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High fun: An ethnography of HIV risk and stigma among gay and bisexual men in urban India

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Abstract

This thesis is an ethnography of HIV risk and stigma among gay and bisexual men in urban India, a demographic that is underrepresented in HIV/Aids research. It explores the effects of the biomedicalization of the HIV/Aids epidemic over the past decade (Kenworthy, Thomann, and Parker 2018) at both the policy and personal level, and asks what an anthropology of the treatment-as-prevention era might look like. I begin by offering an anthropological account of "high fun", as sexualized drug use is known among gay and bisexual men India, attending closely to the some of its "organizing logics" (Race 2015) and the way in which interlocutors make sense of and navigate a variety of risks in these contexts. In doing so, I problematize some of the tendencies of both traditional and critical "chemsex" research, almost all of which refers to gay communities in Europe, North-America, and Australia (Møller & Hakim 2021). I then suggest the failure to reach men who are into high fun is symptomatic of the decline of India's celebrated strategy of targeted intervention, and exposes several tensions in the conceptualization and mobilization of "community" in Indian HIV/Aids governance. Moving beyond prevention, the final part of this thesis focuses on gay and bisexual men living with HIV, some of whom trace their infection to high fun. Challenging the assumption that treatment-as-prevention technologies and discourses will reduce stigma, I argue the discourse of Undetectability, referring to the impact of viral suppression on forward sexual transmission, instead contributes to the closeting of HIV among gay and bisexual men in the face of intense social risk. I then ask how a more thoroughly intersectional approach to HIV stigma might help us understand its persistence despite the medical normalization of HIV/Aids. All this attests to the continued importance of anthropological engagement with HIV/Aids at a time when biomedical triumphalism (Kenworthy, Thomann, and Parker 2018) threatens to marginalize social approaches to the epidemic.

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This thesis would not have been possible without the men who entrusted me with their stories, which I can only hope I have done justice to in these pages.

My understanding of HIV/Aids policy in India derives from countless conversations with HIV workers and activists across India, but particularly those at the NGO in Bengaluru who kindly accommodated me in their offices, despite being of no discernible use.

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Preface: Spiralling

This thesis is the result of a small personal crisis, one that roughly one and a half million people around the world go through each year[1]. On a grey and drizzly day in December 2018, I was called into an iconic sexual health clinic in Soho to discuss a problem with my blood results. In the waiting room at 56 Dean Street, an orange circle, printed in large font and joined by a percentage sign, jumped at me from a black leaflet. “HIV is falling in London’s gay men,” the text read. “We can get it to ZERO.” Inside, the leaflet promoted a mix of biomedical and traditional prevention strategies. The camp record charts playing loudly suddenly seemed unbearable. *I was busy thinking about boys*, taunted Charli XCX, *boys…* I drew a deep breath of hot anxiety and anger just as a counsellor appeared and called out my name.

A few days earlier, Public Health England had announced the U.K. was meeting UNAIDS test-and-treat targets, with over 90% of UK HIV cases diagnosed, treated, and virally suppressed. The agency’s report highlighted that new infections among gay and bisexual men in London were at a historic low, a fact campaigners attributed to the uptake of pre-exposure prophylaxis (PrEP) among HIV-negative men. The news was framed as a vindication of new treatment-as-prevention strategies. “This is an extraordinary moment in the fight against HIV, in which everything seems possible,” commented an ‘overjoyed’ Deborah Gold, chief executive of the National Aids Trust. “We know what works. We have the tools. With the right political will, investment and public support, we can eliminate HIV as a public health threat and make real progress towards the UN target end HIV-related stigma” (Boseley 2018).

This was around the time I was due to submit my ‘Upgrade paper’, detailing the anticipated theoretical and methodological challenges of my project. Originally centred on a proposed new piece of legislation concerning transgender rights and welfare, the scope of the proposed research had expanded to a larger, rather ill-defined inquiry into queerness and normativity in India. After receiving the diagnosis, the research questions I had come up with where crowded out by more acute ones. Who gets HIV just as the epidemic draws to a close? Would this have happened had I stayed in Scotland, where PrEP was already available on the NHS? How will my gay-affirmative but God-fearing parents respond? And if it’s no big deal nowadays, medically speaking, then why do I feel so bad? When I discussed changing my

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[1] The UNAIDS estimate for new infections (not diagnoses) in 2019 is 1.7 million, give or take half a million (UNAIDS 2019).

topic with my supportive supervisor, he gently expressed concerns about the wisdom of feeding these fixations.

Much later, I would learn about a type of meditation during which you inhale the emotions produced by your personal problems and, on the exhale, think compassionately (and more coolly) of all beings suffering a similar fate. Taught to lepers on the Tibetan plateau during the 12th century (or so the story goes), the American nun and nineties sensation Pema Chödrön claims the practice enjoyed some popularity in U.S. Aids hospices before the advent of triple-combination treatment. *Since I'm already feeling this*, practitioners would think about feelings of shame, anger, resentment, physical pain or hopelessness*, may I feel it completely so that all my brothers and sisters who have Aids can be free of it*. Then the person would send out healing in any way that seemed real and comforting to them. While these 'vibes' (to use a more millennial parlance) naturally didn't halt or reverse the havoc wreaked by opportunistic infections, Chödrön suggests this kind of meditation heals at the spiritual level in that people "feel like their disability, their pain, their despair, their fear suddenly has meaning, that there is a purpose to it: it can be used as the basis for benefiting others." (Chödrön 2019).

Whether or not this thesis will bring relief to anyone other than myself remains to be seen. But insofar as it begins with the increasingly private predicament of HIV diagnosis (Flowers 2010) and ends with the bigger picture of what it means to live (all of us) with the virus today, it follows the movement of the meditation. Was I spiralling when I adopted this topic? Most certainly. But 'fieldwork' made it a spiralling outwards, entangling me with the people whose anecdotes and arguments became the chapters that follows. ("From one circularity to the next", writes Édouard Glissant about the spiral in *Poetics of Relation* (1997, 199), "it encounters new spaces and does not transform them into either depths or conquests.") Aimed (like the meditation) at creating greater understanding and compassion, the thesis builds on a tradition of anthropological engagement with the epidemic by the likes of the late Paul Farmer (1992) and countless others. But I am thinking in particular of the HIV-positive anthropologist Robert Ariss, who passed away in 1994 just before completing the first draft of his deeply personal PhD thesis of Aids activism in Sydney. In its introduction, he insisted "we can learn from [HIV/Aids] as much as we can contribute to the effort to live with it" (Ariss and Dowsett 1997, 14).

With that in mind, let us turn to the out-breath.

Chapter 1: Introduction

> I'm HIV Positive.
> I feel so vulnerable about the whole situation.
> It's been a year I got to know my status and I immediately started my ART treatment.
> I'm undetectable now.
> The thought of dying alone without anyone around makes me feel pathetic.
> I've indulged in high fun after I got to know I'm positive too but only after making sure that I'm undetectable.
> I used all safety precautions but I still feel guilty.
> I get very uncomfortable thinking about sleeping with someone when I'm sober.
> I met a psychiatrist who said not to worry so much and that I'm not addicted.
> I can't tell anyone about my status as I don't know how people take it.
> I don't know why my life has become beyond repair.
> (Anonymous, 2020)

These despairing lines were posted to a Facebook page for anonymous confessions by members of Bengaluru's queer community in July 2020. Although the page covers a wide range of topics, from secret crushes to rather niche fetishes, every once in a while someone will submit a confession to the page administrator that takes the form of HIV disclosure, as this one does. While the existence of the Facebook group is a reflection of the greater visibility and mainstreaming of urban queer communities in the wake of (but preceding) the Supreme Court judgement reading down Section 377 of the Indian Penal Code, 1860 to exclude private consensual sex between adults of the same sex from its remit in December 2018 (Rajagopal 2018), posts of this sort are a product of the closeting of HIV among these communities. They tend to be characterized by guilt about having sex while HIV-positive while emphasizing the perceived impossibility of disclosure. This is in spite of the discourse of Undetectability, referring to the way in which viral suppression eliminates risk of sexual transmission, which is invested by HIV/Aids activists in Euro-American contexts and beyond with hopes of reducing HIV stigma (Prevention Access Campaign 2016).

This particular posts also raises the "open secret" of high fun, as sexualized drug use among gay and bisexual men is known in India. While it is unclear whether the author contracted HIV through high fun, the subcultural phenomenon is anecdotally linked to new HIV infections among men who have sex with men by both community members and people working in the HIV interventions targeted to them. Originally associated mainly with Mumbai and, later, New Delhi, the high fun scene was said to be thriving in Bengaluru when I arrived to the city in July 2019 to start fieldwork. On the days I counted, roughly one out of ten profiles on the location-based hook-up app Grindr contained references to "high fun,"

“hf” or “stuff”, which could mean anything from MDMA to methamphetamine (known as crystal meth) and mephedrone (known as m-cat). Yet barring two first-person accounts that frame high fun as an Indian iteration of the global “chemsex” phenomenon (Kamesh 2017, Hanjabam 2019), there is little information available about the scene. And from what I could gather from my first engagements with the HIV/Aids NGO with which I would end up volunteering, staff at targeted interventions for “MSM” (men who have sex with men) were unsure how to reach men who were into high fun – or, for that matter, how to help them once they did.

Recently diagnosed with HIV myself, I planned on studying the gap between the medical normalization of HIV as a manageable chronic condition “like any other” (Moyer and Hardon 2014, 263) and the lived experience of HIV-positive gay and bisexual men, some of whom feel, as the author of this post does, that their life is beyond repair. As explained in the preface, I was entirely pre-occupied with the dissonance between the two. But several of the people I interviewed suggested that if I was interested in HIV, I should train my lens on high fun, which they claimed was becoming increasingly popular in Bengaluru. While I was less interested in establishing a co-relation between involvement in high fun and HIV transmission than my interlocutors presumed, I followed their advice and expanded my focus to include this emerging phenomenon. As a result, what follows is an ethnography of HIV risk and stigma among gay and bisexual men in urban India that comprises three distinct yet inter-related parts, focused on high fun, HIV/Aids policy, and HIV stigma respectively.

Not only has high fun not yet received scholarly attention, the experiences of gay and bisexual men living with or at risk of HIV are in general underrepresented in the literature on HIV/Aids in India (Bharat 2011). This is especially true for sexual minority men from middle to upper class backgrounds for reasons that will become clear in Chapter 2: Methods, Ethics, and Poz/itionality. Conversely, the vast majority of scholarship on chemsex and on the impact of the new biomedical prevention technologies explored later in this chapter, including Undetectability, is based on research with gay and bisexual men in the urban centres of Europe, North-America, and Australia (Grace et al. 2015, Young, Flowers, and McDaid 2016, Girard et al. 2018, Young et al. 2019, Møller and Hakim 2021). And while there is a growing body of scholarship on queer politics in the Indian context, the voices of HIV-positive people are largely absent from this literature.

In this introductory chapter I situate my research in relation to scholarship on contemporary queer politics in India and the anthropology of HIV/Aids after offering a brief and incomplete history of the Indian HIV/Aids epidemic. These overviews introduce the

context in which my research took place, and help me situate it at the intersection of an emerging Indian "homonormativity" (Duggan 2003) and the medical normalization of HIV. Additionally, each of the three parts that comprise this thesis begins with a short chapter reviewing relevant scholarship and introducing the theoretical stakes. These "interludes" for chemsex, community, and stigma allow me to delve into relevant areas of HIV/Aids-related research, which is too vast a field to do justice to here, while letting the ethnography speak in the chapters that follow them. Though the thesis thus spans disparate bodies of scholarship, together these three parts offer a unique window into the landscape of HIV/Aids in contemporary India, thirty-six years into the country's reported epidemic.

HIV/Aids in India

The origin story of HIV/Aids in India is different from the epidemic's history as a "gay plague" in the U.S. and Europe, as Suparna Bhaskaran (2004) has pointed out, not least because the first cases were reported among female sex workers. In 1986, Dr. Suniti Solomon and her student collected over 80 blood samples from a group of unwitting sex workers in Chennai, six of which samples tested positive for HIV. These first reported cases of "the dreaded HIV virus" (Pandey 2016) in India made national headlines, and the women were isolated at a ward in Madras Vigilance Home. Upon visiting them there, a young journalist called Shyamala Nataraj concluded they were held against their will, and in very bad conditions. A few years later in Mumbai, thousands of women were targeted by law enforcement, forcibly tested for HIV, and incarcerated in reformaties. There could be no convictions to justify the cases since the sex workers had not committed any crime, and the Maharashtra government eventually decided to deport the women back to their home states or countries in the face of intense criticism from human rights groups. In a classic case of Orwellian double-speak, the train transporting women from Mumbai to Tamil Nadu was named the Mukthi Express (Liberation Express) (Dube 2020).

The treatment the women endured reflected the prevailing mood and policy response, which in the first years of the reported Indian epidemic was a punitive one. The first national programs of serological surveillance focused on "high risk groups" – understood to mean promiscuous men and women, sex workers, injecting drug users, and people who had had repeated blood transfusions – rather than the general population, thus reinforcing the notion that the epidemic was restricted to these groups (Asthana 1996). Indeed, some of India's first efforts at large-scale serological and clinical surveillance (the Indian Council of Medical Research's HIV task force in 1986, the NICED HIV surveillance centre established in Imphal

in 1987, and blood screening by Vellore CMC's newly established department of virology in 1988) were judged by the World Health Organization to be unnecessary and unethical (Rao 2017). Meanwhile, domestic human rights groups critiqued attempts at discriminatory legislation such as the Aids Prevention Bill of 1989, which would have empowered health authorities to forcibly test people for HIV and isolate those who test positive, as well as introduce penalties for HIV transmission (Asthana 1996). In India's Northeast, drug users were placed in detoxification camps, to little avail (for a history of the HIV epidemic and harm reduction responses in the high prevalence states of Manipur and Nagaland, see Kermode et al. 2010).

The scapegoating of women selling sex helped keep intact the denialism and culturalism that marked official discourse on HIV/Aids throughout the 1980s, during which it was argued that India's social structure of close-knit families and its culture of sexual modesty would keep the country safe from the threat of HIV/Aids (Karnik 2001). As Sheena Asthana explains,

> AIDS was seen as a 'foreign' disease from which ordinary Indians would be spared. The detection, in 1986, of HIV antibodies in Indian CSWs [commercial sex workers] did little to dispel this belief. Although women engaged in prostitution were vilified for 'importing' the disease by having sex with foreigners and were identified as a potential 'reservoir of infection' which threatened the general population, the stigmatization of CSWs served to distance them from an indifferent public and to reinforce the view that AIDS was restricted to specific, well-defined groups. (1996, 186)

These groups initially did not include sexual and gender minorities, since government officials assumed homosexuality in India was limited to a very small number of elite men emulating Western trends (Karnik 2001). Indeed, as Siddharth Dube explains in his memoir (2019), the intense and circular focus on sex workers meant gay men dodged much of the blame. In his capacity as a World Bank researcher, Dube shied away from drawing attention the way in which HIV/Aids was beginning to impact men who have sex with men out of fear of provoking a homophobic response of the sort witnessed in the United States.

Yet in New Delhi, a small activist collective called Aids Bhedbhav Virodhi Andolan (Movement Against Aids Discrimination) was breaking the silence. Though much of ABVA's energies were directed towards advocating for HIV-positive sex workers and people with HIV in general, in 1991 the collective released a booklet called *Less Than Zero: A Citizen Report on the Status of Homosexuality in India*. The 93-page manifesto called not

only for the repeal of Section 377 of the Indian Penal Code, 1860 – a relic of British colonialism criminalizing “carnal intercourse against the order of nature” – but also for same-sex marriage and adoption rights. “Many people deny that homosexuality exists in India, dismissing it as a phenomenon of the industrialized world,” (ABVA 2021, 92) wrote its seven official authors, directly challenging the government’s insistence that homosexuality was a foreign vice emulated only by a miniscule number of the country’s elite (Karnik 2001). Responding to the refusal of the superintendent of Delhi’s Tihar Jail to provide condoms to prisoners on grounds it would encourage homosexuality and was therefore against the law, ABVA filed a writ petition asking the Delhi High Court to declare Section 377 unconstitutional. Although the petition was eventually dismissed (Verma 2020), it foreshadowed the entanglement of HIV/Aids prevention efforts and queer activism in the decades to come.

Organizations like ABVA and other civil society groups put pressure on the Indian government to replace its punitive approach to prevention with a human-rights based one, along with international actors like the WHO and the World Bank. In 1992 – a year after a deep foreign exchange crisis forced India’s economic liberalization - the Indian government received $84 million from the World Bank to launch a semi-autonomous body to fight HIV/Aids, which the WHO insisted should be a dedicated division within the health ministry (Rao 2017). The loan came with the condition that the new National Aids Control Organization would honour the principles of harm reduction and human rights, favoured by Jonathan Mann at the WHO’s HIV/Aids unit and agitated for by local activists. As Dube recalls, Siddhartha Gautam – a member of ABVA and close friend of Dube’s - had written a letter to the World Bank asking them to “ensure their money doesn’t finance Aids-related human rights violations here [in India]” (2019, 165). NACO’s approach was a marked departure from the knee-jerk criminalizing impulse that had thus far characterized the Indian response. Nataraj, the journalist who had visited the incarcerated women in Chennai, remembers being called into a meeting with then-Prime Minister Narasimha Rao and then-Health Secretary Sujatha Rao around the time NACO was brought into existence. “They didn’t make any moral noises,” Nataraj told me when we spoke over the phone, “they just went around the room and asked: what do you need?” Nataraj, who had continued working with sex workers, asked for a whole lot of condoms.

The first phase of NACO’s programming (NACP[2] I, 1993 - 1999) focused on

[2] National Aids Control Programme

improving blood safety, raising general awareness, and STD treatment, and the establishment of state-level “Aids Control Societies”. Meanwhile, international donors were giving small grants to support projects focusing on sex workers and other “at risk” groups, including, increasingly, men who have sex with men, a term that was beginning to be used in HIV/Aids discourse to describe male same-sex activity in contexts were notions of sexual identity had little traction (Boyce 2007), and which initially included *hijras* and other transfeminine people that might not identify as male (Dutta 2013). “Every week we would go to a park and leaflet,” recalled someone involved in Bengaluru’s women’s movement, “we would reach out to the community which was not really named yet – there were *hijras*, there were *kothis*, but we didn’t know them as such. We just knew that they were using this park [to cruise] and they didn’t conform to a heteronormative principle.” Bengaluru’s first HIV/AIDS organization focused on sexual minorities eventually grew out of these grassroots efforts. In 1994, Ashok Row Kavi (who had also been present at the high-profile meeting Nataraj attended) founded Humsafar Trust in Mumbai because, as he explained, “we [gay men] were becoming experts at funerals”. That same year, Anjali Gopalan founded Naz Foundation in New Delhi after witnessing first-hand the devastation Aids was wreaking on gay communities in U.S. cities, and observing the lack of any state engagement with men who have sex with men India. The NGO’s offices quickly became a gathering place for MSM and other sexual minorities, including lesbian women, Gopalan recalled in conversation. And in Chennai a young man had come out as gay and HIV-positive and went on to found an organization for men who have sex with men under the name SWAM, Social Welfare for Men. The name was intentionally vague because, as Shekar told me, “gay was not possible at the time”.

By the turn of the millennium, India’s HIV/Aids epidemic was represented as a “concentrated” one with relatively high prevalence rates among certain “core groups” and low prevalence among the “general” population, imagined, as Gowri Vijayakumar (2021) writes, as elite, dominant-caste, Hindu married women. Yet there were fears the epidemic would spread beyond these groups: “HIV is now firmly embedded in the general Indian population and is fast spreading into rural populations,” asserted UNAIDS’ Peter Piot in 1998 (Rao 2017, 248). As predictions about a looming Indian HIV/Aids epidemic larger than any other in the world grew louder and louder, “NACO was accorded an implicit social sanction to work with criminalized groups,” Sujatha Rao (2017, 249) writes in her memoir *Do we Care? India’s health system*, in which she reflects on her time as the agency’s Director

General. The problem was: how does one reach communities that are generally shunned and sometimes persecuted? As Ravi Verma and colleagues wrote in 2004,

> In the Indian situation MSM activity is so stigmatized that it is not possible to collect data on such cases. Recent studies suggest that MSM activities almost certainly play an important role in the spread of the epidemic (Asthana and Oostvogels, 2001; Kumta et al., 2002; Verma and Collumbien, 2003). Most MSMs are married and conceal their same-sex activities, so that any cases of HIV among them are likely to be categorized as being caused by heterosexual transmission. (Verma et al. 2004, 25)

The quote reflects the prevailing sense that the so-called high risk groups, and perhaps especially "MSM" (men who have sex with men), were beyond the government's reach. For its second phase of planning (NACP II – 1999-2007), NACO devised a system of "targeted interventions" that outsourced HIV/Aids control among the key populations to NGOs working closely with them. It was inspired in part by the success of the "empowerment-based" model of HIV prevention trialled in the Sonagachi Project, in which sex workers in Calcutta's red light district were mobilized to educate their peers on HIV risk under the auspices of Dr Smarajit Jana (Newman 2003), even if it was far less radical (Rao 2017).

This peer outreach approach was popular among international donors, too. With the formation of Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002 and the creation of the multi-billion President's Emergency Plan For Aids Relief (PEPFAR) in 2003, significant amounts of money earmarked for HIV/AIDS prevention in Global South countries were sloshing about internationally. Also in 2003, the Bill & Melinda Gates Foundation launched their Avahan program, which identified six high-prevalence Indian states and several "high risk groups" on which to focus their generously-funded intervention. At long last, forms of the triple-combination antiretroviral treatment "cocktail" that had been announced at the Vancouver International Aids Conference in 1996 were becoming available to people with Aids in Global South countries. The UNAIDS and WHO launched their 3-by-5 campaign, referring to the target of getting 3 million people with Aids on treatment by 2005, and the President's Emergency Plan For AIDS Relief (PEPFAR) had a 40 USD billion budget for scaling up treatment (Rao 2017). Following challenges by governments and global civil society – including organizations such as the Lawyers Collective in India – to the patenting of ART medicines under the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, the World Trade Organization affirmed in the Doha Declaration in 2001 that the trade regulations should be interpreted to and implemented to protect public health and promote universal access to medicines (Hoen et al 2011). On 1 December 2003, then-

Health Minister Sushma Swaraj declared ART would be made available free-of-cost in India the following year. (The threshold for access was increased from 350 CD4 count to 500 later before it was finally lifted altogether in 2018, in line with India's adoption of WHO test-and-treat strategies.)

Although MSM were not included in NACP-II's list of key populations, groups working with gender and sexual minorities benefited from the surge in global enthusiasm for "fighting" Aids. While PEPFAR aid recipients were disallowed from working with sex workers, whose empowerment bothered George Bush's evangelical electoral base (Pisani 2009), international donors generally supported community-based approaches. In Bengaluru, Manohar Elavarthy applied for and received a MacArthur Fellowship Grant to found sexual rights NGO Sangama, to the dismay of those in the city's women's and queer movement invested in "autonomous" (non-funded) approaches. CBOs and NGOs targeting "MSM" mushroomed all over the country, buoyed by "Gates money" and other sources of international funding, and with the tacit approval of NACO. As queer poet, scholar and activist Akhil Katyal has pointed out, the emergence of these community spaces in small towns all over India was key to articulating idioms and identities related to (male) same-sex desire (cited in Vijayakumar 2021).

As anthropologists have since demonstrated, these idioms and identities were shaped by the imperatives of HIV prevention and its risk-based classifications (Cohen 2005, Boyce 2007, Boyce and khanna 2011, khanna 2016, Dutta 2013). In the 1990s, anthropologists were enlisted to help find ways to address risk arising from same-sex sexual behaviours in contexts where the labels "gay" and "bisexual" had little traction (Parker 2001). As Lawrence Cohen (2005) explains, in India this took the form of a *kothi/panthi* distinction first identified by the activist Sunil Menon and European anthropologist Robert Oostvogels in an unpublished study of men using cruising grounds in Chennai. Referring to effeminate males who take the receptive role in anal sex, the *kothi* category corresponded to a felt need to identify those "MSM" most at risk of HIV infection in terms that were locally salient, with anthropologist and HIV/AIDS activist Shivananda Khan arguing in 1999 that the term is useful because it refers to a gendered sexual role in a context where notions of sexual identity are not culturally applicable (Khan 1999, Boyce 2007).

Yet although it is accepted at face value in much research as an indigenous category, the elevation of *kothi* to identity status can be seen as a discursive effect of HIV/Aids effort. Lawrence Cohen argues that the *kothi/panthi* distinction was previously mostly a useful distinction for gossip among gender non-conforming communities in Eastern India, and that

it was only after its popularization in HIV research and intervention that people started describing themselves as *kothi*. “In years of conversations with numerous men who have sex with men,” the anthropologist reflected, “no one in memory ever uttered the words kothi or panthi until the mid 1990s’’ (2005, 272 in Boyce 2007, 186). The kothi thus became a “social fact” through HIV/Aids prevention, which constructed this figure as a culturally authentic iteration of the global category of MSM (Cohen 2005, Boyce and khanna 2011, Dutta 2013). And though Gayatri Reddy’s *hijra* interlocutors used the term kothi as a generic term for “feminized” males (who thus belonged to the larger *hijra* family) (Reddy 2007, Boyce 2007, 196), more recently the programmatic split of “TG” – transgender - from “MSM” and the emergence of a transgender rights discourse in India has sharpened the boundaries between *hijras* and *kothis*, who are now competing for increasingly limited funding (Dutta 2013, Dutta and Roy 2014). Moreover, this division between cisgendered homosexuals and male-to-female transgender persons renders other expressions of gender and sexual variance illegible, argues Aniruddha Dutta (2013).

As Paul Boyce explains (2007, 183), the *kothi/panthi* construct emerged in tension with the rubric of gay used by middle-class groups in Mumbai and other big metropolitan centres. Although groups like Gay Bombay raised awareness about HIV/AIDS among their members and readership, there is almost no scholarship on the impact of the HIV/AIDS epidemic on this demographic. Parmesh Shahani’s ethnography of Gay Bombay, for instance, makes little mention of it (2008). Reflecting the reach of targeted interventions, most scholarship on HIV/Aids and sexuality in India focuses on the socio-economically disadvantaged sexual and gender minorities thought to be most at risk of HIV infection on account of their greater vulnerability to violence at the hands of police and clients (Chakrapani et al. 2008, Thompson et al. 2013, Ganju and Saggurti 2017, Manian 2019). As a result, there is, to the best of my knowledge, no research about the experiences of HIV-positive men from middle to upper class backgrounds who identify as gay or bisexual, described two decades ago by Shalini Bharat, Peter Aggleton and Paul Tyler in their UNAIDS report on HIV/Aids stigma in India as a “hidden population” (2001, 56). The reasons for this are explored in more detail in Chapter 9: Interlude for Stigma.

While the HIV/Aids prevention effort enabled a proliferation of organizations focused on sexuality and sexual rights, gay sex and other forms of “carnal intercourse against the order of nature” remained illegal. This contradiction was brought into sharp relief when four MSM peer outreach workers associated with Naz Foundation were arrested in Lucknow in 2001. As Lucknow senior superintendent of police BB Bakshi claimed at the time, “the two

organisations, Naaz and Bharosa, were running gay clubs in contrast to the Indian culture and ethics under the garb of educating the masses about AIDS and HIV" (Times of India 2001). The four men were charged with conspiring to commit sodomy (by distributing condoms) and possession of obscene materials (leaflets containing HIV-related information). The case became the catalyst for a legal battle that would drag on for almost two decades. Naz Foundation filed a public interest litigation against Section 377, arguing that the anti-sodomy law hampered HIV prevention as well as violating the rights of sexual minorities. They were supported by the Lawyers Collective, which had set up an HIV/Aids unit after supporting Goa's first Aids patient Dominic D'Souza in an employment discrimination case. In an affidavit submitted to the Delhi High Court that directly contradicted the Home Ministry's stance, NACO eventually caved into pressure from HIV/Aids organizations to take their side (Rao 2017).

The episode put on display the state's internal fragmentation, with one arm of the state treating sexual minorities as criminals for carrying the condoms and materials that another arm helped provide (Puri 2016). As Chaitanya Lakkimsetti argues in *Legalizing Sex: Sexual Minorities, AIDS, and Citizenship in India* (2020), the HIV/Aids epidemic effected a shift in the relation between the Indian state and sexual minorities, including sex workers, who through their inclusion as key partners in India's HIV/Aids response were able to challenge their criminalization. Similarly, Gowri Vijayakumar (2021) argues predictions of an Indian Aids crisis created a contradictory opening for sexual minorities and sex workers to lay claims to citizenship, but stresses the provisional nature of this agency. Indeed, the conditionality of empowerment through India's HIV/Aids programming is demonstrated in Chapter 7: Communities Make the Difference, which explores the decline of the community-based approach that characterized India's HIV/Aids response.

After becoming NACO's Director General in 2006, Sujatha Rao scaled up targeted interventions during the agency's third phase of programming (2007-2012), which finally included "MSM" as a key population. By the end of NACP[3]-III in 2012, new infections were down by 57 percent as compared to 2000. India's community-based approach to HIV prevention was seen as key to India's HIV/Aids success story and held up as a global example of best practice to be replicated elsewhere (Vijayakumar 2021). But India's HIV/Aids response has been in decline since then for a complex of reasons. When the third phase of programming came to an end and Sujatha Rao left NACO, the agency started being

[3] National Aids Control Programme

plagued by logistical, financial and capacity constraints. Avahan exited, and, as Rao (2017) recalls, the hand-over of its targeted interventions was less than smooth. Because the generalized epidemic that had been predicted never materialized, India became less of a priority for global donors. Consequently, and as result of the global downturn in funding in the wake of the 2008 Recession, about 80 percent of NACO's budget now had to be sourced domestically. Although the budget cuts began under the Indian Congress Party-led United Progressive Alliance government, NACO's crisis worsened when Bharata Janata Party's Narendra Modi, upon assuming office in 2014, declared that India could go it alone. In an article for *The Caravan* Madakini Gahlot (2015) chronicled the fall-out of NACO's funding and organisational crisis, detailing chronic medication stock-outs and shortages of diagnostic kits and viral load tests, cashflow problems between the states and the centre, and faltering leadership. "I am afraid all the momentum built up by so many hard-working people will be entirely lost," Rao told the journalist. In her memoir, the former bureaucrat dismissed NACP-IV as a "weak update" of its predecessor and lamented the lack of community consultation, warning that NACO had erred in giving up the community-based approach (Rao 2017). The effects of these developments formed the backdrop to my research.

Titled "Paving Way for an AIDS Free India", NACO's National Strategic Plan for HIV/AIDS and STI 2017-2024 (NACO 2017) reflects the global shift away from constructions of HIV/Aids as crisis to a discourse of "ending Aids" (Kenworthy, Thomann, and Parker 2018). The document also commits India to meeting global test-and-treat targets discussed later in this chapter. This "post-crisis" phase of India's HIV/AIDS response is yet to receive academic scrutiny, and in this sense my thesis offers an important update to the scholarship mentioned so far. This is especially true for Chapter 7: Communities Make the Difference and Chapter 8: Targeted Intervention, which explores the effects on some of the developments described above on India's HIV/Aids "communities". What happens to them now that HIV/Aids is no longer a global funding priority, and the threat of a generalized Indian epidemic is greatly diminished? And what does something like high fun – or rather, the lack of adequate services for men who are into high fun – teach us about the state of India's celebrated HIV/Aids response today? Although the scope of my inquiry is limited, as this brief overview has been, by a focus on MSM, their experiences of living with HIV are neglected in the literature on HIV/Aids stigma in India, as Shalini Bharat (2011) points out in her review. Conversely, the voices of HIV-positive people are largely absent from scholarship on queer politics in India, despite the entanglement of the history of India's queer movement with that of the epidemic, most obviously in the struggle against Section 377.

Queer politics in India

In 2003, the Delhi High Court dismissed the Naz Foundation's petition challenging Section 377 on grounds of having no standing in the matter (locus standi). This meant that Naz Foundation and Lawyers Collective, who had attracted considerable criticism for failing to inform members of the queer movement before filing the PIL, now had to call upon this movement to demonstrate the existence of an injured party in the form of a legible "gay" community (khanna 2016). Vivek Divan, who was directing the Lawyers Collective's HIV/Aids unit at the time and is himself gay, served as something of a liaison between the organization and the queer movement and helped organize the series of nation-wide consultations that ensued. As Divan recalls in a personal reflection, HIV vulnerability was seen as a "deeply problematic, highly limited lens through which to claim queer emancipation" (2019, 173), not least because it excluded lesbians (Dave 2012, khanna 2016). But in the process of trying to resolve (unsuccessfully) the crisis of representation, something resembling a singular if not unified queer voice emerged, as akshay khanna (2016) has argued in their semi-autoethnographic monograph of queer activism in India.

After Naz Foundation successfully appealed the dismissal and the Supreme Court reinstructed the Delhi High Court to reconsider the case, it ruled in favour of the petitioners in 2009. The judgement decriminalizing consensual sex between adults was to be in force until Section 377 was amended by Parliament – but the Delhi High Court's authority to do so was challenged repeatedly before the Supreme Court, which in 2013 overturned the decision in Suresh Kumar Koushal v. Naz Foundation (Kediyal 2018). Then in April 2016, five individuals filed a new writ petition in the Supreme Court, in which they argued Section 377 violated their fundamental rights as Indian citizens. Navtej Sing Johar v Union of India was concluded in December 2018, when a five-judge constitution bench of the Supreme Court unanimously declared Section 377's criminalization of private consensual sexual conduct between adults of the same sex is unconstitutional (Rajagopal 2018). At last, Section 377 was, in the words of one attendant of the World Aids Day celebrations detailed in Chapter 7: Communities Make the Difference, gone (though technically speaking it had been read down).

Although the HIV argument gave queer activists a "foot in the door", as Naz Foundation's Anjali Gopalan insisted in conversation, over the seventeen years of legal struggle the strategic emphasis on public health gradually diminished. The petitions that led to the Supreme Court's 2018 ruling in *Navtej* invoked a very different logic than the ones filed by Naz Foundation and, before that, ABVA. Encouraged by an unrelated 2017 Supreme

Court ruling that declared privacy to be a fundamental right, the five individuals in *Navtej* argued that Section 377 violated their constitutional rights to dignity and privacy (Divan 2019). The strategic emphasis on privacy was not new, and queer scholars and activists have long pointed out it marginalizes the sexual and gender minority groups in whose name section 377 was being challenged (Tellis 2010), though their vulnerability to police harassment and violence far exceeded the anti-sodomy law[4]. "The privacy argument actually hampered the efficacy of the campaign and the positive 2009 judgement for countering violence against socio-economically marginal LGBT sections (who more typically have lacked private spaces for sexual practice)," pointed out Paul Boyce and Aniruddha Dutta following the *Koushal* judgement that re-criminalized homosexuality, "the very people whose stories were evoked to bolster the campaign against IPC 377" (2013). (Reflecting on these critiques, Vivek Divan suggests privacy was ultimately taken to mean an essential part of personal autonomy rather than physical space (2019, 175).)

In contrast, the petitioners in *Navtej* described themselves as "highly accomplished" individuals and "prominent members" of the LGBT community, Divan points out, "an attempt at using class privilege to appeal to the most cynical instincts of a judiciary that is widely considered to be inaccessible to the common Indian" (2019, 180). Among them was Keshav Suri, the heir to a chain of expensive hotels that frequently host gay parties. I first met him during an LGBT job fair held on the Lalit's premises, where banks and IT companies boasted of their inclusive credentials and the mythologist and author Devdutt Pattanaik implored queer people to stop begging for rights and improve their "value" (to the market) instead. The petition invoked a similar logic, citing a World Bank report on the cost of homophobia to India's economy as an argument for decriminalization.

For Divan, the difference the first and latest iterations of the challenge against Section 377 reflects new trends in Indian queer politics. "As the 377 case meandered through the judiciary over 17 years, India has leapt towards capitalism, and in this emerging India there is increasingly a new (or more visible) breed of queer activists, who are not particularly 'political' when it comes to making rights claims," he writes. "For them, economic arguments for queer emancipation are perfectly legitimate in the hyper-capitalist India where they have

[4] This is because "the police rarely need to use legal excuses to harass, abuse or rape socio-economically marginalised transgender and gay people", as Boyce and Dutta explain, drawing on conversations with transgender activists Raina Roy and Indira. "And when they do, they often evoke other laws concerning public order, decency, sex work or obscenity. So, the link between IPC 377 and gay/lesbian criminalisation or liberation is more symbolic than material" (2013).

come of age, and Obama's model of 'LGBT rights' as foreign policy is not only kosher, but to be welcomed" (2019, 184). While Divan makes it clear his essay is a personal reflection rather than a piece of academic analysis, his observations chime with recent queer theoretical scholarship about emerging "intimacies" between queer activism, the market, and the Indian state (Sircar 2017).

In his analysis of the World Bank report invoked in *Navtej*, Rahul Rao argues that in the aftermath of the 2008 Recession global institutions of financial governance have started using LGBT inclusion in an attempt to rehabilitate their image in times of capitalist crisis. This, according to Rao, works in tandem with attempts by LGBTI+ individuals to secure corporate inclusion in contexts where the nation-state may not "yet" be responsive to sexual minorities, such as India. In the absence of the extension of anti-discrimination legislation to sexual orientation, one may, for example, appeal to the diversity and inclusion policies of companies with headquarters in London or San Franscisco. At the same time, economic arguments may be invoked to challenge repressive laws or state homophobia. Indeed, Keshav Suri is an example par course of an activist who has "turned to making the case for inclusion, not in a language of justice or human rights, but through a refiguration of the queer as model capitalist subject whose inclusion promises a future of growth and economic dynamism" (2020, 25).

