the world. However, there is no evidence to suggest any direct correlation between the epidemic and poverty. Many of the countries affected are the richer countries of sub-Saharan Africa. An examination of the situation in India also does not throw light on any such link. On the other hand, the states of Maharashtra and Tamil Nadu, where the epidemic spread first, are among the more industrialized states. Yet, incidence and patterns of spread do indicate a complex relationship with poverty, and factors closely related to poverty may lead to a kind of risk behaviour or make people more vulnerable as far as HIV/AIDS is concerned.

India has the dubious distinction of being a country with the largest concentration of people living below the poverty line. A broad feature of the Indian labour market that may be of relevance in the present context is the high degree of mobility observed in the lower rungs of the market as a result of a high level of disparity in regional development, manifesting itself in significant regional differences in job opportunities. This has given rise to much rural-to-urban migration, both within and outside state boundaries, much of which is circular migration.

Thousands of young men migrate from rural to urban areas in search of employment. Very often it is the men who migrate leaving their families behind. It has been found all over the world that circular migration has led to increase in the spread of HIV/ AIDS. As these young men leave their wives behind, they often form partnerships and relationships with other women in urban areas, which might even be linked to peer pressure. Unemployment may also lead to other types of risk behaviour such as subsistence abuse.

Poverty is directly related to nutritional status and health seeking behaviour. This is especially relevant with respect to STIs. The poor in India have low nutritional status that makes them vulnerable to many types of infections and diseases mostly due to deficiency of Vitamin A and iron, which affect the immune system. This makes them more vulnerable to acquiring STIs including HIV. The poor also have less access to health care and therefore many of the STIs remain untreated. In this respect, it is worth noting that in the poorest households women have the dice loaded against them in terms of food, access to health care, a heavy workload and various cultural taboos and restrictions. For many poor women, sex work is often the only means of earning a livelihood and maintaining the family. In these situations poor women become vulnerable to HIV/AIDS not only because they have multiple partners but also because they are unable to bargain for safe sex with their clients.

Education

Education is often viewed as the panacea of all social and economic problems affecting the country. It is used as one of the indicators for measuring social development. It is believed that universal education is necessary for the economic development of the country. Education is deemed to have a positive correlation with population control, decrease in maternal mortality, child survival and so on. In the gender debate, education amongst women also leads to enhancement of women's status.

Education for all is enshrined in the Constitution of India. Article 45 of the Directive Principles of State Policy states, 'the State shall endeavour to provide within a period of ten years from the commencement of the Constitution, for free and compulsory education for all children until they complete the age of fourteen years.' Yet, today, India is far from achieving the goal of universal elementary education.

The causes for such high illiteracy are varied. Many of the differences across regions are because education is under the purview of individual states. An important element is the lack of schools in many areas in spite of progress made. According to a survey, in rural areas 94 per cent of the population has a primary school within one kilometre but 57 per cent of the population has a middle school within one kilometre. Apart from this are the social barriers to access to education. Due to seclusion of girls, many parents are unwilling to send their daughters to schools which are further away. In poor families girls are the first to be withdrawn in times of crises.

In all regions, literacy rates are much lower for women than for men. According to the Human Development Report 1998, only five countries have female-male literacy gap greater than India: Bhutan, Syria, Togo, Malawi and Mozambique. And no country has a gap larger than the state of Rajasthan.

The other problems faced are lack of infrastructure in schools and of the basic requirements of running a primary school. The quality of education is abysmal in many government-run schools. A low student teacher ratio, a situation when a single teacher has to handle multiple classes regularly and absconding teachers add to the problem.

A very important issue is that of the content of education and what is education meant to be. Education for the planners has been to enable the population to know the three 'R's' (reading, writing, arithmetic), but what is equally important is the curriculum, especially in view of the HIV/AIDS epidemic. In a study done in Delhi, it was found that years of schooling had a positive correlation with knowledge about HIV/AIDS, partly because it was part of the curriculum, although that did not mean an increase in autonomy or decision making power.

Most schools are yet unwilling to take a proactive step in including sex-education. This is because of the stigma attached to 'sex' and unwillingness on part of the teachers to discuss these issues.

Community Organizations

Panchayati Raj

The *panchayati raj* institution (PRI) in India has been an age-old institution of local self-governance through which people can participate in decisions and activities concerning their own welfare. Panchayat literally means an assembly of five elders who lead the administrative, judicial and development activities of their villages. This is the only vehicle for relevant and participatory development. The local structure of governance i.e. the PRI can indeed take on the task of making the health care system at the grassroots more accessible and more transparent. There have been a number of successful attempts at using the *panchayats* as the major channels for health service delivery. However, there have been objections against the functioning of the PR system: the powerless are kept out of the structure, it strengthens the traditional strongholds of power. However, efforts are on to strengthen the system. Decentralized planning is replacing the top-down approach and includes wider involvement of non-governmental and community organizations. The establishment of effective two-way referral systems between the community level and various levels within the health service system is critical for effective implementation of preventive and curative health services. The *panchayati raj* provides an opportunity for mobilizing community leaders, *mahila mandals (*local women's groups), village health workers to organize for emergency referrals. However, they have yet to define their roles in implementing health programmes and developing linkages with government and NGO institutions.

Non-governmental organizations (NGOs)

The roots of voluntary action in India as a concept can be traced back to the functioning of social institutions in the medieval period. The earliest NGO efforts were motivated by religious zeal, like the missionary activities in education, health and nutrition, economic assistance etc. Social reform movements against social prejudices by religious groups also emerged in the early part of 19th century. The *Sarvodaya* movement in mid-twentieth century made the maximum impact after independence. Many NGOs started work in different areas with health interventions, tackling issues of employment, education, and agriculture. From the late 70s the idea of people's participation began to emerge, and charity orientation gave way to emphasis on self-reliance. In rural field projects, village

health workers were locally selected, trained and employed for health services. During 80s the NGO movement became stronger and NGO representatives were given place at the policy level and the women's movement was at its peak. Empowerment, commitment and participation were the key strategies.

NGO field projects working in the area of health have different orientations and all the projects provide knowledge borne out of actual experiences. An important lesson from most of these NGO experiences is that most of the health problems of the community can be tackled by members of the community itself, if provided the necessary knowledge, encouragement, training of local workers and support. The inter-personal relationships that NGOs maintain with the communities has always been the motivating factor towards effective implementation of development programmes, unlike the impersonal attitude at all levels of the public health system. Sensitivity to cultural and social factors seems to be the key to effective health care. Openness and communication with the community is vital. This includes granting due respect to traditional health practices, and attempting to incorporate folk remedies. Only a person familiar with members of the community, their language, lifestyles, health beliefs and practices, is able to influence health behaviour. NGO experiences also teach that community-level health services need an adequate referral system.

There have been many non-governmental organizations that have had successful health intervention programmes in different areas. These programmes have been successful because they do not view health as an independent parameter but as an integral component of a complex set of socio-economic, cultural and political factors. Participation by the community has been an essential ingredient of NGO programmes.

NGO responses to HIV/AIDS prevention and care

With the increasing number of HIV cases in India, the shortcomings of the existing public health structure has been much in focus. Number of NGOs have started work on providing support to people living with HIV/AIDS along with community outreach prevention programmes. These are organizations that are directly providing care, counselling to the positive person and the family. A number of existing NGOs have integrated HIV/AIDS prevention programmes within their other development programmes. Several NGOs are attempting to change the negative attitudes of people and their misconceptions about HIV/AIDS in general and among injecting drug users, sex-workers, and truck drivers. These programmes aim to promote safer sex through community based interventions. School children and university students are reached through extra-curricular activities. University Talks AIDS programme is one such attempt to get across to the youth and promote positive attitudes and healthy lifestyles. NGOs are also reaching out to children in schools through educational sessions on HIV/AIDS and sexuality.

The importance of designing interventions for HIV/AIDS prevention among women in general population has begun to be recognized only recently. Efforts are being made to raise awareness, provide information, and strengthen women's capacity through empowerment processes. A broad picture of the range of HIV/AIDS interventions

focusing on women include: interventions designed to empower women, interventions addressing the problems of HIV/AIDS, interventions employing a need based approach and HIV/AIDS prevention in the context of reproductive health.

Despite these efforts, the majority of the non-governmental institutions providing health services are located in urban areas, though there are several examples of successful referral systems in the NGO sector. Very few NGOs provide comprehensive programmes and strengthen referral links. The number of STD services and clinics around the country needs to be increased, and problems of STDs have to be integrated with the reproductive health package. Blood screening facilities are not being utilized by many of the hospitals. There is a high demand for provisions of care institutions like care homes, hospices. The state has spoken about hospices, which need to be developed and implemented through NGOs with the involvement of people. There is a need for professional support in care and counselling people living with HIV/AIDS (PLWH/A).

Government Support

Soon after reporting of the first few HIV/AIDS cases in the country, the seriousness of the problem was recognised and the National AIDS Control Organization (NACO) was set up. Surveillance centres with HIV testing facilities have been set up all over the country to test and report HIV infections. The aim of the NACO is to establish a comprehensive, multisectoral programme in India that would: prevent HIV transmission, decrease morbidity and mortality associated with HIV infection and minimize the socio-economic impact resulting from HIV infection.

The national plan also included improving the level of knowledge amongst medical personnel, to ensure HIV free blood and blood products through blood safety programmes, running public information campaigns on condom promotion and programming, service delivery, STI treatment, counselling and testing centre. NGOs were encouraged to integrate HIV/AIDS activities within their ongoing programmes instead of setting up exclusive AIDS prevention projects. Efforts were also made to promote collaboration with the Department of Youth Affairs and Sports, through the Universities Talk Project, a peer education programme for colleges. HIV/AIDS prevention is one of the services provided under the broad area of reproductive health, contraception, mother and child health care, safe abortion, reproductive health infections and sexual health.

Facilities and trained manpower for sex counselling were found to be inadequate, particularly for handling counselling for HIV/AIDS. Counselling was essential before and after test results especially in helping infected and affected persons to cope; in changing to safer behaviour by those who were at risk; and for those who had doubts, queries, or fears regarding HIV/AIDS. Some successful targeted interventions were initiated for the prevention of HIV/AIDS.

Although the strategic plan was comprehensive, implementation was not easy. The programme didn’t do as expected and was unable to generate a sense of urgency. It became difficult to reach out to diverse cultural groups in the country. Denial persisted even as the reported number of cases tested positive for HIV crossed 66,000 which was

actually an underestimate as per UNAIDS. Denial impeded the implementation of the programme. The conclusions were that infection in surveyed 'risk groups' (sex-workers, MSM, truck drivers, IDUs etc.) was increasing rapidly, which strengthened the prevailing stigma and negative feelings about the risk groups and reinforced the notion that HIV/AIDS is restricted to those 'risk groups'. These countered efforts to make HIV/AIDS everybody's concern. Confronted with this intensified denial, the approach that 'everyone is at risk' did not ring true in the minds of the general public.

Another major difficulty still is that more than a decade into the epidemic and after number of years of surveillance, there still seems to be no consensus on the epidemic. There are widely different estimates about the magnitude of the problem. Although the creation of awareness about HIV/AIDS was a primary goal, the overall awareness in various sections of the population still remains very low. This was mainly due to the cultural sensitivity and inhibitions that hindered open discussion about sexuality and also limitations of the approach, the methods and materials used for information, education, and communication. Not enough attention has been given to monitoring the quality of material produced and even less to assessing the impact of different materials, media and approaches. Most visual material failed to make the link between what was seen as blood borne disease and the use of condoms. The socio-cultural context, values, customs and social status, socialization process and concept of sexuality were not adequately explored. Programme staff did not understand how all these affect interpersonal communications, sexual decision making, sexual practices and behaviour.

Various methods have been made to implement these plans but the goals have not been achieved and there are still wide gaps in knowledge among medical practitioners and low level of awareness among the public. In populations where awareness is high due to the various intervention programmes there hasn't been much internalization of this knowledge and therefore, it has not translated to behaviour change. Focus has been more on prevention programmes, interventions and care have not been a priority.

The major problem is one of adequate supply. Institutional care by the public and voluntary sectors is very few and inadequate and does not meet the demands of the people seeking treatment. Small fragments of the population i.e. the organized sector have some sort of security cover under various government acts and provisions. As most of the workforce does not come under the organized sector, government's security services do not reach them. Increasingly materialistic and self-seeking professionals have replaced the breed of professionals who were responsible for the initial achievements in Public Health. A lot has to do with distortion of values and work ethics in these caregivers. The expensive curative medical services provided by the private sector catering to the urban elite's is very discriminatory, and more of such institutions are needed in the rural settings and in the urban slums.