"Homocapitalism" is a particularly useful frame in the Indian context given the ambivalence of its ruling party, the Bharata Janata Party, on the question of homosexuality. In contrast to the then-incumbent National Congress Party, the BJP made a campaign promise never to support decriminalization during the 2014 elections. As Oishik Sircar explains, "they set up 'homosexuality' against their Hinduized definition of 'Indian culture'," (2017, 17) Section 377's Victorian origins notwithstanding. This contained echoes of not only the denial of male homosexuality during the early years of the Indian HIV/AIDS epidemic but also of the response by right-wing groups to Deepa Mehta's *Fire* (1998), the controversy around which movie is seen as a watershed moment in lesbian activism in India.

Revolving around a woman who finds relief from her arranged marriage through a love affair with her sister-in-law, the *Fire* plot drew heavily on imagery from the myth of Lord Ram and Sati and challenged hetero-patriarchal norms, with the titular fire referring to a climax that invokes the practice of sati. Right-wing Hindutva activists expressed their offense by storming theatres screening the film in Mumbai and Delhi, after which *Fire* was re-submitted to the Censor Board and suspended across the country. L.K. Advani, the home minister in the BJP government, asked why such films are made in India when they can be

made in the United States and other Western countries (Dave 2012), and the Maharashtrian minister of culture agreed lesbianism is “not part of Indian womanhood”. Feminist and queer groups organized rallies protesting the censorship – some of which enjoyed favourable media coverage. As Naisargi Dave explains in her ethnography of lesbian activism in Delhi, the protests challenged the right-wing response through public assertions of being “Indian and Lesbian”, as one sign at a vigil read (Dave 2012). “In interpellating the lesbian as specifically other to the nation,” Dave suggests, “right-wing activists introduced an incommensurability that did not previously exist, and in doing so, also introduced the possibility of commensurating queer desire with national belonging’’ (2012, 164).

The controversy around Fire put on display what Paula Bacchetta’s terms “xenophobic queerphobia” –discursive constructions that posit queerness as originating outside the Hindu nation, and that originate from both right-wing and leftist feminist circles (1999, 143, Dave 2012). Whereas gay male organizing has been linked to health (e.g. HIV/AIDS prevention), lesbian activism emerged uneasily from within the women’s movement at a time when economic liberalization had brought concerns about class and economic privilege centre stage (Chatterjee 2018). In a letter circulating in 1994, the feminist and Communist Party of India member Vimla Faroqui argued homosexuality was Western decadence and a direct result of the liberalization policies (Chatterjee 2018, Dave 2012, 116), thus aligning the left women’s movement with the Indian government on this particular matter. As a result, “one way to protect the community at this political and economic moment in the women’s movement was to assert itself as grass roots and indisputably Indian” (Dave 2012, 114). For example, lesbian activists have highlighted and represented as “lesbian” the double suicides by rural women who had eloped together, so as “to evoke affective urgency and transcend the bias that queer sexuality was strictly a middle- and upper-class phenomenon” (2018, 154), and one of these suicides and the politics of its representation as ‘lesbian’ is the subject of Shraddha Chatterjee’s monograph. Similarly, the subtitle of Maya Sharma’s (2006) ethnography of working class women who love women in Delhi, *Being Lesbian in Underprivileged India in Delhi*, can be understood as a rebuke of the allegation of elitism leveraged against lesbian activists.

These discursive strategies have been critiqued by feminist legal scholar Ratna Kapur (2015) and other activists for reinforcing the Hindu right’s brand of cultural nationalism, but Dave and Bacchetta argue such critiques ignore the ethnographic context in which such claims become meaningful. Well-known scholarly attempts to claim a place for queerness in India’s cultural heritage include Vanita Ruth’s *Queering India: Same-sex Love and Eroticism*

in Indian Culture and Society (2010) and the edited volume she produced with literary scholar Saleem Kidwai, which surveys representations of same-sex love in different periods of India's (or rather, South Asia's) literary history (2008). Devdutt Pattanaik's more marketable equivalent excavates "queer tales" and themes of gender fluidity from "Hindu lore" (2002). While Ruth and Kidwai's edited volume includes a section devoted to homoeroticism in Perso-Urdu literature of medieval India, Pattanaik's claim that Hinduism is accommodating of gender and sexual diversity in a way that Abrahamic religions are not has been taken up by Hindu nationalist websites (VOI 2017). This arguably validates the apprehension expressed by Kapur and others about the conflation of "Indian culture" with Hinduism in queer claims to national belonging, and their warnings about confluence with the ideological agenda of Hindu right, which has been empowered by Narendra Modi's landslide victory in 2014.

Since then, the Bharata Janata Party's position on gay rights has been ambivalent. Responding to the *Navtej* judgement, prominent BJP member Subhramanian Swamy suggested the decriminalization would lead to a rise in "HIV cases" and other "social evils" (News18 2018). Yet other prominent figures within the BJP appeared to take a softer stance. As Sircar recalls, former health minister Harsh Vardhan stated publicly that the government should protect the human rights of "gays" irrespective of Section 377. And in an apparent departure from the right-wing line that "public morality" justified Section 377 (even if it violated, as the Delhi High Court judges had argued in 2013, Ambedkar's constitutional morality), the BJP's second law minister was reported to have said that the "mood appears to be in favour of it". Although Swamy was quick to denounce this on Twitter as a misquotation and insist in his capacity as member of BJP's national executive that "our party position has been that homosexuality is a genetic disorder" (in Sircar 2017, 21), this position is clearly less stable and fixed than he would like it to be.

Yet some suggest there is considerable support for the BJP's nationalist agenda among queer people, despite its apparent hostility to homosexuality. Oishik Sircar notes the invocation of nationalist sentiments at pride marches since 2010 through highly politicized slogans like "Jai Hind" and the singing of the national anthem, which is now mandatory in cinemas. More recent examples of support for the Hindutva project include an attempts to create a "Hindu Queer Alliance" (which was met, in the email thread I was shown, with fierce ridicule and criticism from other queer activists), the argument that the BJP's abrogation of Kashmir's special status under Section 370 is somehow beneficial for Kashmiri queers (Gawande 2019, for critique) and the twitter feed of prominent HIV/Aids and gay

rights activist Ashok Row Kavi, who features in Chapter 7: Communities Make the Difference. These discourses invoke the the notion that Hinduism – and therefore India - is inherently tolerant of sexual diversity, in contrast to the religions of the Islamic invaders who (supposedly) introduced homophobia and the Christian colonialists who (evidently) legislated it. According to Sircar (2017, 21), the Rahstriya Swayemsevak Sangh - the BJP's parent organization whose spokesperson has indicated the possibility of a softened stance on Section 377 – may be receptive to this interpretation if it contributes to the Hinduization of Indian history.

For Nishant Uphadhyay, these developments evidence the emergence of an Indian version of what Jasbir Puar described as "homonationalism" (2007), referring to the wilful assimilation of gay subjects into militaristic and imperialist U.S. discourses and policies. They identify four interrelated logics of this "hinduhomonationalism", the first two of which relate to the projection of Hinduism as tolerant of sexual and gender diversity and Islam as homophobic and violent. "Third, dominant caste Hindu queer, trans, and gender nonconforming folks are welcomed within the Hindutva project as long as they partake in its brahminical and Islamophobic tendencies," adds Uphadhyay. "And fourth, all Hindu/Indian Others – Dalit Others, Bahujan Others, Adivasi/Tribal Others, Muslim Others, Kashmiri Others, North Eastern Others, Christian Others, Sikh Others, etc. – are simultaneously rendered queer as well as queerphobic" (2020, 469). Uphadhyay concedes that there is significant resistance to Hindutva narratives among queer people (including privileged ones), and that we might question whether homonationalism is a useful frame when sexual minorities continue to lack basic protections and rights, and the state's response to demands for full inclusion in citizenship is lukewarm at best and hostile at worst. If, as Chatterjee (2018) suggests, homonationalism remains a threat that looms on the horizon rather than a reality, might Rao's frame of homocapitalism more helpfully describe the present state of queer politics in India?

For Sircar, the apparent contradiction between the BJP's cultural conservatism and the corporate celebration of queer inclusion is a false one. The "immense significance" of the present moment for queer politics in India lies precisely in what he describes as the growing intimacy between queer representation and the neoliberal imagination of "New India", as exemplified by the BJP's electoral promise of *acche din* (good days) to come. He draws on two examples to illustrate this intimacy. The first is a Bollywood-style video for the UN's Free and Equal campaign that depicts a gay man who introduces his boyfriend to his family, whose wealth signalled by their attire and residence. The second is an ad by ethnic fashion

brand Anouk that features a lesbian couple awaiting a visit from one of the women's parents, who will meet the girlfriend for the first time. They share a comfortable and tastefully-decorated apartment; a breeze entering from the window makes the thin white cotton curtains dance and an Apple Macbook lies closed on a desk.

> While both the advertisements locate the normalization of queer liberation in domestic monogamous conjugality—which is a dream for many, and might in fact be a pretty powerful public assertion to challenge the compulsorily heteronormative idea of the family—access to the domestic space and the relationship of conjugality is mediated through caste and endogamous marriage in the first, and in the second, through class as the marker of queer consumerism. Interestingly then, even while queering the discursive pitch, as it were, both the advertisements reinforce some of the very foundations that form the base of the idea of the New India, particularly that of privatization of liberation, and in effect marks a smooth spread of the "epistemic violence" of the caste-class-sexuality complex from heteronormativity to "homonormativity." (Sircar 2017, 10)

The videos' appeal to family values –which include, according to the subtitle of the UN video, (same-sex) "love" – may resonate with the many queer Indians for whom the spectre of parental disapproval and exclusion family life looms large. But, Sircar suggests, they also reflect the emergence of a politics of respectability: its protagonists are upper-middle or upper class gays and lesbians in what appear to be committed monogamous relationships with people from similar backgrounds, regional differences between the two women notwithstanding (indeed, these make the couple "cosmopolitan).

In the U.S., scholars have linked the emergence of what Lisa Duggan calls v"homonormativity" (2003), referring to a shift in U.S. queer politics from a left-wing politics of coalition to a more narrow focus on discrete personal rights, to post-Aids discourses. According to Castiglia and Reed, these shifts went paired with a re-writing or 'unremembering' of (U.S.) queer history, such that gays and lesbians could be turned into a " "respectable" fit for assimilation constituency ready to receive state recognition in the form of "rights"" (quoted in Mowlabocus 2021, 6-7). As Kane Race writes about homonormative discourses that priories marriage equality in the Australian context:

> In their eagerness to present gays and lesbians as respectable, everyday folk, these discourses frequently assume sex, drug and HIV-phobic forms (Liu 2015, p. 2). Their capacity to shut down constructive responses to the realities of sex, drugs and HIV infection will not be lost on anyone who has followed online discussions of any of these topics recently. These remarkably polarised and polarising debates are conspicuous for their denigration of those expressions of queer or embodied life that

> are taken to compromise the public image of sexual minorities as normal upstanding citizens. Needless to say, such instances of 'in-group purification' (Goffman 1963, p. 108) further stigmatise practices that require more constructive, generous forms of attention and open acknowledgement, especially with respect to their public health implications. (2017, 171)

Indeed, high fun was sometimes spoken about in both on-line and off-line community fora in harsh terms as a "scourge", not least because of the suspected connection to new HIV infections, with some people proposing reporting men who make reference to high fun or "stuff" on Grindr to the police. Reflecting on the tension between wanting to "break the silence" around high fun and portraying the queer community in a bad light just as it is gaining visibility in the mainstream, the interlocutor that started the peer support network discussed briefly in Chapter 8: Targeted Intervention told me that he and his friends "have always been very aware of trying to protect the community from media and police attention." When I published an article based on this research in *The Caravan,* and Indian magazine, I had similar concerns. Here was a community that had just been decriminalized – should I be writing about segment of it engaging in highly illegal behaviour?

Yet precisely for these reasons, both HIV and high fun provide a unique windows into the politics of sexuality in contemporary India. What does a phenomenon like high fun mean for the projection of responsible, respectable, and productive queer citizen deserving of rights, including the right to marry (PTI 2022)? How might thinking with HIV stigma contribute towards on-going attempts to develop more intersectional analysis of sexuality in India? These questions are raised rather than answered by the chapters that follow, and the trends in middle class queer activism and representation described in this section form the backdrop rather than the focus of this thesis. But by centring the experiences of HIV-positive gay and bisexual men, which are almost entirely absent from scholarly and mainstream representations of queerness in India, this thesis hopefully contributes to scholarship on the politics of sexuality in contemporary India, as well as to the anthropology of HIV/Aids.

Anthropology of HIV/Aids

In the early 1990s, an anthropology PhD student in Sydney began studying the gay community's response to an epidemic that had begun devastating it. Robert Ariss was an active participant in this community, and himself HIV-positive (Ariss & Dowsett 1998). Published after Ariss died in 1994, it was one of the very few ethnographies that engaged the historic grassroots mobilization of queer men, women and their allies in U.S., U.K. and European cities affected by the HIV/Aids epidemic. Our knowledge of this period of the

epidemic, when it was constructed and experienced as a "gay plague", comes primarily from artistic, oral history, autobiographical, queer theoretical and fictional accounts by queer activists, authors, and artists (see, for example, Sarah Schulman's (2021) *Let The Record Show: A Political History of ACT UP New York, 1987-1993*). There was little to suggest during these early and terrifying years of the epidemic that the condition would spawn a large body of anthropological scholarship, one too expansive and diverse to begin to survey in any detail here. Instead, I rely on review articles to briefly, in a roughly chronological order, highlight some of this body of work's most significant developments and interventions.

According to Richard Parker, anthropology's "failure to establish itself" (2001, 163) in early Aids research left unchallenged a biomedical emphasis in research and policy agendas, which focused on identifying risk groups and behaviours linked with transmission. Interventions relied heavily on psychological theories like Health Belief Model and the Theory of Reasoned Action that assumed people were rational actors seeking to maximize personal gain. But the behavioural change paradigm proved inadequate in stopping the spread of HIV/Aids in increasingly diverse social and cultural contexts. "By the late 1980s," explains Parker, "it had become clear that a far more complex set of social, structural, and cultural factors mediate the structure of risk in every population group, and that the dynamics of individual psychology cannot be expected to fully explain, let alone produce, changes in sexual conduct without taking these broader issues into account" (2001, 165).

Anthropologists were enlisted to study the cultural meanings of sexuality in an effort to make prevention more culturally sensitive. The task at hand was clear: "Ethnographic information about human cultures should be utilized in design and execution of anti-Aids campaigns and in research on the course of infection" (Bolton in Hardon and Moyer 2014, 256), asserted the guest editor of Medical Anthropology's first special issue on Aids in 1989. Informed by feminist scholarship and the emerging field of lesbian and gay studies, this body of work followed a social constructionist tradition interested the "intersubjective cultural meanings" (Parker 2001, 166) related to sexuality rather than individual psychology. It was applied both to settings in the Global South, where dominant epidemiological categories of Aids research such as 'homosexual' and 'prostitute' where most obviously at odds with local systems of classification, and to sexual subcultures in Euro-American contexts. Parker describes this as a shift from the "experience-distant" concepts of biomedical science to the culturally-varied "experience-near" concepts that people use to describe and interpret their own practices and identities (2001, 167), such as the *kothi/panthi* distinction previously discussed.

Over the course of the nineties, the emphasis on cultural analysis was supplemented by political economy approaches that highlighted the way structural forces shape individual vulnerability to HIV and the spread of the epidemic more generally. This body of work "explores interactive or synergistic effects of social factors such as poverty and economic exploitation, gender power, sexual oppression, racism, and sexual exclusion" (Parker 2001, 171) and suggested that the epidemic could not be halted without wide-ranging social transformations that, as Jonathan Mann at the WHO reflected self-critically, were well beyond the remit of what public health officials were comfortable advocating for. Schoepf (2001) argues that this body of work demonstrated how Structural Adjustment Programs, imposed by IFIs on countries in the Global South throughout the nineties, fuelled the epidemic by deepening rural poverty and setting populations on the move, exposing people, put particularly women, to greater HIV risk.

Paul Farmer's seminal study of the Haitian HIV/Aids epidemic, for example, connects the construction of a USAID-funded dam to deepening rural poverty and migration to the city. Haitians had been identified along with homosexuals, haemophiliacs, and heroin-users as a high risk group or, more colloquially, as "Aids carriers" (Farmer 1992, xii).The disease was said to have arrived to the U.S. via the country, described in the mainstream media as a 'little Africa' off the coast of Florida. Not only did Farmer demonstrate that the inverse was more likely (the island was a sex tourism destination for Americans), his ethnography moved beyond this "geography of blame" and to reveal the social, economic and political forces patterning vulnerability to HIV/Aids on the island nation and globally. He did so by tracing the infections of his protagonists, one of whom moves to the city after her family's farm is rendered unviable by the construction of a Dam. Here she, like many other young female migrants without resources, supported herself through romantic and sexual relations with men, one of whom infected her with HIV.

Based on this and other examples, Farmer develops the notion of "structural violence", a term he borrowed from Norwegian sociologist Johan Galtung to describe the "historically given conditions that put people at risk for AIDS and the other afflictions that beleaguer them" (Farmer 1992, 263). Shifting attention from individual behaviours to the social, political and economic contexts in which they occur, the concept radically challenged ideas about "risk" in HIV research and policy, as well as the biomedical individualism underpinning it. Fee and Krieger have critiqued the biomedical model of HIV/AIDS as "profoundly ahistorical… it contains within itself a dichotomy between the biological individual and the social community, and then it ignores the latter" (quoted in Waterston

1997, 1384), and called for a paradigm that attends to “the real conditions of people’s lives and the social and material bases of disease transmission” (Waterston 1997, 1384). Building on this critique, anthropologist Alisse Waterson argued that the emphasis on individual risk removed from view and left intact the power relations determining the shape and colour of the epidemic and driving the racial disparities of infection and morbidity. “A model that considers the individual as locus of change and disease prevention ultimately helps protect, maintain and reproduce existing inequalities,” wrote Waterson, such that "“solutions” to the Aids epidemic are those least threatening to the “status quo”" (1997, 1383). Anthropology thus not only placed risk behaviour in context, but challenged its supremacy in biomedical modes of managing the epidemic. Although an alternative “materialist” epidemiology as advocated for by Adam Geary (2014) in his study of the relation between anti-black racism and HIV/Aids in the U.S. never materialized, these anthropological critiques perhaps helped bring about the increased attention to ‘poverty’ and ‘gender’ in global HIV/Aids discourse.

If the first decade of anthropological scholarship comprised contributions to and critiques of HIV/Aids prevention discourses and practices, the development of effective treatment in the mid-90s shifted attention towards the social and political impact of new medications. In their introduction to *Medical Anthropology*’s fourth special issue on HIV/Aids, Eileen Moyer and Anita Hardon (2014) write of the prevention era (roughly pre-2000) and treatment era (post-2000) to situate anthropological engagement with the epidemic. Anthropologists became interested in the global diffusion of medicines as the efforts towards a global roll-out of ART mounted in the first decade of the millennium, often producing critical commentaries on “what’s at stake in the everyday lives of people affected by Aids” (2014, 258).

In West Africa, limited access to treatment gave rise to new notions of responsible and therapeutic citizens, argued Vinh-Nguyen (2010). As akshay khanna summarizes, this constituted an increasingly biomedicalized form of governmentality, a “form of stateless citizenship whereby claims are made on a global order on the basis of one’s biomedical condition.’’ (in khanna 2016, 139). Claire Decoteau similarly suggested that in South Africa (2013), the ‘right to life’ argument advanced by treatment activists made citizenship rights contingent on people’s ability to embody biomedical technologies of the self, such as treatment adherence, status disclosure, lifestyle changes and a disavowal of traditional healing practices. She links this emerging “biomedical hegemony” to South Africa’s brand of home-grown neoliberalism, and argues the rationale of individual responsibility that connects them obscures structural obstacles to accessing and adhering to treatment. Steven Robins

(2009) argued treatment literacy advocates in South Africa enlisted people new biopolitical projects of health citizenship, and Dominik Mattes (2011) drew attention to the medicalization of everyday lives in Tanzania through forms of disciplinary power and surveillance intended to ensure adherence. These approach are marked by an interest in the impact of ostensible value-neutral biomedical discourses and technologies on individual and collective subjectivity.

The availability of treatment sparked a discursive shift towards medical normalization. Although the discourse of normalization emerged in the wealthy nations just as the newly-formed Joint Nations Programme on HIV/AIDS (UNAIDS) sounded the call for an exceptional global response to the epidemic, by the end of the noughties it had displaced earlier constructions of Aids-as-crisis. Moyer and Hardon explain:

> Since 1996, when effective antiretroviral-based therapies (ARTs) first became available to treat HIV, various discursive, legal, health policy, and institutional moves have been made to reframe HIV as a chronic disease that should be treated 'like any other.' Arguments for this framing have come from diverse positions, including AIDS activists who want to challenge stigma; medical professionals who want HIV patients to be treated like other patients, with a diminished focus on consent and confidentiality; health administrators, who want to routinize and integrate HIV care into existing programs; public health policymakers who want to test and treat as many people as possible in the shortest period of time; and international donors who want to break with the 30-year-long crisis framing of HIV responses, and to push national governments to incorporate HIV care into existing public health budgets and strategies. (Moyer & Hardon 2014, 263)

Anthropologists challenged the assumption that access to treatment reduces stigma. They showed that while this may be the case in some settings (Castro & Farmer 2005), treatment itself can be experienced as stigmatizing because obtaining it requires a minimal amount of disclosure - rendering people vulnerable to stigmatization and discrimination at the hands of health professionals. Moreover, adhering to the strict daily regime makes an HIV-positive status 'real' for both patient and the people around her (Songwathana & Manderson 2001, Hardon & Moyer 2014). From urban adolescents' difficulties to imagine full lives for themselves in the U.S. (Philbin 2014) to the management of stigma and economic vulnerability in Uganda (Mc Grath et al, 2014) and Tanzania (2014) and doctor's refusal to have honest conversations about patients' sexual desires Spain (Villaamil 2014), contributors to *Medical Anthropology*'s fourth special issue explored the gap between medical normalization of HIV/Aids and the social realities of their people living with it. "While the

treatment of HIV in clinical settings may have become normalized," Hardon and Moyer (2014, 264) wrote, "'normal' conditions outside the clinic continue as before, resulting in the continued exceptionality of HIV." In the UK, where Flowers (2010) concluded that the dramatic extension of HIV-positive people's life expectancy has brought new challenges, such as how to re-engage with romantic and sexual relations. As such, decreased morbidity and mortality as a result of widespread availability of ART has not changed the "identity imperative" and the need to manage stigma.

But if treatment did not end HIV stigma, many now hope the 'new'[5] biomedical technologies around which contemporary treatment-as-prevention strategies (TASP) revolve will. TASP comprises a set of discourses, strategies, protocols and technologies that revolve around the idea that getting people to know their status and encouraging those who test positive for HIV to start treatment as early as possible would significantly reduce forward sexual transmission. This is because those with suppressed or "undetectable" viral loads cannot pass HIV onto sexual partners, as evidenced by the PARTNER and other studies that documented zero HIV transmission among serodiscordant couples (Collins 2016, Rodger et al. 2019) and summed up by the slogan U =U, or Undetectable = Untransmittable (Prevention Access Campaign 2016). In addition to Undetectability, TASP promotes the use of antiretroviral treatment (a tenofovir/emtricitabine combination known colloquially by the brand name of Truvada) as pre-exposure prophylaxis (PrEP) after studies documented its effectiveness in preventing HIV infection among populations at high risk of HIV (see, for example, Fonner et al. 2016). Similarly, post-exposure prophylaxis (PEP) is a course of antiretroviral medication that can stop HIV infection in its tracks if taken within 72 hours of exposure to the virus.

Nora Kenworthy, Matthew Thomann, and Richard Parker (2018) trace some of the developments that contributed to the rapid embrace of TASP in HIV/Aids policy and global funding circles from 2010 onwards. The 2007-2008 financial crisis and subsequent donor withdrawals led to a shift from "scale-up" to "scale-down", with donors masking their reluctance to committing to long-term goals with discourses of sustainability, accountability, and country ownership. Meanwhile, the "crisis" rhetoric UNAIDS had sustained through the late 90s to the mid-2000s was replaced by a discourse of "race to end Aids" in an attempt by the agency to stay relevant. A policy document from 2010 introduced "Get to Zero" targets

for 2016 (UNAIDS 2010), and in 2014 UNAIDS launched its "fast-track-strategy" that articulated a vision for "end to Aids" by 2030 by achieving the 90-90-90 goals - 90% of people with HIV diagnosed, 90% of diagnosed people on treatment and 90% of treated people with fully suppressed viral load – by 2020 (UNAIDS 2014b). The ambitious targets were swiftly reproduced in statements issued by other organizations, and the authors write that "the ubiquity of this policy embrace began to make the goal seem like a fait accompli'' (Kenworthy, Thomann and Parker 2018, 963). This, the authors worry, might ironically have the effect of minimizing the remaining challenges in the eyes of donors. HIV largely fell off the list of the post-2015 development goals agreed upon in Berlin.

Moreover, the discourse of Ending Aids occludes a neoliberal cost-cutting agenda of reducing long-term financial commitments by enabling donors to focus on solely biomedical treatment expansion at the cost of other programs, including efforts to strengthen health systems, community-based provision, and interventions addressing the social and economic inequalities compromising the success of exclusively treatment-based interventions. In short, anthropological insights regarding the way biomedical modes of managing the epidemic have obscured the role of structural violence in creating HIV/Aids vulnerability have been side-lined by "an increasingly powerful biomedical triumphalism regarding HIV treatment and prevention, whereby privatised, technological, and, at least in some instances, (allegedly) more cost-effective interventions are promoted, to the deficit of long-term support for lifetime antiretroviral treatment" (Kenworthy, Thomann and Parker 2018, 965).

It is unsurprising, then, that anthropologists have been sceptical of this promissory discourse since its first stirrings more than a decade ago, with Vinh-Kim Nguyen and colleagues expressing concern in their response to proceedings at the World Aids Conference in 2010:

> In the rush to paradigm shift, game-change, rollout and scale-up yet a new set of acronyms and standardized interventions, local epidemiological, political, and socio-historical context is once again being ignored, surely only to resurface later as 'culture' once much-heralded interventions fail to deliver. Holding out for a magic bullet – unlikely to ever come – diminishes interest in the hard, messy work required to enable social change and address the social inequalities and structural violence that drive this epidemic. Biomedical interventions are unlikely to live up to their promise if social determinants of access to prevention and treatment are not addressed. (Nguyen et al. 2011, 291)

Anthropological critique notwithstanding, Associate Professor of Nursing Dr Marilou Gagnon is right to point out, in conversation with writer and historian Sarah Schulman, that

the shift to TASP has happened "very quickly", without the intellectual battles that typically attend a paradigm shift (Schulman 2016, 130).

What might an anthropology of the "treatment-as-prevention" era look like? This thesis engages with the effects of the biomedicalization of HIV/Aids at both the policy and (inter)personal level. The first part offers an ethnographic exploration of high fun. In Chapter 4: Organizing Logics, I approach high fun anthropologically as a sexual subculture with its own social organization and structures of meaning in an attempt to counter the tendency to view sexualized drug use through the narrow prism of HIV risk in most chemsex research. What does it mean that in high fun, as I was repeatedly told, everyone is welcome? What is the relation between the sexual sociality of high fun and the social and sexual hierarchies of India's urban gay communities more generally? I suggest that while high fun's inclusivity invites interpretations of the high fun party as a utopian space free of discrimination, a closer look at some the scene's "organizing logics" (Race 2015) reveals a more complicated picture. Having described high fun in some detail, in Chapter 5: High Risks I ask how interlocutors make sense of and navigate the question of risk in these contexts. Problematizing the conflation of high fun or chemsex with high risk behaviour, I demonstrate that there is a wide range of engagement in HIV risk reduction strategies in high fun contexts. Moreover, interlocutors drew attention to the structural factors that make them vulnerable to a variety of harms – including, but not limited to, HIV infection – associated with high fun, thus challenging the emphasis on individual agency in biomedical discourses on risk behaviour.

Given the emphasis placed on high fun's negative outcomes in interviews with interlocutors, why did so few of them approach any of the NGOs carrying out targeted intervention for men who have sex with men (MSM) for support? This question animates the next few chapters, which focus on Indian HIV/Aids policy. In Chapter 7: Communities Make the Difference, I ask what happens to the communities at the centre of India's HIV/Aids response in the aftermath of the withdrawal of global donors and the perceived decline of India's celebrated community-based approach. Challenging the notion of Indian HIV/Aids programming as a form of community empowerment through biopolitical partnership, I contrast the celebration of "communities" as key partners in the fight against HIV/Aids to the sense of abandonment expressed by HIV/Aids workers employed in targeted interventions. Exploring the perspectives of both men who are into high fun and staff at NGOs hoping to reach these men for HIV testing, in Chapter 8: Targeted Intervention I suggest high fun exposes some of the contradictions and tensions in the conceptualization of "community" in HIV/Aids governance.

The third part of this thesis focuses on the experiences of gay and bisexual men living with HIV, some of whom traced their infection to high fun. In Chapter 8: Undetectability, I ask how new biomedical prevention technologies and discourses, and in particular viral suppression, impact on the way in which HIV-positive men navigate sex and romance. Challenging the assumption that Undetectability will reduce stigma, I suggest it instead contributes to the closeting of HIV among gay and bisexual men in India by enabling ethical non-disclosure in the face of considerable social risks. These social risks, I argue in Chapter 9: Status Anxiety, are related to the way in which HIV stigma undercuts class and caste-based privileges. This chapter asks how we might attend to the relation between HIV stigma and other forms of social inequality in a way that moves us beyond just the intersection between, for example, being HIV-positive and gay. All this attests to the vital role of ethnographic approaches to HIV and biomedicine more generally at a time when social understandings of HIV/Aids are increasingly losing ground to biomedical constructions of the epidemic (Flowers 2010), I suggest in the concluding chapter.

Chapter 2: Methods, Ethics, and Poz/itionality

One crisp Saturday morning in Mumbai, I hopped on the Churchgate-bound train from the northern suburb of Andheri in a slightly desperate attempt to find interlocutors – or, rather, to allow potential interlocutors to find me. I planned to throw my net out in a new locality – the net being the radius of my Grindr profile, the location-based hook-up application on which I had advertised my research, and explained I was looking to speak to people who are into high fun and/or HIV-positive. But after nursing my Americano for a couple of hours in a Kalaghoda coffeeshop with the black-yellow app open on my phone, I had received several invitations to high fun parties and exactly zero expressions of interest regarding my research. Feeling demoralized and a little lonely, I agreed to meet someone I had been having friendly conversation with at a bar in Colaba.

We had almost finished our beers when my companion, himself a social science graduate from a university in London, asked me how my research was going. Quite badly, I replied honestly. "It must be hard to find people who are comfortable speaking about this," he empathized. I said that it is, although it helps that I'm positive myself. My date (?) looked at me as if I'd just grown a tail, and I cursed myself for having disclosed my status when I was already feeling fragile. "Me too," Nithin said after a painful silence, averting his gaze. We ordered another round of beer and stepped outside frequently for cigarettes and discretion, despite our shared concern about whether HIV exacerbates the negative health outcomes of smoking.

Nithin was one of numerous interlocutors who only disclosed their HIV status to me once I myself had "come out" as positive. In this chapter, I reflect on the methodological and ethical implications of doing social scientific research on HIV as an HIV-positive person. The first part of this chapter describes some of the methodological and ethical issues that arose during "fieldwork" - in air quotes because it was often unclear where the field ended and my life started - and how I navigated these. The second part is a reflection on the way in which my positionality as an HIV-positive gay man visiting from London impacted the research process and my relation to interlocutors. Echoing queer, feminist and so-called 'halfie' approaches to ethnography, I suggest my poz/itionality troubles the insider/outsider dichotomy reproduced in some forms of reflexivity.

Ethical and methodological considerations

As Nikhil suggested, "recruitment" was a major challenge: where would I find HIV-positive gay and bisexual men and/or men who are into high fun, and how would I convince

them to speak to me? Upon arriving to Bengaluru in July 2019 I contacted a sexual rights NGO I had previously visited when I attended international school near Pune to ask for help and explore possibilities for participant observation. After some back and forth, I was accommodated in the NGO's modest office (the ground floor of a suburban home). Although I would occasionally help write reports or funding applications, my utility wasn't immediately obvious to my new colleagues, mainly working-class "MSM" – men who have sex with men - and *hijras*, since I did not speak Kannada or any of the other South Indian languages in which the NGO conducted its operations in Bengaluru and wider Karnataka. Language barriers notwithstanding, my "deep" (or, as might be the case, shallow) hanging out did give me privileged insights into the day-to-day workings of targeted intervention, explored in Chapter 8: Targeted Intervention, as well as access to a national network of HIV/Aids workers and activists.

The NGO's director helpfully offered to connect me to HIV-positive people. "How many do you want," he asked during our first meeting. I was taken aback by the question, but should not have been: researchers working on HIV in India typically recruit respondents through NGOs, ART centres in public hospitals, and the PLHIV networks operating under the auspices of the State Aids Control societies (Chandra, Deepthivarma and Manjula 2003, Chakrapani et al. 2008, Thompson et al. 2013, Manian 2019). This reliance on these free-of-cost services has led to a certain class bias in the literature. The women that Cecilia Van Hollen (2010, 2013) spoke to for her study of HIV stigma in Tamil Nadu, for example, came mainly came from lower socio-economic backgrounds. "This is due in part to the methodology I used to make contact with these women," explains the researcher, "since very few middle or upper-class women participated as members of the Networks or attended government hospitals for their maternity health care needs" (2010, 637). Although some NGOs for sexual minorities are more successful at reaching a cross-section of the "LGBT+ community" than others, they have historically targeted the working class men, *kothis* and *hijras* and other transfeminine persons who cruise in public parks and theatres (and are therefore relatively easy to locate) and are assumed to be most vulnerable to HIV infection on account of their exposure to sexual violence at the hands of police and clients (Lorway and Khan 2014, Ganju and Saggurti 2017, Manian 2019). As explained in Chapter 8: Targeted Intervention, the difficulties of reaching men who are into high fun, and middle class gay and bisexual men more generally, for HIV prevention and treatment services is a legacy of this historic focus on poor and working class gender and sexual minorities. And if, as Shalini Bharat (2011) points out in her review of HIV/AIDS stigma research in India, the

perspectives of sexual and gender minorities living with HIV are neglected, this is even more true for the perspectives of the segment of this demographic not utilizing the services of HIV/AIDS NGOs and CBOs and/or ART centres on which researchers rely for recruitment.

It so happened that by this point, I had begun dating someone who had occasionally worked as a translator on these kinds of research projects. With much bemusement A. recalled *hijras* or sex workers bemoaning their dire financial situation and other hardships in conversation with foreign researchers before showing off their latest sari purchases to A. over chai once the interview or focus group had been concluded. Available on demand, these sexual subalterns were, it seemed, keenly aware their biopolitical value to NGO workers, foreign donors, the relevant governmental agencies, and researchers like myself, e.g. to those that together make up the HIV/Aids industry (khanna 2016). I wasn't sure what I would be able to contribute to this kind of research, not least because of my lack of linguistic ability. Despite having studied Hindi in high school (the only International Baccalaureate school to offer the subject), at SOAS and, prior to starting research, for three months at Landour Language School in Mussoorie, I was not fluent enough to conduct interviews in the language. And while being able to understand and speak a bit of Hindi was very helpful while on research trips to Mumbai and New Delhi, it was of little use in Bengaluru, where I had based myself because of my familiarity with the NGO. Yet while my focus on middle to upper class gay and bisexual men in the large urban centres arose from a limitation, it also addressed a gap in the research. Nobody, several of my interlocutors told me, has any idea what is going on with this demographic (and with more affluent HIV-positive people more generally) since they are not usually reached by targeted interventions, tend not to associate with the state-funded networks for people living with HIV, and mostly access health care privately.

Middle class is not a self-explanatory or stable category, especially not in India. As Surinder Jodhka and Aseem Prakash (2016) explain, middle class has become a buzzword in India since the economic reforms of the early 90s, despite its origins in the colonial period and its expansion during the first decades of Indian independence. Economic liberalization, which opened India up to the international flow of capital, ideas, and consumer items, is often identified as the beginning of the ascendance of the "great Indian middle class" (Varma 1999), but the parameters of this demographic are unclear. Sandhya Krishnan and Neeruj Hatekar define it as those who spending between 2 and 10 USD a day, which amounted to nearly half of India's population in 2012 (2015, 40). They distinguish between lower and upper middle class, with the latter involved in traditional service activities and new

knowledge services. Their observation that the new middle class is dominated by upper castes (despite the entry of other caste groups in large numbers) resonates with Ajantha Subramanian's (2019) argument that upper-caste privilege is increasingly expressed as "merit", which works to justify the over-representation of dominant caste groups in India's elite educational institutions and professions. Similarly, in their study of Tamil Brahmins working in the IT sector, Fuller and Narasimhan have demonstrated the continuity of caste privilege through the colonial, post-Independence and contemporary era in *Tamil Brahmins: the making of a middle-class caste* (2021). Although the complex relation between class and caste is beyond the scope of this thesis (see Mosse (2015) for an introduction), it forms important context to some of the arguments advanced in this thesis. Many of the men I spoke to came from upper middle class backgrounds: they had been educated in English-medium schools, spoke a combination of English and other languages with their families, worked in industries such as IT, marketing, or marketing. Others came from more humble origins and/or were upwardly mobile. In contrast, many of the peer outreach workers I spoke to came from working class or lower middle class backgrounds.

As for the focus on "men", this reflects the demographic that is associated with high fun. As Jamie Hakim and Kristian Møller (2021) explain in their introduction the special issue of *Sexualities* discussed at some length in the next chapter, the proliferation of research on "chemsex", e.g. gay male sexualized drug use, stands in stark contrast to the dearth of research on experiments with combining sex and drugs among other segments of the LGBTI+ community (see Pienaar et al. 2018). While I did interview one assigned-female-at-birth non-binary person who told me using MDMA helped them navigate feelings of gender dysphoria during sex with their female partner (as well as being very fun), they did call this high fun as "that's more of a gay male thing, no?" Although I am sure people who don't identify as male also partake in high fun parties, since the platform on which these are advertised (Grindr) is used predominantly but not exclusively by cis-gender men, I did not meet or interview any of them. I use the term "gay and bisexual men" throughout this thesis as this best reflects how interlocutors described their gender and sexuality, barring one HIV-positive interlocutor who identified as non-binary and queer.

I didn't have many difficulties connecting to the relatively more affluent subset of what is now commonly referred to as India's queer or LGBT community. I used the same physical and online spaces as them, from parties at fancy hotels where the cover fee was as high as the London venues I used to frequent to the Facebook groups where queer people share anonymous confessions and gossip alongside news of political victories and setbacks,

mainly in English. But most importantly, I was on Grindr. India has the fourth largest number of Grindr users, after Mexico, Brazil, and the U.S. (Marr 2020), and the app is an increasingly common way for gay and bisexual men to find sexual or romantic partners, alongside other dating apps and websites such as PlanetRomeo[6] (see Dasgupta 2019). Advertising my research on my Grindr "bio" eliminated a worry I had when recruiting through other means, as snowballing or through NGO staff, namely that people might be "outed" without their consent. This had happened during a conversation in London with a friend from India. When I told her about the research I was about to start, Puja began telling me about a friend of hers (whom she named) who had recently tested positive. "He got it through his boyfriend, some rich Delhi kid who was injecting drugs and going to orgies," my friend continued, demonstrating the way in which men who are into high fun are blamed for supposedly driving new HIV infections among gay and bisexual men, as the next few chapters will show. Puja scoffed at my slightly panicked insistence on HIV-positive people's right to discretion, but apologized for her judgemental tone the next day, after a mutual friend informed her I myself am HIV-positive. I did end up meeting the person in question, who became not only an important interlocutor with many brilliant insights but also a friend (Puja, he told me, had been a major source of support when he was diagnosed). But while the method was effective, it was not ethical, and soon after reaching Bengaluru I realized I had to make an active effort to stop people from rattling off names of people who got HIV – along with the names of those from whom they supposedly "got it" – upon learning about my research.

Yet advertising my research on Grindr was a very passive approach. Even if, hypothetically speaking, people disclosed an HIV-positive status on their Grindr profile (hardly anyone does in India), targeting people in this manner seemed unethical, and so I simply waited for people to respond to my request to speak with men who are into high fun and/or HIV-positive. I adopted a multi-sited approach to increase the advertisement's reach and moved to Mumbai for three months after a brief scoping visit during monsoon. Here I conducted more interviews than during all of my time in Bengaluru. Were people more practiced at telling their story in this city of actors and scriptwriters? Was it the sheer size of the city? Or, as one interlocutor in New Delhi suggested, is Bengaluru's close-knit, relatively closed queer circuit particularly gossipy, such that people might have more reservations about agreeing to be interviewed there? Relatedly, my relative anonymity in Mumbai might have

[6]Although I also made a profile advertising my research on PlanetRomeo in an attempt to reach more older gay and bisexual men, this received no responses.

also been a factor. In Bengaluru, I had a boyfriend, several acquaintances and a few friends, and colleagues at city's main sexual rights NGO – all of whom I might, hypothetically speaking, leak information to. When researching a highly stigmatized group of people, being "networked" can thus be problematic rather than useful when it comes to recruitment, and being perceived as an outsider can have its advantages. Travelling to Mumbai, New Delhi, Pune, Hyderabad and Chennai, I was able to conduct a total of 47 semi-formal interviews with men who are into high fun and/or HIV-positive. I also spoke to HIV/Aids workers and activists in these cities, and attended HIV-related events such as an informative session on PrEP, hosted by the group Gay Bombay and delivered by the well-known HIV physician Dr Gilada, and the World Aids Day celebrations that feature in Chapter 7: Communities Make the Difference.

Although several interlocutors traced their HIV infection to high fun, this overlap was not a criteria for inclusion or the object of my investigation. Like HIV, however, high fun is highly stigmatized among India's gay male communities, as this thesis will demonstrate. Moreover, drug use is punishable with up to ten years in jail Narcotic Drugs and Psychotropic Substances Act, 1985 (depending on the quantity one is caught with). Not only was the illegality of drug use likely a barrier in recruitment, it also meant participant observation was out of the question, since SOAS could of course not endorse one of their doctoral candidates engaging in or witnessing criminalized acts. Indeed, ensuring anonymity and safe storage of data was of tantamount importance. I assured interlocutors, whether HIV-positive, into high fun, or both, that recordings of interviews were deleted from my phone after manual transcription. Transcriptions were uploaded to a password-protected Dropbox account, and the "key" linking names, transcriptions and pseudonyms were stored on a separate Google Drive. When permission to record was not given, I took notes which were subsequently typed out and uploaded to the Dropbox.

Aside from the risk participant observation in high fun would pose to interlocutors, it would also raise ethical questions about informed consent, which might be compromised if research participants are intoxicated (and how would I even go about gathering it – by handing out forms as people joined the party?). Personal reasons prevented me from engaging in high fun, too. Though I had attended chemsex parties in London sober (often unwittingly), I had shied away from trying any of the drugs associated with them. Fiona Hutton (2020) has argued that some drugs and modes of consumption need to be stigmatized for others to be normalized. In particular, "injecting drug use, addiction and those who engage in 'risky' drug-using practices are [still] viewed as 'other' and as abject'" (Hutton 2020, 7), which

partially explains my own reservations about injecting methamphetamine (crystal meth) or any of the other drugs used in chemsex.

Although people also snort and swallow drugs in the context of high fun, never having "slammed" – injected drugs – created something of an epistemic distance between me and my interlocutors. "You'll never understand if you haven't tried it," said Kaushik, whom we will meet in Chapter 4: Organizing Logics, matter-of-factly. He explained that because the substance enters the bloodstream directly, the rush is different: more intense and shorter. Other interlocutors similarly suggested not having slammed limited my understanding of high fun, but emphasized its more negative effects and strongly advised against trying. "You'll never come back from it," one warned ominously.

Being a non-slammer also posed a methodological and ethical problem, in that some people may have assumed that as an outsider I would be judgemental or interventionist (as many in Bengaluru's queer community and some in the HIV sector are, as we will find out). As I explain in Chapter 3: Interlude for Chemsex, researchers mainly approach sexualized drug use through the prism of HIV risk, and given that I studied both high fun and HIV I was presumed to have a public health agenda. "Why shouldn't I enjoy it," asked one person defensively in a conversation on Grindr about my research. His sarcastic and hostile tone suggested an awareness of social scientific research's complicity with the disciplining of the (gay male) sexual body. As Dion Kagan reflects, "though contemporary sex researchers may offer more nuanced and considered accounts than, say, sex panic journalism, we are all implicated in the burgeoning definitions and understandings of sexuality that emerge from its discussion" (2018, 138). A., the boyfriend, disapproved of this part of my research for similar reasons. "Leave them to their business," he would say when the topic of high fun came up, "we mustn't be peeping Toms."

Most men stopped chatting with me when it became clear I could not be persuaded to join the party. The people who did respond to my research positively tended to be men who had developed some problem – or, usually, several problems – they related to high fun. They were looking for support or were hoping to create awareness, as Arvind explains at the end of the interview detailed in Chapter 5: High Risks. His story combined all of the recurring themes, including addiction, mental health problems, suicide, isolation, and, last but not least, HIV infection. In contrast, people who seemed to be having a good time doing high fun tended to stop chatting with me when it became clear I could not be persuaded to join the party. My research thus arguably perpetuates a tendency to emphasize negative rather than positive outcomes of sexualized drug use critiqued by critical chemsex researchers (Møller &

Hakim 2021), as I explain in the next chapter, in large part because of the impossibility of participant observation. Accounting for this bias, I suggest this thesis is less about high fun than it is about the stories people tell about it, and this is how I have framed, for instance, the addiction narratives analysed in Chapter 5: High Risks.

Poz/itionality and reflexivity

The differences between my relation to HIV and high fun brought to the fore the question of my positionality and how it influenced recruitment and the research relation. During an informal conversation at a weekend retreat for HIV workers outside Bengaluru, my friend – who was translating for me - told the woman we were talking to that I was HIV-positive myself, and that this informed my approach to the research I was doing. "Of course," the peer outreach worker from rural Karnataka responded in Kannada, "only you understand the pain and the struggles of your community from the inside. I feel like that about transgender people, and I'm sure that's how he feels about people who are positive." I was slightly taken aback by this comparison, hyper conscious as I was of my status as a *gori* (white) outsider. At the same time, the comment allayed an anxiety I had about not having enough distance to the topic at hand, given my investment in the medical technologies and discourses (like viral load suppression) that I was studying.

I started fieldwork in July 2019, half a year after I was diagnosed with HIV. My supervisor questioned, with good reason, whether it was a good idea to change my topic from transgender rights and welfare to HIV stigma. I had felt ambivalent about studying the effects of the Supreme Court ruling in National Legal Services Authority vs Union of India (henceforth NALSA) in 2016 and the proposed Transgender Persons Bill of Rights. Given the centrality of self-definition and self-representation to the debate about transgender rights in India (Orinam 2019), how was I – a cisgender European – going to contribute meaningfully to it (see Boellstofff et al. 2014 for a roundtable discussion on the role of ethnography in transgender studies)? The gap between the medical normalization of HIV as a manageable chronic disease and the experience of living with it, on the other hand, now affected me directly, and was something I couldn't stop thinking about. Although I shared my supervisor's concerns about feeding this new fixation, during my preliminary research I had read somewhere that people who turn their seropositivity into an activist or professional "career" are less affected by the mental health costs (significantly increased risk of loneliness, depression, and suicidal ideation) associated with HIV. And anyway, what is a PhD if not an unhealthy obsession? If I was going to have to deal with stigma, I reasoned, I better get to the

bottom of it.

Being HIV-positive myself helped me built trust with potential interlocutors. Nithin was not the only person who was hesitant to disclose his status to me during our conversation on Grindr: other interlocutors too wanted to suss me out in person first. One soft-spoken interlocutor in Mumbai explained he initially worried I might be posing as a researcher in an attempt to expose him and his history of drug use: "I was skeptical of course – [I thought] is he going to use my picture, make a fake profile, say *he's into high fun and this*". Though this might sound far-fetched, Parikshit's was not an unrealistic fear: such name-and-shame profiles are created with some frequency on Indian Grindr, although they are usually about people's HIV status rather than their involvement in high fun, as will become clear in Chapter 10: Undetectability. "But I took a chance," Parikshit continued. Even so, the full extent to which stigma acted as a barrier for recruitment only became evident later in the interview, after I told Parikshit that I am HIV-positive. "I am also the one," he whispered ominously. Similarly, Faisal, whose experience of high fun is detailed in Chapter 4: Organizing Logics, insisted he was on PrEP until he figured out my status. "HIV positive people will speak only to those they feel comfortable with, other positives only," someone explained once during an interview. "We can also talk about it because you are positive." And when, before joining a support group for HIV-positive gay and bisexual men on Whatsapp, I met with its administrator to address my concerns about issues of privacy and consent, Sri assured me that that as long as I was gay and "poz", there was no issue. (I nonetheless limited my participation to advertising my research for recruitment purposes and very general observation.) I eventually changed my response to Grindr's HIV status prompt to "Positive, Undetectable", since the benefits in terms of recruitment outweighed the risk of negative responses of the sort detailed in Chapter 10: Undetectability.

This is not to suggest that a seronegative researcher could not have done the research, and at least a few HIV-positive men who agreed to speak to me did not realize I too was HIV-positive until much later on in the interview, or after. But it would have been a very different kind of research. When Kaushik – the person who explained slamming to me - clocked that I have HIV too, he touched my hand lightly and briefly with his, and asked how I was doing. The conversation became much more of a dialogue following this recognition, and this pattern repeated itself in other interviews with HIV-positive people. Interlocutors also tended to be frank with me, correctly assuming I hadn't contracted HIV from a blood transfusion or in any of the other "innocent" ways. At the same time, my being a foreign visitor, rather than somebody embedded in the local gay community, likely alleviated

concerns about the kinds of in-group gossip discussed in Chapter 10: Undetectability. Being European, white, and accredited by a U.K. university that has some name recognition in India might have also helped me maintain some credibility as a researcher despite my unusual recruitment method and informal approach to interviews.

I was, in other words, both an insider and an outsider, and it was the dialectic between these different aspects of my positionality that shaped the research relation. The woman who suggested that I can relate to the struggles and pain of people who are positive the way she can when it comes to trans people evoked the peer concept at the centre of India's HIV/Aids programming (Rao 2017, Lakkimsetti 2020). The idea is that sex workers, men who have sex with men and other members of the "high-risk groups" that the state struggles to reach are mobilized to provide their peers with confidential and non-judgemental HIV prevention and treatment services by their own members, and, relatedly, that people living with HIV are best placed to counsel the newly diagnosed. Indeed, interviews with HIV-positive men often eventually took the form of a sort of mutual peer support. Having had a rather awkward and painful conversation with my mother a few weeks after testing positive, I could relate to interlocutors' fear of disappointing their parents. Much laughter and frustration was shared when it came to sex and dating. I once struggled to hold back tears as I listened to a recently diagnosed 19-year-old express fears he would never find romance and acceptance: I reassured him we would both be fine, but was unsure whether this was true. In this way, interviews had a therapeutic effect for both me and, I hope, some of my interlocutors. "Speaking with you I felt like maybe one day I could live with this," said Arvind after we concluded the interview that is reconstructed in Chapter 5: High Risks.

At the same time, there were many things that set me apart from my interlocutors, not least the fact that I was a European visitor. I was diagnosed at 56 Dean Street, the LGBT sexual health clinic in London's Soho that is a global leader in HIV care. Where some of my interlocutors were on antiretroviral combinations that gave them night terrors and depression, I was on state-of-the art medications that manifested no noticeable side effects. Perhaps more importantly, whereas I was one of the very few (or, in some cases, only) person(s) some of my interlocutors had "come out" to, I had enjoyed the support of many friends and lovers when I was diagnosed. Making too much of my "poz" positionality risks obscuring the way in which my experience of living with HIV other dimensions of my social location in obvious and less obvious ways. For instance, I once co-facilitated a focus group with female sex workers on behalf of the NGO I volunteered with. Afterwards, I casually mentioned to one of the middle-aged women who had spoken about discrimination at her ART centre in rural

Karnataka that I was also positive. She just nodded. Perhaps she hadn't understood my Hindi, being a Kannada-speaker with minimal formal education, or maybe she simply didn't care: our shared medical condition was but a minor detail in the larger scheme of things, and one that wasn't going to bridge the gulf created by geography, race, education, gender, and, most importantly, money. (I had not, for one, been scolded or denied touch or respect by the staff at 56 Dean Street.) "Poz" or not, I was a professional male from the rich "West" and she an impoverished woman from a village in the Global South. And despite much-belated advances in treatment access in India and globally, the difference between those living with HIV and those dying of Aids persists along racial and geographic lines (Thrasher 2022). Although I had more in common with the relatively privileged gay and bisexual men who were the focus of my research than either they or I did with the female sex workers, the point remains that experiences of seropositivity are incredibly diverse. Indeed, as I explain in Chapter 7: Communities Make the Difference, the peer concept model is flawed precisely because it elides fissures and differences within the communities associated with (and constructed through) HIV/Aids governance.

At the same time, I sometimes wondered whether I was too much on the "inside" of what I was studying, as a former teacher of mine seemed to imply when we met over coffees at Bengaluru's Koshy's restaurant. "I must say that I am a bit disturbed by your absolute faith in the medical science," Usha said after I finished explaining U = U, or Undetectable = Untransmittable, and that I was studying the impact of this new discourse on queer men. Though the idea that those with suppressed or 'undetectable' viral loads cannot transmit HIV sexually has been mainstream scientific consensus for years now, Usha wasn't convinced. Throughout her many years of struggle with severe illness, she had maintained a healthy scepticism of biomedicine in spite of her dependency on it. Usha was perturbed by my blind faith in U=U, and confused as to how I could study anthropologically a discourse that I was so partial to. "I can say this to you," she judged after hesitating, not having seen me in seven years. "Implicit in these grand scientific claims is also a kind of Western arrogance[7]. There are so many ways of understanding the body."

[7]Whether or not this arrogance is particularly 'Western', as Usha suggested, is debatable: While it is undeniable that "what is commonly regarded as science has (…) served as an arm of colonization and European political, cultural, and intellectual domination", as Lyons and colleagues remind us (2019, 3), Kaushik Sunder Rajan (2017) stresses that today biomedical knowledge production is very much a transnational affair, with key nodes in Singapore and India. At the same time, much HIV discourse emanates, like so many cultural flows, from the U.S., where an organization called Prevention Access Campaign in 2016 began popularizing the U = U slogan.

Usha had a point, and the challenge inspired an STS conference paper in which I reflected on my complicated and sometimes contradictory relationship to the biomedical technologies and discourses that are the subject of my study. At the same time, anthropologists have dispensed with the notion of objectivity that was so essential to the legitimization of ethnography as a scientific method at least since the so-called reflexive turn of the 1980s. Lila Abu-Lughod's (1992) contention that ethnography is not only a "partial" truth – as James Clifford and George Marcus had argued in *Writing Culture* (1986) - but also a *positioned* one is particularly helpful. "The self is my research instrument, and I have to account for that" summarizes Gloria Wekker in conversation with someone who is critical of the anthropologist's tendency to combine activism and scholarship (Polak 2016). Wekker draws on the concept of situated knowledges elaborated by philosophers of science. Inspired by Donna Harraway's claim that "feminist objectivity means quite simply situated knowledge" (quoted in Harding 1992, 437), Sandra Harding argues that rather than undermining scientific legitimacy, "standpoint theory" produces a stronger form of objectivity because biases are acknowledged and addressed. If, as the Wekker explains to the journalist, whiteness is experienced as neutrality, we might say the same about sero-negativity.

In the chapters that follow, I try to make explicit and challenge my own stakes in the game. Despite my critical approach to the "promissory discourses" of treatment-as-prevention (Kenworthy, Thomann, and Parker 2018), including the notion that U =U will eliminate HIV stigma by reducing fear of transmission, I am deeply invested in these discourses myself, as Usha implied. Indeed, if I thought I could analyse my way out of being affected by stigma, I was wrong. On Valentine's Day, I drunkenly posted a rant on social media about the difficulties of dating as an HIV-positive person, listing some of the negative experiences I had had while being "out" (most of the time) as HIV-positive during fieldwork. Though I deleted the post in the morning, suffering the acute embarrassment that some hangovers bring on, a new friend who had seen my cry for attention messaged to ask whether I was okay. Over coffee at our local brunch spot I explained I thought the research was maybe affecting me more than I'd been willing to admit, and my friend nodded and said he understood. He too, it turned out, was positive.

Recounting such embarrassing experiences dispels the myth of the researcher as floating above, and unaffected by, the social relations he or she studies (De Genova 2005). Indeed, queer, feminist and so-called 'halfie' ethnographers have long questioned the boundaries of the proverbial "field" (Abu-Lughod 1991, Weston 1993, Visweswaran 1994,

Browne and Nash 2010, khanna 2016), which presumes the researcher can switch between personal and researcher roles. In my case, Grindr was a major component of the "field". Although I was using the dating app mainly to advertise my research, being active on it as an HIV-positive gay man inevitably led to insights regarding the way in which HIV status is negotiated among gay and bisexual men in India. Although I agree with Kane Race has argued that "nothing should prevent bona fide participants in sexual cultures from representing their experiences of these cultures in scholarly venues and using these reflections to inform their analysis" (2015, 254), I have, unlike Race, not included screenshots of conversations I had on Grindr. But people's responses to my HIV status disclosure of course shaped my understanding of the ways in which stigma operates among gay and bisexual men, as did being in a relationship with an HIV-negative man whose friends repeatedly warned him to "be careful", and having casual sex with several others. There is thus auto-ethnographic dimension to my research that I try to make explicit throughout the thesis: though my experience of briefly living with HIV in India is not the subject of this ethnography, it naturally informs both my understanding of HIV stigma and, as explained, my relationship to the interlocutors. This is, of course, not a novel approach. As Sarah Franklin writes about a fellow medical anthropologist, "[Rayna] Rapp's own retrospection about her encounter with pre-natal genetic diagnosis frames her investigation of the experiences of others" (2003, 71-72).

Researchers' sexual subjectivity remains a taboo subject within anthropology and academia more generally. Yet, Don Kulick has argued, an acknowledgement of erotic subjectivity during fieldwork might help push to the fore questions that are essential to anthropological method:

> For many anthropologists, desire experienced in the field seems often to provoke questions that otherwise easily remain unasked (...) They are questions about the validity and meaning of the self- other dichotomy, and about the hierarchies on which anthropological work often seems to depend. They are questions about exploitation, racism, and boundaries. They are questions about commitment and the politics of desire. They are questions, in other words, that lie at the heart of anthropological knowledge. (Kulick 1995, 5)

The argument is not merely that an acknowledgement of sexuality would enable a more complete account of positionality by putting the person in the anthropologist, as others have suggested (Markowitz & Ashkenazi 1999). Rather, Kulick draws on Evelyn Probyn's commentary on the crisis of representation in cultural studies to argue that eroticism may help

us "ask what exactly a self-reflecting self is reflecting upon" (Porbyn 1993, 62). Rather than transcend social differences or momentarily suspend the boundaries of self/other, sex draws attention to one's partner's particular place in the racial, economic and global hierarchies in relation to one's own. "It is this increased sensitivity of position," Kulick argues, "this heightened awareness of partiality, (...) this increased stake in the game that I would argue might well provide one possible springboard out of a reflexive anthropology capable of using the self in an epistemologically productive way" (1995, 20).

Wekker's (2006) and Lunsing's (1999) reflections on the ethics of their sexual relations with research participants are examples of such accounts. Both authors highlight how their sexual involvement with a research participant led to a constant engagement with questions of ethics and power in anthropological research, from decisions about whether and when to publish the research results (Wekker 2006) to reflections on the inevitability of vulnerability and the importance of transparency in research as well as romantic relationships (Lunsing 1999). By making explicit how the researcher is implicated in the messy social words he or she is describing, acknowledgments of erotic subjectivities in research push to the fore questions about reciprocity, accountability and power that anthropologists stand accused of ignoring.

Although interviews never turned into dates, when the reverse happened – as was the case with Nikhil, although our "date" ended up remaining platonic - I made sure to ask explicitly whether or not I could use our intimate, sometimes post-coital conversations for research or not. Eroticism influenced the research process in more subtle ways, too. When an article based on this research was published, an Indian friend who was also interested in researching high fun suggested that I would never have enjoyed the kind of access I did if it weren't for my "good" and exotic looks. In doing so, my friend drew attention to the under-acknowledged role of what Adam Green has termed erotic capital (2008), a concept explored in Chapter 4: Organizing Logics, as an asset or liability in ethnographic research. In my case, this erotic capital was inseparable from my being racialized as white, although body shape, age, and gendered presentation of course also play a role. My boyfriend went so far as to suggest there was an erotic quality to the intimacy of my interviews, whatever boundaries I erected. "I'm dating a sex worker who is still doing *dandha*," he once cried in mock-despair, using the *hijra* slang for prostitution (lit: business). "You give a little bit of yourself to everyone you speak to." Although the analogy of course grossly trivializes the actual dangers

involved in sex work, I could see what A. was getting at.[8]

The implicit challenge to my research persona directs us towards its performative and relational aspects. As Judith Butler (1990) has famously argued, (gender) identity does not prefigure performance, but is instead constructed and sustained through continuous repetition. It is therefore always unstable and subject to change or misinterpretation – as well as relational. Applying these insights to the relation between researcher, researched, and research, Gillian Rose suggests in her critique of "transparent" modes of reflexivity, we (the researchers) are made through our research and through our relation to our interlocutors or research participants in a process that is necessarily complex, uncertain, and incomplete.

> Thus the authority of the researcher can be problematized by rendering her agency as a performative effect of her relations with her researched others. She is situated, not by what she knows, but by what she uncertainly performs. However, this is not to suggest that as a `decentred self' the researcher can somehow elude the dynamics of power. Indeed, in many ways this argument places the researcher even more firmly in the capillaries of power. Working with a Foucauldian understanding of power as saturating and productive rather than as unevenly distributed and repressive, Gibson-Graham (1994) acknowledge that their academic work must therefore be power ridden too (see also Gilbert, 1994). (1997, 316)

Where reflexivity can sometimes be performed in a way that *closes* the question of power, the decentring/fragmenting of the researching self opens it up. Moreover and relatedly, where the former implies an ontological separation between researcher and researched, the latter directs us to intersubjectivity and relationality.

I have tried to reflect this relationality in my reconstruction and representation of interviews in an effort to emphasize the collaborative nature of knowledge production, adopting a first person narrative and insinuating myself within the text where relevant. Although this is arguably quite standard anthropological practice since the so-called reflexive turn, it resonates with Nicholas DeGenova's call for an "anti-anthropological" ethnography. Drawing on Paulo Freire's (1968) anti-hierarchical pedagogy - in which students and teacher

[8] Of course many researchers – and particularly young female ones – have to actively resist sexualization to be taken seriously, and, more importantly, to not be harassed (Haddow 2021). As some using the handle @internetphi tweeted recently, "anthropologists don't warn women doing fieldwork that cultivating the kinds of relationships where participants are comfortable enough to give u accurate ethnographic data means interacting with men who will perceive that relationship inappropriately no matter how u built it" (2022). Yet arguing for the acknowledgement of erotic subjectivity during fieldwork does not so much trivialize the risk of sexual violence as make the possibility of it during fieldwork more speakable, which we might hope could contribute towards better support (or, indeed, any support) for PhD candidates and other researchers who do have negative or traumatizing experiences during fieldwork.

together (e.g. in dialogue) explore salient themes with the aim of transforming them – DeGenova suggests ethnographers take these concerns and struggles as their object of study investigation rather than the people themselves. He suggests this "dialogic imperative" may be key to recuperating ethnographic practice from its disciplinary genealogy, e.g. its intellectual roots in colonialism, since anthropology's authority has been "based upon rigid inside-outside dichotomies that presuppose and reinforce essentialist notions of discrete bounded intrinsically outside of their meaningful concerns and struggles" (2007, 22). Rather than learning "about" a given people or population, anthropologists would thus be learning *with* them.

Yet DeGenova is under no illusion this dialogic approach would manifest the decolonization of ethnographic method, since the research relation is institutionally mediated and rooted in material and historical inequalities (2007, 30). "None of the foregoing is to presume to have resolved any of the constitutive dilemmas of ethnography," he writes, adding that in his research with Latin American migrants in the U.S, "my own position never ceased to be problematic" (2007, 52). We might add here Achille Mbembe's (2016) reminder that both the political economy and epistemologies of global higher education remain essentially Eurocentric. On the one hand, an openly HIV-positive person doing this kind of research can be welcomed as a step towards meaningfully including people with HIV/Aids in knowledge production about the epidemic in the spirit of the GIPA (Greater Involvement of People with Aids) principle explored in Chapter 6: Interlude for Community. On the other hand, insofar as I am another white European researcher conducting fieldwork in India towards a PhD degree awarded by a UK university that still has the word Oriental in its name, it is symptomatic of and perpetuates the "power dynamics in existing patterns of who is able to study others, why, and to what effect" (Uperesa 2016). (Where is the School of Occidental and American Studies, the author Arundhati Roy once asked rhetorically in a lecture at the school.) Indeed, it so happened that I arrived to Bengaluru just a few weeks after a predecessor from SOAS – also a white gay man studying sexual politics – had left the city. "We call it boyfriend season," quipped an acquaintance I ran into at Bangalore Queer Film Festival, inadvertently hinting at some of the ways in which queer research on queer topics – including HIV – destabilizes the researcher-researched relationship and problematizes the boundaries of the "field" (Browne and Nash 2010).

Conclusion

Detailing the methodological and ethical challenges and practicalities of doing

research on two highly stigmatized topics, namely high fun and living with HIV, in this chapter I reflected on some of the way in which my status as a seropositive researcher shaped the kind of access I had and the sort of research I was able to do. The peer support worker's suggestion notwithstanding, I was not an "insider" in any straightforward way, not least because I was visiting from London. Reflexivity might then mean enumerating the various factors that make me relatively privileged as far as people with HIV are concerned, and an awareness of these factors and how they shape the research process is of course a basic requirement – even if, as Kath Weston reminds us, reflexivity is not "in an and of itself an equalizing act" (1997, 171). But my reflections also troubled the insider/outsider dichotomy that underpins some, if not all, discussions of positionality. Rather than treat my sexuality (gay), serostatus (positive), racial (white) and geographic (European) location as separate aspects of my identity that place me on the inside or outside respectively, I have tried to demonstrate how their interaction shaped the research process and my relationship to interlocutors, suggesting that insider/outsider status – and one's research persona more generally - is always dialectic, relational and fluid rather than fixed and binary. Thinking about poz/itionality in this way might help us problematize the subject that is being reflected upon in chapters such as these.

Chapter 3: Interlude for Chemsex

High fun can be understood as an Indian iteration of a transnational trend referred to in academic and grey literature as "chemsex". Although there is nothing new about queer experiments with drugs and sex (Race 2009), chemsex – both as a queer subcultural practice and as an object of research and intervention - is a relatively recent phenomenon. It is also a decidedly global one, although current scholarship on sexualized drug use among queer men does not yet reflect its transnational nature. In this chapter, I briefly trace the construction of chemsex as a new "high risk behaviour" in behavioural literature from the fields of drug policy and sexual health before detailing some of the critiques this body of scholarship has attracted. Given the absence of literature on sexualized drug use in the Indian and other Global South contexts, the scholarship discussed below is almost exclusively from and about North American, European, and Australian settings. Indeed, addressing this gap in the literature is one of the main empirical contributions this thesis makes, and the ethnography of high fun presented in the two chapters following this one also challenges some of the theoretical tendencies in critical scholarship on chemsex and its construction in public health imaginaries.

Chemsex as risk behaviour

In 2019, Reuters reported that a "surge in "chemsex" parties, where people spend days getting high on drugs and having sex with scores of partners, is re-fuelling epidemics of HIV among gay men in European towns and cities, doctors say" (Kelland 2019). The air quotes around chemsex suggest it is a vernacular term, indigenous to the gay male community in which it is practiced. The explanation gives the article an anthropological quality: chemsex is something that needs to be translated to the non-homosexual general population. One of the people that have been central to this process of translation is David Stuart, the late "chemsex guru" who drew on his past involvement in the scene to pioneer harm reduction services in London. In his account of the term's origins, Stuart recalls first hearing the term used in the context of the city's gay saunas and bathhouses in the late nineties. At that time, "chems" -short for chemicals - was used in communications with each other and with drug dealers to refer to two specific drugs that were "markedly different from the cocaine, ecstasy, poppers, ketamine and speed that had been staples of the gay club scenes for so long" (2019, 5), namely GHB (gamma-hydroxybutyrate) and methamphetamine. Stuart recalls being part of a group of sauna patrons who were united by their preference for these stigmatized drugs and the sexual networks in which they were consumed, if not by much else,

and they called themselves the "chemsex club". The term began being used on the online sexual networking platforms that emerged in the late nineties and early 2000s.

Queer men have, of course, experimented with combining sexuality and drugs since long before the emergence of so-called chemsex scenes. Kane Race argues that in Sydney's queer community, "illicit drugs have in fact always been part of the environment in which both risk and safety (with respect to HIV transmission) have been practiced" (2009, 208). Gay men in New York are said to have suffered an epidemic of crystal meth addiction just as people stopped dying in large numbers of Aids (Schulman 2021). Yet what *is* new is the emergence of drug-enhanced sex as an object of public research and intervention. Stuart explains that many around him struggled to find de-addiction services that could address what he describes as the "gay sex elements" shaping their drug use (2019, 6). He suggests that popularization of the term "chemsex" in the first decade of the millennium enabled a more holistic response:

> When gay communities started to respond to the chemsex phenomenon, as discussion groups sprung up, as Facebook groups were created, as chemsex culture was explored in film and theatre, in performance art, photography and Drag culture, health services were motivated to respond with culturally competent support services. Having a named syndemic, something that set it apart from other forms of drug use, became increasingly important. The existence of the word "chemsex" helped government drug policies and managers developing support programmes to identify a unique kind of public health concern and to respond effectively and with some degree of cultural competency. (2019, 5)

In 2011, the UK National Health Service developed treatment strategies targeted to men combining drugs and sex (Hakim 2018, Stuart 2019). Yet arguably, research into chemsex also contributed to its reification as a discrete subcultural practice. "The term "chemsex" gained prominence in the UK after the publication of The Chemsex Study," suggests João Florêncio (2021, 3). The 72-page report had been commissioned by boroughs in South London seeking to understand the prevalence of sexualized drug use among gay and bisexual men with the aim of minimizing its negative impacts (Bourne et al. 2014). Dr Richard Ma from the Royal College of GPs described chemsex as a "public health time bomb" after an article published in the British Medical Journal connected chemsex to a rise HIV infections in London in 2015 (Hakim 2016, 4).

Beyond the U.K. there had already been much other research into the connection between sexualized drug use and HIV. A systematic review of the literature identified no less than 2492 publications mentioning 'chemsex behaviours' between January 2000 and

September 2018 (Maxwell et al. 2019) in 'high income countries', with references to Europe, North-America and Australia far outnumbering studies in East Asian countries. Since then, there been studies about chemsex in Hong Kong (Wong et al. 2020) and other parts of Asia (Lim et al. 2018), as well as in Brazil (Jalil et al. 2022), demonstrating chemsex is not unique to Euro-American contexts. A cursory search for "chemsex" reveals the extent to which suspected HIV risk shapes the research agenda. A study entitled "Chemsex and new HIV diagnosis in gay, bisexual and other men who have sex with men attending sexual health clinics" (Pakianathan et al. 2018) found a strong association, and also claimed men who are already HIV-positive are more likely to engage in chemsex than their HIV-negative or untested counterparts. Similarly, a different study found 3 out of 10 HIV-positive men engage in England and Wales engage in chemsex, leading the authors to worry that chemsex "may therefore play a role in the on-going epidemic" (Pufall et al. 2018, 261). The aforementioned systematic review also confirms this link, and suggests that while there is a range of estimates regarding the extent of needle sharing, condom-less sex is common in chemsex settings (Maxwell et al. 2019). A study from Hong Kong confirms the link between chemsex and new HIV infections among MSM in the city (Wong et al 2020). Many of these studies draw on surveys and questionnaires, retrospective case review using data from sexual health clinics, and HIV surveillance to confirm the hypothesized link between spikes of HIV infections and/or the transmission of other STIs (which increases HIV risk) among gay communities and sexualized drug use. One study simply speaks of "HIV-related behaviours" (Sewell et al. 2018) – presumably referring to the sharing of injection equipment and condom-less sex with multiple partners rather than, say, renewing a prescription or partaking in an online peer support group.

Other studies focus on the motivations behind chemsex in an attempt to explain it. Graf and colleague draw on interviews with "drug-using MSM" and experts in Germany to suggest that "the effects of the drugs are used to intensify sexual feelings and to achieve greater intimacy" (2018, 151). Similarly, a qualitative inquiry into "motivations and values" associated with chemsex among gay men in South London suggests that the drugs used enhance the qualities of the sex that men value by increasing libido, confidence, disinhibition and stamina, and also make other men seem more attractive (Weatherburn et al. 2017). This resonates with findings from New York, where researchers identified an "elective affinity" between the effects of methamphetamines and the pressures associated with the gay male sexual circuit (Green & Halkitis 2006). These pressures have been correlated by scholars, journalists, service providers and people with lived experience to the long-term social and

psychological effects of homophobia and the HIV/Aids epidemic.

In a *Huffington Post* article, Michael Hobbes (2017) posits chemsex as a symptom of an "epidemic of gay loneliness" resulting from the trauma of homophobia and a crude, app-driven hook-up culture characterized by fear of rejection. David Stuart similarly links chemsex to the "uniqueness of gay sex and gay culture" and lists several factors that shape it:

> ■ societal attitudes of homosexuality – particularly the ones that manifest as a disgust of the gay sex act – can seriously inhibit the enjoyment of homo-sex;
> ■ cultural and religious attitudes to homosexuality can seriously inhibit the enjoyment of gay sex;
> ■ the trauma and stigma of the AIDS epidemic can seriously impact the enjoyment of gay sex;
> ■ the technological/sexual revolution that occurred with the arrival of "hook-up" apps and smartphone technology seriously impacted the experience of gay sex and love and relationships;
> ■ a gay-specific rejection culture born of "hook-up" apps associated with gay tribes, body shape and fitness, race, sexual performance expectations, plus an ability to "market" oneself in order to be successful within that culture, seriously impact the experience and enjoyment of gay sex; and
> ■ from all of the above, can be derived a concept of risk and danger associated with gay sex, which can seriously impact the enjoyment of homo-sex (for better or worse) (2019, 4)

Drawing heavily on social psychology frameworks, these popular analyses posit chemsex as the outcome of more general pathologies within gay communities: a response to loneliness, insecurity, and trauma.