HIV/AIDS in India is by and large still a hidden infection. Caregivers forget the professional ethics and carry their own biases to their workplace. The reaction to HIV among healthcare workers is often dependent not upon what they know about the virus, but what they believe they know.

This reaction includes an exaggerated fear of contagion and an instinctive categorization of the infected person. The key role of healthcare workers and all intervention programmes should be to ascertain the nature of the prevailing mythical frameworks and to provide alternative narrative based upon rational truths and sound ethical principles.

III. Socialisation, Heterogeneity and Power equations: Findings from the field

Strategically, HIV/AIDS prevention and control programme is now principally oriented to special groups for several reasons. There is evidence that these groups are more vulnerable to the virus than the general population and given the large population of India, targeting programmes for smaller groups are easier to start with.

However, it needs to be noted that all these groups and communities studied, whether practicing high-risk behaviour or otherwise, are not isolated groups, but are in constant interaction with each other. Findings from the field indicate that the interaction between the various communities blur the boundaries between the low and high-risk groups. Lack of infrastructure in terms of health care, education, employment combined with patriarchy increases the vulnerability of all sections in the society.

In this study, the findings have been collated from groups and communities who are viewed as practicing 'high-risk behaviour' as well as those who are considered at "low risk". The low risk groups are represented by the discussions in some lower income communities in Delhi. Traditionally, MSM, sex workers, and intravenous drug users are among those considered as practicing high-risk behaviour. Street children have been included as group that is highly vulnerable.

Settled and Migrant Communities in Delhi

The so-called mainstream community is becoming increasingly vulnerable to HIV/AIDS in India due to lack of knowledge, awareness and unsafe multi-partner sex. The position of women in the society, socialisation of boys and girls, segregation, the culture of silence and the taboo on discussions on sex contribute to the increased vulnerability of the low-risk groups. The ISST study on Gender Dimensions of HIV/AIDS in 2000, reveals that even the single partner married women are vulnerable, those generally considered to be a least risk group.

Our field studies with married women, adolescent boys and migrant workers confirm alarming trends of high risk for HIV/AIDS among these mainstream groups. Discussions with workers of an NGO working in the low-income groups in Delhi, further corroborated the appalling state of health care in Delhi slums and the resulting risks of HIV/AIDS.

Due to increasing unemployment in rural areas, migrant and/or seasonal workers constitute a large part of the labourforce in most Indian cities. This group, though very much part of the mainstream workforce, happen to be a very high risk group, due to long separation from their wives and the resultant risk-prone sexual behaviour.

The Focus group discussions were conducted in a community with lower middle class population and squatter slum settlements. The local people are the owners and let out rooms to the migrant population. The migrant populations are mainly rickshaw pullers,

small-scale industrial workers, tailor and are in the unorganised sector from Haryana, Bihar, U.P. and Rajasthan.

Socialization

A girl gets married soon after puberty. The parents started looking for a groom when they started their menstrual cycle. They all reported that their mothers had said '*you have grown up now and you have to behave yourself*.' A girl does not discuss these things with her parents because it is not considered proper. Sometimes she may be able to tell her sister, sister-in-law or mother but it does not make a difference. Even if the boy has a bad reputation, the girl has no choice. She is told that it is her fate (*kismat*).

The daughters-in-law in a family never sit on the *charpai* or cot. They sit on the floor, as they are not allowed to sit at the same level with their mothers-in-law. The custom depicts the subordinate status of daughters-in-law in the family. They also keep a full or partial veil when they walk about in their neighbourhood. The daughters-in-law also cover their faces completely when any man happened to pass-by. The mothers-in-law, on the other hand, did not observe any veil and joked with the men in the neighbourhood.

In most cases, the girl is married to an older boy. Under this circumstance, the girl becomes more vulnerable as her newly married husband might have had premarital sex.

'*Men also go to the sex workers before marriage. If he does not get married in time, he might take the 'wrong' path'*, says an aged participant of a focus group discussion in Delhi.

Moreover, there is a broad trend in Indian society where the man has to prove his manliness on the first night of the marriage. In many cases, the man visits sex workers before marriage to gain practical knowledge on sexual intercourse. As the use of condom is low, there is an increased risk of getting infections, which could be further transmitted to his bride.

Boys typically are given more freedom than girls, though adolescent boys are exposed due to the lack of knowledge and taboos. Moreover, sexual outlets are often accepted for growing boys and youth as a necessity. A lot of emphasis is also placed on the boy's "character" as well, and a certain degree of control is exercised by many parents over their son's actions. Girls are often viewed as evil and the cause for luring away boys.

'Adolescent boys might be visiting sex workers. We can't keep tabs on where they are going. But if we get to know then he'll get a sound thrashing. We keep an eye on the young girls. Girls are equally responsible for luring boys. Why should we always blame boys? Parents should therefore keep an eye on their children…'

'If we feel there is something obscene being shown on the television then we don't allow our children to watch it and switch it off. Children who are sensible won't watch these programs'…

'Couples should change the sleeping arrangements. If the children are grown up enough to understand what's happening then the child should not sleep next to his or her parents.'

Source : Focus Group Discussions with married women in Delhi.

Whether accepted or not, it is a fact that adolescent boys are initiated to sex early in life, mostly through visits to sex workers or friends of the same or different sex.

'*Many of our friends visit sex workers. Boys have a curiosity for going to sex workers as they hear stories from older boys and also want to experience sex… in the peer group, it is related to the prestige and status in the group. Friends laugh at the boys, who do not have any experience in sex*', says boy of seventeen years. '*The incidence of homosexual activity and bisexual activity is prevalent among boys in our community. Sometimes, older boys and men force younger boys to have sex*'.

Source : FGD with adolescent boys in Delhi

Visiting sex-workers is not uncommon among the migrant labourers. Due to long separations from their wives, they tend to visit sex workers, very often it is done under peer pressure.

'People do visit sex workers, sometime on G.B. road sometimes here in nearby areas…even here in our locality, women are available.' Says a participant in the FGD who has come from U.P. '*Otherwise, what can a person do when his wife is not here?'* says another.

Source : FGD with migrant labourers in Delhi.

Women's Health

The common illnesses around the community were identified as fever and influenza. For illness and sickness women prefer visiting private doctors. There are a number of private doctors across the slum. They don't like the response of doctors in the government dispensaries who are impolite and they feel that their medicines have no effect. Government dispensaries generally don't give enough time to them, are rude and invariably there is a heavy rush there.

They feel more comfortable with private doctors. At times they even get injections when medicines don't work. They said that they preferred going to lady doctors for certain illnesses, which they are unable to speak about to the male doctors. For common ailments and illness they don't mind the male doctors. They said that the doctors would boil the needles and then use them again. At government dispensaries they are not concerned about mother's health but emphasize more on children's vaccinations and family planning. Earlier they would at least get iron tablets but now these dispensaries don't give tablets.

The women feel their children need more attention and care, '*we don't need to spend unnecessarily in getting ourselves treated. During frequent fever and illnesses we (also husbands) use self-medication.'*

If the woman of the house falls ill she has to do all the housework irrespective of the illness. If she is unable to get up the husband says she is just creating a fuss.

None have ever used oral contraception. Few have used copper T and few have got themselves operated after 4-5 children. Only one woman admitted that her husband uses condoms as a means of contraception because her husband says that she is already so weak and contraceptives have their side effects. Men think that the use of condom is very inconvenient, as a result they don't want to use them. Some women said that it tears easily so it is useless. Another said that if men were gentle and loving then it wouldn't tear so easily. It is believed that it is always better for the woman to get herself operated. If the man gets himself sterilised and in spite of it the woman becomes pregnant, the woman gets labeled as having a bad character. Vasectomy isn't always successful.

Source : Focus group with married women in Delhi slums.

HIV/AIDS awareness among men and women

The women from the selected group had never heard about HIV/AIDS from the television. Despite, an awareness workshop, which was held within the slum for a couple of days, very few, were able to tell the modes of transmission. Most said that they didn't know what the preventable measures were. Not much of the awareness-generating program had been internalised by the members. Responses like, '*Hum to achchi jagah mein rehte hai. Yahan pe yeh sab bimari nehi hai*' (We all stay in clean places. We don't have these diseases around here) were given by number of women

The boys who are studying in schools know about HIV/AIDS. In many of the schools, where NGOs have conducted programmes on sex education are aware of all information about HIV/AIDS. One of the boys said that he used condoms. The awareness of boys who study in schools where intervention has not taken place is very low and they have just heard of HIV/AIDS, but do not know the modes of transmission correctly.

The migrant labourers, with whom the FGD was conducted, told that all of them heard about HIV/AIDS. They know it as a killer disease, which may be transmitted from sex workers. They also know that it may be transmitted from a 'used needle' because it is 'dirty'. They told that, the doctor should open a new pack of syringe every time before he injects it. When they were asked if they check it or not when they visit hospitals or private doctors, they told some time they forget to check all those detailed things, and some time it is not at all possible to check because the doctor prepares the syringe with medicine behind the curtain. When the question asked, "Did you ever ask the doctor or the pharmacist, whether it is a new syringe or sterilized?" One of them said, "Never. The doctor may scold me. Nobody like us, (illiterate and poor) dares to ask this question." It seems, when they visit a doctor for a serious health problem, they are more concerned to get the medicine, not so much for the syringe whether it is sterilized or not.

In the FGD with the migrant workers, one person told that, "People do visit sex workers, some time to G.B. road or even here in nearby areas…even in the neighbourhood women are available." The question was asked, " Do they use condoms?" The answer was, "No I have not heard of condom use by any of our friends. I heard educated people use condoms. (*Humne suna hai ki pade-likhe log nirodh istamal karte hai. Hum to nehi karte….Bahut dikkat hota hai. Fisal jata hai).* I have tried this long back once with my wife. It is bit difficult, because it slips".

They told more about their sexual behaviours. While chatting during the leisure time, very often the issue of sex comes up. A fellow may tell that he knows a woman in nearby area who might be available for sex, but not a sex worker. A new fellow might show interest to go with him. He will have sex with her without condom. They feel they do not have to use condoms during sex with a known woman. The reasons are, (1) they think, as she is not a brothel based sex worker, she has a little chance to get HIV; (2) If she would have HIV/AIDS, it would have been known from her appearance (*Agar koi aisa bhayanak bimari ka shikar ho jaye to dekhne se hi pata chal jayega*). Moreover, it should be mentioned here that they do not know the difference between HIV and AIDS. One of them told, " Many of our friends try to keep relations only with few women. They do not go to an entirely unknown woman at G.B. road (red light area of Delhi) or elsewhere, unless somebody, who knows her, takes him."

Sometimes people suffer from STDs, if not many of them. Generally, they prefer to go to the ayurvedic healers or to the private doctors. Somehow, people believe that ayurvedic medicines heal these diseases quickly. They also feel that it is easier in maintaining privacy, if they go to an ayurvedic healer. They prefer to go to a private doctor, basically an unregistered medical practitioner. They think, it is easier talking to a private doctor on these matters openly. They are not comfortable in going to hospitals. Moreover, one has to spend a whole day for this.

Source: FGD with men, women and adolescent boys in Delhi.

A positive woman in her marital family

In one of the cases studied by ISST research team, they spoke to Asha, a 32-year old HIV positive widow with 2 children. After her husband's death, due to AIDS-related illness, she was asked to get herself tested. Presently, she is suffering from loss of appetite and weakness.

Asha's husband came from an extended joint family. After her husband's death, she continued to stay with her in-laws and she said she was being treated well by her in-laws and they were taking better care of her than they had of their son. She felt that it might be due to the guilt factor that their son's wrong doings had brought her to this state. She came to know that her husband had relations with other women outside marriage, before his death. She says, '*It's not possible for an ordinary Indian woman to leave her husband, so I never thought of it. Moreover, I had to take care of him.*'

Later the research team visited Asha's parental family. Asha's mother told that her son-in-law frequently fell ill and her daughter took all the responsibilities of care and treatment. Her mother also says, '*During his last days my son in-law was in the hospital, most expenses were borne by us. I used to carry food for him regularly. From his family only his younger brother and one of his uncle were with him, even his own parents refused to meet him when he was in his death bed.*' After the death of Sunil, Asha's husband, Asha was sent back by her in-laws, they didn't want to take up her responsibility and the fear of infection was very high. Her mother had a lot of discussion with the in-laws saying that, '*she got the infection from your son, it was no fault of hers, why won't you keep her with you.*' They accepted Asha and her children to stay with them. However, during periods of long illness she stays at her mother's place. The mother says, '*She feels comfortable here but presently she is back at her in-laws since her sister in-law delivered a child and an extra helping hand was required at the in-laws place. After all she is staying with her in-laws she has to do some of the household work.*'

Source: ISST's study on Gender Dimensions of HIV/AIDS, 2000.

NGO Effort

The field workers of an NGO in Delhi informed that one of the major ways to prevent HIV meant that one had to prevent and treat STIs, which was prevalent in the community. Their work was mainly to mobilise the community to attend the clinic, which helped people to discuss all reproductive health problems and also provided individual counselling. The number of clients visiting the STD clinic, run by the NGO, has increased in the past year. The field workers feel it's a difficult task to motivate men to visit their centre or even to make them listen. '*Men generally have pride and think that they know everything. It gets very difficult to get across to them. Women on the other hand are much more open and feel free to talk because they don't have anyone else to turn to*.' Sexual activities with opposite sex among the adolescents are rampant.

The field workers conducted awareness meeting with the women of a new block. The awareness program was to tell the community of STIs and the services provided by the same NGO. They were told that STIs need attention and one must not feel hesitant to visit doctors. They explained that through treatment of STIs one could be safe from HIV. Two plays highlighting STD problems in women and one on HIV were performed. The play focused on the consequences of HIV, its effect on the family, why one needs to treat STDs and how the community responds to it.

As observed by the researchers, the impact was more when the situations were enacted out and the group slowly started talking and opening up. If few more such follow-up meetings take place with the same group then along awareness; behavioural change is also possible. Also simultaneous meetings with men and women within the same community should take place. As the women rightly questioned: '*how do we tell our husbands to use condoms?'* Later there were number of women who spoke individually to a counsellor of that NGO and were able to talk more freely on a one to one basis.

Sex Workers

Legalistic definitions of prostitution are culturally and historically relative. Prostitution is not always subject to criminalisation and, in some cultures, the practice may be regarded as a sacred rite. In those societies where prostitution and related behaviour are criminalised, it is typically the prostitute rather than the client whose behaviour is regulated, reflecting double standards of sexual morality.

In ancient India, this institution was not only recognised but acquired more and more prestige. Prostitutes could wield a great deal of power through their relationships with noblemen and aristocrats. Today, it is an outcaste profession. Yet the increasing incidences of prostitution and the expansion of red light areas suggest that the profession enjoys the patronage of the society. The growing male dominance, industrialisation has led to the commercialisation of the traditional institution, sanctioned by social and religious customs for certain castes. Trafficking in girls/women is one of the lowest forms of violation of human rights today, where women and girls are sold like commodities and ironically is a highly profitable industry. There are new entrants into this profession everyday. These are women who are victims of social oppression and poverty. Large number of the sex workers are descendents of old traditional and religious groups – like the Devadasis in North Karnataka and South Maharashtra, Basavis in Andhra Pradesh, temple dancers in Orissa, etc. There are also other communities who have been sending their daughters into prostitution for generations like the Nats and the Bedias of Rajasthan. Women enter into this profession in two ways:

a) voluntary prostitution where women adopt it voluntarily due to lack of any other means of livelihood, the family may be aware of it and might promote it.

b) women are forced into prostitution through religious and customary practices, kidnapping, rape and sale of their bodies through intermediaries.

Prostitution should be viewed in the context of the overall situation of the status of women in India. Besides economic reasons, old cultural and religious practices, patriarchy, socialisation process, superstitions are important factors that need to be understood. There are various other socio-psycho-situational factors and motivations behind a girl or woman wanting to continue with sex work. Sex workers have a very low status in most societies. In ours, it is probably the worst anywhere. They are labelled as ‘bad women’ and the vectors of HIV and other sexually transmitted infections. They are harassed by the police, the pimps and the clients alike and most of the times have to give in to the demands of the clients of not wanting to use condoms. They have no alternatives since their subsistence needs are being met through this profession but the price they are paying in terms of their health is significant.

It is difficult to give the exact estimate of the number of prostitutes in India. The available estimates of Devadasis are just guesses. A survey conducted by Ghosh and Das in the red light areas of Calcutta in 1987 among 6,698 female sex workers found that the average number of clients per worker per day was 2.7, and the rates for both short-time

and night visits varied considerably in different areas. About 37 per cent of the sex workers reported that they were either forced by family members or others or were betrayed by someone with false promises of a job. 59 per cent of them were abandoned by their husbands and 13 per cent were widows. 30 per cent were domestic helpers before becoming sex workers. The term call girl refers to sex workers who do not carry out trade at her place of residence but at a hotel or client's residence. Their rates are on the higher side and they have the option of choosing their clients. They are mostly linked to upper class prostitution.

Laws regarding prostitution

The objective of Suppression of Immoral Traffic in women and girls Act (SITA, 1956) was not the abolition of prostitutes and prostitution but to inhibit or abolish commercialised vice, namely the traffic in persons for the purpose of prostitution as an organised means of living. An underlying assumption in the SITA is that prostitution is a 'necessary evil' that provides an outlet for uncontrollable male sexuality. Though SITA did not aim to punish prostitutes, it gave enough power to police and other government agencies to terrorise, harass and financially exploit a prostitute. The Immoral Traffic Prevention Act, 1986 is a uniform legislation applicable to the entire country and is an amendment of the SITA (1956). It does not confine prostitution only to the act of a female offering her body for hire, but recognises sexual exploitation or abuse of a male or a child for commercial purposes. The main thrust of ITPA is enhancement of punishment and creation of new categories of offenses. The objectives of the Act are two-fold: it recognises the abuse of power by the police during raids and prohibits male police officers from making a search of female sex workers unless accompanied by female police officers and secondly it seeks to draw women away from prostitution through their rehabilitation in Protective Homes which should prepare women for gainful employment.

With this background, ISST conducted two short field studies in two different communities where women are involved in prostitution. These were the Devadasis of Karnataka and the Bedias of Rajasthan.

Devadasis

The cult of dedicating girls to a deity, called Devadasis, is prevalent in some parts of India. A `Devadasi' means a woman dedicated to, literally a slave of, a deity, whose duties comprise a combination of ritual and community entertainment to assert positive fertility and prosperity.

Religious prostitution has been in practice in several parts of southern India since the third century AD. Pre-puberty girls from poor low-caste homes are dedicated by an initiation rite, to the deity in the local temple during full moon. The system of dedicating women to a temple is a religious act to appease the deity. Sometimes even before menarche she is auctioned for her virginity, `the deflowering ceremony' becoming the privilege of the highest bidder. Yellamma is represented as the principle Goddess who is worshipped, but recent research has shown that other deities such as Meenakshi, Jagannath and Hanuman are

also propitiated in this manner. On account of being married to God or Goddess `Devadasis' are called `Nitya Sumangali' (for ever married).

However, in the areas where the system/ cult is prevalent, they call themselves `Basavi', `Jogati'/`Jogin', `Devali', `Naikin' and at times `Sule' (prostitute). All these terms have sexual connotations – either of celibacy (as in Jogin) or of prostitution (as in Sule).

Several factors are said to be responsible for the origin and existence of the divine prostitution in India. The reason that temples require whole-time devotees to serve them was a primary factor. This, in turn, led to the belief that women thus dedicated would appease the Gods and would ensure the fertility of the women in that culture. Hence they developed their own status, roles and rituals, whereby they participated in religious/auspicious ceremonies in the community. Over time, the custom encouraged exploitation of one section of society – especially the poor families in the lower castes – by others, using religious sanctions, and they gratified male desire.

Other factors which could have caused the system may also be noticed:

- The custom of dedicating girls to temples emerged as a substitute for human sacrifice, with the aim to appease Gods and Goddesses and thus secure their blessings for the community as a whole.

- It is a rite to ensure fertility of the land and an increase of human and animal population.

- It is part of phallic worship, which existed in India from early times.

- Probably sacred prostitution sprang from the custom of providing sexual hospitality for strangers; and if such hospitality is offered by the mortal wives of a deity, prosperity was bound to result.

- The Devadasi cult represents licentious worship offered by a section of society, subservient to the degraded and vested interests of a priestly Class.

- Devadasi system is a deliberately created custom in order to exploit lower caste people in India by upper castes and classes as:

a) The upper castes have influenced the establishment of an order of prostitutes who are licensed to carry on their profession under the protective shied of religious belief.

b) The establishment of such system due to poverty facilitates them the access to low caste women to fulfil their carnal desire.

c) The system ensures that the powerful in society can command anything by creating fear in lower-caste people.

There is no evidence of temple prostitution in early times, though it certainly existed in ancient civilization. The earliest reference to girls being dedicated to temples appears in a Tamil inscription dated back to 1004AD. In the Karnataka region, since time immemorial, prostitution has been existing and Devadasis have been part of this profession. By the 7th century AD, the Devadasi institution seemed to have taken firm roots in the Indian culture. By the next two centuries many temples were built in South India and Devadasis were recruited to provide various ritual to Gods and Goddesses. In northern India, the destruction of temples by Muslim invaders led to the decline of Devadasis but it continued unabated in the south of India. Even after state governments enacted legislation during the 1920s and 1930s preventing the dedication of girls to temple Gods and Goddesses, the institution has survived in some places in different forms and on a smaller scale.

The present study was conducted in the Bellary and Kudligi taluks of Bellary district in Karnataka. Bellary is one of the most backward and drought-prone districts in the country. The available government infrastructure and services are quite inadequate and of low quality. The majority of the population belongs to scheduled castes and tribes and other backward communities. Health problems are compounded due to malaria, gastroenteritis, AIDS etc. A number of these Devadasis are living in Kudligi taluk and Bellary taluks along with the other sex workers who come from other general communities. The Devadasis are called Basavi in the region. The Basavi does not have marriage but lives in her parent's house with any man of equal or higher caste whom she may select and her children inherit her father's name. In earlier times it was considered prestigious for a rich landlord to keep young girls. He would bear all her expenditure. The present situation is very different, where it is a daily sex business. In this district most Devadasis practice from home, though there is also a large proportion of Devadasis in the red light areas of Chennai and Mumbai.

Family, socialisation, sex work and marriage of devadasis

Most of the Devadasi mothers are also Devadasis. These days there are a number of poor families with many daughters and no male member to earn a livelihood. The eldest daughter in these cases is dedicated as a Devadasi even though the mother is not a Devadasi. There are cases where girls lose their virginity before marriage and are forced to become Devadasis. Most of the Devadasis stay with the parental family.

One strong reason for dedicating their daughters to God in the name of Devadasi or Basavi is that the family gets some income and they are taken care of by the man to whom the girl is dedicated. The girls enter prostitution at the age of 12 years or whenever she attains puberty. The practicing Devadasis stay within the community but in separate areas or street and are not always found in groups. For example, in Kudligi most of the Devadasis are staying in an area, which is closer to the bus stand and centrally located. In Bellary the Devadasis don't stay in the outskirts like other sex workers. They are scattered and stay amidst the community.

These days, many Devadasis marry one of their partners or clients who are mostly from their own caste (valmiki) and sometimes from upper castes (lingayats). Some unmarried

youngsters also come forward to marry Devadasis due to the influence and education by the local NGOs and government department schemes. They are mostly from the same caste and from the same locality.

Some mass marriages are arranged by government department (KSWDC-Karnataka State Women's Development Corporation), Women & Child Development Department and local NGOs. These initiatives have not been successful and have raised questions about its real outcome on the lives of Devadasis. Some Devadasis have been left in the lurch by men who married them for benefits.

Some Devadasis in Kudligi (colony) are staying with a single partner without any official marriage. The Devadasis usually stop sex work after marriage. They stay loyal to those whom they marry. Sometimes these Devadasis may entertain other clients if it is inevitable and the partners/husbands are not capable of supporting them financially. Few partners/husbands don't stay with the Devadasis but visit them frequently, fulfil their demands and support the family with cash, clothing etc. They will have their own families staying separately.

The young unmarried men who marry Devadasis stay within the community. They are considered as any other family, because the Devadasis would be staying before marriage with the community because of the religious sanction and the marriage would have officially taken place in the community.