The selection of studies cited above is admittedly arbitrary given the rapid proliferation of behavioural chemsex research. Indeed, scholars like Jamie Hakim (2018), Kane Race (2015), and Dion Kagan (2018) suggest that this "incitement to discourse" about chemsex constitutes something of a moral panic. Rather than contest the empirical connection between new HIV infections among queer men and sexualized drug use, these scholars critique the narrowness of studying the latter only in relation to the former. They and other scholars suggest several ways of approaching drug use in sexual settings differently. After outlining briefly some of the perceived issues with the type of chemsex research described above, in the next section I draw on a recent issue of *Sexualities* dedicated to "critical chemsex studies" to highlight alternative approaches along the three lines identified by the special issue's editors, Jamie Hakim and Kristian Møller (2021).

Critical chemsex studies

For media scholar Jamie Hakim, the framing of chemsex as a "public health time bomb" is reminiscent of the media coverage of the Aids crisis in the 1980s. "The discourse on chemsex produced in the British media and some of the other sexual health literature arguably amounts to a multi-faceted panic discourse" (2018, 253) condensing elements of moral panic, sex panic, and techno panic, argues Hakim. Illustrating the alarmist tone that characterizes much discussion of chemsex, Hakim cites a review of *Chemsex* (2015) that describes the documentary as relating a "nightmarish story of everyday annihilation" (Flynn in Hakim 2018, 253). Hakim also takes issue with a tendency to locate the reasons behind the emergence of chemsex scenes in individual biographies and/or the rise of hook-up apps, and is particularly critical of the notion – as articulated in Stuart's list of contributing factors - that queer people are traumatised by homophobia and are subsequently unable to form enduring relationships. This, Hakim argues, privileges homonormative ideals of intimacy as the norm and pathologizes queer men and their sexual practices.

In *Positive Images*, Dion Kagan (2018) makes a similar connection, but refers to a more recent iteration of Aids panic. He sees a parallel between representations of chemsex and the flurry of research and media coverage around "barebacking" in the 1990s and early 2000s, aimed at understanding why gay men deliberately and proudly eschew condoms while knowing fully well what risks this entailed. In his critique of public health and gay media framings of barebacking, Tim Dean (2009) argued that this question presumes from the outset that barebacking is pathological, e.g. something that requires explaining so that it can be curtailed. Popular theories included a lack of self-worth, suicidal tendencies, the perceived inevitability of HIV infection, or survivor's guilt. "Similar to the explanation offered for meth use in the Chemsex documentary," Kagan (2018, 140) points out, "barebacking, in these accounts, is seen as a symptom of gay men's problematic socialisation in a homophobic society alongside the historical trauma of HIV/AIDS". In his attempt to counter the notion of barebacking as pathology, Dean analysed barebacking as a form of resistance against the disciplining of gay male sexuality – yet this logic, Kagan argues, renders the barebacking or risk-taking subject as pathologically transgressional.

Kane Race (2015) also makes this parallel in his analysis of the role of digital dating platforms in facilitating "party and play", as sexualized drug use is known among queer men in Australia. He takes issue with the type of behavioural literature discussed in the previous section, and proposes an alternative approach that is decidedly anthropological:

> Little attempt has been made in this literature to approach these behaviours as a culture; that is, a cluster of activities and practices that are meaningful for participants with their own *organizing logics* and relative coherence; a significant source of pleasure, connection, eroticism and intimacy – notwithstanding the known dangers. In this respect, an analysis of PNP may prompt a productive confrontation with one of the central paradoxes of HIV prevention among men who have sex with men. Many of the sites that epidemiologists identify as pathogenic are also key sites for the elaboration of significant social bonds. In these spaces, participants are undertaking some of the affective groundwork from which relations of community, care and connection may emerge. (2015, 256, italics mine)

This proposal brings to mind Gayle Rubin's call for an "anthropological understanding of different sexual cultures" (Rubin 1984, 154). As such, it is somewhat reminiscent of Tim Dean's analysis of barebacking as a culture with its own language, rituals, etiquette, institutions, and iconography, and one that engenders new and uniquely democratic forms of kinship and relatedness. But while Dean rejects the frames of public health altogether, Race argues that paying attention to the social bonds developed in party and play scenes can attune us to organic, improvised forms of collective harm reduction.

Drawing on Michael Warner's notion of queer counterpublics (2010), Race refers to these collectively improvised and embodied forms of harm reduction as instantiations of "counterpublic health". Both a student and former practitioner of Australia's community-based HIV prevention efforts, Race supports the pragmatic approach to harm reduction that has characterized this response but critiques its reluctance "to enter the fray of meanings, pleasures, and value" (2009, 240). In their attempts to offer an alternative to the punitive, moralizing, and pathologizing approaches to risk behaviour, harm reduction practitioners position themselves as value-neutral ("we don't judge") so as to deflect their opponents' accusations of condoning or promoting drug use. Yet while this manoeuvre is understandable, it results in a failure to engage the significance of pleasure in contexts associated with HIV risk.

Race draws on Foucault's (1976) distinction between *scientia sexualis* and *ars erotica* to propose a way of learning from pleasure, considered not the anti-thesis of safety but "the medium through which certain practices of safety take shape" (Race 2009, xiv) One particularly illustrative example comes from Eric Southgate and Max Hopwood's ethnography of drug use in Sydney's gay night life. The authors describe an elaborate "folk pharmacology", a sort of informal, crowd-sourced manual that delineates what drugs and outcomes are (un)desirable, how to accomplish the desired effects, and how to avoid

becoming a “messy queen” (Southgate and Hopwood quoted in Race 2009, 222). Considerations of pleasure are thus key to the collectively improvised forms or shared protocols of harm reduction that, Race argues, should be attended to closely and affirmatively.

These insights resonate through an emerging body of critical engagements with queer male sexualized drug use, or what the editors of a recent special issue of *Sexualities* term “critical chemsex studies”. In its introduction, Jamie Hakim and Kristian Møller critique the quick adoption by service providers and researchers of the “chemsex as risk” paradigm, which frame has overdetermined analyses of sexualized drug use. The special issue’s aim is to showcase and advocate for “more generative, explorative and critical approaches” (Møller and Hakim 2021, 1) that problematize and/or move beyond the risk paradigm. “Based on previous research and the contributions to this special issue,” write Møller and Hakim, “we propose that critical chemsex studies operates along three axes: one working within public health that attempts to move beyond the *risk paradigm*; another which attempts to understand its *cultural dimensions* as it interrogates the discursive, sociopolitical and economic landscapes in which chemsex has materialized and finally, a third centring *pleasure* and its organization of gay identity, intimacy and sociability” (2021, 3). Without summarizing the entire special issue, I will briefly outline some examples of these three approaches before situating my research in relation to this young subfield of scholarship.

The first approach is inspired most clearly by Kane Race’s notion of counterpublic health, defined by Møller and Hakim as the way in which personal and communal health is negotiated in the absence of institutional resources or interventions. This strand of research attends to some of the organic experiments in harm reduction that the “rush to risk” (Bryant et al. 2018) overlooks. For example, Drysdale and colleagues (2021) explore the understanding and prioritization of risk among Australian gay and bisexual men who use crystal meth for sex and identify a range of harm reduction strategies that go beyond public health guidelines. Research along this line is motivated by the perceived “lack of understanding of real life scenarios in which drug use emerges” (Moller & Hakim 2021, 4), with several studies aimed at mapping out the socio-material contexts in which sexualized drug use takes place (Drysdale et al., 2020; Hopwood et al., 2018). Qualitative methods thus provide an alternative to the positivist research methods that dominate in public health literature on chemsex. As Joanne Bryant and colleagues explain, “because public health research often uses positivist methods, and because it tends ultimately to rely on biomedically-informed concepts of human behaviour or action, public health studies typically

reproduce individualised and often pathologizing understandings of drug use" (2018, 224). They argue for greater inclusion of gay men's experiential knowledge of drug use in sexual contexts, analysed through the lens of social theory, in research on chemsex.

The second and third approaches move beyond the focus on risk rather than trying to complicate it with empirical evidence, emphasizing instead the cultural and sexual politics of chemsex. Jamie Hakim's aforementioned study of the chemsex scene in South London, for instance, relates its rise to consolidation of neoliberal spatial and cultural politics in London. Hakim argues that in locating the reasons behind sexualized drug use in individual biographies, we fail to account for the historical conditions that contribute to its popularity. Interested in why chemsex became as widespread as it did in parts of South London around 2010, Hakim points to two socio-economic shifts that followed in the wake of the 2008 recession: the aggressive gentrification of areas like Vauxhall, with several gay clubs among the casualties, and the influx of migrants from other parts of the U.K and Europe. Chemsex thus offers opportunities for intimacy and togetherness amidst the closure of public queer spaces and the more general privileging of competitive individualism under neoliberalism. Yet Hakim stops short of arguing that chemsex is a form of resistance to these conditions, since, as he disclaims, "there was no evidence in the interviews that gay and bisexual men were consciously developing this practice in any explicit political sense" (2019, 274).

Similarly asking why chemsex has developed now, Sharif Mowlabocus (2021) addresses the relation between chemsex and its context of increasing levels of social and political acceptance of homosexuality in the Global North. Mowlabocus draws on Lisa Duggan's (2002) influential conceptualization of a "new homonormativity", referring to the domestication and depoliticization of U.S. gay politics from the 90s onwards and its alignment with the state and capitalism. Chemsex is often framed as posing a challenge to homonormativity since it has "been heavily criticized as deviant and extreme, and as completely disconnected from the sentimental norms of relationships" (Amaro in Mowlabocus 2021, 4). Drawing on interviews with 12 men were part of London's chemsex scene during or in the years before 2018, Mowlabocus argues that the 'rebellion' against both homo- and heteronormativity is indeed part of chemsex's appeal. Moreover, chemsex parties provide a space for sexualized queer collectivity and intimacy increasingly hard to get by, not only because of gentrification (as Hakim argued) but also because those gay bars that do remain are increasingly sanitized and, as one interlocutor put it, "dead" now that gay men can navigate to mainstream nightlife with relatively ease. Yet while chemsex thus functions as a "'queer rem(a)inder': an opportunity to (temporarily) become 'evil queers' engaged in

practices that are 'beyond the pale' and (in terms of the drugs consumed) illegal," (2021, 11) Mowlabocus suggests that the forms of self-control and resilience appealed to by interviewees during descriptions of their ways of managing their come-downs complicate the seeming opposition between chemsex and homonormative identities. The emphasis on personal responsibility, rather form forms of collective aftercare, are part of the same neoliberal cultural and rhetorical fabric as homonormativity.

Also interested in the relation between chemsex and queer culture more generally, João Florêncio (2021) argues chemsex must be understood in relation to the history of queer of drug use and sexual experimentation. Writing against the above-mentioned interpretations of chemsex as a form of self-harm driven by internalised homophobia, Florêncio focuses on "chemsex's potential as a life-affirming cultural practice" (2021, 2) that sustains and reproduces both transhistorical queer kinship bonds and the individuals that engage in it. Chemsex is, according to him, a "strategy of queer subcultural reproduction and survival that ensure the maintenance of tranhistorical kinship bonds between queers past and present in their shared becoming towards more capacious possible futures" (2021, 2). These arguments are similar to those advanced in Florêncio's (2020) monograph on "pig" subculture, a sexual preference defined by the proclaimed and advertised lack of limits, indiscriminate attitude to partner selection, preference for all manner of bodily fluids – which, Florêncio argues, rupture the boundaries of the bourgeois body. Queer theoretical engagements with the cultural politics of chemsex might thus be understood as part of a longer tradition of identifying subversive potential and a democratic ethos with marginal queer sexual practices or scenes, from Samuel Delaney's phenomenal auto-ethnographic account of gentrification in New York through countless sexual encounters in *Times Square Red, Times Square Blue* (1999) to Tim Dean's (2009) polemic on the ethical openness to alterity demonstrated, supposedly, by bare-backing and bug-chasing.

Finally and relatedly, critical chemsex studies counters "dominant notions of chemsex as always already trauma-based or trauma-inducing" (Møller 2020, 4) by centring pleasure. Research in this vein is inspired by critical drug studies and its problematization of the addiction-pleasure dichotomy (Dennis 2019) underlying, for example, Stuart's (2019) distinction between 'problematic' and 'non-problematic' relations to chemsex. Emphasis is placed on the ways in which drugs modify and enhance sexual pleasure, including by loosening the hold of gender and sexual norms (Pienaar et al. 2018). "The approach is indebted to feminist and queer theories of sexuality that consider the generative, unruly aspects of sexuality as they transcend and disturb otherwise stabilized relationships between

affect, power and identity," explain Møller and Hakim (2021, 5). Invoked here is the transformative potential of pleasure, not just at a personal level but also at a societal one. This approach also draws on a tradition of grassroots queer harm reduction that is as old as the reported epidemic itself: as Kane Race emphasizes, "HIV education has in fact been most effective when it has foregrounded and articulated the embodied pleasures of endangered groups" (2009, 50).

Critical chemsex studies and queer theoretical engagements with sexual subcultures more generally are multi-disciplinary and draw on different methodologies. Whereas both Hakim's and Mowlabocus' arguments are grounded in interview-based ethnography that requires them to temper their interpretations of chemsex, Florêncio offers little empirical evidence to support his claims. Tim Dean's (2009) arguments about barebacking and bug-chasing are based on their representation in porn and on online forums – although the philosopher hints at his own involvement in adjacent sexual circuits, this is not framed as auto-ethnography. This may be related to a more general tendency towards the polemic in queer scholarship previously decried by British Aids activist Simon Watney: "Sadly, much of contemporary Lesbian and Gay studies seems always to know in advance what it is going to discover, thus the lives of actual lesbians and gays are neatly evacuated from the range of enquiries, and are replaced by fetishized 'texts', which have to stand in for real people" (2000, 251). By ethnographically attending to high fun scenes in urban India, the following two chapters thus offer an important contribution to the critical study of chemsex in the form of in-depth, if partial, empirical evidence.

Moreover, critical chemsex studies is self-consciously Eurocentric in orientation. This is in spite of evidence of the popularity of chemsex in parts of Asia (Lim et al. 2018), Brazil (Jalil et al. 2022), Lebanon (Azhari 2021), and doubtlessly many other places. The editors of the special issue admit this limitation:

> Despite the call for papers inviting consideration of geographical diversity, this issue only represents research carried out in Britain and Australia. Critical chemsex studies, therefore, has a long way to go in order to catch up with the rest of the field in related medical and health contexts. What role does chemsex play within regional conjunctions of economies, politics and cultures of gender and sexuality? How does chemsex pleasure take shape in these contexts and what generative potential do they have? The answers to such questions would help qualify national debates about chemsex in ways that do not merely reproduce imaginaries based on findings from London and Sydney. (Møller & Hakim 2021, 6)

This disclaimer warns against simply applying the insights of critical chemsex studies to an understudied Global South context - in our case, that of urban India - and thereby reproducing the Euro-American metropole as the site of (queer) knowledge production and the Global South as the 'field' where this knowledge may be tested.

I began this chapter by introducing high fun as an Indian iteration of chemsex, implying that proliferation of chemsex-like subcultures outside of Euro-American contexts can thus be understood as an extension of the internationalization of queer identities (aided, in large part, by the global effort at HIV prevention) described by Dennis Altman (2010). Rohit Dasgupta's analysis of "global queering" through online dating sites in India – primarily the German website PlanetRomeo – provides a helpful example in terms of situating the local in relation to the global: Dasgupta suggested an Indian appropriation of global norms emanating mainly from the U.S by showing how new ideals of gay masculinity were integrated into local hierarchies of class, caste and gender performance. Yet as Navaneetha Mokkil (2019) has argued in her monograph on sexuality in Kerala, the problem with the "global gay" argument is that it posits sexuality in India as derivative, as always playing catch-up with sexual norms and discourses in the West. Interlocutors, however, explained the emergence of chemsex scenes in exactly these terms, with several people pointing to a time lag in terms of trends by suggesting India is "always ten years behind". The limited available secondary sources on queer sexualized drug use in India are two personal accounts that both frame it as chemsex: One is titled "Sex, Drugs, And Illness: How Chemsex is Harming India's Gay Men" (Kamesh 2017), and the other "I Lost Myself To India's Chemsex Scene and Overdosed, but Survived to Tell the Story" (Hanjabam 2019). (Sadam Hanjabam, the author of the latter article, not only told the story, but also founded an NGO in the North-eastern city of Manipur to address issues related to mental health and drug use among queer youth.)

At the same time, the next two chapters suggest high fun poses a challenge to some of the tendencies in traditional and critical chemsex research discussed in this chapter. As explained above, in an effort to critique and move beyond the narrow frame of HIV risk that predominates in public health research on chemsex, researchers have called for an approach to sexualized drug use that pays attention to the forms of sociality engendered through it, including relations of care. Chapter 4: Organizing Logics responds to this call for paying attention to the social organization of high fun. The scene's apparent inclusivity invites utopian readings of the high fun party as a site where normative sexual and social hierarchies are temporarily suspended – yet a closer look at the intimate arrangements that enable this

inclusivity complicates this thesis, and the tendency to identify queer sexual subcultures with a transgressive, democratic or anti-homonormative ethos more generally. Chapter 5: High Risks offers an ethnographic alternative to the biomedical, positivist styles of research critiqued above by paying close attention to how interlocutors make sense of and navigate the question of risk in the context of high fun. In their accounts of a host of harms – including, but not limited to HIV infection – they associate with high fun, interlocutors drew attention to the interpersonal and societal relations through which these risks emerged. Together these chapters suggest that while high fun has much in common with chemsex scenes elsewhere, it must be studied on its own terms and in relation to the specific socio-cultural context in which it is embedded.

Chapter 4: Organizing Logics

Faisal remembers the first time he had high fun like it was yesterday, he told me as soon as I pressed recording – my placing the phone screen-upwards between us the unspoken cue for his monologue. The young entrepreneur had come straight from the gym and was wearing tiny black shorts and a black tank top that hugged his chest tightly. His muscular physique and carefully-groomed appearance made Faisal look identical to the aspiring actors and models that earn this part of Mumbai, home to Bollywood's casting studios, its nickname 'little LA'. I noticed the waitress, an art school drop-out in her early twenties, ogle him through the window separating the till from the outside seating area as she prepared the protein-rich breakfast Faisal had ordered.

"It was a monsoon day in 2013", Faisal began his narrative. He was on his way to pick up his exam results at his college in South Mumbai when he received a message on dating website PlanetRomeo – "this was before Grindr was big"– from a friend inviting him over to someone else's place for sex. "I arrived and they were doing something with a pipe," Faisal recalled. Having moved to Mumbai from Orissa's sleepy capital of Bhubaneshwar, his only knowledge of drugs came from the movies, and Faisal was hesitant at first. "But they were both bottoms and as a top you have your limitations," he explained. "I had come twice already and they could on and on, their energy was unmatchable. So they said *–why don't you smoke this? It'll make you relax*."

The man hosting them was a Mexican expat whose company had put him up in a spacious apartment in Colaba, Mumbai's prime-property district. "He was good-looking, had a fancy job," elaborated Faisal, "so when it comes your way, it's not creepy, you don't go to a dark alley to be introduced like in the movies." Faisal took a drag, coughing as he inhaled. Within seconds, his heartbeat soared and all nervousness about the threesome slipped away. Although he still could not get an erection, he joined the two others in what he described as "deep wild French kissing" followed by "manic rimming". The three of them carried on like this all through the night, with breaks for smoking more meth, drinking water, and eating. Faisal had an exam later that day but could not care less: "I was only thinking about getting a hard on and just... fucking." He managed to get an erection in the early morning hours. The chivalrous host had a flight scheduled for noon and dropped Faisal off at home in a northern suburb on his way to the airport. Faisal didn't fully understand what he had been a part of. "But I thought it was fun, something very cool."

Vikram's first experience of high fun, also in Mumbai, was less positive. "I was

sitting over there," the twenty-six year-old recalled, gesturing towards the other end of the dimly-lit, noisy Bandra bar we met in. The boisterous laughter of other patrons protected us from eaves-droppers, the wall of noise making our conversation feel intimate. "I was on a date with this nice guy, and he said – *do you wanna do it*. And then when we got to his place, this other guy was there as well, and he was like – *you should slam, you should slam,*" the sales employee continued. "I tried it and immediately my body started feeling very loose. It was just five units, but I didn't know what units where." Units, Vikram would later learn, refer to the measures on the syringes used to inject, or 'slam', drugs. "I was chewing my mouth, I had bruises everywhere," recalled Vikram. "I was scared and thought, I'm not gonna do this again."

This chapter revolves around Faisal and Vikram's attempts to make sense of "what just happened?!", as Kane Race puts it in *The Gay Science: Intimate Experiments with the Problem of HIV* (2017, 25). Both men continued to have high fun for many years after these first experiences, and their reflections on the scene in Mumbai offer rich and detailed – if, of course, partial - descriptions of its social organization. Responding to the call by Kane Race and others to pay attention to the socio-material contexts in which chemsex takes place and the forms of sociality it engenders, this chapter examines some of high fun's "organizing logics" (Race 2015, 256). I begin by exploring the notion, advanced by several interlocutors, that high fun is marked by a radical inclusivity that contrasts sharply with mainstream gay male sociality. I then take a closer look at some of the intimate arrangements that enable this inclusivity. I suggest that Faisal and Vikram's accounts reveal an erotic economy of drugs and desire, in which what Adam Green describes as "erotic capital" (2009) functions as an important form of currency alongside cash for purchasing "stuff" (drugs) and a place in which to take them. The normative social and sexual hierarchies of gay male dating are thus re-configured rather than suspended in high fun.

Everyone is welcome

After completing fieldwork, I published an article about "chemsex" and the present state of India's HIV/Aids response in a magazine for long-form journalism. "I wish *Caravan* had better priorities than this report," commented one reader on the magazine's social media post promoting the article. "So much is going on in the lives of ordinary queer people that sleeps in the shadows of rich gays." The comment reflects a more widely-held assumption that since the drugs consumed in high fun are costly for most Indians, high fun must be the preserve of a minority of relatively affluent gay and bisexual men in the large metro cities.

This is also the demographic presumed to be most quick to adopt or emulate supposedly "Western" cultural practices and identifications. Staff at the NGO I conducted participant observation with in Bengaluru, for example, presupposed that addressing high fun would mean targeting the "IT crowd". They were not wrong - the upscale neighbourhood of Koramangala, where many of city's IT industry workers live, has a reputation for being a high fun hub, as does like relatively wealthy South Delhi neighbourhood of JP Nagar.

The notion that high fun is a "rich gay" phenomenon is not so much erroneous as misleadingly incomplete: though my interlocutors all hailed from middle to upper class, English-medium backgrounds due to the limitations outlined in Chapter 2: Methods, Ethics and Poz/itionality, the scenes they described involved men from all walks of life, "ordinary" or not. Indeed, high fun's remarkable inclusivity was a big part of its appeal, with interlocutors frequently contrasting this aspect of the scene to the rigid hierarchies that organize gay sociality more generally. Some of them described using drugs as a way of medicating insecurities engendered by the erotic and social hierarchies of gay male dating. High fun, in these accounts, offers temporary respite from the experiences of rejection and discrimination (or, crucially, anxious anticipation thereof) associated with gay hook-up and dating culture: "a world', as someone using the pseudonym Koshan Kamesh put it in a 2017 Buzzfeed article, "where stigma, stereotyping, abuse, shame and bullying didn't exist" (Kamesh 2017).

Sunny, a counsellor in his fifties, was among the people who articulated the appeal of high fun in terms of a search for acceptance. "There are no questions asked," he said about the scene in Bengaluru, "not about your job, your [HIV] status, nothing." The counsellor first got into chemsex when he was living in London and found himself isolated and unsupported in the aftermath of marital breakdown. Soon after downloading Grindr he was invited to a party. "There was a group of hot man in that room, and of all colours", Sunny recalled, "some of whom would not have looked at me twice normally." Sunny worried about his size and his complexion – especially after encountering the racial hierarchies of the U.K. "And here they were, doing *everything* with me. I felt desired and wanted, and I became part of that group." He continued when he returned to India, where he felt isolated "as a fifty-six year-old gay man who is [HIV] positive." The lack of a conversation about serostatus made high fun scenes appealing to some of the other interlocutors who were both HIV-positive, too, suggesting the correlation between seropositivity and likelihood to engage in chemsex (Pakianathan et al. 2018, Pufall et al. 2018) may apply to the Indian context too. The reasons for this will become clearer in Chapter 10: Undetectability, which describes the difficulties of

disclosure in hook-up settings.

In Chennai, a human resources professional with a gym-trained body similarly explained his experimentation with sexualized drug use as emerging from a desire for validation. “There is no discrimination [in High Fun],” he told me after describing his insecurities about his complexion. “Any guy who wants to join can join, everyone is welcome.” He too was HIV-positive, but had contracted the infection during rather than before the period in which he was having high fun frequently.

In Mumbai, Anthony related the appeal of high fun explicitly to what he described as the “sociality” of the gay male community when we met at his co-working space. “We’ve created a really shitty place for ourselves,” sighed the scholar, who considers himself an addict in recovery. “We’re an entire community created around sexuality, so everything is about looks, bodies, performance.” This chimes with Walt Odets’ (2019) thesis on the psychology of gay men: because our collective identification derives from our sexual marginalization, we over-emphasize the importance sexuality and sexual performance at the cost of other forms of relating. “We’re very inhospitable as a community,” Anthony continued, “so when meth comes in which rewires your brain in a particular way to give you confidence when you don’t have confidence, to makes you sociable when you’re asocial, to enable you to do so much more sexually.”

Anthony’s explanation points to what researchers in New York described as an “elective affinity” between the social and sexual pressures of Manhattan’s gay sexual subculture and the pharmacological effects of methamphetamine (Green & Halkitis 2006). Joanne Bryant and colleagues (2018) similarly argued methamphetamine use among gay men should be understood in the context of what they called “sex-based sociality”. “This is my relation to the drug,” said Rounak, another interlocutor in Mumbai, about crystal meth after explaining struggling with being ‘fat’ and gay. “I just feel… *sexy*.” In a personal narrative published by Vice, Sadam Hanjabam similarly related the emergence of high fun the prevalence of body shaming and rejection within the gay community, such that “in order to have sex, people are now ready to pay, and this drug makes all these insecurities go away” (2019). These suggestions that drugs are a way of medicating the insecurities engendered by the rigid beauty standards and discriminatory dynamics of gay male dating resonate with David Stuart’s argument about the “uniqueness of gay sex and gay culture” (2019, 4). And if, according to Stuart, religious and cultural factors also limits gay men’s ability to enjoy (sober) sex, interlocutors invoked similar explanations by suggesting, for instance, that getting high is the only way in which some Indian gay men can enjoy receptive penetrative

sex, e.g. getting fucked. Others, like Sunny and Rounak, pointed to the general mental health effects of homophobia, suggesting that the difficulties of growing up gay "in a country like India" are so great that "all Indian gay men need therapy".

As explained in the previous chapter, critical chemsex scholars take issue with the way in such explanations "reduce [chemsex] to a self-harming practice driven by low self-esteem" (Florêncio 2021, 2), thereby neglecting other social and structural factors contributing to the popularity of drugs among queer people (Pienaar et al. 2018) while pathologizing gay men as unable to sustain intimate relationships (Hakim 2018). Yet these normative explanations of chemsex as a response to "gay loneliness" (Hobbes 2017) and a culture of rejection enjoyed considerable popularity among the men I spoke to. Body-related insecurities were exacerbated, some argued, by the growing dominance of Euro-American images and ideals of gay masculinity described by Rohith Dasgupta (2019). "Beauty standards are increasingly modelled on white gay men in porn," said one friend from Delhi who always smoked a joint before having sex, and thinks he contracted HIV because his partner liked to have high fun. "So how are any of us [Indian gay men] meant to feel confident?"

High fun is thus explained as a response to the erotic and social hierarchies of normative gay sociality. But does it also subvert them? Might we consider high fun a kind of fleeting utopian space where social distinctions seize to matter? As mentioned, the inclusivity of high fun extended beyond body size to class, with several interlocutors stressing they encountered people from "all socio-economic backgrounds" at parties. Someone I befriended in Bengaluru had made similar observations during his research for a play he was working on. At a public event on "chemsex" in Bengaluru, the playwright pointed out that many of the men he interviewed described scenes of remarkable – almost unimaginable – diversity, with autowallahs mixing with architects and Bollywood directors. Someone else I met in Bengaluru was working on a proposal for a PhD project that would explore, among other things, what happens to caste in this context, having observed that no one looking for high fun on Grindr mentions their caste status on their profile. They described high fun parties as places where gay men meet irrespective of caste, creed, class, or race.

This chimes with a tendency in queer theory to identify marginal and transgressive sexual practices or subcultures with uniquely democratic forms of sexual sociality. Some of this work is inspired by Samuel Delany's (1999) *Times Square Red, Times Square Blue*, in which the science fiction writer and literary scholar offers a luminous and fine-grained auto-ethnographic account of the cruising that occurred in and around the porn theatres of New

York's Time Square prior to their demolishment to make an argument about the social and political cost of gentrification. Recounting countless blow- and hand jobs, a few romances and many friendships, Delany demonstrates that pre-gentrification Times Square facilitated a form of casual cross-class contact that used to define life in large cities. The gentrification of neighbourhoods goes hand in hand, Delany suggests, with a shift towards an ethic of *networking* geared towards strategic social gain. As Kane Race summarizes, "if contact depicts a mode of sociality premised on the possibility of having the sort of unplanned 'erotic, interclass encounters' once associated with gay cruising in urban space (p. 188), networking is said to be 'class bound and membership oriented' (p. 191), and predicated on 'unprecedented control over one's erotic engagement with others' (p. 193)" (2018, 173).

Inspired by this distinction, Tim Dean (2009) argues self-identified barebackers - and in particular those belonging to the 'bug-chaser' subset who articulate a wish to be infected with HIV and say they will accept any and all (cis-male) partners - demonstrate an ethical openness to alterity that he contrasts to conventional gay male dating. The former, Dean argues disapprovingly, is increasingly mediated by apps that privatize queer intimacy, both by bringing it into the home (rather than the cruising ground or sex club) and by making it more like (pre-arranged, instrumental) *networking* rather than (random, indiscriminate) *contact*. Kane Race critiques this opposition, which he argues is rooted in a nostalgic romanticism – "as if sex at public cruising spots were always egalitarian and indiscriminate!" (Race 2015, 256). In *The Gay Science,* he draws our attention to the ways in which some of the gay and bisexual men who use apps like Grindr resist "the precalculative logic that digital devices try to configure in their users" (2018, 19) by invoking, for example, the elusive and unpredictable element of 'chemistry' or writing something to the effect of 'open to all' on their profile. For Race too, "exposure to alterity" - be it in sexual set-ups or not – may be the condition of possibility for the "particular adventures in intimacy" (2018, 175) associated with queer subcultures. In a similar vein, João Florêncio (2020) hails the radical openness and porosity of gay "pig" masculinities, referring to gay men who define their sexuality in terms of having 'no limits'.

In these accounts, a literal and metaphorical openness to otherness – whether in the form of viruses, persons, or an array bodily fluids – marks the sociality of queer sexual subcultures, particularly marginalized ones. This openness to otherness is especially significant in a context in which inter-communal and inter-caste sexual contact is violently discouraged. As Rahul Rao writes, "we can be in no doubt that the erotic remains a key terrain of struggle in contemporary India, given the violence with which erotic transgressions

across lines of caste and religion are routinely punished" (2020, 172). Might the mere existence of scene that crosses the fault lines of class, caste, language and religion that normally divide gay communities in India be, in this context, a minor erotic revolution? Does it pose a challenge to the emerging forms of homonormativity described in Chapter 1? A closer look at the some of high fun's organizing logics cautions against a utopian reading. As Faisal and Vikram's accounts show, the scene's inclusivity is enabled by intimate arrangements governing the distribution of "stuff" and bodies to put stuff into. Despite revolving around the principle of reciprocity, these arrangements left both Faisal and Vikram – and possibly some of their partners – feeling exploited.

Intimate arrangements

In the months following his adventure with the Mexican expat in Colaba, Faisal became part of sexual avant-garde of sorts, involving the city's richest and most handsome men - many of them with ties to the Bollywood industry. "But then trends changed," Faisal explained. "Earlier it was people who had good houses, lots of money, access to this kind of thing. They would do it with people who were very good looking, so then every model and actor was doing it. It wasn't accessible to normal people." At one point Faisal lived next to an enterprising drug dealer who would 'collect' a number of models and actors and host sex parties at his place. "It's a business: the more people you get hooked, the more money you make."

"But then *those* guys started looking out for people who would buy them drugs – and that's when the entire thing changes," Faisal continued. "People who were plain-looking saw it as an opportunity to sleep with good-looking guys and exploit their vulnerability." Faisal counted himself among the latter group. "I used to get this all the time", he said, affecting a camp voice, "*heyyy, I heard you're into HF, I could get us a hotel room and some stuff and we can enjoy each other*… And you look at them and I'm like, I don't know how they have the audacity? Really, am I that easy to approach?" It made Faisal feel objectified. "Just because you're looking at a good-looking person – what am I, the whore of town?" he said, sounding exasperated. "But sometimes I've been broke and wanting to do it and I was vulnerable, and I went ahead with it, [thinking] *it's okay, I don't need to spend a whole bunch of money, I'm gonna have some fun…*"

Once at the party, people would use Faisal to "recruit" more guys: "They'll say like, why don't you call some of your friends, tell them you're here in this hotel. They wanna recruit via you, they'll make a Grindr profile with my picture." If most of my interlocutors

were drawn to high fun because it made them feel desirable, Faisal had the opposite problem. Muscular, tall and lean, Faisal embodies the beauty standard that other interlocutors found so oppressive. Yet this created expectations that Faisal struggled to live up to. Fearing he would turn out to be less masculine as expected in real life, Faisal would make sure to speak from his stomach and not make too many hand gestures. “I was getting too much attention on Instagram and it was making me nervous,” he explained, “so the first thing I’d want to do if I arrived somewhere is inject.”

It was a Catch-22 situation. While drugs helped Faisal deal with the pressure to perform and turned him into dominant ‘pure top’ people expected him to be, his participation in high fun in turn led to more exposure and objectification. Details about Faisal’s looks, the size of his dick (large, he told me) and his stamina made their way through the gay grapevine. To illustrate the point, Faisal pulled out his phone and showed me a picture of his carefully-sculpted upper body that recently made the rounds on Twitter.

Faisal was usually the star of the show at high fun parties. There was a boy he used to run into at High Fun parties, a migrant from East India who worked as porter. One evening, the five of them met in a hotel. Faisal got all the attention while the hotel porter, whom Faisal describes as a “very normal, very plain-looking guy”, was left out. “Afterwards he was very upset,” Faisal recalled. “*They didn’t touch me didn’t do anything with me because I look like this.*.” The next thing Faisal heard about him was that he had committed suicide. “He had a very limited income so he couldn’t cope with his addiction,” reckoned Faisal.

Over the years Faisal developed a serious habit, one he blamed on the person who ‘introduced’ him to *slamming* – injecting, rather than snorting, smoking or swallowing drugs. “If you haven’t injected yet, please don’t ever do that!”, Faisal insisted. “You won’t come back from there.” He seemed mournful at what he described as his lost, small-town innocence. “I was too juvenile”, he said, “and had just come to the city.” Was he angry with the person who first slammed him? “I forgave him long back,” Faisal answered pensively, “because I did far worse.” “You mean you introduced other people?”, I asked, unsure whether Faisal meant to himself or to others, and trying sound as neutral as I could. “Actually, no,” Faisal back-tracked or clarified. “Whenever I got to know someone’s been doing it I’ve been extremely unhappy.” To illustrate his ethical stance, Faisal told me about the time his dealer “introduced it” to an 18-year-old “child” and Faisal threatened to break the dealer’s jaw if he ever did something like that again.

Faisal explained he struggled to control what he described as his addiction, for which he was seeing a therapist. He said he had met some guys with a far worse problem, one whom

moved in with Faisal when he ran out of money. “He’d beg me to do it with him, get high with him, and he’d steal money from my pockets. He was this good-looking model, had a contract with a nice agency, and I’d met him through a really influential person at one of these orgies,” recounted Faisal. “So from seeing him there to seeing him in my house, when he was having sex with a really ugly peddler just to get the stuff because he had lost his job and all his money… it was a very sad ending.”

*

A few weeks after the date that ended in bruises and a bad comedown, Vikram was invited home by someone who encouraged him to give high fun another try. “We had MDMA. It was 300 rupees, 1 gram! Now it’s like 3000,” Vikram explained. “I don’t remember when it was, but it was a lot of money at the time. So in this way, one person would connect to another person always. If I’ve been doing this for a really long time, and there is this new guy, I will introduce him to this drug, and then again he will introduce other people to this drug – so it’s like a chain. First this drug, and then another drug…” What kind of people did he meet during these parties? “In general,” Vikram said, “there’ll be some cute twinkie guy, a hot top, one ugly-looking guy who basically started it - so everyone has to do it with everyone, irrespective.

Initially Vikram would have High Fun every alternate month to allow time for recovery, which for him would take about a week or two. When he started doing it more often, money became an issue. “I had just started a new job in retail,” Vikram explained, “and the salary wasn’t very much.” Because he would buy drugs on payday, Vikram never saved, and his mother used to ask him where his money was going. Around this time, he had begun meeting a businessman who was more than happy to foot the bill. “This guy was like a huge fat guy, and he seemed to like me. He owns a lot of property in my area – he’s one of the Sindhis, the richest one, and they have a lot of property in Bombay. *And* he’s gay. And I had just started with the job and money was low - and it was expensive for me.”