In Bellary, the Devadasis are practicing sex from their homes. Community here generally places the Devadasis at a better position compared to other commercial sex workers because it is a traditional practice. Even if not married, most Devadasis have one or two partners. The earnings of the practicing Devadasis depend on their age and looks. The young and beautiful ones get more customers and more money. The men say that the Devadasi gets better treatment than the wife does because she is always available for the man.

Rajamma's story:

Rajamma is a very young woman of 21 years. She was born in a lower middle class family belonging to Bellary. She has two younger brothers. Her father was a porter and mother a housewife. She says, '*When I was 3 months old I had wounds in my head. No treatment could cure me so my maternal grandmother prayed to God that if my wound heals then I would be dedicated as a* Devadasi. *When I was 12 years my grandmother wanted to make me a* Devadasi, *my mother was against it but my father was not bothered, as he was an alcoholic. I didn't know what was happening. I was young and good looking, and all clients preferred me. I was practising sex at my mother's place in a small room. I became fed up of entertaining clients and whenever I used to see my friends who had married and were living happily with their husbands, I felt bad. Fortunately, during that time (1996), I learnt about one of the government schemes – promoting* Devadasi *marriage, I decided to get benefit from the scheme. I decided to come out of the profession of prostitution. I had to face a lot of opposition for this decision of mine. I had*

already two children by then. However, ultimately with the help of one of the local NGOs I married one of my clients. He was not married before. I got some financial support also. I bought a goat. At present, both my husband and me are into construction work. I have four children now. Two years back I got my tubectomy done. The operation has created some complications for which I need to undergo another operation but I do not have the money to get myself treated. My eldest son who is 8 years, works with us at the construction site and the rest three go to school.'

Rajamma is now a married woman and the community does not see her as a Devadasi anymore. She keeps visiting her parental family during festivals and they too visit her. She performs all the important festivals at her house.

Health, Health care, Awareness about STIs/HIV

The commonly found ailments among the Devadasis are fever, cold, backache and stomach-ache. Devadasis prefer to go to private doctors because in government hospitals and Primary Health Centres (PHCs) there are no doctors, medicines are usually out of stock and in addition the treatment they get is not good and they have to wait for long time. In spite of free services proclaimed at government hospitals, they'll have to bribe their way through.

In all the focus group discussions, the awareness on STIs and HIV was very high but none of the Devadasis disclosed their health status i.e. whether they were suffering from STIs. They knew about the modes of transmission of HIV and that unprotected sex is the main route of transmission. The source of information regarding these was found to be radio, T.V, posters and advertisement in cinema halls. At the Bellary District Health Office (DHO), they are conducting awareness programmes regarding HIV/AIDS, which reaches only Bellary taluk population. The Devadasis seemed to believe that HIV is nothing but STD. They also said that condom use was a method for preventing transmission. They said that though they insist that their clients wear condom, most of the time the clients refuse and try to convince the Devadasis by paying more.

Health care facilities

Few of the health care institutions and caregivers were interviewed. In Kudligi taluk there is no treatment available for STDs. In the Bellary town doctors and caregivers from government hospitals, private establishments like Nursing homes and non-governmental organisations were spoken to. The government hospital does not have HIV testing facility and no beds to keep the AIDS patients. The dermatology and STD department refers the cases that show symptoms of HIV to Bangalore government hospitals. In one of the private hospitals the doctor said that there are 2-3 new cases of HIV every week. They refer the patients to an organisation in Bangalore that provides care and support to the patients. In another nursing home there are 12 cases of HIV reported almost every month. Whenever married persons are found to be HIV positive their spouse and children are also tested for HIV. An organisation has started a counselling centre in the campus of a nursing home.

Bedias

The '*Bedia*' identify themselves with the *Kshatriya Rajputs* and come under the Scheduled Caste category in India. Traditionally, the community was vagrant gypsy-like groups. Prostitution has been a profession of women for generations and is the major source of income for the community. Earlier the women and the girls used to serve as concubines to the men of the upper castes. They always lived in the villages of rich farmers to whom the Bedia women reportedly were concubines. The community is divided into various clan groups. They practice community endogamy and clan exogamy. They largely live in extended families. Their women, who earn from prostitution, largely contribute to the family income. According to traditional accounts, a large part of the Bedia earnings came from prostitution and dancing. Now most of them are engaged in agriculture. Traditionally the Bedia women do not entertain people from communities considered lower than their own. In the last few decades, as the practice of concubinage declined in the region, the Bedia women got involved into prostitution.

There are a large number of Bedia populations in the Bharatpur district of Rajasthan. Our study was conducted in two villages in Bharatpur. Their relationship was always unfriendly with *Jatavs* and *Gujjars*. The Bedias consider themselves higher than these two communities and they have been always looked down-upon by these two communities. Due to this reason a number of Bedia families shifted to the neighbouring village, where they are the majority. In the early eighties, the relationship became worse. The *Jatavs* and *Gujjars* repeatedly protested against prostitution by the Bedia women inside the village. They felt it was having a bad influence on their women folk. Many of the Bedia shifted to the outskirts of the village. The girls and women in the profession started spreading out to the cities like Delhi and Mumbai and to other towns in North India. They are also functioning in small numbers on the highways. At present a large number of Bedia women who are in prostitution in different towns and cities are actually from these villages. The men also prepare country liquour, which they sell during the evening. The men who visit to buy liquour also have sex with the Bedia girls. In the recent years number of the Bedia families have acquired agricultural land. There has been a slight diversion from their main income source. The men don't work full time on the fields, they employ the widows and women from nearby villages to work on the fields. These women observe and get influenced by the Bedia groups and see that there is enough money earned through sex work. These women too start selling sex.

***Family, socialisation, sex work and marriage of* Bedias**

In the Bedia community girls enter prostitution as early as 12 years. Traditionally only the eldest daughter of the family used to be sent. During the field study it was found that any daughter could be sent to prostitution. In cases of poor families who don't have landed property all the girls take to prostitution one after the other to support the family. These girls or women may function from home or are sent to red light areas through the pimps. The pimps and the middlemen are part of the Bedia clan. These girls could be sent to the red light areas of Mumbai, Delhi, Alwar and to other small towns in and around Rajasthan. From their place of work they send money and have links with families by visiting them during festivals. From early childhood the girls are sent to visit their sisters

and cousins who are into the *dhanda* (sex work). The girls observe all the happenings. As a key informant says,

Young girls get to see the glamorous side of the profession, they see the money involved and experience a better life. By the time they attain puberty they have seen a lot of the profession and are already accustomed to the whole tradition. They are asked to decide whether they want to marry or they want to enter the dhanda. The girl's family is paid around rupees twenty to thirty thousand by the first client for deflowering the girl. By rule the girl can never refuse this man ever in her life and has to be available for him anytime. The girls are then taken to other areas by a relative who is operating as a pimp. In the first few years the girl is made to change her place of work every few months so that she does not develop emotional attachments with any particular client. All her earnings are mainly sent to the family as the family subsistence depends on it. Most of those women and girls visit their home during festivals. During this time number of them bring suitcases loaded with gifts for the family and come in a car. In the Bedia *village, most of these households are having televisions, music systems and mini generator sets of their own. The man in the family, mostly the father or the brother is the pimp who invite clients and negotiate.*

The girls, who are not getting into prostitution, get married with somebody in the community. Marriages are arranged through negotiations at guardian's level. There is also a rule in the community that once a girl is married she never gets in to prostitution. But the present situation is different and in a number of cases this rule is not followed. The *pradhan* (local leader) of Bedia village says,

Lot of money is coming from prostitution and people get tempted. My own sister in-law is into the business. It is her misfortune. She got married, but her in laws forced her into prostitution. It is completely against community's law. A married woman cannot step into it. We later brought her to her parents family. But as she was already in prostitution, no body can marry her. She cannot live a respectful life. When we asked her to choose whatever she wanted to, she had no option but to choose prostitution. A prostitute can marry if she finds someone.

There are cases where many of the sex workers also marry one of their clients. Many a time, the couple then works as pimp. The girls could be their own girls, could be bought or 'kidnapped'. When the women cannot attract many customers due to their age, they start their own business by bringing their girls into the profession. In one case, a sex worker who has been into the profession for more than fifteen years was very insecure because she didn't have a child, *'I am very worried. I desperately want to have a child but I have problems in conceiving. Who'll look after me in my old age?'*

In another case of a Bedia girl, Preeti, who was working as an educator with a local NGO was forced into prostitution by the community. Although she opposed and refused to join the profession the social pressure was so strong that she had to give in. Presently she is in Delhi and functioning independently, her brother who is with her manages and negotiates

with the clients. She is working in a reputed hotel as a beautician from where she gets her clients too.

The Bedias are spread across other districts in Rajasthan. At some other districts, buying and selling of Bedia girls is very common. They sell Bedia girls only within the Bedia community. After few years of work, they are sold again to some other pimp.

Health, Health care, Awareness about STIs/HIV

In the Bedia community awareness about HIV seemed high, they said that they knew about condom use and asked their clients to use it but in some cases they couldn't. Initially they said that they asked their clients to use condoms but when the researchers asked that if the clients refused to use condom could they say no to them. To this they replied, *'No, we can't refuse clients if they insist on not using condoms. After all, this profession is providing for our subsistence needs.'* The sex workers do not visit the PHC for their illnesses. They said they never had any serious health problems and didn't have to visit the doctor. If they fall ill they manage to take care of one another. During illness most of the time the Bedia family takes care of their girl and take her to doctors as fast as they can. But ten to twenty years later when she is unable to entertain enough customers and is unable to get enough money the family does not take care of the woman. She has to look after herself.

A visit to the Bedia household consisting of 9 members highlighted the vulnerabilities of the young girls in the profession. The eldest daughter of the family is in Delhi. The next daughter is suffering from neuro-syphyllis. According to other informants she is still working. The one, who was spoken to, Meena, is the third daughter who had entered the profession two years back. At present she is around 17 years. She is suffering from major STIs, which have not been treated. There is no one who will take her to the town. She hasn't even visited the village PHC. Her vision is deteriorating. In spite of all these complications she is still continuing with work. She says *'The family is in debt and I have to continue. My elder sister who is in Delhi has already paid her part of the debt (around a lakh).'* Meena has three younger sisters and two brothers. She earns Rs. 400 to Rs. 500 per night, as she informed our research team. Meena says, '*I make it a point that the clients use condom. If the client does not know how to put it on I help him do so.*' She also informed that she was in love with one of the clients who visited her and she did not use the condom with him. The clients who visit her are mostly from the neighbouring villages. She said it pained badly during sexual intercourse and she had swellings in her body. Her mother said that they are discriminated, the *thakurs* of the village do not allow them to take water from their well. Meena said that there have been a lot of interventions that have taken place. She said that a number of NGO health workers had come to this area. They talked to the girls like her. The NGO workers had once taken Meena to a health camp but there had been no improvement and she had not visited the doctors after that. Her parents did not seem interested in taking her to hospital situated in the town. There was no initiative shown from their side.

When the *pradhan* was asked about HIV/AIDS, he said,

Yes I've heard about HIV/AIDS. It is a dangerous disease. I know one girl who was working in Bahrain and came back very sick. Doctors told that she has AIDS. She was kept in a 'Women's Home' (nari niketan) at Delhi. No she did not stay with her family. But her family used to visit her as far I remember.

Health care facilities

The nearest Primary Health Centre (PHC) is located at a distance of 2 km from the Bedia village. The doctor at the PHC said that he felt that 70% of the general population suffered from STIs but very few reported to the PHC. He also informed that none of the Bedia people come to his clinic. He said that availability of medicines and trained staff was always a problem. As there was no lady doctor and the auxiliary nurses were not trained enough very few women came with their problems. Even if a woman came with a STD problem the auxiliary nurse informs the doctor of the symptoms and he has to give medicines without checking the patient. The women are embarrassed to get themselves examined by the doctor. The doctor advises them to bring the husband along but the husband never reports. Once a case of HIV was reported and the officers from the district level turned up to isolate him from the community. The doctor said that,

We as doctors are asked to do a lot of things and bring about a change in the mind set of people during our posting in villages but it is always frustrating because nothing goes in to these villagers head. They are very ignorant and I have to run after them for their well being. There is a man who is suffering from silicosis. I have come to know about his symptoms from the workers of an NGO, which is working in this region. I had to run after him, as he himself was not coming to the PHC. People think that I am corrupt. They think I do not distribute the medicines properly. It gets very difficult to drive sense into these people's heads. Facilities at the PHC are not good.

In one of the areas on the highway, where the sex business is functioning by the Bedias, an STD clinic was established by the government. Unfortunately, the response from the Bedia community was poor and the clinic was closed down soon. According to an informant the Bedia men don't like to send their girls to the clinics as they feel that outsiders could lure the girls. No HIV testing facilities are available in the district or even the surrounding districts. There are no blood banks in the district. Recently a private blood bank has been set up. Abortion is a common practice among the Bedia women in prostitution. They mostly get it done privately.

Efforts until now

Few interventions have been made by local NGOs to rehabilitate the Devadasis. An organisation in Bellary works with the Devadasis. A mass marriage had been organised by them. They also have started some micro-credit activities. In the year 1989, one of the NGOs rehabilitated some of them and provided them training in tailoring, basket making and also supplied the required equipments. They were also provided with houses to stay. Some Devadasis have stopped practising sex and they are all settled with single partners.

Few are earning their livelihood through stitching etc. Some have even become drama artists. Most of them (both men and women) go for construction work. When the women go for work the aged women (mostly ex-Devadasis) look after the children. In other districts of Bangalore few organisations are working with Devadasis, providing rehabilitation to those who want to come out of sex trade.

Interventions with the Bedia community have not been continuous and sustained, it has mostly been through outsiders who have come and gone and although the awareness about HIV among the community is very high it has not translated to change in behaviour.

Successful interventions to empower sex workers have taken place at Sonagachi, the red-light areas of Calcutta and at Jaipur in Rajasthan by NGOs. At Sonagachi sex workers have formed support groups by themselves to educate their peers on how to protect themselves from STIs and HIV. Even the HIV positive sex workers have their support group to provide emotional, social and practical support to their counterparts. Four levels of negotiations summarise the range of empowerment strategies in the context of safer sex practices:

Negotiations with self – to improve perception of self, self-esteem, articulation of their rights and legitimate social identity.
Negotiations with clients – to include solidarity building within group of sex workers, male sex workers, clients and permanent partners.
Changing and challenging structures and institutions like the police, legal machinery, educational institutions, medical establishments and other groups like the pimps, madams.
Negotiation with ideologies – this includes challenging the construction of the good (wife) and the bad (whore) women.

The project in Rajasthan has aimed to reduce the risk of HIV infection among sex workers, their clients and the general population in five districts. The organisation has held training camps and initiated general development activities. They seek to improve the lives of sex workers, address issues such as land rights, health care and access to safe drinking water, electricity and basic education for children. The initial response from the community was a demand for general community services rather than condoms.

Strategies

Number of positive characteristics of the Bedia community comes into focus. Family acceptance towards prostitution was spoken out by all. One could enter these families and create strategies to communicate about better sexual health of the daughter who is into prostitution. Another intervention to educate the community and bring about behaviour change could be through the sex workers who are visiting their families from Delhi and Bombay. They carry lots of gifts and goodies for their family. They could include communication materials in these to make their families aware of the hazards of the profession and how one can prevent oneself from diseases. There has to be a strong network with the local PHC doctors and rural medical practitioners (RMPs) who need to

be sensitised. Key cultural variables like: lifestyle, sexuality norms, secrecy surrounding HIV/AIDS and confidentiality, perceptions should be borne in mind and made available to the groups who are working towards HIV preventive programs. These could include the local NGOs or the local doctors and RMPs. Another groups of people who need to be targeted are the local people around the Bedia community who are the clients to the Bedia sex workers. In the Devadasis there is a greater degree of community acceptance due to its religious sanction. Different communication strategies for each group will be more effective than a single method of educating people. Health interventions by local PHCs and NGOs functioning in the area have to include education and behaviour change programs about HIV/AIDS. They cannot be one-sided messages but participatory. During the field study, doctors and care givers expressed that educating the community regarding preventive and care aspects of HIV/AIDS is necessary and counselling is an essential component to care facilities. The positive social dimensions of the community and the group have to be highlighted during these discussions and then gradually proceed towards the increasing risk behaviour and the fear of contracting HIV. All these need community involvement. Different groups of men and women need to be involved, sensitise people to report their STIs and to tell them that it isn't a matter of embarrassment. One of the local NGOs working in and around the Bedia villages has employed the young members of the community to open libraries in the area. Books are being provided to the community. These libraries have memberships and number of adolescents in the village are members and have access to these books and magazines. IEC (Information Education and Communication) materials could be made available to the community through these libraries along with other daily magazines and storybooks.

At an NGO level, women’s organisations, community-based organisations need to collaborate to inform their members about life threatening illnesses due to their lifestyles through discussions, slide shows in a very non-judgemental way. To encourage behaviour change, peer educators need to know when to enlarge the basic message, when to listen and when to empathise and how to bring information on HIV/AIDS/STIs into conversations about other issues. Pressure to use condoms needs to be encouraged during these discussions.

Rehabilitation of women who are coming out of sex work or who want to come out of it has to be integrated within other programs. Another important task is to lobby political leaders for legislative changes and to look in to the basic infrastructure like health care and educational facilities in the areas. The law on Immoral Traffic Prevention Act needs a whole new chapter on rehabilitative process, dealing with medical treatment, monitoring, follow-up action, education and mainstreaming techniques. The law is ineffective with regard to upper-class prostitution. There is also no provision in the Act for a competent legal aid service for the victims.

Men having Sex with Men (MSM)

The findings presented here are based on our field study in Calcutta.

Homosexuality, or sexual activity between persons of the same biological sex, is a phenomenon which exist universally, but is subject to wide variations in its incidence and in the way that society and the culture 'frame' homosexual acts or relationships. To develop appropriate prevention strategies, we should understand the psycho-cultural frameworks within which sexual behaviours operate, and the context in which they operate in India. A distinction needs to be made between homosexual behaviour, found in most known societies, and homosexuality as a particular role around which individuals construct identities and communities of 'sub-cultures' are framed.

Homosexuality is a matter of strong social disapproval in contemporary India and was a taboo subject in public forums until recently, when some educated and professional men and women took leadership in demanding recognition and rights of homosexuals. There is not enough space for the homosexuals in this country to talk about it, though a number of ancient Hindu texts, including *Kama Sutra* do talk about homosexuality. Even the Vaishnavic notion of worshipping Krishna, where the devotee's body contains the feelings of Radha, can be interpreted as a concept of sexual dualism. In Islamic Sufi literature homosexual eroticism was a metaphorical expression of the spiritual relationship between god and man.

Along with the societal denial and disapproval, Section 377 of the Indian Penal Code (1860) criminalises homosexual acts in this country. This statute is based on the British law – Offences against the Person Act (1861) – which was subsequently instituted in all colonised countries, including India and Ireland. The law was passed making the act of sodomy illegal, but not homosexuality as such. In independent India the section 377 of the IPC is still in force. Homosexual activists in India think that because of the existence of this law, male homosexuals are 'subjected to systematic harassment, blackmail and extortion at the hand of enforcement agencies and the public. On the other hand, scrapping of this law without an amendment of existing 'rape-law' would wipe out the last option for lodging a complaint against male rape. It should be mentioned here that rape is quite common in homosexuality.

Indian homosexual movements that have come up recently are strongly westernised and lean towards upper middle class and upper class people. Moreover, people from upper income groups with access to resources are more vocal and have more access to western information. But in general, homosexual behaviour is still almost totally unacceptable. Even if it exists in the society, the responses of the community are mostly: '*It does not happen in our community…it is not part of our culture*' or '*our men are not like that'*. Many men, even if born with homosexual orientation, would not be determined or adventurous enough to translate it into homosexual or bisexual behaviour.

However, it should be mentioned here that cultural construction of homosexuality in India is different from that it in the west. First of all, homosexuality is not politicised in

this country like many countries in the west. Second, physical proximity among the people of same sex is quite natural here. Some homosexual activists in this country think that Indian society is not so homophobic as in the west. They think that in some country in the west, strong anti-gay lobbies also exist side by side with a strong gay lobby. The lobbies are absent here, and in India, kind of discrimination the homosexuals face, mostly in the form of verbal insult and teasing.

In India, MSM can be categorised into the following:

Amongst males-who-have-sex-with-males networks, boys/men are self-defined as *koti* or *dhurani*. They cut across income groups, class, caste, religion and region. They gender themselves through effeminate behaviour in specific spaces. Their exaggerated behaviour makes them visible in several public arenas, which is used as a flirtation mechanism. Males in need of sexual discharge irrespective of their sexual choices may often respond to these feminised males for oral sex, masturbation and where space and a measure of privacy permits, anal sex. Significant numbers of *koti*s also sell sex in certain environments.

*Koti*s speak of the 'real man', who is the *panthi,* also known as *giria* or *parikh*. It is not a self-defined term like *koti*. Among the males who exhibit a so-called 'normative' behaviour, some may sexually desire other males, while for many it is simply an act of sexual penetration. The *panthi* visits specific locations where he knows *koti*s are available for sex, for which he may or may not have to pay. MSM have their cruising points and are generally seen at these points (like the lake and parks) from seven to ten in the evening.

Sexual relationships between the *kotis* and the *panthis,* both for commercial and non-commercial purposes are prevalent. Some of these *kotis* have their fixed *babus* (patrons/clients). Rest of the crowd look for new partners every night. The act of sex does not necessarily depend on monetary transactions as lot of emotional attachment and liking or disliking develops in the relationship. *Koti*s have sex with their partners for gifts, money or just for pleasure.

Many of the men stated that they liked anal sex because it was 'tighter' than vaginal sex. They seek out *kotis* as sexual partners due to non-availability of women for anal and oral sex. Recent anecdotal evidence indicates that many males see females as vectors of sexual diseases and therefore unsafe for sex. They also feel that vaginal sex is more risky than anal sex.

The majority of the *panthis* are invisible. In India, it is a hidden group. They do not want to reveal their sexual identity. Many of them are either married or likely to be married in future.

The third group among the homosexuals is known as *dupli*. Duplies are that kind of homosexuals, who believe that there should not be any unequal power dynamics in sexual

interaction. It is not important for them, who is penetrating whom in a sexual act. Hence, they can be both penetrated by their partners or penetrate their partners.

Socialisation Process of MSM

The socialisation process is a very important phase in the lives of the MSM. The childhood years are important for knowing the self. This is the time when gender notions are yet to be developed. They like dressing up like girls and playing with dolls. They do not face much gibes from their elders in this period. During school years the distinct realisation that they are different dawns on them. This is the time when others easily mark them for their effeminate behaviour. Their classmates start teasing them. At the same time, problems also come from friends, neighbours and relatives. They develop low self-esteem. On the other hand, in their sex life, rejections come from their 'dream men' too. A number of the *kotis* are also forced to have sex with senior boys. Experiences are not negative always. Few of them start enjoying the sexual act by that time. Persons with a similar attitude and sexual identity come together and a community feeling develops. As a result, a network among the *kotis* forms at the local level.

Manish a twenty-three years old young man shared his own experience:

I was born in a middle-class family of South Calcutta. I clearly remember that I used to play with girls and dolls. I really loved to play with girls. Very often my relatives teased me about this. 'Are you a girl, that you are playing with girls?' Once my aunt asked me, 'Can't you play with boys of your age?' But I felt that I was more comfortable with girls than the boys.

At the age of ten when I was in 5th standard my cousin, during a marriage gathering, sexually abused me. The boy was around twenty years old. This went on for 2 years, whenever he would visit my home, he would have sex with me. I was scared of that boy. But I never protested against it. Whenever I tried to stop him, he started ridiculing me for my feminised behaviour. He also used to complain to others about my behaviour, and elder ones in my family used to get a chance to scold me. But if I allowed him to have sex with me, he did not complain against me to others. This (having sex with him) gradually turned into pleasure and I have discovered that I have feminine desires.

At this point of time, I realised that I was different from other boys. Around that time I watched a movie, and attracted towards a famous cine star, who acted as the hero in that movie. I felt a strange attraction and desire for that man. I was too embarrassed. I even started questioning myself, 'what happened to me? How can I tell others that I love him.' My self-esteem was very low during this time. Fortunately, I got a few friends in school, whose ideas and behaviour were similar. My own group members and I used to stick together. We used to be teased and cornered by other boys but our group used to move together. We were always ready with dividers and compasses from the geometry-boxes against any physical abuses in the school campus.

When I was in class 7 my friends took me to the lake. The lake has been one of the important cruising grounds for male homosexuals of South Calcutta. Initially, I was

teased by the kotis of my age but later they accepted me. I was very happy to meet others whose behaviour was so like mine. I understood that I was not alone. They taught me everything. From them, I came to know that I am a koti.. I came to know the terminology used for homosexual and homosexuality, and other words. Gradually, I realized that I could love a 'man' of my choice.