“So that night, everyone went away, he didn’t let me go,” Vikram continued. “He was like, I have more to do, and gave me the drugs like that. And that night I ended up doing around 10 units. It was just – you do it, have sex and done, you do it, have sex and do it.” Vikram laughed when I asked whether he was attracted to him. “No, I was dumb.” Did he enjoy the sex, at least? “What was done to me I was happy with that,” said Vikram cryptically. “I’m versatile, and he was a bottom, so that works out for him. He was very respectful, but when we got high there’d be many people, you wouldn’t see their face.

Irrespective of their looks, this is how it was – you shoot with anyone, even if you don't like them. Nowadays people are like, no, *I wanna do it with you only*, but earlier it used to be like this. I am a bit ashamed of it, but maybe I was just dumb."

They started meeting almost weekly at different bungalows the businessman owned in Bandra. He always bought the stuff, and Vikram never paid. They would have High Fun four three or four days, and Vikram lost his job. With the businessman's money and properties and Vikram's twinkie youthfulness, the two made an efficient team. "He would use my pictures to get people to come," Vikram explained. "I was the face for the party, the bait. People would see me and come – but they'd have to fuck him as well, that was the deal." Some of the people they invited had never done high fun before. "He called this one guy over, and I see him doing it often now." Vikram's voice was tinged with regret. "He's a very good looking guy – we had an amazing time. But the second time I saw him doing it, it was very heart-breaking. I didn't force him to do it – I said*, if you wanna do it, come here, otherwise don't do it.* But he's a top and the others were bottom so everyone wanted him and let him get in the mood, and we'd all do it…"

Divergences from the social and erotic etiquette instituted by the generous host would result in tension. "Fights used to happen," Vikram recallled. "Once this guy robbed us, another time these guys tried to do it with each other but not with us, and people kept arguing about stuff. And some people would just use and go inside the washroom and then come out." One time, they had called someone over who had picked up stuff – drugs - for them. They paid him, but the guy turned aggressive. "He was pushing the other guy and he was trying to do it to me. It was the high." After one slam, the guest wanted more, and began preparing another injection. This angered the businessman, who told him to leave, so the guest turned to Vikram. "He was like - I'm ready to do it more, you pay for me." Given Vikram's financial troubles, he wasn't able to. He and the businessman let their guest have the slam he'd prepared for himself and kicked him out after that. "You can't behave that way!" explained Vikram indignantly. "Later he messaged me *–I'm yearning, let's do it*. So I said, fine, but let's share the cost. And he's like *– no, give it to me*. And I said sorry, but even I have my limitations." In these kinds of scenarios, Vikram felt looked after by the businessman. "He's a good guy, he takes care of people."

After some months of this, Vikram resolved to only do high fun once a month, so he stopped seeing the businessman. "I want to control it," he tells me, "but I don't know how to control it. While I was with that guy [the businessman], we used to do a lot of guys together – but he used to treat me like a bitch. He'd order me around. I didn't have a job and I couldn't

give any money, so I'd be like – fine, I'm getting my stuff. And he started taking control over me, which made me think I needed to get away." Vikram thinks the businessman had little difficulty finding a replacement. "There was this twinkie who had just started, so he told him, you know, *let's do it more*. He kept on spending, kept on spending…"

Erotic economies

Vikram and Faisal's accounts both confirm and complicate the notion that in high fun, everyone is welcome. While Vikram claimed that in high fun, everyone "does it" and "shoots" with everyone, "irrespective of their looks", he seemed ashamed at having slept with people so indiscriminately. His account is littered with appearance-based value judgements: Vikram distinguished between "very good looking", "ugly", and "twinkie" guys, and described the Sindhi businessman as a "huge, fat guy" in a manner that suggested he did not valorise or fetishize these qualities. Similarly, Faisal differentiated between "plain-looking" and "good-looking" people, suggesting that the former used high fun as an opportunity to sleep with people who would normally be out of their proverbial league. He considered himself, but also his model friend who slept with an "ugly-looking" peddler to access drugs, a victim to this dynamic. In sharp contrast to the suggestion that high fun is free of discrimination based on physical appearance, both Vikram and Faisal – but especially Faisal – are very aware of their favourable position in the erotic pecking order and use it to access drugs.

What emerges from their accounts is a complex economy in which both economic and erotic forms of capital are important currency. Sociologist Catherine Hakim (2010) suggests that in addition to the forms of economic, social and cultural capital identified as important sources of social status and mobility by Bourdieu (1984), we might speak of erotic capital to refer to the way that desirable personal and physical attributes can be mobilized for social, romantic and economic gain. Hakim identifies at least six forms of erotic capital: beauty, sexual attractiveness, social skill in interaction, liveliness, social presentation, and sexual competence. The framing of the concept is unapologetically heteronormative: "Erotic capital is thus a combination of aesthetic, visual, physical, social, and sexual attractiveness to other members of your society, and especially to members of the opposite sex, in all social contexts" (2010, 501), summarizes Hakim, although she later states that the concept "applies to the heterosexual majority as well as to minority gay cultures." She argues that while women generally have more erotic capital than men "because they work harder at it" (2010, 499), their ability to utilize it has inhibited by stigmatizing "moral ideologies" perpetuated by

both feminist theory and patriarchy. Her suggestion that erotic capital may be cultivated as a strategy for women's advancement has sparked much mainstream and academic debate, a discussion of which is beyond the scope of this chapter (see instead Green 2013).

An important difference between Hakim's usage of the concept of erotic capital (which she claims, incorrectly, to have coined) and its usage in the sexual fields approach from which she explicitly departs is that the latter emphasizes socially constructed and context-specific nature of desire. Despite ostensibly elaborating on Pierre Bourdieu's theory of practice, Hakim treats erotic capital as a "personal asset" (Hakim 2010, 19) rather than as something that is valorised in a given social field. For this reason, Adam Green argues, "Hakim's concept suffers because, at its core, it is asociological, glossing over entirely the structures of age, race, class and context that mediate women's desirability" (2013, 149). In contrast, the earlier theorizations of sexual/erotic capital from which Hakim explicitly departs treat the concept as a "field-specific resource" (Green 2013, 152) that is conferred to individuals who confirm to the "hegemonic systems of judgements" (Martin and George in Green 2013, 152). "Put differently," summarizes Green, "erotic capital is rendered sociologically, not as the objectified property (or ''personal asset'') of the individual alone, but as a property of both individuals and the particular sexual fields they inhabit" (Green 2013, 152-153).

In other words, erotic capital is always contingent, with different qualities and characteristics valorised in different socio-sexual contexts. "Within any sexual field", Green wrote in an earlier article,

> a history of relations exists that prompts actors to assign to themselves and others a categorical ranking, which corresponds – more or less faithfully – to the prevailing currency of erotic capital. The more highly specialized a given sexual field, the less latitude actors have to evade ranked classification in the process of "playing the game." In turn, a hegemonic currency of erotic capital is expressed in social relations that confer status upon sexual actors situated differently in the field's erotic hierarchy – that is, the field's *tiers of desirability*. (2008, 32, italics in original)

In contrast to interlocutors who suggested desirability is democratized in the "sexual field" of high fun, Vikram and Faisal articulate a clear erotic hierarchy based not just on looks, but also on stamina, sexual positioning (with "tops" and/or versatility valorised), gender performance, and penis size. Yet these tiers of desirability are complicated by need for money to buy drugs and for a place in which to take them. "When it comes to high fun, your discrimination is: person who has stuff, person who has place, person who has neither stuff

nor place," explained Kaushik, an education professional in Bengaluru. "That's the hierarchy." Since Faisal and Vikram had neither, they relied on their erotic capital to access drugs.

Faisal's experience of objectification (as he called it) illustrates a key feature of Green's theorization of erotic capital and the difference between his and Hakim's usage of the term. Faisal possesses many attributes that are generally considered attractive. But his erotic capital was also related to his social positioning as a bisexual Muslim man. As Faisal claimed, people often expected him to be a dominant, virile and masculine top. This expectation appears to be inflected by popular representations of Muslim men as "strong, active, [and] conquering" (Hansen 1996, 166) – a trope of hyper-virility that serves to further the right-wing, Hindu nationalist myth of a Muslim demographic threat, as Thomas Hansen has argued in his study of the ideology of the right-wing Maharashtrian political organization Shiv Sena. The pressure of appearing masculine and Faisal's related efforts to modulate his erotic habitus accordingly by limiting hand gestures and lowering his voice might thus be related to a homoerotic spin on this right wing-trope. Indeed, as he himself suggested, drugs helped Faisal become "the fantasmic Muslim-as-hypermasculine-hypersexual" that Paola Bachetta (2013, 137) traces in the writings of RSS ideologues. This adds a racial/ethnic – as well as gendered - dimension to the argument that drugs like crystal meth gay and bisexual men cope with the pressure to perform sexually (Bryant et al. 2018).

In this way, tiers of desirability are shaped by historic forms of social stratification without simply reflecting them. Instead, they are mediated by what Green describes as the "peculiar logic of sexual desire" (2008, 38), including fantasies of submission. Faisal's story resonates with the examples Green gives from his interviews with Black gay men who frequent white gay sexual sites in New York City's Chelsea and West Village neighbourhoods. These men self-consciously navigate the "historical specificity of racialized constructions of black men and their sedimentation in the white homoerotic imaginary" (Green 2008, 38), with some moderating their self-representation (like Faisal) to fit controlling images of black gay men as hypermasculine. "Some whites want a "big black buck" – term from slavery – a stallion, a breeder, virile and dominating," explains one of Green's interlocutors, "and I fit that fantasy" (2008, 38). Others reject this fetishization or are unable to meet the terms of this narrow racialized construction of sexual attractiveness (Green 2008, 43). Similarly, while the trope of Muslim hyper-virility afforded Faisal a great amount of currency in high fun contexts, it also fetishized him in ways that he ultimately found limiting - particularly when it came to his desire for romance and finding someone who

would (as he put it to me) simply hold his hand.

Faisal and Vikram's negative evaluation of the erotic economies they describe resonates with Marcus Mauss' (1925) theorization regarding the ambivalence of the gift – the gift being, in this context, "stuff". Faisal appeared offended that men he considered to be in a lower tier of desirability approached him, yet often took them up on their offer anyway, rationalizing that he could have fun without "spending a whole bunch of money". This, however, left him feeling like "the whore of town". Faisal's invocation of the stigma associated with sex work is suggestive of the transactional nature of the exchange. It may be helpful here to think of "stuff" as something akin to what Yunxian Yan, in his study of social networks in a village in north China, described as an "instrumental gift" given in exchange for favours or services (1996, 285). This concept blurs the distinction between gift and commodity that was so central to Mauss' original conceptualization of gift-exchange as generating social bonds between different groups through the obligation of reciprocity.

The expectation of reciprocity was very evident in Vikram's description of the Sindhi businessman, who had made explicit the terms of the "deal". These were of a sexual nature – everyone who joined their party had to fuck him, and some could not fuck Vikram – but also, crucially, involved a more subtle social etiquette. Indeed, Vikram's claim that "you can't behave that way", referring to the aggression of the guy who demanded more drugs, suggests there are certain normative ways in one does or *should* behave at a high fun party. The businessman enabled Vikram to take have high fun in a safe and controlled environment, and he was, in that sense, a "good guy" who took care of his guests and made sure none of them took too many drugs or behaved in anti-social ways. Yet Vikram also felt the businessman treated him "like a bitch", taking advantage of the fact that Vikram could not, at this point, afford to purchase his own drugs. What Kane Race (2015) describes as relations of care can thus simultaneously be experienced as ones of control. In our context, the ambivalence is perhaps exacerbated by the nature of the gift, which in and of itself produces notoriously ambivalent affects, e.g. the "high" and the "comedown" (Hakim 2018). Both Vikram and Faisal describe their growing dependency on drugs as a vulnerability that was exploited by the men they met in high fun contexts.

The tragic story of the hotel porter Faisal met at high fun parties illustrates high fun's erotic economy by way of negative example. Unable to reciprocate properly for lack of both erotic and economic capital, the "plain-looking" migrant felt excluded and embarrassed in a manner reminiscent, perhaps, of the humiliation that Mauss (1925) claimed befell those who failed to reciprocate properly during potlaches of the Indigenous communities in North-

America's Pacific Northwest. In contrast, a conventionally attractive actor I spoke to on Grindr in Pune boasted of never paying for drugs while also complaining of free-loaders. "Ppl usually host for me bcoz they really wanna do [it] with me," he wrote, "And I just go for sometime fuck like crazy and m back [home]. They pay n I use." A little later, he clarified that he only slept with middle and upper class people because poor people were "unhygienic and too cranky and freebies using loads of stuff and moreover ask for transportation and what not." Though this seems ironic, it is not necessarily contradictory. While my interlocutor could reciprocate properly by fucking "like crazy", he said poor people "can barely perform and how can we expect them to be kinky and dirty but clean at the same time." Erotic capital, in his account, is linked to the cultural capital of being well-versed in the global scripts of queer (kinky) sexuality. This is the right kind of dirty, contrasted to poor hygiene – which accusation in the Indian context carries casteist undertones (Apurva 2021). The complex relation between *erotic* and other forms of habitus was brought into sharp relief when the actor told me he could tell people's socio-economic status by the way they talk and dress, which in India as elsewhere are important markers of both class and caste distinction (Bourdieu 1984). "It shows a lot," according to the actor.

Thus, while some men may fetishize working class men as sexual partners, as Ashley Tellis' psychoanalytic portrait of three gay men in Mumbai has showed (2015), others stigmatize them as unhygienic, ill-versed in the scripts of modern gay sexuality, and, in the context of high fun, greedy and unable to hold up their end of the bargain. One person told me that "you have to be really careful with who you do [high fun] with". When I asked him on what criteria he bases his decision, he explained unambiguously that he avoids poor people, since "they just want the drugs". The adverb "just" again suggests a failure of reciprocity. This dispels any notion of high fun as a uniquely egalitarian queer space. Vikram and Faisal's account suggest that in high fun, the erotic and social hierarchies of normative gay male dating are re-configured rather than suspended. And while the erotic economy of drugs and desire they described enables cross-class and inter-caste contact, it also left both Vikram and Faisal feeling exploited. This complicates the imperative to identify ethics of care and organic forms of harm reduction in chemsex cultures.

Between care and control

The notion of "getting introduced" to high fun, certain drugs, or certain methods of administration came up repeatedly in Faisal and Vikram's account, and was a theme in my conversation with other interlocutors too. Kane Race warns that when attending closely to

drug use, it can be tempting to create moral hierarchies of actors (2015), for example by making a distinction between those doing the introducing and those being introduced. Instead in this section I suggest the idiom of getting introduced was key to interlocutor's reflection on and anxieties about the ethics of high fun, particularly when it comes to perceived imbalances of power and significant age differentials. At the same time, introducing someone to high fun – likened to one interlocutor to a rite of initiation – also involves the transmission of expertise and techniques that might reduce the risk of overdose. Moreover, the operation of power is far from straightforward in these contexts: while the ability to provide drugs and/or a space in which to consume them gave interlocutors some degree of control, this control was not always as explicit and total as it was in the case of the Sindhi businessman Vikram was seeing for a while.

The topic of introduction was fraught with feelings of guilt and blame, as was evident from Vikram's conflicted feelings about the guy he and the businessman invited to their party, and who he later saw lose his way with high fun. Vikram's emphasis on the fact that he didn't "force" the guy betrayed an anxiety about his role in his perceived addiction – and he clearly blamed the Sindhi businessman for encouraging his own dependency on drugs. Moreover, his account suggests there is a kind of supply-demand logic to introduction: the more guys are introduced, the more high fun can be had. And for dealers or peddles, there's an immediate economic motivation. Faisal's recounting of his anger at his dealer for "introducing it" to an 18-year-old "child" seemed intended at demonstrating his ethical stance: he would never, as he stressed, do such a thing, and felt resentful at the person who introduced him to injecting drugs (slamming). In Bengaluru, an interlocutor in his thirties who said he had been introduced to high fun by a "random guy on Grindr who had something he said he wanted me to try" instructed me to block his number if he ever relapsed. "If I talk to you I'll have my way," explained John, who was otherwise caring of me to the point of being slightly paternalistic, giving me unsolicited advice in matters ranging from housing to HIV disclosure. Evident from this ominous warning is an ethical stance similar to that of Faisal's – yet John did not expect himself to be able to abide by these ethics once high, suggesting these boundaries are far from fixed in reality.

As evident from Faisal and Vikram's account, some of the anxiety about the ethics of introduction are related to age differentials, with Faisal mourning his lost innocence. In Mumbai, Rounak told me he once left a date because of the presence of a much younger guy. Not only had the man Rounak had agreed to meet not informed him there would be a third person, it seemed to Rounak "like he was initiating this younger guy":

> This other boy looked no older than 23, although my date said he was 26 – and he looked like, poor. And then they went into this other room and the older guy administered the injection. When they came back out and the three of us had sex, my date kept giving the younger guy instructions - *lube lagao* [put lube], *aram se* [take it easy]. And I thought, did this guy, this younger guy, know where to get tested for HIV and other STIs? Would he be able to afford rehab, if it came to that? And what I was doing here?

When the two next went into the kitchen to slam, Rounak put on his clothes and slipped out the door. Introducing youngers guys is, as he put it to me, where he "drew the line". His comparison to initiation brings to mind Tim Dean's campy anthropological interpretation of barebacking and bug-chasing as a rite of imitation in which "a culture's elders are transmitting to the younger generation a material substance along with their wisdom and experience," (Dean 2009, 83), as well as Florêncio's argument about chemsex as a form of subcultural reproduction. Indeed, more detailed accounts of "introduction" to high fun suggest it involves the transmission not just of substances like methamphetamine or other drugs, but also of bodily techniques and what we might consider harm reduction advice between people with wildly diverging degrees of knowledge and experience.

Slamming for the first time and 'getting introduced' to high fun don't always coincide, but in Pramod's case it did. "I didn't know what was going on – just that he put a band around my arm and was injecting something white into my vein, and blood went into the syringe," the soft-spoken teacher told me when we met at a mall in Mumbai. Pramod broke out in sweats and panicked. His date gave him a head shower, which helped a little, but after two hours of lying still on the bed (his date had told him to relax) Pramod was asked to leave. But Pramod had had told his parents he wouldn't come home that night. When his date noticed Pramod was still sat at the bus stop outside his apartment building an hour later, he called him back up. "Look, I know it's your first time, so let's do it again and see how it goes," he said. They took five units instead of ten and carried on for fifteen blissful hours to the sound of trance music and porn. "Is this what you call doing drugs?" Pramod asked afterwards. He continued doing high fun from time to time and simply stopped when he began to feel the joyous binges were interfering with his career. By then, he had contracted HIV.

Ashwin, who I visited in his small, no-frills apartment near Bangalore's Electronic City, was similarly naïve. Having moved from a village in the Northeast, he began using PlanetRomeo and Grindr to make friends in the new city. He was invited home by a doctor who lived in what struck Ashwin as a remarkably posh apartment. "I had never seen drugs in

my life – so when we went into the bedroom and he started crushing something and mixing it with sterile water, I asked, *are you a diabetic*?" The doctor laughed and offered Ashwin some MDMA. Ashwin initially declined but the doctor was persuasive, telling Ashwin what to expect and reassuring him that he could trust him. "He seemed like a really professional gay type," Ashwin recalled. Within seconds after the first shot, Ashwin felt great. The doctor played some music, put on some porn and went down on him. But after they administered the second dose Ashwin started shivering and had trouble breathing. His erection shrunk. The doctor gave him a blanket and told him to do deep breathing before going into another room to get some sleep. The next morning he dropped Ashwin home on his way to work. "And don't worry," the doctor said as Ashwin stepped out of his car, "just drink lots of milk". Ashwin blamed the doctor for causing a brief but dark struggle with drug dependency and depression that he had mostly recovered from when we met.

These accounts provide some evidence of an "ethics of care" or the improvised forms of harm reduction – from cold head showers to downwardly-adjusted dosages to a glass of milk – that men engage in in the absence of institutional safety guidelines or services. This is particularly significant given the absence of drug awareness education in Indian schools other than abstinence promotion, which partially explains Ashwin and Pramod's naivety. At the same time, this ethics is complicated by the power differentials in terms of experience, age, and class. Yet because of the erotic economy described in the previous section, the operation of power in high fun contexts is not always as straightforward as in the above-described encounters.

Faisal's claim that plain-looking people exploit the vulnerability of good-looking ones when they offer them drugs is mirrored by Rounak's account of getting introduced to crystal meth. The 31-year old creative is hyper-conscious of his class and caste privilege, topics he explores in his art. One time, Rounak connected with someone on Grindr who said he knew a place where they could have high fun. When the guy picked Rounak up in the 'auto', Rounak noticed the rikshaw's meter was at 200 INR, around 2 GBP. "He'd clearly been driving around looking for someone with stuff," Rounak inferred, "and he looked like someone for whom 200 rupees is a lot of money." The place the rikshaw dropped them off turned out to be a cowshed. "Yes," Rounak confirmed when I look surprised, "There was kettle there! So I said – *look, no way I'm doing this*. I was high, but still." They went back to Rounak's apartment block, but as they approached Rounak noticed his flatmate standing outside the building. "I panicked and I just ran off, leaving the guy there. I didn't even give him any stuff." The evident disparity in socio-economic status meant Rounak would obviously be

giving his partner drugs, and he seemed to feel a little bad that he hadn't in the end.

Yet while Rounak did not seem the slightest bit resentful at being the person who usually paid for the drugs, he was angry at the conventionally-attractive, muscular man who introduced him to methamphetamine (he had been using mephedrone and methoxetamine up to that point). "This dude was from like…a *lower-economic strata*," said Rounak, choosing his words carefully. "And he really used me and my addiction." I asked whether this was because he could get drugs through Rounak. "Yes," confirmed Rounak. "And he would. I remember the day we got it from a different dealer and him holding up the stash and him saying, *damn., this is white*. And I was so zoned out I said it's cool, I don't care. But then it became an obsession." Rounak's partner leveraged his relative advantage over Rounak in terms of erotic capital to get Rounak to channel his economic capital towards his habit, thereby also fuelling Rounak's own addiction to the point where Rounak is now, in his words, "a fucking meth addict".

At other times, being the person who provided the drugs did give interlocutors a sense of control. Kaushik, a software developer in met at a swish coffeeshop in Bengaluru's Koragamala neighbourhood, attested to the demographic diversity of high fun. "I've seen guys who are struggling to make ends meet continuously use it and stealing it off people," he explained. I asked him what he would do if I didn't have much money but agreed to have high fun with him.

> You mean you'll have sex with me and won't have to pay for drugs? Sure, that happens, *if you're good-looking, handsome.* Basically if I am with someone I don't charge them for sex. It also depends, right. I wanna have a good time – so my idea is, you don't have to pay for it, but just relax and chill out. I want you to respect me, respect the place. Be your normal self, don't be the stupid fool which most people turn into. People people usually take more than they should, so they can't function, they just lie in one place.

Two things stand out from Kaushik's response to my hypothetical scenario. First, he would only share drugs with people who possess erotic capital. Second, reciprocity involves not just sexual interaction but also "respect", which is related to a "series of moral judgements around desirable sensations, uses, outcomes and behaviour" (Race 2009, 222). Indeed, being the one providing the stuff gave Kaushik control over dosage and timing, such that people do not turn into "stupid fools" or becoming incapable of doing anything other than lying around. In this way, considerations of pleasure need not be opposed to harm reduction, as Kane Race argues with reference to the example of tactics used in Sydney's queer nightlife to avoid becoming a

"messy queen" (2009, 222).

Sometimes, however, they *are* opposed. Anthony in Mumbai used to share his drugs freely with his two regular high fun partners, both of whom were working class men who had migrated to the city in search of jobs. He explained that being the one who bought the 'stuff' enabled him to insist on one-on-one hook ups - as opposed to group ones, where there would be more risk of blackmail or violence - and on using a condom. "But this one time a guy protested, saying he'll lose his hard-on if he puts on a condom," Anthony recalled. "And because I was also supplying the drug - often the guys are very hot, using the drug for free - I also wanted the sex to happen." In the end, the sex lasted only a minute and Anthony wondered whether it had been worth having to take PEP again, as the one month course of preventative antiretrovirals had previously not sat well with him. "But he had fun, I rationalized, and I guess I did too…"

Anthony's financial investment in the drugs might have gone to waste had he not agreed to have unsafe sex. As a larger guy, Anthony was painfully aware of his relative lack of erotic capital vis-à-vis his partners. He knew his date could have left and joined any other high fun party happening in Mumbai, whereas he would likely spend the remainder of the night alone. "For men with an erotic capital deficit," Green points out, "the process of negotiating sexual practice – including safer sex – is made more complex, materializing against the backdrop of disadvantageous structural conditions of the sexual field" (2008, 40). Anthony luckily had access to PEP, something that people with less cultural and economic capital than him (such as his regular partners) do not. Yet what is evident from his experience is that despite what we might have assumed due to a tendency in HIV research and policy to associate relative economic power with safer sex agency (Pisani 2009, for critique), being the person providing the drugs thus does not always translate into control over the encounter.

This insight notwithstanding, the power asymmetries resulting from high fun's demographic diversity are clearly a source of anxiety among interlocutors. Although the notion of "getting introduced" is the focus of much of their ethical reflection, introduction to high fun also involves – much like a rite of initiation- the transmission of forms of knowledge and experience that might reduce risk in the context of high fun. At the same time, concerns about exploitation – and particularly of younger boys – caution against any celebratory reading of such practices as forms of counterpublic health, not least because inequalities in terms of access to HIV, de-addiction and mental health services once the party is over. In an interview with the U.S. magazine *Poz*, porn performer and activist Jacen Zhu described a similar dynamic in the U.S. "Meth is highly addictive," he told the interviewer, "and now

[the] Black sex worker is getting addicted [via wealthy white clients], and it is trickling down through the Black community" (King 2020). Here we might recall that Faisal implied the hotel porter's lack of resources to support his addiction or afford help in fighting it was a key factor in his suicide. Rounak, too, was very aware of his relatively privileged position in this regard: "Think of those fucking people who can't do anything [other than] go back to their villages and after four months you're literally shivering and sweating!"

Conclusion

In this Chapter, I have bracketed off the question of risk so as to be able to focus on high fun's sociality, which is described by many interlocutors as uniquely inclusive. For Sunny, Rounak, Anthony and other interlocutors, drugs helped ameliorate the psychological effects of a felt or a perceived deficit in erotic capital. Moreover, the high fun scene itself emerges in such narratives as not just an effect of, but also an escape from these hierarchies – a space where normative "tiers of desirability" (Green 2008) were suspended, such that everyone is welcome (including, crucially, HIV-positive men). This inclusivity extended to class and caste, inviting a utopian reading of high fun as a space of "contact", in Delany's (1999) sense of the word, at a time of increasingly violent majoritarianism and what some argue are nascent queer alignments with the logics of Hindutva (Sircar 2017, Upadhyay 2020,)

Jack Halberstam (2011) revisits Delany's thesis to argue that there is nothing inherently progressive about cross-class contact, be it sexual or otherwise. This resonates with an observation by one of Parmesh Shahani's (2008) interlocutors, who claims that middle class gay men will sleep with people from lower socio-economic backgrounds but won't consider dating them. This question aside, attending more closely to some of high fun's "organizing logics" through Faisal and Vikram's accounts of their experiences of the scene in Mumbai, I argued that high fun's apparent inclusivity is sometimes enabled by a complex erotic economy governing the distribution of "stuff" and bodies to put stuff into. Erotic capital functions as an important resource in these reciprocal exchanges, alongside the ability to purchase drugs and/or host parties. As such, the erotic and social hierarchies of gay sociality are thus not so much suspended or subverted but rather reconfigured to the end of having (high) fun.

The erotic economy described in this chapter is but one of the possible organizing logics of high fun, and possibly more prevalent in Mumbai than some of the other cities where high fun is common. As Vikram explained, there is a growing trend towards agreeing

to sharing the cost, although the need to explicitly indicate a preference for this prior to the encounter suggests that this is not yet the norm. The unevenness of the relations of exchange complicates the imperative to identify an "ethics of care" in high fun contexts. Foregrounding instead the way interlocutors reflect on the ethics of high fun, I argued that the idiom of "getting introduced" reveals a great deal of moral ambivalence, particularly when it comes to perceived power differentials. At the same time, power does not operate in any straightforward way in high fun contexts: while the ability to purchase drugs and/or access a place in which to take them offers some degree of control over the encounter, this control is far from total, as Anthony's example illustrated. It also hinted at the way in which high fun's erotic economy bears on people's ability to have safer sex in ways that are anything but straightforward, and at how economic privilege determines access to harm reduction services in the aftermath of risk. These risks, as the next chapter will demonstrate, are far from limited to HIV infection – which in fact features as something of an afterthought.

Chapter 5: High Risks

Responding to my profile on Grindr, Arvind told me he had a story he wanted to share with me. I could sense the gravity in his message. "It's long," Arvind cautioned when we met a few days later in a quiet corner of a smart, spacious café in Bandra, an affluent western suburb of Mumbai. "And I'm sorry if not all of it is relevant." I asked Arvind not to worry about that. "Just start at the beginning. We have time." Arvind beckoned the waiter to order a green tea before starting his narrative, which took most of two hours.

Arvind is one among several the interlocutors who trace their HIV infection to high fun. These stories confirm, anecdotally, a popular construction of high fun as the new "high risk behaviour" behind HIV transmission among MSM that mirrors the framing of chemsex as "re-fuelling epidemics of HIV among gay men" in Europe (Kelland 2019). In his personal account in Buzzfeed, for example, Koshan Kamesh warned that "chemsex parties where unsafe sex and shared needles proliferate can become a hotbed for the spread of HIV and hepatitis" (2017) after drawing attention to the relatively high prevalence of HIV among men who have sex with men. One HIV-positive man I interviewed explained he was "quite appalled" at the emergence of high fun scenes: he had recently spoken with someone who "totally got HIV through high fun", which he described as a "dangerous trend." He suggested that if I was interested HIV among gay men, I needed to look at high fun. In Delhi, an NGO worker who also hypothesized this link conceded that that because of the lack of data, "whatever I'm saying is anecdotal".

In contrast to most research on "chemsex", the aim of this chapter is not to confirm or challenge this suspected connection between new HIV transmissions and high fun. Instead, I ask how Arvind and other interlocutors make sense of and navigate "risk" in the context of high fun and how these insights might further both our anthropological critiques of the biomedical risk paradigm. In doing so, I hope to offer an ethnographic alternative to the public health literature on chemsex, which tends to isolate and then co-relate different risk factors and health outcomes to establish causation and correlation, as I explained in Chapter 4: Interlude for Chemsex. Against this atomizing approach, this chapter stays close to Arvind's detailed narration of his experiences in an attempt to place risk in context and demonstrate its profoundly relational nature.

After detailing Arvind's story, I relate it to the way in which other interlocutors describe and navigate HIV risk in high fun contexts. In contrast to the perception that no one

practices safe sex in high fun, the interviews suggest widely varying degrees of engagement in HIV risk behaviours (unprotected sex and sharing needles) and HIV risk reduction strategies, while also revealing some of the factors that circumscribe agency for harm reduction. Moreover, HIV is but one of the risks interlocutors associated with high fun, with drug dependency emerging as a more acute concern for many. Drawing on critical drug studies, I suggest that stories like Arvind's may be understood as addiction narratives through which risk is made sense of. These narratives both confirm and complicate medical and mainstream constructions of addiction-as-disease (Carr 2010, Pienaar and Dilkes-Frayne 2017), challenging in particular its individualizing tendencies. And by raising the spectre of suicide, stories like Arvind's generate "at risk" subjectivities and an affective urgency that propels individual and collective forms of harm reduction. I hope some of this urgency is conveyed in what I will argue is a necessarily lengthy reconstruction of Arvind's account of "risk" in the context of high fun.

Arvind's account

"As far as I remember, this whole concept of high fun has only come up in the past seven years," Arvind began his narrative. While Arvind wondered sometimes what it would be like to have sex while on drugs, his friends dissuaded him from trying, insisting it's not something he should consider.

In 2018, Arvind met someone he described as a "ten on ten, on paper". The two of them fell into a fairy-tale romance, and within months flew to Europe to get married. In India, the Supreme Court had just read-down Section 377.

But there were a couple of issues in their relationship. For one, Arvind is Hindu while Aziz is a Muslim, "so that became a *huge* debate." Arvind's parents' initial adoration of Aziz wore thin when they realized things were getting serious. "They are fine with my sexuality," Arvind explained, adding that his mom even attended Pride with him last year. "They're just not fine with me moving in with a man and getting married – especially if he is a Muslim." Aziz's family, on the other hand, were more supportive. "Because they had seen five years of drug abuse and they were finally seeing him [Aziz] get better."

Arvind moved in with them when things got too tense at home, but struggled to adjust to the new household and the unspoken but extensive etiquette that governed it. "Now," Arvind explained in soft tones, "being Muslim in this country is as good as being black in America. You don't get a lot of privileges when you are not Hindu – that's a fact, and it's getting worse. And that's when a lot of things started going wrong." Their relationship

became more turbulent, and Aziz's relation to drugs mirrored its ups and downs. "If it was strained, he [Aziz] would take drugs, and if it was fine, it was great."

So when one day Aziz and Arvind moved into a hotel room because some construction was underway in Aziz's family home, they quarrelled on WhatsApp over whether Aziz should bring his stash of MDMA or not. Aziz insisted he would not use it, they would just bring it and see how they feel. Arvind lost the argument. By the time Arvind arrived to the hotel, Aziz was coming up on his high. Arvind's initial anger mellowed into disappointment before turning into depression. "And that is when I wanted to escape as well."

It was his first experience of consuming anything stronger than a generously-poured gin and tonic. "And it was… *great*," Arvind recalled incredulously. He began, but struggled, to explain the feeling. "Have you ever tried it?" I nod. "Okay," Arvind continues, "I'd never felt so good in my life. And for those moments, our relationship was perfect." They got through 8 grams of MDMA in three days, having sex continuously. By the end of it, Arvind's bum had torn up and he had patches all over his arm. "And the moment the high came down, I started blaming him. And he started fighting with me and again we came back to the same place we'd left off from."

A week and a half later, Aziz took drugs again, "and then it sort of didn't stop." In protest, Arvind threatened to leave him. "That is when he burned his body. He took spoons and forks and started heating them up and burning himself, just to get my attention."

Five years before he met Arvind, Aziz left a well-paying job in Qatar for a long-term boyfriend at home in Mumbai who, it turned out, was cheating on him. Newly single and unemployed, Aziz struggled to find work in India – "there are not so many opportunities given to Muslim people," Arvind stressed – and his mental health deteriorated. One night, he was drugged and raped by three guys, or so he told Arvind.

"After that moment he *tried* to stop himself," Arvind continued after pausing to accept his delayed green tea, "but then he sort of went into…that route. And then he a kept fighting addiction, he kept leaving, he kept coming back." One morning in 2016, Aziz's mother found him minutes after he went unconscious following a suicide attempt. She had her son admitted him to the hospital under the pre-text of a stomach bug, Arvind explains, "because no doctor will touch him if they got to know that a) he was having drugs, and b) he was suicidal. Suicide is a punishable offense [in India]."

Arvind went to his parents' place, but told Aziz he would stay with him on one condition: that they would find help. He had a psychiatrist friend who suspected Aziz may have developed a personality disorder, or had a pre-existing mental health condition

exacerbated or triggered by consistent drug use. She advised against sending Aziz to rehab, where mental health tends to be entirely neglected and which she called a 'last resort'. The psychiatrist they found for Aziz disagreed, insisting rehab was the only option.

"If you're a mental health patient, then there is *nothing* for you!" lamented Arvind. "And that's the problem in this country. Mental health is never talked about. Being mad is stigmatized *so much*: the moment you say you have a mental illness, it costs you your relationship, it costs you your job, and there is no information about this." A friend insisted the invention of mental illness was America's way of selling drugs and suggested Arvind push Aziz to do Ayurveda instead.

Moreover, Arvind explained, "rehabs are very expensive. Or government-run." Eventually, Arvind called one of the expensive ones. But there was a month-long waiting list, and Arvind was not sure he would be able to keep Aziz to his promise for that long. "He was like: 'You just want to prove I am loony so you'll but me in a loony bin'. He was so stigmatized." In hindsight, he thinks rehab could have helped Aziz.

All this time, Arvind was convinced that Aziz was the one with the problem, while he had – or at least looked for – the solution. "I thought *he* had an issue, *he* was an addict," Arvind said, "but maybe I should have gone too." I looked up from my lineless notebook to communicate my confusion with a frown, not wanting to interrupt the flow of Arvind's narrative.

Arvind explained. Sometime in January, Arvind discovered Aziz had been cheating on him while. While Arvind was staying at his parents' place, Aziz had no way to access money to buy drugs. "So he called someone who would give him drugs for free,'' Arvind recalled matter-of-factly. "Cause he was very good-looking, so he could just give himself off to someone and in return get drugs."

Sounding pained now, Arvind continues: "Knowing that, my whole world came down." He considered that it was the addiction driving his husband to do this, and that he wouldn't cheat if he was sober. Perhaps, Arvind thought, Aziz was a narcissist after all, as his psychiatrist friend had suggested. "At that time, though, nothing mattered. It was like he did this to me, how could he?" But when Arvind was about to leave, Aziz called his peddler and ordered drugs. He tried to stop him, but to no avail. "And again the whole room started smelling of drugs and it was so bad, and I couldn't leave and I couldn't be with him," Arvind recalls. "So I said – do you have some more?"