Initiation of Sex in the life of a homosexual

Young men and boys, usually unmarried, may find themselves sexually aroused through body contact either through play or sleeping next to each other. Many a time it transcends into a variety of sex acts. Here the sexual act may be mutual masturbation or thigh sex. Male to male sexual acts is very narrow in this context. These kinds of sexual acts are not seen as sex but as *masti* or *khel*, a sexual play between boys. On the other hand, it is not seen as a serious act because it does not involve a woman.

Where there is an age or power hierarchy or both, anal and oral sex may also occur, generally the younger partner acting as the receptive partner. This type of sexual activity can be called 'dosti sex' (friendship sex) and are linked to discharge sex without any construction of sexual identity. Their desire may be focussed on females. Non-availability of females leads them to this. They will get married in future and may continue this kind of sex too. Unequal power or age hierarchy also may lead to sexual abuse. In hostels or at home, young boys are often abused sexually by the senior boys or elder relatives ranging from cousin brothers to uncles. Many a time sexual exploitation by seniors and colleagues becomes the initiating factor.

Friendship and Romance

Romance and friendship in the true sense come in the later years at school. Many of the *koti*s establish relationships with so-called 'straight men' at this stage. The relations are not stable always. The partnerships continue from a week to three months generally. But stable and yearlong partnerships are also reported. The emotional attachment is much more intensive for the *koti* than the other person in the pair. Other person's sexual preference and identity is not known in most of the cases. He may be a bisexual or a homosexual. Rejection in love comes quite often in life.

Manish narrates, *In the 9th standard, I joined a gym near the lake. A boy of my age, Vinod, also was a member of that gym. Both of us became good friends and came closer. I developed a soft corner for Vinod. We had sex several times. Later the partnership broke. We parted after some time (after their secondary examination) and we stopped going to the gym. Vinod started going around with girls. Later we met again in the college but the relationship never renewed.*

During the second year of my college I had an emotional relationship with a man who was staying with our family as a paying guest. During that time, we were facing several domestic problems. My father had a cerebral attack. He helped us a lot. He almost became a member of our family. We came closer and established an intimate relationship. Even my association with my organisation weakened during this time.

Unfortunately, the relationship with the person did not continue any longer. I noticed a change in that person. He was not coming back home regularly and was moving around with several girls. He also started avoiding me. I was quite depressed. It took me a long time to get over this episode in life. I went into a major depression, lost a year in college. I promised myself that I would never have any emotional relationships in life.

Akhil, a support group member of around twenty years of age, comes from a lower-middle class background in Calcutta. He narrates his own story:

Presently, I'm attracted to a young businessman who visits me at the lake. I have become emotionally dependent on that man. He comes every evening to meet me. We sit together near the lake and chat for a long time. Recently, a friend of this man is attracted towards me. My friend introduced this fellow. He meets me whenever my friend is not in town. He did not like this and questioned me about this. Anyway, now he plans to marry and settle down. He asked me if I want to stop the relationship. I told him that I did not mind continuing.

Male Sex Workers in Calcutta

A number of *koti*s in Calcutta are engaged in sex work in some form or other. Several dynamics exist in the homosexual sex work. One popular form of sex work is gift-sex. It is a form of male sex work, where the service provider receives gift instead of cash. In Calcutta, the gift starts from a pair of leather shoes, to an expensive jacket and may be to a cellular telephone. Lot of gift sexes seems to be happening in hotels and guesthouses. The waiters, massage boys are involved in sex-work in these places. There are also a number of youths, who are looked after by their clients, in terms of accommodation, clothing and food. Many male sex workers appear to work in public sex environments, where clients are from across the classes. Sometimes, clients will take them to a guesthouse from the 'pick-up' area. In South Calcutta, the lake area is one of the most important cruising venues for the homosexuals. By six o'clock in the evening they come to this place in search of their clients. The monetary transactions start from 50 paisa per sexual act. It may go up to 200 Rupees per act. The rate varies between good-looking *koti*s and bad-looking ones and also the appearance of the *panthi*. If 'he' is handsome, a *koti* may agree to have sex with him for less money. The sexual act takes place behind a bush in a park, in the deserted platform or railway compartment, in one of their houses or in a hotel.

HIV/AIDS and risk in their sexual behaviours

Homosexuals are extremely vulnerable towards STD and HIV transmission. Discussions with many of them in Calcutta indicated low prevalence of condom usage for anal sex. 'It spoils pleasure' is a very common expression. Also, it is commonly believed that HIV is transmitted only through vaginal sex. Many a time anal sex is seen as '*masti*' by the *panthi*, and is not considered real sex, and so they indulge in unprotected sex.

Emotional involvements are another reason that leads to unprotected sex. If the *panthi* is handsome or a nice man with a gentle disposition, *kotis* may develop an emotional

attachment towards him. It becomes totally unimportant to use a condom in such cases. Emotional attachments also reduce the bargaining power of the *koti*s. Many a times the relationships do not last long. Moreover, these men are sometimes desperate to get a partner, which further reduces their bargaining power. They do not even hesitate to go with a complete stranger.

Akhil, an MSM in Calcutta, narrated a story:

One night I was returning home at 10 o'clock in the night with a friend of mine – Bappa. Suddenly we noticed that a stranger was following us from a distance. My friend and me took a different route so that we could reach near the main road quickly. The route we chose was risky as number of thefts and robberies occur there. After crossing the main road near a cinema hall we looked back and found the man standing on the other side of the road. As soon as we looked back the man called my friend. Bappa told me, 'He is calling me'. I asked him whether he is willing to talk to the man. Bappa replied, 'Yes, let him talk to me'. Both of us went to him. The man told me that he wanted to talk to my friend privately. At first I did not agree. I thought that Bappa might be in danger. I had never seen that man before. But I found that Bappa was too keen to spend some time with him. They talked for a long time. I was watching them from a distance. The man told that he would come later some day. He was also asking my friend if he was available there every evening or not.

The place of sexual act is another important factor in determining whether a condom will be used or not. The sexual acts, which take place near lake, deserted railway platforms or railway compartments are mostly without condoms. These sexual acts are of short duration. Due to the shortage of time and space, the *koti* neither can bargain with his client nor can he monitor his client for the use of condom. Their partners often cheat them by taking out the condom before penetration. A support-group member, who is working among the *koti*s in Calcutta, informed that condom use is very low. Although he distributes condoms the *koti*s do not use those.

After a risk assessment programme done by an organisation in Calcutta, it has been found that condom use in the suburbs is absolutely nil. In South Calcutta few demand condoms and there hasn't been much response among the *koti*s of North Calcutta. North Calcutta is relatively more congested as compared to the southern part, hence there is lack of availability of space and open venues to hold such discussions. A difference in the outlook of the people is observable between the residents of north and south Calcutta. The former are the traditional people with conservative viewpoints and the latter have a relatively modern, indifferent and non-interfering outlook to life.

Anal sex is very common among the homosexuals in Calcutta as else where. During anal sex, number of these *koti*s land up with ruptures and injuries. They visit the local practitioners and are unable to explain the situation to them. They generally say that they have piles. The doctor gets to know and threatens the *koti* that his family will be informed if he does not speak the truth. He is operated only when he tells the truth.

Self-esteem is generally low among the *koti*s in Calcutta. The low self-esteem drives one towards risky behaviour. In the terminology of male power, the male who is penetrated during sex is considered to be like a female and hence inferior. The simultaneous 'giving up' of male power makes a *koti* a subversive and timid entity in the eyes of the others, and they are marginalised in society. There is a little urge to protect oneself from any harm. In a number of cases, *koti*s have got themselves castrated or have tried to do the same to join the group of eunuchs in search of an identity. Many *koti*s have a high level of dissatisfaction with their male bodies. This also negatively influences their sense of self-esteem.

*Koti*s at the lake have a strong community feeling. They keep contacts with each other and help each other. At times they discuss their problems and try to figure out the possible solutions.

However, there is a distinct difference between the *koti*s from the low and the high income groups. The ones from the higher income group have separate cruising venues and don't interact with other *koti*s. MSM who earn Rs 500 do not interact with those who earn Rs 200. A member termed these people as selfish.

NGO Efforts

An NGO in Calcutta is working on a number of projects, one of their main projects being with the MSM community. Back in 1995, few *koti*s had started discussions on their group behaviour, attitudes. The possibilities of establishing an organisation were talked over by them at the lake-side or one of their houses. The initiative was aimed at developing communities of men who are largely discriminated by society. They have been trying to pose options towards the life of MSM and have been working with these men with parallel constructions of masculinity. The organization has a resource centre on male gender studies. It believes in studying male gender as a separate extant identity but integrating it in the study of both masculinity and femininity. At present, they are conducting a risk assessment among *koti*s in Calcutta. They have several outreach programmes at different cruising venues in Calcutta. Support group members provide counselling and condoms to the MSM.

Very few organisations in Calcutta are taking such efforts to address issues of MSMs. These interventions are taking place at small community levels and need to be integrated in all HIV programmes.

Strategy

HIV/AIDS intervention strategies for homosexuals should be linked with awareness raising and other larger issues. Space for discussions on gender construction and sexual preferences might change the attitude of the society towards homosexuals.

At a broader level, decriminalisation of homosexuality is necessary for providing a cultural space. With the legal reform, there will be more societal acceptance. Negotiation power of the *koti*s, also will be widened which will lead to reduction of risk behaviour.

Preventive actions for HIV transmission cannot be taken care of without these larger reforms.

Street Children

UNICEF has defined street children as, 'those who are of the street and on the street.' 'Of the street' refers to those who live in the street and 'on the street' to those who spend significant part of the day on the street either for vocational reasons or on a wide range of other activities like begging, rag picking, car washing or attending to some side street shop. UNICEF has included them under children in difficult circumstances. They are also called 'high-risk children', 'children in need of care and protection', 'abandoned children', etc.

The problem of street children is a global one and exists in both the developed as well as the developing countries, with a difference in size and magnitude. As the countries are becoming more and more urbanized, the number of street children is swelling. The following are the categories of street children:

1. Children on the street – these children still have family contact in more or less regular nature. Their focus in life is still the home. Very few attend school, most return home at the end of each working day.
2. Children of the street – this group is smaller but complex. Children in this group see the street as their home and it is there that they seek shelter, food and a sense of family among companions. Family ties exist but are remote and their former home is visited infrequently.
3. Abandoned children – they are the ones, who have severed all ties with the biological family, they are entirely on their own, not for material but also for psychological survival.

Every Indian city has a sizeable number of invisible children who live in shocking inhuman conditions. These children are found on the streets, railway platforms, markets, slums and squatter colonies. Along with other miseries in their lives, these children are exposed to high-risk sexual behaviour in the early years. The children have often been subjected to abuse and harassment. Sex is easily available for them. Finding it very hard to make both ends meet, they are driven to a life of precarious survival. Health services, for this marginalised group, are inaccessible and unfriendly. The major focus of the existing HIV/AIDS programmes is on school-going children. The responses to prevent the spread of the infection in out-of-school children are isolated interventions by some NGOs. There are few efforts to link work on prevention of HIV/AIDS with developmental programmes that address poverty, gender, education and access to health care.

Running away from home and socialisation on the streets

For the present study, discussions with street children were held in Calcutta. Children run away from home early in life at the age of 7-8 years. Most have contacts with their families and visit their family once in a while. They run away from families due to

beatings from their father and stepmother, lack of space at home, in search of a better life and to seek freedom. Some said that they could not fulfill their parents' wishes and ran away. Some did not like to go to the schools and study. A large number of children run away from home, as they cannot bear the stress of the family problems. Some are motivated by friends who have already run away.

Story of Babu, Samir and Vijay

Babu (21 years) has been living in the Sealdah Railway Station for past thirteen years. He narrates his story:

'I come from a low-income family. My father used to sell sweets at 'melas'. I had an elder brother also. We used to live together. My mother died during delivery when I was a seven year old boy. My father remarried. My stepmother was so nasty towards my brother and me, one day my brother left home. He never came back. I too tried to runaway from home. Once I had left home also but came back. I was scared. I did not know where to go. I was being beaten up regularly by my stepmother. One of my neighbours advised me to runaway from home. Finally, one day I ran away from home when I was only 8 years of age. My aunt dropped me at the railway station. I couldn't locate my elder brother. I started staying on the roads and used to beg and eat leftovers at the station, till one day, when an unknown person in the station called me and stated that he is my friend. He agreed to share his small space in the platform with me.'