Once they were high, Arvind suggested they invite some people over, since Aziz had already opened up the relationship. "And he was like- *are you sure?* And I said I was."

"We had a foursome, and it wasn't him going out and doing it – I was finally levelled with him, you know, we had reached that stage where we could go back to the relationship." Arvind paused for dramatic effect. "But I was so wrong. Because he never stopped. He kept having sex with numerous people and I kept following him, thinking that if he did it and I did not do it, I'd probably have to leave."

This went on for a few weeks, until Arvind decided he could not do it anymore. Aziz kept doing high fun, borrowing and stealing money from friends and Arvind, "doing thing that he knew there was no coming back from". Their fights were intensifying: "I started being very nasty to him," Arvind admitted, "because I was *really* hurt!" He requested Aziz get tested. They were both negative.

Interrupting Arvind for the first time, I asked whether they usually used condoms. "Yes, always", Arvind said immediately. He qualified that when they were together they would never use condoms, but with others they did. "Or so I would think. Because every time we were together, I saw he was always making sure the other person was using it, and I of course also made sure."

One evening, Arvind returned from a work trip to find Aziz looking like a shell of his former self. He had been high for all of the 48 hours Arvind had been away. "I hugged him and I cried, and he said: I don't know whether this is the Arvind I should believe, or the one who is extremely nagging and constantly fighting." Arvind swallowed his tears and his pride. He decided to go home to his parent's house, as he often did when they fought. It would be his last night in his childhood home as his parents were selling the house. Anyway, Aziz would go to sleep soon, he figured.

Usually at this point, Aziz would threaten to take more drugs once Arvind left. This time he didn't. Perhaps Aziz was too exhausted to even pretend to entertain the idea of another high, Arvind thought to himself.

At around one in the morning, Aziz messaged Arvind to apologize for being such a disappointment. "You've tried so hard to help me, and so has mom," a next message said, and then another one followed, explaining that the only impediment to their relationship was Aziz's drug addiction and that he loved Arvind so much. "And I just asked him,'' Arvind told me, "*are you suicidial*?"

Aziz said he was not, but Arvind alerted his mother anyway. Because Aziz's first suicide attempt was at 3 am, she never slept until four of five in the morning. Arvind messaged Aziz to let him know his mother would be checking on him. "It's okay," came the reply, "I've tried really hard, I love you and wish you a good night."

Arvind returned to watching a tech review on YouTube and fell asleep to a discussion about a phone's battery life.

"And at around 3.40 AM, I received a call from his father saying he had passed."

I had long stopped taking notes so as to be able to maintain encouraging eye contact, but now I was welling up. "It was actually the come-down from the drugs that was excessively difficult for him," Arvind continued. "He could not handle it."

When Arvind reached his husband's home, Aziz's father – a God-fearing man who had always referred to Arvind as Aziz's 'friend' – hugged Arvind tightly. "We have lost our son," he said, "but we know what you have lost."

After that, Arvind carried on going to High Fun parties. A shaman had consoled Arvind that Aziz would return to this world soon, and, though Aziz's mother insisted this was heresy of the gravest degree, when Arvind got high he could almost feel Aziz's presence.

He described himself as being 'passively suicidal' during this period, which is when he started having sex without condoms, "because now I have no one to spread it to." I asked whether he considered himself to be engaging in high risk behaviour.

"Yes," Arvind confirmed immediately. "That's why I kept getting tested." By the time he got his negative result, he had taken a conscious decision not do it (High Fun) anymore, and so didn't get on PrEP. "But the moment he died I went back to it and didn't care. I wanted the disease more than anything else."

His death-wish notwithstanding, sometime in June Arvind tried to get Post-Exposure Prophylaxis (PEP) after a night of unprotected sex with multiple partners. "I went to Humsafar Trust" Arvind recounts, referring to Mumbai's main HIV NGO carrying out Targeted Interventions for MSM/TG – men who have sex with men and transgender women. "They said they wouldn't give it directly, that I needed a prescription, and gave name of a doctor who is more, uhm, more *for* homosexuals, he treats people in in the community." But Arvind's attempts to meet the doctor kept being frustrated. "I waited for 48 hours and then he just left, without seeing me." It was late in the evening, and Arvind didn't know whether there were any other doctors who would give him a PEP prescription. "So at that point I thought – okay, if I have it, I have it. Now I can't do anything."

A few weeks later, Arvind embarked on a second attempt to access PEP at one Mumbai's most prestigious and expensive hospitals. By the time he got his consultation, the 72-hour post-exposure window in which the preventative antiretroviral course needs to be started had almost expired. "You need this, not PEP," said the doctor without looking up from Arvind's blood results. He scribbled down a prescription for what Arvind rightly

presumed were antiretroviral medications. “Don’t worry, it’s not a death sentence anymore,” the doctor added coolly, placing his pen on the prescription pad. And that was that. When Arvind went to do another blood test, the nurse bellowed loudly ‘’UNIVERSAL PRECAUTION SYSTEM’’. “And that was for me,” Arvind realized. “I googled what it meant and I was like – *Oh my god! Why would you say that*?”

Still feeling passively suicidal, Arvind delayed treatment for a while before realizing he could not saddle his parents with the shame of an Aids-related death and the drug debt he and Aziz had racked up. Moreover, he did not want to risk infecting anyone were he to go back to doing high fun again. “But for three days, after starting the medication, I was more depressed,” Arvind concluded. “Because I was going to live. While he has moved on. It was extremely difficult – I felt I was actually doing something that was against my wish.”

Though he doesn’t plan on telling anyone about his status till he is “more okay with it", Arvind wondered whether he should tell his parents. He worries about becoming the subject of gossip. “When my husband committed suicide, we were both topics of discussion at a lot of brunches, and it wasn’t nice.” Arvind winched at the recollection. “Everyone was curious how he passed, and some people asked – was it the *virus*? And I was like – so what if it was!”

Arvind didn’t know whether Aziz gave him HIV or whether it was someone else, nor does he know whether it matters. He was in therapy to deal with his depression, which he partially attributes to growing up gay in India. “I think we all need therapists,” Arvind said after acknowledging that this is a luxury. “Because we have faced so much oppression.” He assures me he discussed meeting me with his therapist before making a decision. “He was very happy, he thinks it’s part of the healing process. Because it’s like: I’ve been through this, but maybe knowing about my story would help somebody else make a wiser decision.”

Risk behaviours

Arvind was not the only one of my interlocutors to contract HIV through high fun, which is, as already mentioned, framed by service providers and queer men alike as driving new infections among MSM. Instead of confirming or contesting this hypothesis, I draw attention in this section to interlocutors’ perception of the prevalence of HIV risk in high fun contexts and their strategies for navigating it. The wide range of reported HIV risk behaviour and HIV reduction practices problematizes the easy conflation of high fun with HIV risk,

though those interlocutors who attempted to have safer sex and/or avoid needle sharing cited several factors, both interpersonal and structural, that constrained their agency to do so.

Condoms

Faisal was among the people who insisted that nobody practices safer sex in high. "They're not even scared of it," he explained. "I've never come across a guy who didn't wanna get fucked by me without a condom. *Just fuck me* [they say]*, breed my hole*." Faisal maintained throughout most of our interview that he was on PrEP and was therefore unconcerned about condoms, but he disclosed his positive HIV status after I told him about mine. Although he said he "might be breeding every fucking hole because I know I'm undetectable", he felt bad about taking away people's right to make that decision for themselves. "But sometimes I'm like, when I'm high, I don't tell anyone," Faisal continued. "I never came across a guy who wanted me to use a condom anyway. This community is too shallow. I was never a dick person -but I know my friends are so obsessed with big dicks – so they think a condom is an impediment. So they're like *– I don't want safe sex with him, I want to feel it properly."* In this account, the general unwillingness to have safer sex in context of high fun – along with, crucially, being undetectable– relieved Faisal of feelings of guilt for not disclosing his HIV status. His white lie hints at some of the paradoxical effects of treatment-as-prevention technologies and discourses, explored in Chapter 10: Undetectability.

Vikram, who said he was HIV-negative, painted a slightly more ambiguous picture of the scene in Mumbai. He said he always uses condoms – except with some people. "Because I know them," he explained, "and they're my friends, and we've been doing it for a long time." I asked Vikram whether his friends use condoms with new people, and he said they do, of course – "but then some people don't". Rounak, on the other hand, always insisted on using condoms, and recalled with some annoyance that the day prior to our interview someone had refused to use one. "And I asked him – *are you on PrEP? Have you tested yourself?*", he continued. The guy wasn't on PrEP and hadn't been tested recently. "And I said, *that's dangerous!* And then that turned him off, made him depressed." Although this anecdote complicates Faisal and Ravi's claims that nobody practices safer sex at high fun parties, it also demonstrates the difficulty of having a conversation about it. Indeed, Rounak avoided the kinds of group parties typically associated with high fun because it was harder to ensure safer sex in these contexts: "I've been in situations where I've said no because people just didn't use a condom or whatever."

But when it comes to high fun, one-on-one encounters appear to be the exception rather than the rule. "I was not enjoying one-on-one, I wanted two, three, or a group!" recalled Pramod. "When you're a bottom, you know how it happens. You're not satisfied with one, you want more and more and more, and when you're high you're searching, searching, and searching. So it was all groups, foursomes, fivesomes, sevensomes, one guy going, the next guy coming…" Pramod contracted HIV during this phase, something he attributed to the time he had a bad anal rupture after living out a porn-y fantasy of being double penetrated. He avoided seeking medical treatment, unsure how he would explain the injury once at the hospital. While there is nothing inherently risky about multi-partner sex, the risks of unsafe sex are of course multiplied when there are several partners involved, as are the chances of getting fissures or other anal injuries that might facilitate HIV infection (if you are bottoming).

Serosorting

In the absence of consistent condom use, "serosorting" –selecting partners of the same HIV status – can be a strategy of negotiated safety, as Australian HIV/Aids researchers have argued (Grov et al. 2015). Yet in the context of high fun, this strategy is compromised by the lack of any explicit discussion about serostatus (which, as I suggested in the previous chapter, contributes to its appeal among HIV-positive men who are fearful of rejection and stigmatization). In Chennai, 25-year-old Ravi claimed, like Faisal, that people generally don't use condoms in high fun – "tops would take them off, even bottoms would take them off," he recalled. He stopped having high fun after contracting HIV, worried, like Arvind, that he'd have unsafe sex again when he's high. "People think that if you look good, you don't look ill or ugly, it's safe," Ravi explained.

This assumptions reflects a more general conflation of HIV and Aids explored briefly in Chapter 10: Undetectability, which also details the social risks that prevent most HIV-positive interlocutors I spoke to from disclosing. This makes positive sero-sorting an unlikely strategy. Although John, who suspected he contracted HIV through high fun, told me he mostly got high with a group of people who were also HIV-positive afterwards, he too conceded that non-disclosure was a more common strategy. John explained that once he did start disclosing, nobody wanted to meet him anymore. Others, like Kaushik, suggested the expectation of disclosure was unfair in the context of high fun, because "in chemsex, nobody talks about safe sex". After an initial phase of being precautious, Kaushik stopped using condoms sometime around 2018, "and then of course the HIV happened with that." Although

Kaushik discloses “on principle”, he clarified that “when you talk about chemsex, I do not.” This is mainly because he is undetectable and believes himself to be posing no risk, but he admitted with apparent regret at having had “mistakes” before achieving viral suppression.

Moreover, the social risks of HIV disclosure explored in Chapter 10: Undetectability make positive serosorting an unlikely strategy. Although John, who suspected he contracted HIV through high fun, told me he mostly got high with a group of people who were also HIV-positive afterwards, he too conceded that non-disclosure was a more common strategy. John explained that once he did start disclosing, nobody wanted to meet him anymore. Others, like Kaushik, suggested the expectation of disclosure was unfair in the context of high fun, because “in chemsex, nobody talks about safe sex”. After an initial phase of being precautious, Kaushik stopped using condoms sometime around 2018, “and then of course the HIV happened with that.” Although Kaushik discloses “on principle”, he clarified that “when you talk about chemsex, I do not.” This is mainly because he is undetectable and believes himself to be posing no risk, but he admitted with apparent regret at having had “mistakes” before achieving viral suppression.

Sharing needles

Kaushik wasn’t actually sure whether it was the condomless sex that caused his infection or sharing injection equipment. “A lot of people are okay with using cleaned needles,” the educational professional explained, “and they don’t question it, they just want to get high.” Several people I spoke to expressed an intention to avoid re-using needles, and a biochemistry graduate in Bengaluru even showed me the chemical waste bag in which he disposes syringes after using them. But this is not always viable in the context of a high fun party. “People rush into it so they forget where it’s been or where they kept theirs, or they think it’s theirs and re-use it,” explained Faisal. “So I’ve been in a similar situation where I thought that’s my needle, or it’s the last needle and it’s early morning and I don’t wanna go to a medical shop.” The injecting equipment often used in the context of high fun are stocked in the ubiquitous pharmacies. “I don’t know what they thought I was doing with fifty syringes a month,” said Anthony, smiling wryly. “You can be a diabetic, but you don’t need fifty syringes.” His mild concern at what the staff at his local pharmacy made of his purchases suggests the stigma on drug use – and in particular injecting drug use – may further militate against consistent use of new syringes.

In Mumbai, Rounak seemed slightly horrified when I asked him whether he’s every shared or re-used needles. “Never, oh god, no!” he exclaimed. ‘”I’ve gone to people’s houses

and they've given it to me in a syringe once they've done their ration, and I'm like – *sorry, I'm not doing that, I don't know where it's been*. So I would always bring my own or watch them take it out of the pack." Despite this, Rounak goes through phases of being hyper vigilant, when he realizes "you're sleeping with men who are injecting needles, giving them blowjobs with bleeding gums – and then any symptoms I have I'd be like I have AIDS – sorry, HIV." Though none of that sounded particularly risky to me, Rounak insisted that he could "totally" be positive. "I freak out about the fact I need to get myself tested," he sighed. "And I've not had unprotected sex ever – but obviously, you're in a blur sometimes." Though rationalized in biomedical terms - HIV transmission via oral sex is a theoretical possibility, albeit an obscure one – Rounak's sense of being-at-risk seemed to stem from the fact that he was part of a "high risk group" rather than from his involvement in any specific risk behaviours. It reflects the way in which "key populations come to exist in an isomorphic relation with sexual risks and HIV," as Paul Boyce and Fabian Cataldo (2019) argue in their critique of the circular way in which knowledge about key populations, including men who have sex with men, is produced and communicated.

Others avoided injecting drugs altogether, preferring instead to snort, swallow or smoke them. But the immediate rush that comes with "slamming," as well as its relative cost-effectiveness, make it an appealing method of administration. "It's like your first kiss," explained Kaushik, "Your brain is suddenly flooded with serotonin, maybe a hundred times more than the normal level. Everything is beautiful, the rainbow suddenly has more than seven colours."

PrEP/PEP

Both PrEP and PEP could significantly reduce HIV risk in high fun contexts. Yet as is clear from Arvind's experience, the required prescription is not always easy to get by – even for those with the means to access private physicians and purchase the medications. His trials and tribulations demonstrate the difficulties of accessing PrEP and PEP, despite their availability in the private sector since 2014. In that year, Indian pharmaceutical company Cipla was granted regulatory approval by the Drug Controller General of India to sell a generic version of Truvada as PrEP, which it priced at INR 2,200 a month (Dutta 2016). Although NACO is said to have been "toying with the idea of introducing PrEP" (Yasmeen 2018) among key populations for a few years now, and several studies exploring PrEP's acceptability among sex workers, men who have sex with men and transgender women have been conducted (Reza-Paul et al. 2016; Cakrapani et al. 2015; Chakrapani et al. 2019),

movements in this direction have been slow. The strategy document for the fifth phase of HIV/Aids programming (2021-26) makes no mention of either PrEP aside from a commitment to "strategic information expansion into newer areas like Pre-Exposure Prophylaxis, HIV Self Testing etc. through demonstration projects" (NACO 2022, 23). A cynic might conclude that the agency is using such projects to stall the roll-out PrEP for key populations.

At present, PEP is only available at government hospitals in cases of 'occupational hazard', when a staff member is exposed to HIV risk, or rape. "And that's medico-legal cases of rape," pointed out HIV physician and LGBT advocate Dr Ramki Ramakrishnan, "in which a cis-gender man rapes a cis-gender woman who is not a sex worker." Little is known about the uptake of PrEP via prescriptions from private physicians and (technically illegal) over-the-counter purchases, but a 2017 survey with 2,494 men who have sex with men documented obvious socio-economic and geographic disparities in knowledge and access (Patel et al. 2018). Treatment-as-prevention is thus far from a *fait accompli* in India, but rather exemplifies a stratified and incomplete process of biomedicalization (Young et al. 2015)[9]. Kaushik only knew three people who were on PrEP - "they are the ones who can afford it," he explained.

Given the difficulties of insisting on condom use during high fun as described by Anthony, PrEP/PEP seems like an easy – if expensive - harm reduction measure. Indeed,

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[9] Two cases unrelated to high fun bring into sharp relief the resulting disparity. If knowledge of and access to PrEP and PEP is limited to a well-heeled and well-travelled subset of India's queer communities, as I was repeatedly told, Vishal, the bureaucrat's son I befriended while he studied in London, embodies this demographic. "It's really cheap in India," he explained when he visited me in Bengaluru. But when Vishal needed PEP urgently, he struggled to pay for the expensive rapid HIV test, the consultation at one of Hyderabad's best private hospitals, and the medication itself, given that he couldn't tell his family what he needed money for. "And this is still *me*," Vishal reflected incredulously. "I'm still like, upper-class, educated, upper-caste, from like a quote unquote elite family or whatever. If I can't get access to this health care, I can't really imagine what it's like for someone who doesn't have that kind of privilege." In the end, Vishal's doctor – a gay man he had met on Grindr once – spotted him the money.

A few months later I received a call from someone I had interviewed to discuss her job as a peer outreach worker for Kerala State Aids Society. Back then, she had looked confused when I asked her about PrEP/PEP: "It's a tablet, right?" she said after a long pause. "I don't think we have it in in India." Now, she called to say she had had unprotected anal sex and needed PEP. But at around 6,000 INR, around 65 GBP, the price of the required rapid HIV test alone was half her meagre government-job salary. Since her documents identified her as male, trying to get a prescription through a government hospital by claiming to have been assaulted was not an option. I did not know what to tell her. Although the NGO I was volunteering with in Bengaluru had recently conducted an awareness campaign about PrEP/PEP to gauge willingness for uptake among transgender women, they could not, as the director had stressed repeatedly, provide it.

Anthony took a course of PEP after the encounter he described, and is now on PrEP. Yet some of the NGO workers I spoke to worried the availability of PrEP/PEP, without proper counselling and monitoring, might have counterproductive effects – particularly in high fun contexts. Dr Sam Prasad at AIDS Health Foundation in Delhi worried that "in chemsex parties you've got people lying about taking it, often missing it, taking drug vacations, or not being regular on it." For him and others I spoke to, like Dr Ramakrishnan, NGOs and CBOs working with MSM have a responsibility for educating "the community" on PrEP/PEP. "Otherwise," Prasad forecasted, "it will be a flop." Humsafar Trust, along with social network Gay Bombay, sponsored one such event in Mumbai, which I attended. But as long as they do not have the mandate to provide it, people like Arvind rely on the availability of a handful of "gay friendly" practitioners – or, as in Anthony's case, chemists willing to ignore the requirement of a prescription – to access PEP.

Troubling the popular conflation of high fun with high risk, interlocutors thus described a wide range of risk behaviours and risk reduction strategies, and also stressed the interpersonal and structural dynamics that mediated their agency for harm reduction. Their accounts showed risk to be a highly contingent affair. In this section I have attended to some of these contingencies, ranging from the opening hours of the local pharmacy to the availability of a gay-friendly physician and the effects of drugs on a partner's ability to maintain an erection. In Arvind's case, condom-usage was contingent on his agreement with Aziz, as well as the value their relationship gave to his life. After his death, Arvind had little reason to protect himself, and this indifference resulted ultimately in his HIV infection. Yet although HIV risk is thus a significant part of Arvind and other people's subjective experience of high fun, as this section has shown, it appeared as something of an afterthought in Arvind's story.

Addiction narratives

Arvind's story is first and foremost an account of Aziz's addiction to drugs – and, Arvind realized later, of his own addiction, too. Similarly for Rounak, the young creative in Mumbai, HIV was a secondary concern: after telling me he felt he needed to get tested for HIV, Rounak added that "that's not my problem – my problem right now is getting rid of this addiction". This resonates with Drysdale and colleague's (2021) study of the prioritization of risks among Australian gay men who, as it turned out, were far more concerned about substance dependency than HIV transmission. Indeed, this theme dominated my interview transcripts to such a degree that I worried my research would perpetuate a tendency in

chemsex research to approach it as always-already resulting from and in trauma. Kristian Møller and Jamie Hakim suggest that the "critique of risk-oriented chemsex analysis can, in part, be framed by the conceptual interrogation of addiction discourses so central to critical drug studies" (2021, 5), and in particular the dichotomy between addiction and pleasure that organizes how drug use is made sense of (Fay 2019). Moreover, "while not all gay and bisexual men who use psychoactive substances report problematic use, those who do often become representative of chemsex practices more generally, and the harms they experience become attributable to all men who use drugs for sex", as the authors of a study based on 88 interviews with gay and bisexual men in four Australian cities point out (Drysdale et al. 2020, 1).

In other words, there is a risk that in foregrounding stories such as Arvind's, we reinforce the slippage between chemsex, addiction, and all the mental health issues associated with it. At the same time, the centrality of addiction in my interviews means the theme cannot be ignored in favour of a more pleasure-focused approach: while pleasure was undoubtedly part of my interlocutors' experience of high fun, it was not what they wanted to talk about. Rather than suggesting they reveal the "truth" about high fun, in this section I approach my conversations with Arvind, Rounak and other interlocutors as productive of "addiction narratives" that simultaneously reference, re-inscribe and challenge normative ideas about addiction-as-disease (Car 2010). This is not to suggest that their accounts aren't authentic or to dismiss the various forms of suffering they narrate, but rather to situate these accounts in relation to a dominant, medicalized understanding of addiction as simultaneously a disease of compulsivity *and* as one that must be overcome through individual responsibility (Weinberg 2000). This approach is inspired by Kiran Pienaar and Ella Dilkes-Frayne (2017), who draw on Annemarie Mol's conceptualization of "ontological politics" to argue that rather than reflect a prior reality of addiction, such re-constructed biographical accounts "make" addiction and those who see themselves as affected by it. Insofar as they confirm the construction in mainstream media of addiction as a disastrous state of being out of control, such narratives may inadvertently contribute the stigma associated with drug use. They also tend to remove from view the contexts through which addiction materializes by portraying it as an individual pathology (Keane 2001).

While Arvind's was the most arresting, of all the accounts of "addiction" I heard during my research Rounak's was the most detailed. The young creative reached out to me at a time when, as he put it, he was "fucking drowning", and wanted to find support. When we first met on the terrace of an upscale pub in a Western suburb of Mumbai, Rounak explained

he had just taken his first dose when he messaged me on Grindr the previous day. He had come back from a three-day wedding in Delhi, where he didn't do any drugs. But the moment his plane landed in Mumbai, Rounak's body became warm and his head was buzzing. Rounak was overcome by cravings that he said he can't explain. "It's the worst feeling, actually," he elaborated nonetheless. "The minute you decide you want to do it and your last hit, when you know you can't do it anymore and need to change your life. These two phases are the worst."

Leaving the airport, Rounak wondered whether he should ask his close friend to come collect him. Instead he bought some syringes from a nearby pharmacy, met his dealer, and arranged a hook-up with a regular partner. "We've always had an amazing time," said Rounak, "but today he told me – *I really want to leave this. There are nice people who slip into this, and it's fucking crazy*." They had high fun till they run out of stuff, sometime earlier that day, which explained why Rounak seemed both a little wired and tired. "You keep doing it till you fall asleep," he explained "You wake up and if you've got something left, you're gonna do it. But if you have nothing then sense prevails and you're like – *I've got to stop, I've got to talk to someone*." Rounak bargained with himself after his partner left: he resolved he would try to do high fun less by limiting it to once a month**.** But then he counted the days and realized it had only been seven days since he last got high. "And it felt so long!'' he said, sounding incredulous. "Seven days! That's a week!"

Rounak first started doing high fun after moving from Delhi to Mumbai to pursue a career in art. He struggled to grapple with the pace of the glittering metropole, and began to feel like he was failing in his social and professional life. When one night someone invited him to have 'high fun' on Grindr, Rounak accepted the invitation. "I was either naïve or just stupid," he recalled harshly. "I thought that injecting was not a big deal." Rounak had taken drugs before, at parties. "And I was like, *it's fine – I don't think I'm addicted to it*. Then it slowly creeps in, you crave it, and then it spirals out of control."

A few months before our initial meeting, Rounak was invited to work on a project with one of his favourite artists. For a while, Rounak stopped using drugs altogether. "It can't be this easy," he thought, and soon enough he started taking drugs again on the weekends, sometimes alone and sometimes with sex partners. "But it would spill over [into working days], and I'd be late, I'd fuck up, I'd make mistakes." Rounak flinched slightly as he described working on something the day after having 'done it', and going into the toilet to shoot up. "Everybody knew I was high," he said, staring at his drink. "Can you *imagine*? And this artist is someone I idealized. This what I wanted in my life. And when you fuck *that*

up…"

The other incident that made Rounak think his relationship to drugs was becoming problematic was the episode with the man who took him to cowshed, recounted on the previous chapter. "If this is not addiction, then what is," Rounak asked himself rhetorically. The way in which the compulsive nature of his own behaviour and that of his "desperate" partner made Rounak think or realize he was addicted corresponds roughly with a medicalized model of addiction as a disease of compulsion and popular depictions of addiction as a state of disorderly dysfunctionality (Carr 2010, Keane 2001). In Rounak's narrative, (spiralling out of) control emerged as a key idiom to make sense of the difference between "addicted" and not.

This was typical of my conversations with men who were into high fun more generally. "I remember one time," recalled Anthony in Mumbai, "I was with my regular partner, it was the end of the meeting, and he said, *We're not addicts, right? We have control over this?* And I said, *no, no, we're not…* but while I was saying it I thought – what's the difference? And that's when I began entertaining that maybe I could be… an addict." Conversely, people who were keen to emphasize that they were *not* addicted often stressed that they were able to control it, whereas other people weren't, invoking neoliberal notions of self-governance and restraint observed by Sharif Mowlabocus (2021) in the context of London's chemsex scene.

Yet while elements of Rounak's narrative invoke "the discredited identity of the 'addict' as lacking self-control and driven by a compulsive attachment to drugs" (Pienaar and Dilkes-Frayne 2017, 146) that undergirds both liberal and traditional discourses on addiction, Rounak also described attempts at actively asserting agency over his drug use, such as when he bargained with himself about the length of intervals between different sessions. When I met Rounak at a coffeeshop a few weeks often our first meeting, I noticed his hands were trembling as he booked tickets for a movie we were going to watch later that day. We had attended the same gay party on Saturday, and I asked how the rest of Rounak's night had been. "Good," Rounak replied, unconvincingly. "Good," I said. We sat in silence while I focused on rolling a cigarette from his pouch of tobacco. "Yeah, I did it again," Rounak admitted eventually, softly. "Could you tell?" I nodded casually while licking the edge of the rolling paper. "But I don't feel that bad. I've decided going cold turkey isn't going to work." Rounak explained this was the longest time he had managed to abstain, and that he had figured he'd try to space it out, setting the date for when he's going to take drugs next in advance. "Does that make sense?"

This approach was similar to Kaushik's, who realized he needed to regulate his drug use after missing a funeral while suffering a psychosis triggered by withdrawal.

> K: So that was the moment of reflection for me. *Hey, even though you like it, it has to be in a regulated manner*. And that's the approach I usually go by now. Because it's my life so if I'm enjoying it and not harming anyone, sure.
> C: Now you feel you got a handle on it?
> K: Not really, I don't think you can ever get a handle on it, right – it's the craving which you get, you manage your cravings. I have moved on from once in a week to once in two months. And probably I will want to keep it at once in six months kind of a thing. So I'm like mid-way my target.
> C: But it almost sounds like the fact you've got something to look forward to makes it easier? K: Exactly – I can fool my brain into thinking *hey I'm going to use it again, so don't freak me out by saying I'll never use it again*.

Kaushik's reflection complicates the overlapping binaries of compulsion/volition and addiction/pleasure that organize addiction discourses (Fay 2017, Pienaar and Dilkes-Frayne 2017). His recognition of his relationship to drugs as problematic did not preclude acknowledge of the pleasures involved: indeed, Kaushik began to regulate his drug use precisely *because* he likes it. Moreover, looking forward to getting high helped him stick to his self-imposed timelines, hinting at the ways in which pleasure and harm reduction need not be mutually exclusive.

Perhaps it is because it is of these ambiguities that he considered himself to have been a "borderline addict" when he had the psychosis. As Dennis Fay has pointed out, pleasure and addiction are rendered antithetical in therapeutic addiction discourses, such that "while pleasure is addictive, addiction cannot be pleasurable" (2017, 152). We might recall here that although Arvind portrayed his late partner's drug use in overwhelmingly negative terms, he did not omit the forms of enjoyment it involved from his account. He described the first time they used MDMA together as a great experience, explaining he had never felt so good in his life, and his relation to Aziz had never seemed as perfect. He added, however, that they started fighting again as soon as the drugs ran out. This qualification resonates with an observation Fay made about her interviews with drug users in the U.K.: "Participants often spoke of the pleasures of their drug use, but then quickly followed this with a 'but' to indicate the many negative components" (2017, 153). Rounak denied the element of pleasure altogether. "It's not fun man," he said when I asked about the 'fun' part of high fun. "It's not fun."

Another tension in Arvind's account was that between individual and social

pathology. Arvind related Aziz's addiction to his undiagnosed mental health issues. Yet his narrative is packed with references to the context in which it unfolded: from the vicissitudes of their relationship ("if it was strained, he would take drugs") to Aziz's minority status as a Muslim in India ("as good as being black in America") and his not unrelated difficulties finding work. Arvind also mentioned the stigma on "being mad", the lack of sensitivity around mental health in rehabs and their prohibitive fees and long waiting lists as factors in Aziz's decline. This challenges the de-contextualization implicit in therapeutic and popular discourses of addiction as personal pathology. In her analysis of three autobiographical addiction narratives, Keane argues addiction discourse "requires that acts be understood not as discrete events emerging from the contexts in which they took place, but as recurrent expressions of a singular ongoing pathology" (Keane 2001, 568). While Aziz's various relapses appear as different iterations of his addiction in Arvind's narrative and my reconstruction of it, Arvind seemed to suggest the addiction itself cannot be separated from both the immediate context of their inter-communal, unrecognized same-sex marriage and the wider social, political and economic context.

In accounting for his addiction, Rounak oscillated between self-condemnation and sociological explanations. "Who am I going to blame," he asked at one point in our interview, not at all rhetorically. "There is a part of me that says, this had to happen to you: you're so reckless, so irresponsible. But there's also a part of me that's like: this happened *to* me." In an attempt to allay Rounak's negative self-talk, I shared something the counsellor at my sexual health clinic had told me after he delivered my HIV diagnosis: *You made a mistake*, *but that's okay. People make mistakes all the time.* "But your mistake is not a mistake because…" protested Rounak. "How do I explain it? The worlds we enter, which are unsafe, are worlds we enter because we're pushed to that world!"

Struggling to find the right words, Rounak related a joke by the American comedian Margaret Cho: You know how people say that gay people are fucking all the time? Well, if you tell people that it's wrong that they're fucking who they're fucking, they're going to fuck even more! "Especially in India," Rounak continued, "people look at the queer or gay world as something dirty." He sighed. "Maybe it is. But, like, you *make* it dirty!" He compared the lack of queer rights in India, despite the read-down of Section 377, to marriage equality in the U.S. "Here you still think about it as something that's done in a public toilet – without a condom. And that's what you think about when you grow up: a gay boy will think he won't be in a relationship, but he'll feel someone's dick up in a bathroom and that's love," Rounak explained. "So you've fucked love up for him."

Rounak's conflicting explanations reflect the difference between biomedical paradigms of behavioural change that privilege individual choice and promote personal responsibility and anthropological and sociological critiques thereof that highlight the structural factors that constrain individual agency. Indeed, his view that we (queer people) are pushed into unsafe words echoes Paul Farmer's (1993) well-travelled notion of structural violence as the social, political and economic factors that put certain individuals and groups in harm's way. As previously explained, psychologizing accounts that frame chemsex as a symptom of the collective trauma of homophobia (see, for example, Hobbes 2017) are critiqued by critical chemsex scholars for privileging heteronormative forms of intimacy and implying that gay men are uniquely damaged in their ability to form relationships (Hakim 2018). Yet insofar as the pathology being identified in such explanations is social-political rather than individual, the addiction narratives discussed above counter the de-contextualization and individualization inherent in medical and therapeutic discourses of addiction, even as they also draw on these popular constructions. Interlocutors drew attention to the contexts of structural violence and institutional failure in relation to which their addictions emerged. They also emphasized attempts at self-regulation, challenging the popular perception of addiction as a state of total loss of control - even as control was a key idiom through which interlocutors distinguished between problematic and non-problematic drug use. Moreover, it is through this prism of addiction, rather than just HIV alone, that "risk" is apprehended and experienced in the context of high fun. This sense of vulnerability is heightened when such narratives raise the spectre of suicide, as Arvind's did.

The spectre of suicide

Aziz's suicide is one among several that are attributed, anecdotally through speculation and rumour, to high fun. By linking high fun to death, the most dramatically negative of possible outcomes, these stories engender a sense of being-at-risk that surpasses, but is sometimes related to, HIV infection. In this section, I draw on Jean and John Comaroff's (2006)[10] ethnography of South African crime statistics and stories and Shraddha Chatterjee's (2018) monograph on the politics of representing 'lesbian' suicides in India as such to consider the epistemic and productive dimensions of stories about high fun suicides.

[10]Since writing this chapter three graduate students at Harvard have come forward to draw attention to John Comaroff's long history of sexual harassment, which they claim the university was aware of when it hired Comaroff (Elleser 2022).

I suggest such stories generate an affective urgency that propels forms of individual and collective attempts at harm reduction, and that implicates me and this thesis too.

In their study of the social life of crime statistics in South Africa, Jean and John Comaroff draw attention to the unknowability of actual rates of crime given the likelihood of both over- and underreporting. Similarly, it is difficult to determine the exact number of suicides and/or overdoses that may be linked to high fun. In its stead, several interlocutors offered an informal tally, and, in Mumbai, the organization Gay Bombay is said to keep one too (my attempts to confirm this were unsuccessful). Faisal said he knew "like eight or nine" people, among them the Bengali hotel porter who – according to Faisal - committed suicide as a result of his inability to either sustain his habit or get help with de-addiction. The death of a poor migrant worker, one of millions in Mumbai, with few connections to the relatively expensive gay scene other than high fun is less likely to send shock waves through the gay community than that of well-known and much-liked or coveted member of the scene, as Aziz may have been. Given its the relative lack of "grievability" in Butler's sense of the word (2009), the migrant worker's death may not be included in many high fun tallies.

Additionally, the secrecy and taboo that shrouds both suicide and drug use may encourage over-reporting, since the extent to which the deaths of young queer men can be linked to high fun is hard to determine. Some deaths may be wrongly attributed to high fun, as Faisal complained when he told me about a suicide by someone who had been 'clean' for years: "I don't know for what reason [he did it], but people associate it with drugs. That tag is still there." Comarrof and Comaroff explain that crime statistics rely on the initial, quite arbitrary coding of a reported episode by police officers: a recorded rape attempt is not reclassified as 'murder' after it has gone through the courts and the victim has died of sustained injuries (Comaroff & Comaroff 2006, 219). Similarly, whether or not and to what extent a suicide is actually the result of high fun is beside the point: once someone is coded as an addict, the tag sticks.

At other times, families might be expected to cover up the 'real' cause of death, whether it is overdose or suicide. A few weeks into India's Covid-19 lockdown, one of the members of a tiny, informal collective of gay men hoping to 'break the silence' on high fun in Bengaluru forwarded a picture of a poster of a young man in our WhatsApp group. A garland was draped around the poster, which, in typical South Indian fashion announced the man's untimely 'expiry'. "So here's one more dead with regards to HF", wrote the person who forwarded the image, although he wasn't sure of the details surrounding the death. The next day, he followed up with a screenshot of a blurred-out WhatsApp conversation in which

someone, presumably a relative of the deceased, stated officiously that X had died on X date due to Corona. "Of course they're going to say he died of Corona which is quite rare for people of his age," one person in the group suggested. "There is so much stigma and shame associated around gay sex and drugs that for all concerned I'm not surprised they would go with the Corona option as no one would question it. And now with funerals also being extremely quick and private people hopefully won't pry."

Among the rumours that proliferated as a result of Arvind's decision to respect Aziz's family's wish for privacy was that it may have been 'the virus' that took his husband. While that suggestion was on the more outrageous end of the plausibility spectrum, its invocation of the obfuscation of Aids as a cause of death resonated with a connection drawn by Anthony. He recalled that when he was still doing high fun, from time to time he would come across obituary-style posts on Facebook about a gay guy who had died very young, in his twenties or thirties, and people would be really upset. "But unlike an actual death," the scholar explained, "there was never a discussion about how he died, or what the circumstances were. There was a lot of silence, in a way that reminded me of the silences around Aids deaths in the 90s." He offered a moving account of attending some such funerals, which would always be marked by the curious absence of customary conversation about the deceased's life and death. Later, Anthony would learn through some cryptic reference to homosexuality that the person had died of Aids[11]. Similarly with High Fun, "there seems to be an unwillingness to talk about it, perhaps to protect the family."

The silence of which Anthony speaks and the speculation that Arvind's experienced in the wake of Aziz's death are complimentary rather than contradictory. Both work in tandem to convert singularly tragic incidents into symbols of the state of the (gay) community in general, and the high fun scene in particular. "For the most part I didn't know these guys," Anthony continued,

> but a friend who knew I was using would say – have you heard about this? And I'd say, do you know more? And he'd say – *how can you know more, but what do you think happened?* The friend of mine who introduced me to NA [Narcotics Anonymous] he was saying people were taking their lives because it seems their

[11]In the short story *Death of the Gay Man* (2005), mythologist Devdutt Pattanaik offers a rare account of this discretion. In it, the deaths of gay men are passed off as accidents, with HIV/Aids a secret that is literally taken to the grave. Whereas visibility was a key strategy in the queer response to the early epidemic in the US, with ACT UP staging political funerals, an HIV-positive activist who was part of the group *Gay Bombay* in the 1990s told me gay men mostly died discrete deaths. While beyond the scope of this thesis, a tracing of these silences would make for an important, if challenging, research project.

> hallucinations were getting too strong and that was pushing them over the edge. We were both activist from the older days of queer organizing, so instinctively we have this bone in our bodies that makes us want to do something about it.

The friend's comment, italicized for emphasis, illustrates the way the unknowability of 'high fun suicides' facilitates the conversion of these singular episodes into cautionary stories that circulate widely. "Tales of this kind," write Comaroff and Comaroff, "are less about uniquely horrifying events than about the "fact" that such things have become commonplace" (2006, 173). They create the sense that it could happen to anyone.

The conversation propelled Anthony to start attending a twelve-step program *and* to begin organizing an informal structure of peer support. Similarly, Faisal qualified his death toll estimate (8 or 9) for Mumbai by saying he didn't know all of them personally. "Three of the guys I had met, a few I had spoken to but never met," he explained. "But the suicides actually gave me the idea it [high fun] could be really really dangerous, and can make you very vulnerable." Vikram, also in Mumbai, felt the same way: "Two guys hung themselves. One guy just died, I don't know how. It was very eery to hear that." For Vikram, the unknowability of the exact number of suicides attributable to high fun strengthens, rather than undercuts, its ability to produce fear. This in turn propelled him to take action: "I didn't immediately stop it, but someone else came to me and was like, we need to stop."

We might understand these individual and collective 'at-risk' subjectivities as forms of what Comaroff and Comaroff describe as moral subjects and communities, conjured up in South Africa by statistics and stories. The anthropologists argue that these 'mythostats' turn the unknowable into the knowable and the abstract into the sensate through a phenomenology of fear, thereby converting extraordinary events into a generic perception of vulnerability. One of the examples they give involves a deadly attack on gay men at male massage parlour in Cape Town that was widely publicized as a hate crime, though the attackers' motives were unclear: "Their victims are at once unusual and horrifically commonplace: you, I, could be next" (Comaroff & Comaroff 2006, 174). Similarly in the WhatsApp conversation about the supposed Covid-19 death, one person later wrote emotively that "4 deaths is too many deaths," referring to the estimated high fun death toll in Bengaluru. "God forbid it's one of us on that poster with a garland around it." Like Anthony, this person invoked the number to argue for collective action, in this case a third event in the series of semi-public talks about high fun that the members of the WhatsApp group had organized.

Shraddha Chatterjee's (2018) argument about the "affective urgency" evoked by representations of lesbian suicides in India also provides interesting contrasts and

convergences. Chatterjee explains that highlighting the tragic fate of same-sex women couples who commit suicide together helped lesbian activists illustrate the gravity of the problem of compulsory heterosexuality while countering the notion that it was merely an 'elite' concern (which, detailed in Chapter 1: Introduction, used to be a common refrain in the women's movement (Dave 2012)). The incidents took place in non-urban areas and involved women who were not especially privileged in economic or caste terms: socially and geographically speaking, they were far away from the metropolitan centres of lesbian activism.

In speculation about high fun suicides, on the other hand, class position does a rather different kind of work, since such stories tend to involve a fall-from-grace trope. Vikram, for example, fancied someone he met at high fun parties who seemed to have everything going for him. "And out of the blue I get the news that this guy has hung himself," he recalled. "He was handsome, a friend of all, he travelled the world, his boyfriend was white… so many things! Their parties were very elite, very chique." The man's social status made his death all the more shocking and more relatable, even if Vikram himself was nowhere near as privileged. If this could happen to someone like *him*, the logic goes, it could happen to any of us. Race and class, write Comaroff and Comaroff about the disappearance of a young, wealthy white woman named Leigh Matthew, made her case "at once exceptional (….) yet capable of typifying the nation as trauma" (Comaroff and Comaroff 2006, 236). The death of Vikram's 'elite' acquaintance comes to symbolize a community at risk in a way that the hotel porter Faisal knew does not.

Yet at the same time, the specific conditions of suffering – including structural ones – are elided in this process of converting a death into a high fun mythostat. Just as crime statistics tend to obscure the geographic specificity of crime in South Africa, which is concentrated in areas with high levels of deprivation whose residents are mostly Black and Coloured, deaths like Aziz's are abstracted from their complex contexts when they start to circulate as yet another addition to the high fun death tally. Interested in the politics of representing suicides as 'lesbian', Chatterjee examines a documentary by the Calcutta-based group Sappho for Equality that narrates the story of two young women who killed themselves. She points out that the documentary's frame of heterosexual violence obscures the other structural positions occupied by the women, including caste and class. "What does the act of representing Swapna and Sucheta as lesbian lovers who commit suicide to them, their materiality, and their other realities," Chatterjee asks (2018, 77). Similarly, turning the death of someone like Aziz into a totem of the vulnerability of the male queer community in

general, and people engaging in high fun in particular, obfuscates the other factors that contributed to his suffering. These included – according to Arvind – his struggle with pre-existing mental health conditions and the stigma associated with them, his difficulty to find work in an Islamophobic economy, and the specific ups and downs of their relationship. Instead, people re-inscribed his death in a more familiar narrative: that of 'the virus' pushing a serotonin-depleted addict over the edge.

None of this is intended to undermine the importance of the affective urgency generated by such stories, or to take away from its sincerity. During the final round of edits of this thesis, another death was reported in the WhatsApp group. This time, the name sounded familiar, and I asked to see a picture as I tried to keep a terrible sense of dread at bay. "Fuck," I wrote when my suspicion was confirmed, unsure of what else to say. I wonder whether there is anything I could have done to help my interlocutor, who said he was recovering when we finally managed to speak after several relapses and appeared very isolated. ("It's just that feeling of being loved," he told me when I asked about high fun's appeal, "at least for that time when you're together.") The other members of the group, one of whom also knew my interlocutor personally, suggested they really needed to organize another event. I wanted to offer some sort of contribution but I was not sure what I could do from far away, and what all this analysis is really for.

Conclusion

In this chapter, I have tried to recount Arvind's narrative in some of its "irrelevant" detail so as to place risk in context, and offer an ethnographic alternative to the biomedical, positivist styles of research that predominates in literature on chemsex, which tends to rely on retrospective case study review using data from sexual health clinics and surveys (Bryant et al. 2018, for critique). Arvind's story epitomizes the fundamental relationality of risk that this chapter has tried to demonstrate, not least because the story of his experience of high fun is also the story of his relationship with Aziz. Moreover, Aziz's struggle with mental health and addiction is not simply attributed to high fun, but contextualized with reference to the various interlocking stigmas, forms of institutional failure, and structural relations of inequality that exacerbated these struggles. In doing so, Arvind's narrative complicates the biomedical individualism that continues to underpin dominant notions of risk behaviour, the anthropological critiques detailed in Chapter 1: Introduction notwithstanding.

Instead of treating risk as arising from discrete behaviours that can be isolated and investigated, I have approached it as the "property of a relational system" (Orange quoted in

Kagan 2018, 136). As Kagan writes, drawing on psychoanalyst Donna M Orange's insights, "risk-taking isn't a discrete 'conceptual atom' available for isolated empirical analysis, but rather the upshot and the agent of dynamic historical, technological and interpersonal contexts" (2018, 136). In this chapter, I paid close attention to interlocutors' descriptions of these contexts. While my interviews with Arvind and with other interlocutors demonstrate varying levels of engagement in risky behaviours, including condomless sex and sharing needles, and in risk reduction strategies, they also highlighted the contextual factors that circumscribe individual agency. Moreover, the addiction narratives related in this chapter draw attention to the relation between high fun and what we as anthropologists have come to understand as structural violence, or the forces of marginalization that place some people in harm's way (Farmer 1999). This challenges individualizing tendencies of medical and popular constructions of addiction as individual pathology. At the same time, paying close attention to these narratives might help us resist the temptation of what João Biehl and Peter Locke critique as overly deterministic accounts of structural violence. My "microanalysis" of Arvind and Aziz's painful story was an attempt at "understand[ing] the macro without reducing or bounding the micro, accounting for the effect of structural violence, power, expertise, and the embodiment of sociological forces while still crediting the against-the-odds openness and ambiguity of individual lives and interpersonal dynamics" (Biehl and Lock 2010, 336). Arvind and Rounak's accounts demonstrate the entanglement of personal and structural afflictions. They reveal the way in risk emerges through what Sonja MacKenzie, in her study of HIV/Aids among Black communities in the U.S., has called "structural intimacies", or the complex interplay between "large-scale social forces, local cultural worlds, and their embodiment in the sexual" (2013, 13) - and it is for this reason that I have recounted them in considerable detail.

Despite revolving around stories of suffering, this chapter also hinted at forms of individual and collective harm reduction. I suggested these are motivated in part by the circulation of stories about suicides like Azis's as "high fun deaths" contributing to informal death tallies, conceptualized as mythostats. Some of these efforts, one of which will be explored in more detail in Chapter 8: Targeted Intervention, can be understood as attempts at creating a community-based response in the absence of formal services and may thus qualify as examples of what Kane Race (2017) described as counterpublic health. For as the next few chapters will show, high fun shines a light on the failure of India's celebrated system of targeted interventions and the decline of its community-based approach more generally.

Chapter 6: Interlude for Community

India's HIV/Aids prevention strategy is often described as a success story, both by international observers (March 2014) as well as by the Indian government itself. A Indian Ministry and Health and Family Welfare press release from 2015 touts "the fact that new infections have declined by 66% from 2000 and 2015, and AIDS-related deaths fallen by 54% from 2007 to 2015" as concrete proof that India is delivering on its global commitment to halting and reversing the epidemic (Press Bureau of India 2015). Although they are conspicuously absent from the statement, the decline of new infections is often attributed to the role played by key populations – formerly known as high risk groups – in the prevention effort (Rao 2016). The Indian community-based approach revolving around an intricate system of targeted interventions carried out by NGOs and CBOs (community-based organization) on behalf of NACO is held up as evidence notion that "communities make the difference", as the theme for World Aids Day 2019 stated.

Yet where were these targeted interventions when Arvind, Rounak, Faisal, Vikram and other men who are into high fun needed them? The next two chapters suggest the lack of harm reduction services in contexts of queer sexualized drug use is symptomatic of the decline of the community-based approach over the past decade, and explore some of the reasons for this decline. As explained in Chapter 1, India's replacement of a punitive approach with a human-rights based one took place in the aftermath of economic liberalization in 1991, opening India up to global flows of finance and ideas. Domestic criticism of the harsh treatment that sex workers and drug users were receiving in the name of Aids prevention combined with a growing international consensus that criminalizing "high risk" groups or behaviours was counter-productive. People like Jonathan Mann, director of the WHO's Global Programme against Aids, were inspired by the successes of people living with or at risk of HIV/Aids in organizing grassroots prevention efforts and advocating for research, treatment, and dignity (Chan 2015). These groups were some of the first collectives to ground their claims for rights and resources on a medical condition, pioneering what medical anthropologists would come to refer to as biological citizenship. In this chapter I briefly survey this history and the conceptual cluster of biopolitics, biological citizenship and biosociality before exploring, in the following two chapters, the construction of "community" in Indian HIV/Aids programming.

HIV/Aids communities

The deployment of a biomedical condition as the basis of individual or group

subjectivity is relatively novel. “Perhaps the templates for these new forms of biological and biomedical activism were the campaigning groups that arose around AIDS,” Carlos Novas and Nikolas Rose suggest in their review of scholarship on biological citizenship, “especially in the English speaking world” (2003, 18). The U.S. American experience of grassroots mobilization in response to Aids is the most well-known one, and influenced the shape HIV/Aids activism – and arguably health-based activism more generally – would take globally. Though it is now recognized that HIV/Aids had been circulating among the American racialized underclass in the years before it became a reported epidemic (Thrasher 2022), the condition was first identified as a disease cluster among gay men, after which it famously reported as “gay cancer” in 1981. This, along with the conditions initial entry into medical discourse as Gay-Related Immune Deficiency (GRID), speaks volumes of homophobia that shaped early apprehension of the condition, argues AIDS historian Sarah Schulman in *Let The Record Show: A Political History of Act Up New York, 1997-1993* (2021). In the absence of an identified viral agent, there was much scientific speculation linking the disease to a so-called homosexual lifestyle, whether via poppers or fisting.

It was true, of course, that urban gay communities were disproportionally affected – and it was these communities that forced HIV/Aids onto the agenda. Dennis Altman (2010) has linked the powerful mobilization around HIV/Aids in North America to the existence of a strong gay liberation movement and associated cultural institutions (e.g. gay press, shared venues) that provided the communicative infrastructure for effective grassroots service provision and activism. The notion of a gay community, itself only a few decades old, chimed well with the epidemiological concept of a core group, according to which some segments are more likely to transmit STIs than others on account of their engagement in risk behaviours (Barnett & Whiteside 2002, 82). “Gay men,” writes cultural theorist Cindy Patton in *Globalizing Aids*, “could be understood as transmission vectors safely trapped within the protective perimeter of “community,” a sharply defined “risk group” because their “risk factor” was thought the be coextensive with and exclusive to their group” (2002, 23). The grassroots political responses and service organizations inadvertently aided this conflation of socio-political notions of community and the biomedical risk group concept.

Over time, US. American Aids activists’ relation to their government became less antagonistic and more cooperative. “It was through their identification as members of this community, that those in ‘high risk groups’ were recruited to their responsibilities as *biological citizens*” explain Rose and Novas, “and health educators came to realise that it was only by means of the translation mechanism provided by AIDS activists that they would be

able to gain the allegiance of the active gay men who were their primary target" (2003, 18, emphasis mine). Aids activism and the uneasy alliance that developed between the state and a profoundly stigmatized group might thus be understood as a kind of precursor to what Rose and Novas term "rights bio-citizenship" (2003, 6). As a result of this symbiotic, if not unproblematic relation, HIV/Aids came to be dominated by what Patton earlier had described as a "queer paradigm" (Patton 1990) linking the containment of the epidemic to the governance of deviant (e.g. queer in the un-reclaimed sense) groups who engage in risky behaviours - rather than, for example, to changing the material and political conditions that pattern HIV vulnerability in the U.S. and globally (Farmer 2009, Geary 2014). In the U.S., these groups were initially referred to as the four H's – homosexuals, Haitians, heroin-users and haemophiliacs (albeit at risk due to blood transfusions rather than any "deviant" behaviour).

Since then, risk taxonomies have expanded to include many other groups. In *Politics in the Corridor of Dying*, Jennifer Chan (2015) traces ten stereotypes that populate global HIV/Aids discourse: the promiscuous gay, the criminal junkie, the dirty whore, the innocent mother and child, the Aids orphan, the hormone-charged youth, homosexualis africanus, suspicious foreigner or migrant, transgender pervert, and dangerous outlaw. She argues that "by singling out already marginalized and stigmatized sections of society— variously called "vulnerable populations," "subpopulations," "at- risk groups," "most- at- risk populations (MARPs)," "key populations," and "key affected populations"— this type of risk taxonomy replaces "a scientific problem (what factors are causally responsible?) with a moral and political one (who is accountable?)" that legitimizes the control of the AIDS body" (2015, 26). The label "high risk group" has been dropped in favour less incriminating phrases. UNAIDS terminology guidelines from 2015 state that the term high risk group should be avoided because it implies that risk is contained within a group, thus giving a false sense of security among people who do not belong to these groups (but may be engaging in risk behaviours, or married to someone who is) while stigmatizing those who do. In its stead, the agency recommends "key populations", "in the sense of being key to epidemic's dynamics or key to the response" (UNAIDS 2015, 8). The principle of governance-through-community (Nove & Rose 2003, 18) thus persists, and the ambivalence of the explanation speaks to the doubleness of the relation of these communities to the state.

Decades before these developments, infected and ill people also began asserting themselves as a distinct community. At the Fifth Annual Gay and Lesbian Health Conference held in Denver, Colorado in 1983, a small group of self-identified "people with AIDS"

(PWAs) wrote and presented a manifesto that became known as the Denver Principles. In it, they demanded freedom from discrimination, greater inclusion at all stages in AIDS treatment, research and policy, and outlined their rights to emotionally and sexually fulfilling lives (and deaths) as people with Aids. As activist Sean Strub explains,

> this was the first time in the history of humanity that people who shared a disease organized to assert their right to a political voice in the decision-making that would so profoundly affect their lives. Yet, the concepts codified in that document were not original; they were informed and inspired by the women's health movement that arose in the 1960s. They reinforced the message that the personal is political and that women—and those facing a stigmatizing, life-threatening illness—needed to become agents for change, for themselves and for their communities. In the months and years that followed, The Denver Principles spawned a self-empowerment movement that launched thousands of organizations and became a lifeline for people with HIV around the world. (Strub 2019)

Eleven years later, these principles were formalized as Greater Involvement of People with Aids (GIPA) Principle at 1994 Paris Aids Summit. In the intervening decade, "PWA" networks and related notions of self-empowerment spread across the globe, often overlapping with identity-based community organizations of sex workers, gay men, drug users and other affected groups (Chan 2015, 192). As the Vinh-Kim Nguyen (2010) has argued in his ethnography of patient networks in West Africa, the discourse of *being a person with HIV/Aids* became an important tool for accessing care and treatment at a time when medications were scarce due to their unaffordability.

The adoption of the GIPA principle - among other factors including Jonathan Mann's belief in a pragmatic, human-rights based approach, global grassroots activism, and patient-expert alliances - led to the emergence of what Chan (2015) characterizes as a community regime of power (in addition to science and governance). While the inclusion of people who are affected by HIV/Aids in policy making is doubtlessly a positive development, Chan raises questions related to subjectivity, legitimacy, and accountability:

> Who comprises this AIDS community? To whom is it accountable? (…) Has part of it morphed into dominating power structures? What does it mean and do when AIDS activists invoke the community "we"? (…) How does the AIDS community derive its identity, power, and legitimacy? In what ways is the community constructed and

> conditioned by other power systems? Who decides who counts as a member of this community? (2015, 190)

Chan's air mile-heavy methodology reflects the global nature of these networks, with international INGOs as brokers between donors based in Europe and North-America and local "community-based organizations" (CBOs) or NGOs working closely with, and often staffed by, "community". The targeted intervention explored in chapter 8, for example, is funded by a British organization via large international NGO based in New Delhi.

Biosociality and biological citizenship

These developments have been approached by medical anthropologists through the frames of biosociality, biosociality, and biological citizenship. Key to this field of scholarship is Michel Foucault's (2008) notion of biopolitics, developed during a series of lectures between 1978 and 1979. The concept emerges from the philosopher's wider concern with a shift from negative (repressive) to positive (enabling) forms of governmentality in modern Europe, starting in the 17th century – although both technologies of power persist and work in tandem. Whereas disciplinary power operates through limitation and submission, the mechanism of power that characterizes biopolitics seeks to maximize and mange life in general. "The second [pole], formed somewhat later, focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary," Foucault explained in the first volume of *History of Sexuality*. "Their supervision was effected through an entire series of interventions and *regulatory controls: a biopolitics of the population*" (1976, 139). In other words, while sovereign juridical power is the power to '*take* life or *let* live', biopower could be defined as "a power to foster life or disallow it to the point of death" (1976, 139). This latter aspect of biopower has been revised and elaborated by Achille Mbembe in his theory of necropolitics, which proposes that racism is the main condition for acceptable death (Mbembe 2019).

Medical anthropologists like Paul Rabinow, in contrast, have mainly focused on biopower's *productive* qualities. Biosociality refers to the way in which medical technologies, disease classifications, genomics and knowledge of genetic risk generate novel forms of individual and collective subjectivities (Rabinow 1996). These new categorizations and identities sometimes form the basis of political action, as Adriana Petryna has shown in her influential ethnography of the claims made of the Ukrainian state in the wake of the 1986 Chernobyl disaster (2011). Petryna identifies in these claims an assertion of "biological

citizenship", articulated in this particular case as "a demand for, but limited access to, a form of social welfare based on medical, scientific, and legal criteria that recognize injury and compensate for it" (Petryna 2004, 262). This constitutes a break with traditional legal-philosophical conceptions of citizenship, point out Carlos Novas and Nikolas Rose (2003). They propose thinking of citizenship as a *projects* (rather than legal fact) through which the state relates to its subjects and vice versa, and argue that biomedicine and biology play an increasingly important role in these projects. They use the term biological citizenship to describe "all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as populations and races, and as species" (Rose & Novas 2003, 2). While this encompasses a wide range of articulations – the authors illustrate their thesis with the examples of bipolar affective disorder, Huntington's Disease, and PXE – we are interested here in biology-mediated citizenship projects of "communities", and particularly HIV/Aids communities.

Novas and Rose point out that the forms activism takes are shaped in part by the specific biopolitical histories and modes of government of different national contexts, including presuppositions about persons' rights and obligations (2003, 7). In the case of Chernobyl, for instance, claims for compensation must be understood in relation to the wider context of democratization and harsh market transition that characterized the 1990s in post-Soviet Ukraine (Petryna 2004, 261). In India, the construction of HIV/Aids communities contains echoes of British colonial governmentality. Suparna Bhaskaran (2004) identified a continuity between HIV/Aids governance and what Arjun Appadurai described as "colonial numerology", e.g. the enumerative practices of population management that continue to inform politicized modern identities in India. In his critique of postcolonial governmentality in India, political scientist Partha Chattjeree (2006) developed the term "political society" to refer to the majority of society that lacks access to stable citizenship as individuals and can only access resources as populations groups that are targets of governmental policies. Others have critiqued Chatterjee's division between civil and political society, suggesting claims to governmental welfare and citizenship rights can be inter-mixed strategies (Corbridge 2005). Applying these insights to HIV/Aids governance in India, Aniruddha Dutta suggests that "political society marks an arena of negotiation between non-elite claims to citizenship and the biopolitical management of populations" (2013, 500).

The rights struggles by some of the communities associated with the HIV/Aids epidemic – sexual and gender minorities and sex workers – exemplify this type of

negotiation, with the HIV/Aids epidemic playing a key role in the self-conception and mobilization of these criminalized groups not just as populations for targeted behavioural change, but as *communities* that can lay claim to citizenship, to varying degrees of success. In *Legalizing Sex: Sexual Minorities, AIDS, and Citizenship in India*, Chaitanya Lakkimsetti (2020) argues that that HIV/Aids heralded a shift in these groups' relation to the state. Previously the subject of judicial power and excluded from developmental programs, sexual minorities – which include, for Lakkimsetti, transgender people and female sex workers – were now enlisted in one of the state's most important biopower projects: preventing a full-blown Aids epidemic. In the process, they were empowered to resist their marginalization and exclusion from citizenship. Gowri Vijayakumar (2021) makes a similar argument in *At Risk: Indian sexual politics and the AIDS crisis*, but she stresses the provisional nature of this resistance. She argues that the construction of a looming HIV/Aids crisis enabled a temporary, conditional and contradictory opening for sexual minority and sex worker activists to make demands on the state as citizens, first and foremost by challenging their criminalization.

The next two chapters explore what happens to these communities now that the rhetoric of Aids-as-crisis has given way to a discourse of "ending aids" through biomedical means. Chapter 7: Communities Make the Difference focuses on the discursive aspect of "community" as it is invoked in Indian HIV/Aids programming and explores the decline of India's celebrated community-based approach to prevention. I show that in the aftermath of the withdrawal of international donors, the community HIV workers whose role in halting India's epidemic is often celebrated feel abandoned. The allegation that communities are no longer invested in or listened to now that the epidemic has been contained among them challenges the notion of Indian HIV programming as a win-win situation, e.g. a biopolitical project that empowered marginalized sexual minorities while protecting public health, by revealing its necropolitical dimensions. The shift away from community-based HIV prevention explains in part why targeted interventions, described as under-resourced and out-dated by the people working in them, are failing to reach men who are into high fun. But high fun also exposes tensions and contradictions inherent in the conceptualization of community that underpins the system of targeted interventions, I argue in Chapter 8: Targeted Intervention, which explores what "community" looks like in practice. In other words, while high fun demonstrates the continued need for community-based approaches to HIV/Aids prevention in the era of treatment-as-prevention, it also challenges us to re-think some of the

classifications and assumptions and inform such approaches.

Chapter 7: Communities make the difference

"Today's World Aids Day is an empowerment day," the host of the celebrations organized by India HIV/Aids Alliance in New Delhi addressed her colourful audience, using a combination of English and Hindi. "I am saluting you as community, humbled, to give you a big thank you," the president of the National Network of PLHIV continued. "Because communities make the difference. *Usko matlab kya hai*?"

What does it mean to say that communities make the difference? And does this still hold true today, following the global downturn in funding and the turn to treatment-as-prevention strategies? In India, communities are credited with having halted the epidemic through the system of targeted interventions. Yet these interventions, as we will see in the next chapter, are not doing so well. In this chapter I critically engage the notion of Indian HIV/Aids prevention as a story of community empowerment through partnership, encapsulated by the 2019 World Aids Day theme of "communities make the difference". After attending to the celebrations, I contrast this notion to the allegation of abandonment related to me by MSM and transgender HIV workers. Drawing on conversations with HIV/Aids activists across the country, I then outline some of the perceived reasons behind the decline in the community-based approach: the decline in international funding, the rise of Hindutva politics, and the global shift towards global turn to test-and-treat strategies as means of "ending Aids". I suggest these developments reveal the precariousness of projects of biological citizenship and bring to the fore the necropolitical dimension of Indian HIV/Aids programming obscured by the celebration of "communities".

Celebrating community

"*Aap kaun hai*?" The MC asked the groups that had come from all over the country to fill the auditorium at a location in Luyten's Delhi after her introduction. Thanks to my volunteering with one of these groups I too was invited. Who are the communities associated with HIV/Aids prevention in India, and how have they been empowered through their involvement in this biopolitical project?

"Sex worker!" shouted a few people on the front rows. "Really", said the MC when the rest of the attendees remained silent, feigning surprise. "Only sex workers?" "Young leader!" declared a suited teen next to me, as if reporting to duty. "Okay. *Aur*?" "Pee-el-atschj-ai-fee community," offered somebody else, the clunky acronym for 'people living with hiv' clearly part of her everyday vocabulary. "Thank you," the MC affirmed. "Transgender!"

shouted one of the women from the bloc to the right from me. "Yes. And?" Cries of "MSM, MSM" rose in the back. "And finally," the MC continued, "the marginalized within the marginalized…?" Silence. "PwUD community," a man in the middle of the auditorium responded eventually, almost inaudibly. "Yes!", exclaimed MC excitedly. "WOMEN IN SEX WORK COMMUNITY!" came another contribution from the front row. "We already covered those." The MC then asked us to stand up as she read out different identity categories associated with HIV/Aids, and I noticed the women sitting next to me looking at me when the MC arrived at PLHIV.

What all has the PLHIV community achieved, the MC wanted to know next. "*Are, bolo!*" she added when no replies came, "*ek* sentence *me bolo*", tell me in one sentence! She led by example, suggesting that because "we stand unitedly and we fought for ourselves", any person living with HIV [in India] now has access to treatment. "What else?" "Kill the bill!", screamed someone from the back of the hall, presumably referring to the Trafficking for Persons Bill introduced by India's Minister of Women and Children's development in 2018. "We empowered ourselves. SEX WORK IS WORK." "Fantastic," affirmed the MC, "all movements started with HIV – nobody cared about sex workers, transgender… everything got highlighted with HIV." At this point, someone in the audience shouted "NALSA", the shorthand for the 2014 Supreme Court judgement in National Legal Services Authority v. Union of India that recognized transgender people's right to self-determination and directed the Centre and state governments to devise and implement welfare schemes for transgender people (Orinam 2014). "*Sirf India mein hai* third gender recognized as legal," the woman continued at the top of her voice (though Nepal beat India to it in 2007), "and transgender *ke liee* special programs *hai*," and there are special programs for transgender people. "What about MSM," said the MC, not missing a beat, "what is your biggest contribution?" Someone a few rows behind me rose and shouted "Section 377 *KHATAM HO GAYA*," causing the room to erupt in cheers and applause. "Section 377 is gone," the man added for the merit of non-Hindi speakers.

The exercise in interpellation reflects the way in which HIV/Aids governance has given birth to new categories of identification, including "MSM" – despite that acronym's origins as a category that was meant to circumvent the question of sexual identity in contexts where terms such as gay or bisexual have little traction (Boellstroff 2011, Boyce 2006, 2007, Boyce & khanna 2016, Boyce & Cataldo 2019). As Suparna Bhaskaran explains, India's HIV/Aids response facilitated the constitution of sexual outcasts as "sexual minorities" (Bhaskaran 2004) not just populations for behavioural change targeting, but *communities*

whose voices mattered if the fight against HIV/Aids was to succeed. In the process, these groups were turned into "politic-moral actors with access to a particular lexicon of health, risk and rights" (Misra 2003 in khanna 2016, 4) even as their behaviour remained criminalized. As Aniruddha Dutta points out, the activist-state-funder network that akshay khanna refers to as the 'HIV-AIDS industry' (2016) extends beyond HIV/Aids programming, enabling community-based activism for rights and empowerment that many among the lower class and caste sexual and gender minority groups would not have otherwise had access to (2013, 487). "I was part of a team that helped draft the proposal to the Global Fund for funding for MSM communities," HIV/Aids activist Aditya Bondyopadhyay recalled during an interview. "And one of the things we insisted on was the establishment of small CBOs [community-based organizations] across small towns, at the district level, et cetera. So that created a political movement for LGBT rights that could go beyond just HIV." As explained in Chapter 1: Introduction, this mobilization was key to the challenge against Section 377 – itself sparked by the arrest of MSM outreach workers under obscenity charges.

The MC's second question reflects the way in which "the new political subjectivities formed through these projects give marginalized groups the power to speak back to the state as well as fight back against repressive state power," as Chaitanya Lakkimsetti (2020, 4) argues. She draws on two of the struggles referred to by the events' attendees, the fight against Immoral Traffic (Prevention) Act, 1956 (ITPA) and the challenge to Section 377, to argue that the HIV/Aids epidemic furnished previously criminalized groups with new subjectivities and political opportunities. It did so by prompting a shift in the relationship between the state and sexual minorities from repressive or juridical power to bio-power. Previously excluded from developmental projects and relevant to the state only as subjects of persecution, if at all, sexual and gender minorities and sex workers became key partners in one of the state's most important biopolitical projects, namely HIV/Aids prevention. As Sujatha Rao (2017) recalls in her memoir, the growing consensus that India's epidemic was concentrated among "high risk groups" gave NACO sanction to work with criminalized groups. Under her leadership NACO included these groups not just as targets for behavioural change, but as partners whose participation as peer educators was of crucial importance to the success of the HIV/Aids programme. "The promoters of these HIV governmentality projects mobilize high-risk groups as agents of governance by reimagining them as a *community* with the right not only to be served, but also to be heard", writes Lakkimsetti. "In the routine, mundane, and seemingly banal practices of targeting marginalized groups, these biopower projects produce discourses and subjects capable of greater political agency" (2020, 51-52).

HIV/Aids, in other words, enabled sexual minorities to lay claim to citizenship, to varying degrees of success.

The partiality of these gains was reflected in the difference in tone and content of the responses solicited by the MC's prompt. The sex workers' response was a rallying cry: their fight was still on-going (in May 2022, the Supreme Court ruled sex workers should be treated with dignity and respect by law enforcement, and that no criminal action must be taken against any adult engaging in consensual sex work while the anti-trafficking bill is pending (Outlook 2022). The gay men and transgender women, on the other hand, were jubilant, having won decriminalization and some degree of state recognition. The woman representing the transgender contingent at the World Aids Day represented the recently-passed Transgender Persons (Bill of Rights) Act as a victory by and for the trans community. "We're an important stakeholder," she said, "so we celebrate today." Yet on the eve the Bill passed, transgender and queer activists staged a protest outside Bengaluru's town hall, where the Bill - along with the BJP- was denounced in no uncertain terms. As colleagues at the NGO I volunteered at explained, opinion on the Bill was divided along lines of religious practice/identity, political affiliation, region, and, crucially, gender (the Bill barely mentions transmasculine persons). The Tamil Nadu Rainbow Coalition in Chennai expressed "profound dismay" at the Bill and lamented its violation of the principle of self-determination emphasized in NALSA (Orinam 2019). The fact that the speaker considered herself an important stakeholder when many transgender people and organizations have lamented the lack of meaningful consultation and opposed crucial elements of the legislation reflects her investment in the narrative of empowerment-through-partnership, but also raises the question which part of "community" is empowered.

When the MC asked the PwUD (people who use drugs) contingent of her audience specifically what they had "contributed", a well-known harm reduction activist stood up and answered demurely that "actually, we have not had much success…." He explained that there were no significant contributions till date, but that drug user organizations like the one he founded have made the government understand the importance of oral substitution therapy, which was slowly expanded during NACO's third phase of programming (Rao 2017). Drug use remains highly criminalized under the Narcotic Drugs and Psychotropic Substances Act, 1985, with possible punishments ranging from 6 months to 20 year jail sentences and even the death penalty. (Indeed, it is this legislation that made the NGO workers I spoke to hesitant to start a conversation about high fun, let alone provide things like needle exchange services.) The measured and barely audible response was at odds with the celebratory atmosphere

created so skilfully by the MC. Had the drug user community really been able to make a difference? Were the government and/or the courts ready to listen to their concerns?

Lakkimsetti's fieldwork period – 20 months of research conducted between 2007 and 2015 – coincides roughly with the heyday of India's HIV/Aids response, not least because of Sujatha Rao's commitment to scaling up targeted interventions when she became NACO's Director General in 2006. In her memoir, Rao (2017) boasts of the extensive exercise in "community consultation" that preceded the National Aids Control Program (NACP) III, NACO's third phase of programming (2007-2012). She recalls meeting Ashok Row Kavi, a prominent gay activist from Mumbai, whom she describes as a "great help" in sensitizing NACO staff "on issues related to gays, various categorisations among homosexual community, and their specific problems" (2017, 267). Rao learned that "gays cannot help their sexual orientation," (2017, 267) and that "we" have no option but to accept them and give them the required social space. Embarrassing though this account may be, it is indicative of the way in which HIV/Aids forced the state to provide tacit sanction for engagement with groups that were outside the pale of respectability - even if Kavi shares many of the same caste and class privileges as bureaucrats do. Rao is clear that under her leadership, the agency was guided by the principle of harm reduction, not morality: "the issue was not 'should we' but 'how should we'" (Rao 2017, 249), and communities provided the 'how'. MSM were added to NACO's list of key populations in NACP III.

But Rao worries NACO's relationship to the "communities" has changed since her departure. When planning for NACP IV began in 2011, a letter by civil society groups to the economic adviser to the PM that advocated for a community-based approach over a techno-managerial one went ignored. There was also a gathering in New Delhi where HIV/Aids workers appealed for a more inclusive approach, registered their concern over what they perceived to be an "ad hoc and top-down non-consultative process" (Rao 2017, 287), and demanded an independent review of NACP-III as well as widespread consultations for the preparation of NACP-IV. A report was prepared and swiftly buried, leading to a perception of a lack of respect from NACO. When the plan for the fourth phase of programming was published in 2016, communities dismissed it as a "weak update" that took no account of how the ground realities had changed (Rao 2017). "NACO has erred in giving up the community-based approach", concluded Rao (2017, 288).

The World Aids Day celebrations in Delhi were intended both as a celebration of communities and an opportunity to consult them, as one of the organizer's explained to me. "We are part of the solution, not the problem," the MC reminded her audience before they

split into groups (based on community, e.g. MSM with MSM, sex workers with sex workers, young leaders with young leaders, etc.) to discuss the next phase of HIV/Aids planning and come up with a list of demands to be presented to a panel including a NACO official and the minister of Social Justice and Welfare. But, as the organizer reflected later, there was not enough time to delve into NACO's plans for its next phase of programming, and no strategy document to guide the discussion. Leaving the event, I realised I was none the wiser about the details of NACP-V - which was later postponed to 2021 (NACO 2022) - or what exactly the officials who comprised the panel were going to do with the feedback that had been presented to them with much gusto by spirited sex workers and with less gusto by disillusioned drug users. As I made my way to and informal gathering about high fun that Anthony helped organized (his reflections on it are discussed briefly in the next chapter), I realized there had been no mention of high fun during the brainstorming session with "MSM", nor had there been any recognition of the area of overlap between people who use drugs and men who have sex with men, and what such overlap might require of service provision.