Samir (24 years) comes from a low-income refugee family. His family had come from Bangladesh and settled at near Calcutta. He tells:

'I ran away from home when I was 7-8 years old. I just felt like running away one day because of lack of space. I never had any interest in studying. When I came to the station I became a rag picker. I used to move around in the surrounding areas of the station. I was noticed by an NGO and was put into school.'

Vijay (11 years old) lives in a congested area of north Calcutta. At present he works in a tea stall as a dishwasher. He shares his experience:

'I ran away from home when I was 8 years old. My original home is at Bangaon, in 24 parganas near India – Bangladesh border. My mother died when I was 6-7 years old. My father is a vendor. He started living with another lady and stayed separately from us. My two younger sisters and me started living with my grandfather. Villagers started teasing us. One day I ran away from home and came to Sealdah station all alone.'

Boys and girls after reaching the street or railway station find difficulties in obtaining food. Soon they start earning through rag picking, working in tea stalls or stealing. Slowly a relationship develops between the older ones and the new comers.

Sexual abuse/sex in Life

For most of them, sex starts in their lives with sexual abuse or forced sex. A large number of the boys are also sexually abused repeatedly by some men in the station, which lead them to indulge in sex early in life. Some of the boys watch adult movies with older boys and friends. Later they try to enact the scenes from the movies. Gradually, they start having sex with their peers.

Forced sex is a big problem in children's lives. The child cannot protest to that. He is threatened that he would be thrown out of the platform. A number of times, the little boys were taken to hospital for treatment of injuries caused by forced anal sex. This becomes the initiating factor for the children. The peer educators later found the same boys indulging in sex for pleasure. The kids agree to have sex for money and food also. Some time older men show a lot of affection towards a particular young fellow who might be a newcomer to the area. They provide food and a place to sleep and later compel the young boy to have sex with him. Even in the cinema halls, older men have sex with young boys in the darkness.

Babu tells, *'The man who provided me shelter in the station sexually abused me one day. I was badly injured.'*

Anwar (12 years old) tells, *'An aged person in the station, who lives with his family there, sexually abused me. He did bad things with me.'*

The girls who come to the railway station also indulge in sex in early life. For them too initially it is forced sex. The railway police who patrol the station in the night take the girls to vacant train compartments and have sex. Secondly, both these girls and boys steal raw vegetables from the goods trains or the trolleys. While stealing, if a policeman catches a girl she is forced to have sex with that policeman or else the policeman threatens to arrest her. The older boys also accompany the girls to steal vegetables. They give the girls protection in exchange of a sexual favour. Most of the times, the girls agree to this for survival.

In leisure time, boys chat with their friends on their sexual experiences. They discuss how they went with a girl to have food in a restaurant or to watch a movie. They also share their experience of approaching and persuading girls to have sex. They talk about sexual postures and use their own terminology to identify both male and female sex organs. Most of these boys do not use condoms.

The NGO educators think all these have an impact on the peers. This makes them more inquisitive towards sex and sexual activities. Both boys and girls after sometime have sex for pleasure. The peer educators counsel these boys on HIV/AIDS, STIs and condom use. They are shown slides of genital infections. Many of them listen to them carefully and now ask for condoms. Few even come to the NGO clinics for condoms. Girls at the station also collect condoms from the girl peer educators. Peer educators told us that the cases of STIs have come down sharply. Now only a few cases with STIs come to the

clinics. The peer educators think that their education works positively among 80 per cent of boys and girls.

Both boys and girls think that girls have not acquired enough power or command to bargain on sex. The boys can apply force on them. The girls are scared of the boys. If they don allow the boys to have sex with them she might have been injured with a blade by a boy. Finally it is easier for them to offer a sexual favour to the boys because they are the persons who can help them in stealing vegetables from the trolleys and give them other basic information. The girls cannot even evaluate the bad effects of these activities on their lives. The girls do not indulge in sex for money always. They like to have sex. Even the girls who know the dark sides of unsafe sex indulge in sexual activities some time for fun's sake. The girl peer educators think that the bargaining power of girls who are not so good-looking is lower than the good-looking ones.

Love and Romance

Numbers of girls coming to the station are less than number of boys. Whenever a new girl comes to the station, the boys in the station keep an eye on her. She has to depend of some of those boys for her survival. Gradually she becomes intimate with a few or one of them. Some time she becomes close to somebody else outside the station. The peer educators say it is very risky to make friendship with unknown men, as there are some people who are involved in girl trafficking.

The boys have a competition among themselves to take possession of a girl in the station. The girl may be attracted to a particular boy even if his income is less than that of another fellow. The second fellow who earns more tries to convince the girl. He lures her by getting a dress or cosmetics for her. The girl sometimes changes her mind and shifts to another guy. The incident may lead to heated arguments between the boys. They declare their right on the girl on the basis of their expenditure capacities. The overall impact is bad. The boys discuss among themselves and said that, *'the girls are greedy, they change loyalties very easily for money.'*

Young guys even sometimes marry girls living in the station. These marriages do not last longer than a month or two.

The story of Vijay: *'I fell in love with a girl of my age at the station called Mamoni. Mamoni was the sister of one of my friends. That friend of mine asked me to marry Mamoni, but I did not make up my mind till then about marriage. Mamoni liked to watch movies, I took her to movies several times. We also had sex several times inside the garden, in the station premises. Later on, Mamoni became too greedy. She started moving with other boys for money and dress. She even established a relationship with Pavan, a porter. He is a well-built young man. Now I have stopped interacting with Mamoni. Even if we meet, we don't talk to each other.'*

Drug/Alcohol addiction

The boys mostly spend all the money on buying meals, watching films and also buying 'synthetic solutions', which they are addicted to. They tear off a part of a cloth and pour the solution on it and sniff. After sometime they feel dizzy, and in this state either steal things, indulge in sexual activities or just sleep off. A number of boys are also addicted to alcohol and drugs like ganja and charas (hashish).

NGO Efforts

We talked to members of one NGO which is working with socially disadvantaged children in Calcutta through education and social mobilisation. They have drop-in-centres, night shelters and a half-way house (24 hours residential centre). The NGO works with the street children at the railway station and other places in Calcutta. In response to the street children's life style, an HIV/AIDS awareness programme was set up. Street children are trained as peer-educators to reach out to their friends and immediate community with information on sex and sexuality with special focus on HIV/AIDS. Three clinics run to respond to the health needs of street children. Counselling programme for the children is integrated with condom distribution.

Strategy

Any intervention programme on HIV/AIDS should be integrated with other existing programmes and the basic needs of the community. There is need to have inter-sectoral links with other development programmes like health, education, and judiciary.

Provision of adequate resources and other facilities like sex education, health camps, and production of educational materials in the local language and role-plays are important. Schemes for vocational training leading to rehabilitation and integrating them into the mainstream have to be part of all intervention programmes. There is also a need for psycho-social interventions and counselling by social workers and agencies. The need to establish more community centres for children should provide education, training and shelter to these children. Such centres are essential to get the children together for conducting welfare programmes. It should be a centre for education, welfare and recreational programmes.

Health programmes are of considerable importance for street children as they lack physical, mental and social self-being. They should inform children about prevention of disease and promotion of health. This can be achieved if one is part of their life to understand their lifestyle, their attitude and way of thinking. A planned programme for street children can attempt to change the behaviour of the individual or modify the environment to meet specific needs of the individual.

Drug Users

The phenomenon of 'traditional' drug use in Asia has been well documented since the presence of the British in the region. Substances such as cannabinoids and opioids have found their way to Western markets at substantial profit margins which resulted in International pressure for Supply Reduction and crop eradication measures.

Drug users are a highly elusive group in India. Information on the magnitude of the problem among the general population is available from four kinds of sources: research projects, data from treatment centres, views expressed by key informants like government officials, teachers, community leaders and addicts. Most recent studies of drug use have shown escalation of intravenous drug users (IDUs). Those who inject drugs are still an isolated group in our society. The risky behaviour of this group is needle sharing, which is known as one of the most important route of HIV transmission.

The profile of the IDU in India has been diverse and dependent on the location of the user. In the north-eastern states of India such as Manipur and Mizoram the IDU cuts across all socio-economic strata. In the other regions in India, the lower socio-economic slum communities appear to have been targeted. Those who indulge in this behaviour, mostly use a common syringe in a group. Injecting drugs with non-sterile syringe is one of the key risk factors leading to HIV. The entire system of taking drugs makes them vulnerable as far as HIV/AIDS is concerned. The other groups of people, who actually do not indulge in taking injecting drugs, are also at high risk because of their sexual behaviour while addicted. The twin epidemics of HIV and substance abuse are fuelled by a low awareness of the routes of transmission of HIV/AIDS due to community marginalisation and social policies that prevent and prohibit access to sterile needles and syringes for IDUs.

A life dependent on drugs

Young people start taking drugs in their school days. Most of the time they start taking so-called soft drugs like *charas (*hashish*)* or *ganja* (marijuana), later they shift towards hard drugs like heroin or other chemical drugs like ecstasy drugs. They increase the doses gradually. They collect money from their parents, if possible, to buy drugs. Otherwise they may indulge in stealing or other illegal activities. It has been told that peer pressure is high among the drug users. It should also be mentioned that peer pressure is not the only factor in starting a life with drugs. A substantial number of young people start taking drugs only for fun or experimentation, at times it has nothing to do with depression or peer pressure. An activist from Sahara told us that taking hard drugs or ecstasy drugs is also due to lot of exposure to the western society through televisions and films. It was also reported that many of them start taking drugs just to experience it. It does not take much time for many of them to become completely addicted in the process.

Once addicted a drug user first goes in search for his or her drug of choice. If it is not available then any kind of drug is accepted. Anti-epileptic and anti-spasmodic capsules are also swallowed or injected.

According to informants there is a hierarchy among drug users based on the types of drugs being used and the way the dose is being taken. ID users are rated the lowest and will always be found in separate groups. The upper middle class drug users are more into western drugs and ecstasy drugs, which is orally taken. Number of users come from the middle class too, but according to the psychologist at Sahara there is a lot of guilt involved.

Drug and sex

Additional risk behaviour is multi-partner sex after taking drugs. Initially, drug use heightens sexual desire. Not only the IV drug users, all the drug users including the alcoholics are equally vulnerable towards HIV if they indulge in multiple sex or unsafe sex while under the influence of drugs. A number of intravenous drug users – men, women, and children – sell sex to manage drug money. Most of the street children who themselves are the peddlers get into drugs, some men get their wives to manage money for their drug habits. These women, in turn, also end up using drugs and selling sex to manage the money.

Attitude of family and community

Family bondage is still very powerful in India. There are strong emotional attachments within families. But as far as HIV/AIDS is concerned, economic burden is the main problem for the family. Most of the time, family cannot afford to keep a positive person with full-blown AIDS, as the medical expenditures are too high. It is not true that the affected persons are dumped in the care-home. The family members do keep track of their loving ones.

In some cases families should be motivated also. They may be compelled to take back an affected person. In a project in Pune, NGO volunteers motivated the neighbours. They were cited examples from various cases, where a positive person was staying in a family.

The community looks down upon the addict who is mostly stigmatised, marginalised and alienated from the society.

Cultural and Regional Variations

There always exist regional differences in the attitudes of the people. In Pune, young people will say NO to drugs but they may indulge in unsafe practice of sex through multiple sex partners or they may visit a sex worker. But in Manipur, the social respect for the women is certainly high. The young people may use drugs but may not indulge in promiscuity so easily.

False Beliefs about drug use

- Once a person starts taking drugs, he/she can’t stop (proper intervention can help a person to stop drug use)

- A drug user always lies, cheats, steals (it does happen in a number of cases, but one can't label a drug user as a liar/thief)
- He/she starts taking drugs because of his friends or the company he is in (at times the person who does not have any friends and lonely also takes drugs)
- People take drugs only when they are low (drugs are always associated with negative emotions which is not true, at times even the happiest of people take drugs, it adds to the sense of elation)

NGO Efforts

The Manipur intervention programme has a day care centre and a rehabilitation centre. At the day care centre they have drug users dropping in during the daytime. Some just drop in because they are curious as to what is going on. During the time they are there they are counselled, told about consequences of drug use. The whole programme is kept very non-judgmental and non-threatening. Anyone who enters the day care is accepted. After a number of such visits, a drug user might decide to go for abstinence and goes for their detoxification program. Once the person is little stable and not being dependent on drugs, home visits are made to the family to counsel them and asking them to support the concerned person. According to the informants experience who himself has been a drug user, says that although family support is there in a number of cases, there is a lot of hesitance in it. Family lacks confidence and faith in the drug user and are always a little wary about the person's drug use status. The informant said drug addiction is much different from alcohol addiction. People having alcohol problems have more family support but the family tends to lose patience with drug users, as it becomes equally traumatic for them. There are cases where the drug users have stripped their home off things, cases where they keep threatening their families that they will commit suicide if they are not given money. The family finds it very difficult to handle such situations.

Rehabilitation

At one of the NGO rehabilitation centres in Delhi, the abstinence programme is followed, they have income generation and vocational programs too. The drug users themselves feel they need to be kept busy or they might have a relapse. They are kept busy with sports activities and other income generating activities.

In relapse cases, relapse is manifested much before actual drug use. There are signs that make it evident that the person will have a relapse. Lying, stealing, avoiding people are few of the signs that they recognise. During this time the NGO tries to bring the person in the right track by counselling him or her.

Some of the key informants spoken to, were ex-drug users and are presently working and providing support to the other drug users who are under the NGO care. A clinical psychologist who is also working at the NGO for the past 4 months provided some insight into the lives of drug users.

The informants said that the rehabilitation programme is different from the rest of the rehabilitation programs run by government or organisations. The NGO gives more

emphasis on emotions such as love and showing patience while handling drug users who come for rehabilitation, unlike other programs who handle them by giving negative reinforcements. They accept anyone who comes to them without being judgmental. At times they have to be tough but that only helps the person to get back into track. The environment is very casual and free with no restrictions imposed on anyone. Only in extreme cases where the individual gets drugs in and gives trips to others, or molests someone, is action taken. Classes are held for people who are illiterate and music, sports activities are frequently held. One of the ex-drug users said that he tried harder to stay off drugs now, if he had been punished or sent to prison he wouldn't have stopped taking drugs.

They have harm reduction programmes in Delhi. Though at times they said it was frustrating but at times they did see positive outcome of their counselling, which resulted in gradual behaviour changes. They would ask the drug users to gradually decrease their doses of drug intake. They have seen the change in certain cases where individuals have drastically cut down their daily doses of drugs and are more functional than what they had been. Their families have been very happy with the changes and have visited the counsellors in the further visits. They have gone back to working and bringing money home. They said that percentage of successful cases were less but even if they are able to change the behaviour pattern of 5 in 100, they feel it is worth the work put in. Abstinence is even tougher, but there have been successful cases where individuals have stayed clean for number of years. They have incorporated HIV/AIDS, hepatitis awareness in their programme, but they feel it does not lead to absolute behavioural change. The high-risk behaviour after drug use is difficult to check. Providing sterile injections on a regular basis is not always possible. At times, the urgency to fix oneself overpowers ones feeling of personal safety. Among the lower income group, there is an attitude that HIV is just another virus, it does not bother them whether they have it or not. All said that other programmes like income generation and vocational programmes have to be part of harm-reduction and rehabilitation programs. If the drug user is not provided with some alternative, then it becomes difficult to have effective rehab and outreach programs. When a funding organisation provides funds it is mainly based on rehabilitation programmes, they leave out the other aspects linked to effective programmes.

Some other organisations have also opted for harm-reduction programmes. They have put most of the injecting drug users on oral maintenance therapy and few have also abstained from taking drugs so as to reduce the risk of contracting HIV. For the oral maintenance approach, these organisations have not been provided support from the government and these organisations find it difficult to obtain funds for their programmes.

The **Narcotics Act** in India treats all drugs (soft and hard) similarly. A person caught carrying 5gms of cocaine, heroin or ganja would be equally punished and the sentences are equally harsh. All agreed that laws have to be modified and need to be milder. A drug user in the Indian situation is treated worse than a murderer. The informants spoke from their own personal experiences in the prison where they were treated badly by all, the attitude of a prison guard to a sentenced murderer towards them was similar. The drug users were given the lowest status and were treated as 'the scum of the earth'. Giving

examples of areas where drug is easily accessible, they spoke about a congested area in Delhi where drug users flock around 4-5pm in the evening to buy their dose for the day from a seller who visits them everyday. The police around the area are well aware of the happenings but get their share of money from the peddler.

Strategy

One of the most effective strategies for preventing HIV infection among IDUs is to minimise sharing of injecting equipment by ensuring ready access and utilisation of such equipment. Many models of needle-syringe programmes exist, including dedicated needle and syringe exchanges, needle and syringe medical prescription, pharmacy provision, secondary needle and syringe exchange, distribution through drug injecting peers, prison exchange programmes, and vending machine dispensing. The largest number of papers presented at the conference on IDU interventions focused on needle and syringe programmes, addressing such issues as models of service delivery, characteristics of clients, effectiveness of interventions and meeting the needs of specific populations.

Outreach, particularly incorporating peer and community-based approaches, is also a common component of many programmes targeting IDUs. Services provided should include: needle-syringe exchange and disposal programme, condom programming, peer education (including current and ex-drug users), abscess management and other primary health care, support groups for people living with HIV, referral to detoxification, detoxification camps, family support groups, crisis support shelter and long-term rehabilitation services which must be part of all drug programmes. The interrelationship between sexual behaviour and non-injecting drug use is complex, poorly understood and little studied and further research needs to be done in this area.

IV. Culturally Conditioned Beliefs and their Implications

The entire world of sexuality and HIV/AIDS is shrouded in mystery for the average Indian people. To this environment were added hundreds of myths and 'false beliefs' on sexuality and HIV/AIDS that were nurtured along the development of the disease.

Many of the religious and mythological notions in India have been interpreted in different ways at different points of time. Most of the time, the texts are interpreted by the interpreters with little knowledge, which may add different dimensions altogether. People often have a tendency to construct social prescriptions for themselves on the basis of these interpretations. Due to the lack of scientific knowledge, people easily derive unscientific, cause and effect equations. Young boys grow up with numerous misconceptions and guilt about masturbation. They believe in the knowledge they acquire from their peers. The absence of clearly-defined, transparent and socially-accountable sexual mores, and the prevalence of fostered myths and secrecy, spell disastrous implications not only on the spread of HIV/AIDS in India, but also in the way it is confronted.

The table below lists a set of culturally-conditioned beliefs and myths that have provided fertile ground for the formation of culturally conditioned beliefs regarding HIV/AIDS:

Beliefs

General Assessment	*Implications*
• Sex is a taboo subject (Sex should not be discussed openly across genders and age groups)	Misconception on sex, sexuality, lack of knowledge on sexual organs, sexual intercourse and sexual activities • Narrowing down the space for discussion on sex and sex-related matters • Lack of positive language on sex. Sex is within the invisible realm, and very often there are no commonly available appropriate terms to even discuss sex and sexual behaviours in the public arena
• Sex within the marriage is perceived as a duty for procreation	• Tendency not to go to the doctor Going to sex workers by men is accepted by the society
• Masturbation leads to impotency and loss of memory, therefore it is better to go to sex workers.	Multi-partner sex through frequent visits to sex workers

• Lack of urgency regarding the epidemic amongst people and policy makers	Little behaviour change in people, lackadaisical attitude of the government
• Female ignorance of sexual matters is a sign of purity	• Reproductive health of women is not a matter of importance • A culture of silence and tendency to hide sexual problems
Woman, who is engaged in any kind of sex outside marriage, is a *patita* (fallen woman)	Sex workers are regarded as public property. Social hatred for sex workers

'*Masturbation leads to impotency and weakness, because one drop of semen is equivalent to a thousand drops of blood. Still, all of us practice masturbation, knowing that it is bad for health. People who do this very frequently, suffer a lot in their married life*', says an adolescent boy in one of the focus group discussions in Delhi.

Myths

- HIV and AIDS are the same things
- HIV/AIDS can be contracted only through vaginal sex
- Touching and kissing an infected person spreads HIV
- Sharing food spreads HIV, as do mosquito bites
- If your home and environment are clean you will not contract HIV
- Person who is not suffering from any STIs will not contract HIV
- (Held by the upper and middle classes) HIV/AIDS is prevalent only in the slum dwellers and lower classes, as they frequent sex workers. According to the lower class and slum dwellers, HIV/AIDS is contracted by the rich, as they have the money to frequent sex workers
- Sex workers are storehouses of all sorts of STIs. If you don't go to sex workers you will not get HIV/AIDS
- No need to practise safe sex with known or expensive sex workers, as they are clean and safe
- Sex with virgins cures STIs, including HIV
- If you urinate immediately after sex, you won't get any STIs
- Sex is essential to release body heat which accumulates after long hours of driving
- Condoms are unhygienic, because the semen collects in it and touches the penis

- Use of condom reduces sexual pleasure
- Injections are the answer to every illness
- Pure women (loyal to the husband and his family) do not get HIV/AIDS
- If a person looks healthy he/she cannot have HIV
- If someone has AIDS, it would be known from his/her appearance

V. Conclusion

The handbook presents the widespread cultural practices and attitudes in the context of HIV/AIDS prevention and care, and focuses on some groups and communities that show focused and specific manifestations of Indian culture. It also broadly covers the socio-cultural background of Indian society in the context of HIV/AIDS, which show an enormous variety of cultural practices and beliefs all over the country. Such a discussion highlights the importance of taking culturally specific and culturally appropriate HIV/AIDS intervention strategy in this country. A common general strategy can be developed at the broader level, but for specific cultures and communities the intervention programmes should follow an appropriate culturally-correct policy which can work faster in the community to make them understand the serious situation as far as HIV/AIDS is concerned.

Mainstream Indian culture and traditions firmly stand on the values of patriarchy. The widespread impact of patriarchy is found at all levels of social institutions starting from family and kinship to marriage and sexuality. Although, women take greater responsibility within the family, males maintain their superior status. The values of patriarchy are so strong, that any intervention would not be whole-heartedly accepted by the society. Here lies the importance of taking a cultural approach to HIV/AIDS prevention and care, mainly to reach every corner of our society and to make the intervention programme successful. One possibility is to highlight that the main focus of patriarchy is male responsibility. In the present context of a cultural approach to HIV, intervention strategies need to identify and strengthen positive characteristics in the culture where the male assumes responsibility as the patriarchal head.

It has been found in the field study how patriarchy institutionalises values and practices within different cultural groups within the population. In the present study, we have seen that though the Bedia women take greater responsibility of the family sustenance through the profession of prostitution, the whole system is institutionalised and directed by the men and is supported by the women members of the family. Among the MSM in Calcutta, the relationships between the '*kotis*' and '*giriyas*' are similar to heterosexual types of relationships. Negotiating safe sex becomes difficult for the *koti*. Most of the times they get emotionally involved with their partners and they say that they do not like to be demanding, as they might lose their partner to someone else.

Moreover, under the strong influence of patriarchy, sex becomes a complete taboo subject. It narrows down the space to talk about sex and sexuality and therefore causes hindrance for sex education. Lack of positive language on sex makes sex a more hidden and obscure subject for the adolescent population. Due to the absence of proper sex education, sex becomes an issue of uninformed discussion among peers which, in turn, results in unscientific and incorrect information among young boys and girls. The lack of knowledge on sex continues even in later phases of life. A lot of myths are generated due to the lack of space for knowledge. The influence of patriarchy on the one hand and myths and incorrect knowledge on the other make a large section of Indian men and

women vulnerable to HIV/AIDS, as sex is the most important medium of HIV transmission.

Prevention and care of HIV/AIDS is crucially dependent on social and sexual behaviour of the population, apart from factors such as the level of awareness. An intervention programme oriented for the cultural aspects of the society would help to understand the intricacies of the sexual behaviour of a community. Even such a programme could be evolved from the community itself in association with its members. Sexual behaviour and social interaction patterns are culture-specific. No uniform strategy package can be designed that will uniformly address to all cultural groups.

It is important to keep in mind that macro-economic packages have a direct impact on different groups. Any effective intervention strategy has to understand these broader macro policies along with specific intervention for specific groups. A common macro level strategy, taking into account the cultural milieu and diversities, and a minimum strategy for all specific groups have to be evolved.

Any intervention programme on HIV/AIDS should be integrated with other existing development agenda and the basic needs of the community. There is need to have inter-sectoral links with other development programmes like health, education, and judiciary.

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