"Transgender *zindabad*, *samalaingika zindabad*, sex worker *zindabad*, plhiv zindabad, *saab loogh* zindabad," the transgender community leader had concluded her speech at the top of her voice. Long live transgender people, homosexuals, sex workers, people with HIV, and everyone else. "Policy is ours, targeted interventions are ours," she continued, epitomizing the ideas of partnership and empowerment that the event sought to affirm. Yet this notion of community ownership over Indian HIV/Aids programming is increasingly at odds with the reality on the ground.

Empowered or exploited?

By the time I interviewed staff at NGOs and community-based organizations (CBOs) in various Indian cities three years after the publication of Sujatha Rao's memoir, the answer to its rhetorical titular question was a resounding no. "They don't care," insisted Vishnu Prasad, a seasoned peer outreach worker in Secunderabad and himself an HIV-positive gay man/*kothi*. The office in which we met was a very narrow room on the second floor of a non-descript building located in an alley in a lower middle class neighbourhood. It is a long way from the gleaming office in central Hyderabad the organization enjoyed during the noughties, as Prasad stressed. Funded through the Avahan project launched by the Bill & Melinda Gates Foundation in 2003, the organization at one point employed around 60 staff to deliver a mandate that covered the entirety of what was then the undivided state of Andra Pradesh. "The government was able to listen to us at the time," Vishnu explained. "It was community-

based projects then. But now they are tailor-made projects from NACO. *You need to do this, this…*" Why doesn't this top-down approach work, I asked. "It's not specific enough!," Prasad exclaimed with evident exasperation. "And in NGOs they [NACO] are appointing non-community field staff: they don't understanding our feelings, our emotions. Maybe he's educated, but can he intervene if you don't understand our feelings?" This, for Prasad, was a key difference between a community-based approach and a techno-managerial one - while "community people" have *feeling* for the people they are working with, while "NACO bureaucrats" do not. Moreover, Prasad felt NACO bureaucrats were no longer willing to listen to community members. "Do they know our sexual needs," asked Vishnu rhetorically. "When was the last consultation? How will they know what the new generation of MSM is up to? And how are we supposed to hire peer outreach workers at salaries of 8,000 rupees?"

"What rubbish," objected someone who is part of one of the Technical Resource Groups assisting NACO with gathering feedback from key populations, amongst other things, when I presented him with these allegations. He conceded there may be issues with staffing and stagnating salaries due to the shrinking budget, but that NACO continues to listen to affected communities. However, an employee of a major HIV/AIDS organisation told me that NACO has not organised a meeting with MSM groups in three years. He added that instead, consultations are hosted by international agencies and NGOs—and that the government *does* listen to the feedback that is presented. The World Aids Day celebrations were an example of such a consultation. In Bengaluru, I attended a full day of consultations organized by the NGO with which I was volunteering and other groups. The audience in attendance a combination of middle class activists and NGO workers and working-class peer outreach workers, some of them living with HIV. All were thoroughly informed of the issues at hand before voicing their critiques, of which there were many. But, as the NGO organizing the consultation complained afterwards, no one from the Karnataka State Aids Control Society or NACO had shown up.

The issues raised by Prasad – lack of consultation, top-down governance, and stagnating targeted interventions – resonated with other CBO/NGO workers and activists, many of whom felt they were bearing the brunt of NACO's funding crunch and institutional chaos, detailed by Gahlot (2015) and discussed briefly in Chapter 1. As Times of India Nagpur reported in 2014, six months into the financial year organizations working for NACO were still without funds (Gwalani 2014). While some of the reasons behind this were specific to that year – such as the transition into National Aids Control Program (NACP III) (phase four of programming), the change of government at the centre, and a proposed merger

between NACO with the National Rural Health mission – others were more structural, and had lasting effects. A *hijra* I spoke to in Chennai exaggerated only slightly when she told me she can earn more with a few blowjobs than she does per month as a peer outreach worker, pinching the bridge of her nose for comedic effect. In Maharashtra, peer outreach workers are working without pay for months on end, claimed Meena Sheshu and Aarthi Pai of sex workers' organization SANGRAM.

The exchange between them and Anjali Gopalan, who joked I got "three for the price of one" when I visited her at Naz Foundation's office in New Delhi, illustrates the perceived problem well:

> Aarthi: One of the things about the interventions in SANGRAM is it just gives you a sense of the strength of communities. Despite the fact that last year they did not receive *any* money, for literally what was a period of close to nine months. Meena, how many months did the TIs not get salaries last year?
>
> Meena: Oh my god, it's not just the TI money – they don't have a proper chain of management of anything! So we had huge stock-outs. Not getting money for ten months was the least of our probl...
>
> Anjali [raising her voice]: I'm just saying, show me a bureaucrat who doesn't take her salary for ten months!
>
> Meena: The point is that - now they've even explained it to us – the system is such that you don't get you're salaries for six months. So they're expecting these communities….
>
> Anjali: What about the NACO fellows not taking a salary?! Then?!
>
> Aarthi: No, the point that I was trying to just make was that for the first time, we're actually getting a life demonstration that *if* these were *not* communities… And, you know, now with this understanding of community-based organization – this is my pet anger now – you're not expecting the NGOs to work without money, but you're expecting the communities to work without money. Because they should.

What Aarthi Pai and Meena Seshu were suggesting is that communities *do* make the difference, but that this is taken for granted. They implied that the celebrated peer-to-peer model – and, indeed, the very notion of community – is exploited by NACO in its effort to minimize investment in targeted intervention infrastructure, with Anjali Gopalan stressing that the white collar workers of NACO would never accept such conditions for themselves.

This suspicion that "community" is operationalized as a cost-cutting strategy, in which the labour of prevention and treatment linkage services is out-sourced to groups whose

work can be taken for granted, was shared by Shuba Chako in Bengaluru. In the office of Solidarity Foundation in Bengaluru, an organization that works with sex workers and sexual and gender minorities, she explained that CBOs were created with the large amounts of international funding that became available in the early 2000s. "Our idea when we accepted the funding was that programmes can be handed over to these CBOs and people can then decide for themselves and take it forward," she reflected. "But their [NACO's] idea of this CBO pushing was more from an instrumentalist viewpoint. This model is cheaper than the NGO model and more effective, 'cause you can keep salaries lower, whereas with NGOs you get professionals, people with qualifications, and you have to pay higher salaries."

A project manager at an HIV/Aids NGO by and for sexual minorities in Delhi protested these double standards by asserting peer outreach work as a form of *professional* labour. "Everybody wants their bread and butter," he explained,

> Without bread and butter, who will work? If my basic needs are met, then I can work. But if there is no funding support, then how can I work? We can say it's professional work versus social work – social work I can do for one day, but professionally I need to get paid. So in that way, it's high time we think about where we are going [with the targeted interventions].

Through this distinction between social and professional work, the project manager critiqued the devalued status of peer outreach work, challenging the notion of "partnership" invoked in narratives of Indian HIV/Aids policy. His and other interlocutors' comments suggest the empowerment-model of HIV/Aids prevention is increasingly experienced as a form of exploitation. Moreover, insofar as community work can be taken for granted as labour of love, the notion of "community" paradoxically justifies/enables NACO *not* to invest in community-based approaches. The rhetoric of "communities making the difference" thus masks the operationalization of community as a cost-cutting strategy in the context of the withdrawal of international donors.

Kickstarted by a World Bank loan to the tune of $84 million, the first two phases of India's HIV program were funded mainly through international organizations, including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM, founded in 2002) and USAID. In 2003, the Bill and Melinda Gates Foundation launched its own project in states it had identified as high-prevalence. At a whopping $250 million, later increased to $338 million, Avahan's budget was larger than that of the entire NACP III - and much of it went to

targeted interventions (Rao 2017). But when the HIV programme entered its fourth phase in 2012, "the Indian government was expected to provide nearly 80 percent of the funding, while external donors gradually reduced their role" (Gahlot 2015), leading – according to Gahlot's interlocutors at NACO – to the introduction of the kind of red tape that the autonomous department had previously been spared. "And then Gates walks away," recalled Gopalan, referring to Avahan's long drawn-out exit and the less-than-smooth phased transfer of its targeted interventions to NACO between 2008 and 2013 (followed by another three years of hand-holding) (Rao 2017). "And everything came to a standstill. And the government kept doing what it does in its half-arsed manner."

The Bill and Melinda Gates Foundation were not the only international donors to majorly scale down their role in halting India's HIV/Aids epidemic following the global Recession of 2008 (CITE), with the Global Fund to Fight AIDS, Tuberculosis and Malaria reporting a $3 billion shortfall in 2009 (MacInnes 2019). And because India's HIV/Aids statistics had improved, the country was not a priority: the threat of a generalized epidemic had not materialized, is in part due to the efforts of the "communities" to contain the epidemic. (If it is true, as former UNAIDS epidemiologist Elisabeth Pisani (2009) has claimed, that alarmist warnings of generalized epidemics relied on strategically gloomy interpretations and representations of available data, we might question how big this threat really was, but this is far beyond the scope of our discussion here.) Meanwhile, the decline of donor enthusiasm was matched by a nationalist rhetoric of self-sufficiency (*swaraj*) when the Bharata Janata Party came to power in 2014.

The effects were keenly felt by the communities who previously enjoyed earmarked funds. During an interview in the office of SAATTHII (Solidarity and Action Against The HIV Infection in India) in Channai, Dr Ramki Ramakrishnan explained the situation as follows:

> The smaller organizations whose bread and butter was actually going out and doing prevention are feeling the pinch now, because a lot of the large scale prevention programs funded with World Bank [money] or [by] large donors are being scaled down. The government wants to be more self-reliant, but they've also scaled down. But part of it is also that they are not seeing new cases. I've heard this from the government: *When we actually go to the field and do a field verification, a lot of them were actually identified [as HIV-positive] two years ago. So if there are no new ones does this means we have saturated?* And there are definitely issues with the unreachability of some of the groups. So I don't think it's good to sit back and say,

> *Ok, we've controlled it*. So yeah, you get that sense of abandonment with the TI [targeted intervention] NGOs…

Dr Ramakrishnan's interactions with the Tamil Nadu State Aids Control Society, to whom he acts as an advisor, suggest that the limitations of targeted intervention in reaching "new" populations are mistaken for their success by evidencing "saturation". This paradoxically justifies the very underinvestment that in part prevents targeted interventions from, for example, reaching men who are into high fun and other groups of people who are traditionally reached by these organizations, as the next chapter will show.

More generally, the sense that targeted interventions have served their purpose reflects a central tension of the community-based approach, namely that between partnership and population management. According to Sheshu, the government's approach to "communities" was always instrumentalist. "The rationale is that *they are vectors of HIV, we are going to get infected through them, better give them rights and if you give then rights then they'll use a condom*," she explained. "I mean, it was ridiculous, but that was the argument." Sheshu recounted reading a Maharashtra government document that labelled female sex workers as vectors and suggested we need to work with them to ensure the "bridge population" of men who pay for sex are safe, and "good wives at home" will not get infected. And so the perceived need for targeted interventions diminishes along with that of a threat of a generalized epidemic. "They were only interested in empowering people insofar as that would stop the spread to the general population," summarized Gopalan cynically. In Pune, HIV/Aids activist and professional Vivek Divan echoed this sentiment. "There is no attention to HIV anymore, the money is gone," he said. "Everyone thinks the problem is solved because the heterosexual epidemic – mainstream heterosexual – is under check."

For Aniruddha Dutta, the disposability of community HIV/Aids workers reveals the necropolitical dimension of Indian HIV/Aids programming. Describing the low salaries earned by peer outreach workers and the sudden termination of some of the projects in field-site, Dutta argues that

> the biopolitics of HIV-AIDS control is thus coupled with the necropolitical dispensability of workers in neoliberal economies (Puar 2007: 35), discarded after the accrual of prestige and symbolic capital by the state and funders; recently, the National AIDS Control Organisation and one of its funders, the World Bank, triumphantly announced the reduction of HIV prevalence in India (IDA 2009). If political society is an arena of negotiation between the biopolitical management of populations and non-elite claims to the rights of citizenship, the inclusion of lower

> class/caste gender variant communities as MSM fails as political minoritization, casting them as exploitable target groups without gaining them legibility or agency as a political identity. (2013, 504-505)

The rhetoric of community empowerment, in other words, masks forms of labour exploitation and the precarity of low-tier HIV/Aids workers, whose livelihood is dependent on the vagaries of international funding and domestic politics. Adding to their woes, interlocutors suggested that the ascent of a political force that flouts its contempt for minorities and civil society does not bode well for the community-based approach.

Authoritarian tendencies

In 2014, the Bharata Janata Party rose to power in a landslide victory attributed to its charismatic leader, Narendra Modi, infamous for his apparent complicity in a three-day period of violence targeting the Muslim minority when he was Chief Minister of Gujarat. The BJP is considered by many to be the political arm of the Rashtriya Swayemsevak Sangh, a Nazi-inspired paramilitary volunteer organisation that advocates for a Hindu *rahstra* or nation. The commencement of my fieldwork coincided with that of Modi's second term, during which no time was wasted to solidify the Hindutva project. The Citizenship Amendment Act (CAA) and the associated proposal of the National Register of Citizens (NRC), which together threaten the exclusion of Indian Muslims without the right documentation from citizenship, were the most conspicuous of Modi's attempts to disenfranchise India's 204-million strong Muslim minority (Verma 2020). Protests swept the country during my stay, to no avail. "What a fascinating time for you to be here," commented a friend's mum earnestly, "when you can really see the country slide into fascism."

While the decline of the community-based approach began in 2012 under the Congress Party-led UPA government, many activists I spoke to attributed the decline of the community-based approach to this changing political landscape. Several people told me the current government cares even less about HIV/Aids treatment and prevention than previous ones. Others suggested that the BJP's ideology impeded the community-based approach: "There has been the right-wing rise in India," said a board member of one NGO, "and that's created a certain way the money for sexual minorities can go." Although, as explained in Chapter 1, the BJP's response to the reading down of Section 377 has been ambivalent, Subramanian Swami's suggestion that the 2018 Supreme Court ruling decriminalizing homosexuality would "give rise to HIV cases" (News18 2018) suggests he sees the communities affected by HIV as the problem, and not a part of the solution. More

worryingly, in 2014 the then-health minister Dr Harsh Vardhan suggested that NACO should promote "purity in relationships and Indian values" (Gahlot 2015).

Dr Sam Prasad at Aids Health Foundation in New Delhi believes the government favours a return to the culturalist ethos that marked the initial response to HIV/Aids in the pre-NACO years (1986 – 1992), during which it was claimed that India's social fabric of tight-knit families provided protection against Aids. "The government is in denial," asserted the country program manager of the international foundation:

> It doesn't want to showcase that they have a prevalence 4 or 5 times more than what they're projecting, in my experience. With our rapid testing program in 11 states we are hitting almost 1% reactivity rate every year for the past five years – whereas the government in its ever-greening mode always wants to showcase 0.2% for the country. And in the latest report, you'll see that 9% [prevalence rate] has come down to 3% for transgender. How come? Have they all died off? Are they not coming in? Are they even having sex? So there is something called the reports, the data, and the reality – and the reality is far.

This alleged manipulation of data[12] to project India as a very low-prevalence country reflects a more general denial of sexuality, according to Prasad.

> We're a country of culture, ethos, pathos – bullshit! Newspaper reading does not produce children. We are the most sexually active nation with the highest population in ever of youth in the world. And all of them are having sex - whether homosexual or heterosexual or bisexual or whatever, they're having sex. Denial is the most dreadful disease India has, including about communities – LGBTI communities – at the NGO level and at the government level. We are the country that gave the world Kama Sutra - sexuality as divine enjoyment - but now there is so much hiding and closeting and judgemental attitudes.

This denialism, Prasad thinks, is what is driving the epidemic:

> This is the major scourge, more than HIV. This is the disease that is killing more people, this stigma which prevails out of this judgemental attitude as a public norm, and we're backing it up with culture. Behind the cultural rhetoric you are giving the virus the chance to spread, you're pushing the disease underground and they're dying and spreading the disease there. Had it been very open where we can sit and talk like

[12]These allegations were vehemently denied by somebody who works closely with NACO. The agency itself refused my repeated requests for a meeting or comments. Among the NGO workers I spoke to, it was generally understood that projected prevalence rates do not necessarily reflect reality, for a variety of reasons including wilful manipulation.

> this it would've been very different. How many families can actually sit about condoms?

Prasad linked the denial of sexual and gender diversity in India to a more general taboo on sexuality, suggesting that what's at stake is sexuality rather than "homophobia" per se**.** As Ratna Kapur reminds us, Hindu nationalism is hostile to any expression of sexuality "outside the model of the good Hindu wife," which includes, but is not limited to, homosexuality (2015, 10). Corroborating Prasad's claim that the government is "tearing down condom advertisements", Anjali and her friends spoke of a "complete black-out" on HIV, intended to protect the "general" (non-"community") public from such obscenities.

Prasad was also concerned about the harassment of NGOs. "They [the government] are asking so many unnecessary and difficult questions," he said, "many NGOs have been closed, and many are told that you are promoting homosexuality and promiscuity." The BJP's hostility is not limited to NGO's or CBOs working with sexual minorities, but extends to any organization found to be uncooperative. During the heady days of anti-CAA/NRC protests, the director of the Bengaluru NGO with which I volunteered shared his dilemma with me. "I encourage all our staff to go protest - but we're telling community members not to carry our placards," he said, visibly worried. "As an individual I would like us to be very political, but at the same time, all our staff depend on their salaries since they are from marginalized communities." The emphasis on salaries highlights, again, the precarious situation in which community HIV/Aids workers find themselves. Although the NGO has enjoyed a relatively good relation to the Karnataka State government, in the past few months they received three notices about "silly things". "And now recently they asked us to declare that we will not do anything against the national interest, or engage in anti-national activities," the director sighed. "And I signed it. Because *that* [the protests] is *our* country!" That day, most of the staff left early to join a human chain across the city that was formed in protest of the police shooting at Jamia Millia Islamia University in Delhi, which left several protestors dead. I went straight home on the insistence of the director, because a foreign student had recently been deported for attending the protests.

What the director was worried about was the revoking of the permission to receive foreign funding - a tool that the government was using with increasing frequency to shut down NGOs, often on the pretext of corruption or financial mismanagement. "Civic space has shrunk since Prime Minister Narendra Damodardas Modi came to power in 2014," states AVERT, an agency that gives information and advice on HIV/Aids globally. Its latest review

of the HIV/AIDS response in India noted the historically strong presence of organisations led by at-risk communities. "In 2018 UN Secretary-General Antonio Guterres expressed concern over civic freedoms in India, in particular over India's Foreign Contribution Regulation Act, which places CSOs who receive foreign funding under scrutiny and has been used to silence groups that criticise the government." One of the most high-profile of such cases involved Anand Grover, who I had a few days after fresh allegations against him and Indira Jaising emerged about misusing foreign funds for political purposes, and a month before their office was raided by the police (Ghoshal 2019). Their Lawyer's Collective played a major role in advancing access to HIV treatment worldwide by challenging patent law and protecting the rights of HIV-affected people and communities in India, starting with the case of Dominic D'Souza. The NGO was also a key player in the challenge against Section 377: it provided Naz Foundation's legal support and organized the series of nation-wide consultations that galvanized something approximating a unified queer voice after being initially accused of representing "the community" without their consent and input (khanna 2016). Now, according to Grover, they were "the most trolled group". This is not because of their support of HIV-affected communities, but because of the organization's human rights work more generally and because of taking up "sensitive cases" against prominent figures in the BJP (Ghoshal 2019). The harassment of HIV/Aids organizations is thus symptomatic of a wider crackdown on civil society – yet because they work with marginalized communities, HIV/Aids organizations might be particularly vulnerable.

Ashok Row Kavi, the gay activist who enlightened Sujatha Rao on the needs of homosexuals back in the 1990s, does not think the questions the government asks of HIV/Aids NGOs are unnecessary at all. When we met at a members-only club in Mumbai, Kavi told me that the previous year (2019), the government de-registered six thousand NGOs because they didn't file their accounts. "You can say that the government is dangerous," he said in a mocking tone, "that it's against the NGO sector, but why have *you* not filed your income tax in three years, why are *you* not clean?" Kavi went on to claim that George Soros announced at Davos that he does not like the current Indian government and is going to disrupt it, "and he's working through the NGOs!" He was convinced that NACO's "collapse" was a result of the agency having being manipulated by NGOs with foreign funding. These NGOs – including Humsafar Trust, the one Kavi had founded in 1994 and had recently left on bad terms - only have themselves to blame for their inefficiency: "everyone has become complacent and co-opted." Blaming the government made no sense, "since it's the same not-caring government that was there before." The gay rights pioneer went on to decry what he

referred to, inchoately, as the "Islamist" tendencies of the queer left, and suggested the lack of consultation was really a failure on the part of HIV/Aids activists to come to terms with the electoral "Hindu consolidation". (No love is wasted between Kavi and the other activists I spoke to[13], though they share many critiques of NACO's functioning and the disruptive role of Avahan.) One of the key players in India's community-based approach, Kavi now embodies the nationalist hostility to foreign interference that was making it hard for these organizations to operate.

Can communities, in this context, still make a difference? "There is a tokenism in the way communities are engaged," opined Aditya Bandyopadhyay, a long-time gay rights activist who was part of the Lawyer's Collective HIV Unit and has been a key player in Asian "MSM" and HIV networks. We spoke on video call while we were in a harshly-enforced lockdown, he with his partner in Pondicherry and I alone in Bengaluru. He suggested the perceived authoritarianism of the BJP does not lend itself to community involvement in a way that the paternalism that characterized Congress governance perhaps did. "Like most fascist dispensations, they are a top-down organization," Bandyopadhyay explained. "They come with the notion that they know what's best and they need not consult anyone." Some worried that in this political climate, the adoption of test-and-treat strategies might provide cover for a government that anyway does not want to invest in marginalized communities.

During the extension of its fourth phase of programming (2017-2021), NACO committed itself to test-and-treat strategies and meeting the UNAIDS 90/90/90 goals. The National Strategic Plan for HIV/Aids and STI (2017 – 2024) was sub-titled "Paving Way for an AIDS Free India", reflecting a wider trend towards "ending aids" discourses that has accompanied the consensus around the effectiveness of treatment-as-prevention. Nora Kenworthy and colleagues (2018) have historicized this development, which they critique for potentially having a counterproductive effect on funding and political commitments: if the HIV/Aids epidemic is practically over, why should it be a priority?

This was echoed by activists who worry that the discourse of treatment-as-prevention provides cover for a government that anyway does not want to invest in HIV/Aids prevention and treatment, and in particular in the affected communities. "The BJP believes it is all no

[13]"I don't mind if these people take me as a fascist," he said, referring to a reputation among fellow queer activists for being right-wing Kavi has earned through historic disputes and recent tweets. "Tomorrow I will probably be on a public trial as a judge to execute them."

longer a problem," Shyamala Nataraj – the journalist who had exposed the forced incarceration of HIV-positive sex workers in 1986 - explained over the phone from Chennai.

> So they've basically said we don't need more money and we can manage it ourselves. So evidently they don't think it's a problem. The second thing is that they are only looking at whatever is left of it: so now the pragmatic approach is test and treat, na? It's moved so far, and it's so medicalized now, that they don't *have* to take a position. They can say – oh anyway it is so low, and people are getting tested and viral load is going down.

TASP strategies and discourses may thus facilitate an apolitical approach to HIV. The rush to present indicators that India is on track to "end Aids" also, Nataraj continued, threatens to undermine the commitment to human rights and autonomy: "If you are going to have to present to how close to 90 you get then obviously it's [testing] going to be mandatory, no?"

Interlocutors were divided on the merit of the discourse of "ending Aids". Vishnu Prasad, the senior outreach worker in Secunderabad, said it was a good slogan with a bad strategy: "We are getting positives again, so where is end aids?" Vivek Divan, the gay activist who headed Lawyer's Collective HIV Unit and has continued studying and teaching human rights and health since, thought such global goals might galvanize political will. But in Delhi, Sam Prasad chuckled when I brought up the slogan: "The way India would reach the goal is to underreport [prevalence]. In reality, there is no way we would reach that goal." Indeed, a study done by the Indian Council of Medical Research (ICMR) suggested India may miss its target of ending Aids by 2030 as the decline in annual new infections was, at 27%, much lower than the national target of 75% for 2020 (Sharma 2020). Importantly for the purposes of our discussion, HIV prevalence continues to be higher among the so-called key populations, "especially people who inject drugs," the ICRM reports (Sharma 2020). Others felt the global targets are just a way for UNAIDS to keep its salaries and jobs in place. Gopalan cracked up when I raised the slogan ("Ending…. ," she shrieked, gasping for air, "Aids…. haaaa… by 2030! eeeeh hahaa!"). "They just to give the printer some work," chipped in Meena Seshu, mocking what she perceives to be the hollowness of the rhetoric. Indeed, the discourse of ending aids has been interpreted by some as strategy for the UNAIDS to maintain its relevance as the construction of Aids-as-crisis lost currency (Kenworthy, Thomann, and Parker 2018). There was also concern that in the context of declining political and financial support for community-based HIV/Aids prevention and treatment, treatment-as-prevention discourses may prove not just superficial but counterproductive. As Gopalan put it, "just hoping there is enough of the medicines floating around to stop some of the transmission isn't enough." Bondyopadhyay was sceptical too:

"While it's true that treatment is probably having an impact, I'm also seeing increasing rates of infections among the young."

Conclusion

As I revise this chapter, NACO's fifth phase of programming (2021 – 26) has commenced and the strategy document that was absent from the World Aids Day celebration has been released. Subtitled "anchoring the national response towards ending the AIDS epidemic" (NACO 2022), it re-commits India to achieving the goal of ending the HIV/Aids epidemic as a threat to public health by 2030 and reports progress towards the "full realization of 90-90-90", despite missing these targets ("at the end of 2020, 78% of PLHIV knew their HIV status, 83% of PLHIV who knew their HIV status were on ART, and 85% of PLHIV on ART were virally suppressed" (NACO 2022, 13)). Yet in addition to continuing the scale up of test-and-treat strategies, which were launched in April 2017, and universal viral load testing, introduced in February 2018, the document promises an increase in spending on targeted intervention, from INR 421.11 crore in 2021-22 to INR 484.92 crore in 2025-26 (NACO 2022, 41)[14]. A press release by the Ministry of Health and Family Welfare, however, claims the programme includes "community strengthening" and a "community feedback loop" and that "the community will be engaged in the design, concurrent appraisal and feedback of the project" (Ministry of Health and Family Welfare 2022). Yet despite an acknowledgement that "the prevalence rate among HRG [high risk group] population of female sex workers (FSW), prisoners, men who have sex with men (MSM), hijra/transgender (H/TG) people and injecting drug users (IDU) is 7-28 times of adult population," (NACO 2022, 25) and a pledge to "keep beneficiary and community in center" (NACO 2022, 35) as one of the programme's guiding principles, the document has little to say on targeted intervention or mechanisms for community consultation.

Nonetheless, the increase in budget allocation for targeted intervention suggests treatment-as-prevention has not entirely displaced the community-based approach, as some interlocutors seemed to worry it would. It remains to be seen whether this increase in spending will alleviate some of the concerns and problems faced by community HIV workers, many of whom might question the sincerity of the stated commitment to community engagement. As this chapter has shown, the celebration of the role of "community" in Indian HIV/Aids programming contrasts starkly to realities on the ground, which suggest the

[14] One crore is ten million Indian rupees

community-based approach has been in decline since its heyday during NACP-III (2007-2012). For Gowri Vijayakumar (2021), the developments in the years following her completion of fieldwork in 2013 revealed the precarious nature of the relationship between HIV/Aids communities and state agencies and the conditionality of the former's inclusion. This chapter has explored some of these developments and highlighted this precariousness, which I argued – following Dutta (2013) – challenges the notion of Indian HIV/Aids programming as empowerment through biopolitical partnership (Lakkimsetti 2020) by revealing the necropolitical dimension of Indian HIV/Aids programming.

I also suggested, more tentatively, that there are signs that the chauvinistic cultural politics of the BJP may be antithetical to the pragmatic approach to HIV/Aids control Sujatha Rao favoured. More worryingly, the ruling government's overt hostility to civil society has shrunk the space in which NGOs and CBOs working with affected communities can operate. And although NACO's Director General Alok Saxena acknowledges that "newer risk behaviours, like soliciting partners on virtual platform, etc. have emerged for which programmatic focus is essential," (2022, 25) the lack of consultation alleged by community HIV/Aids workers like Vishnu Prasad suggest the agency may not be able to respond effectively to changing realities on the ground and new transmission dynamics. "Communities *do* make the difference," said one of the speakers at the World Aids Day celebration. "And I want to thank NACO and [HIV/AIDS] Alliance for supporting us. But if you don't involve women who do drugs and listen to their issues, then you can't realize what we need. And if you can't design services for us, well, then I don't think the next generation will be AIDS-free."

As I demonstrate in the next chapter, services for drug users are failing men who are into high fun, too – and so are services for men who have sex with men. Yet even as high fun illustrates the continued need to engage and consult "communities", it also reveals contradictions in the way this concept is operationalized in the context of targeted interventions.

Chapter 8: Targeted Intervention

The stagnation of India's celebrated system of targeted intervention explored in the previous chapter partially explains why these interventions barely featured in the high fun narratives explored in Chapter 4: Organizing Logics and Chapter 5: High Risks. But high fun also challenges service providers and us to re-think some of the classifications and assumptions on which targeted interventions are based. Having argued for the continued need for community-based approaches to HIV prevention, in this chapter I suggest that high fun reveals contradictions in the construction of "community" in the context of HIV/Aids programming. As explained in Chapter 1, targeted interventions aim to contain the spread of HIV to the "general" population by promoting prevention and treatment among the populations considered to be most at risk. Since these populations have been shunned or even persecuted by the state and mainstream society and were thus considered hard to reach, interventions were outsourced to NGOs and what came to be known as "community-based organizations" (CBOs) with proximity to the populations. Key to this strategy, which was in part modelled on the successful mobilization of sex workers in Calcutta's Sonagachi district under the auspices of Dr Smarajitjana (Newman 2003, Rao 2017), was the figure of the peer educator tasked with informing her peers of prevention and/or treatment options and feeding back data to NACO (via the NGOs/CBOs).

In the first section of this chapter I explore some of the reasons why the interlocutors who are involved in Mumbai's high fun scene did not avail themselves of services provided by that city's targeted interventions. These reasons, I argue, are related to and reveal several contradictions in the conceptualization of "community" underpinning the system of targeted interventions. I then offer an ethnographic account of one targeted intervention for MSM in Bengaluru that aimed to reach men who are into high fun, figured as a distinct population promising a high "yield" of HIV-positive test results. Finally, I contrast this target-driven approach to Anthony's reflections on an attempt at creating a network for peer support, which I argue entails an alternative approach to high fun that may help revitalize the increasingly antiquated system of targeted interventions – along with, of course, renewed financial investment.

Between "MSM" and "IDU" in Mumbai

Referred to sometimes as India's 'Aids capital' for its relatively high HIV prevalence, Mumbai is home to several NGOs carrying out targeted interventions on behalf of the

Maharashtra State Aids Control Society, which represents NACO. Yet none of the interlocutors I spoke to in this city had approached these NGOs to talk about high fun, even when they felt they needed help. In this section, I draw on interviews with these men and with staff at two of the city's main HIV/Aids NGOs to explore some of the reasons behind these. These are related, I suggest, to the essentializing effects of "community" as it is conceptualized in HIV/Aids policy. Not only does high fun fall in the gap between services for "MSM/TG" – men who have sex with men and transgender women/*hijras* – and "IDU" – injecting drug users, it also foreground some of the fault lines within the former category.

The NGO that, as its staff agree, is best positioned to provide harm reduction services to men who are into high fun is Humsafar Trust. Founded in the early 90s, when, as senior gay and HIV/Aids activist Ashok Row Kavi put it to me during an interview, "we were becoming experts at funerals," the NGO grew into one of the country's most high-profile LGBT organizations. In 2019, it opened India's first LGBT HIV clinic. "Until now we would get testing done for the community members at our centre", Kavi explained to a Hindustan Times journalist. "If tested positive for the disease, they would be asked to go to Sion Hospital, but there was a huge dropout (rate) there. Because of how the community is perceived outside, a lot of these people wouldn't seek treatment" (Hindustan Times 2018**).** In this conversation, Kavi invokes community as a self-explanatory concept, referring, presumably, to members of sexual and gender minorities assigned male at birth. At the clinic, a discrete office up a flight of stairs in a no-frills mall in Andheri, there is a poster displaying a caricature taxonomy of different types of "MSM". Nothing indicating that lesbian and bisexual women or transmasculine persons also use the 'LGBT' clinic, and there were none in the waiting room when I visited. Envisioned as a safe space free of the societal stigma attached to gender and sexual nonconformity that acts as a 'barrier' to services, the initiative epitomizes the community-based approach to HIV prevention and care.

Yet several of the men I interviewed avoided coming into the clinic precisely *because* it was run by and for "community". Faisal expressed the need for queer-specific services and complained that the advice he had been given about addiction had always been from a "straight point of view, not a gay point of view." Yet he was reluctant to speak to anyone at Humsafar Trust about what he perceived to be his problematic relation to high fun, though the organization had been able to help him with sexual health concerns in the past. "Just going there looking like this", he said, presumably referring to his gym-trained body and striking jawline, "fifty people the next day will ask me, *why did you go there?* So you can't go there without being noticed." Once, someone who worked at the organization got Faisal's

number through the database and began messaging Faisal on WhatsApp. “I understand it’s *community*,” Faisal conceded, “but probably they should have some program to filter people so you don’t feel like being surveyed.”

Similarly, Arvind told me he was glad his HIV was detected at a private hospital rather than at Humsafar Trust. “I don’t know how many more people would have known,” he said, adding that “gay men talk”. Precisely because he has long been involved in the “community”, including with “Humsafar”, he would not want his status to be known there. This was true for Vikram, too. “No, I don’t feel like I can talk to them about high fun,” he said when I asked him if he had considered approaching the LGBT clinic for support. Once, he found out about a romantic interest’s HIV-positive status because it was “leaked” from there. “So I’m really scared about talking about all these things,” Vikram explained. “When a woman talks to another woman… they talk *everything*.” As with Arvind, Vikram’s social investment in Mumbai’s queer circles heightened his concerns about confidentiality: “When you have a good name in community, you’re scared of losing it.” One of Vikram’s more serious crushes had recently expressed interest. “But if he gets to know about this,” Vikram worried, meaning his involvement in the high fun scene, “I’m not sure how he would feel about me. Some way or the other people will know, and I don’t want that.”

The assumption is that people whose connection to the labels “MSM/TG” or *gay* is most tenuous – heterosexually married men having sex with other men on the down low, for example – are hardest to reach. While this may be true, for both Arvind and Vikram it was precisely the extent and quality of their investment in the local queer community -of which “Humsafar” is a key site - that prevented them from utilizing a community-based service. This contradiction arises from the doubleness of “MSM” as a *biosocial* (Rabinow 1996) rather than just biomedical or social grouping: “community” is both the site of biopolitical intervention and of sexual, romantic and social bonding. This ambivalence is foundational to the concept of HIV/Aids communities. “Where activists saw communities ripe for ideological transformation,” wrote Cindy Patton about queer men in the U.S. during the 1980s Aids crisis, “epidemiologists saw collectivities linked through common behavior and a virus” (2002, 12). Yet while these groups were able to organize effective responses precisely because of pre-existing social and political networks, as explained in Chapter 7: Interlude for Community, high fun troubles the assumption of inter-community solidarity.

Imagined as a guarantee against discrimination, the very presence of “community” instead raises concerns about confidentiality and stigmatization. Staff at the Humsafar Trust clinic are well-aware that concerns around privacy stop some people from utilizing their

service "People feel scared sometimes to get tested," explained Prakash, a former Mr Gay India who is now the clinic's digital outreach officer. "Because of the taboo, because of fear of confidentiality, and because fear that someone might know him." Prakash insisted that the NGO's staff maintain confidentiality at all times, and denied accusations to the contrary. "But sometimes what happens is, people waiting outside might see [someone] and gossip. People who are not [HIV] positive are also made positive." This dynamic is exacerbated when drugs are involved. "As soon as they know you are into high fun, people will start ignoring you," Prakash explained, describing a culture of "drug-phobia within the community" that discourages men who are into high fun from messaging him during outreach. His own popularity within the community is problematic in this regard too. On the one hand, his large social media following and multi-lingual fluency gives him a reach that, as we shall see in the next section, most targeted interventions lack. On the other hand, his status as a well-connected and buff social media influencer can be intimidating. "There will be a session that I can see on Grindr is less than a kilometre away," the employee told me, "but I won't get an invite because they know I work here and think I'll judge them!" As a result, people only come to him when the "water is already above the head", making it difficult to intervene. In other words, Prakash's strong relationship to the community has a counterproductive effect when it comes to high fun. "Because community love gossip," he summarized.

In addition to concerns about confidentiality, interlocutors felt they could not relate to the "peer" counsellors. Arvind hadn't been back to Humsafar Trust because he felt patronized the last time he was there. "The counsellor started explained things to me in a very *Indian* way," he said. "He – she – the person was non-binary, so I'm not sure – but she was like, *an Indian woman would never leave her husband*. *So why would you do that, why would you leave your husband?*" This advice invokes the patriarchal norm of wifely devotion that may resonate in *hijra* lexicons of izzat/respectability revolving around the (mostly theoretical) disavowal of sexuality (Reddy 2005). But it was experienced as judgemental by Arvind, who was more at home in the globalized millennial vocabulary of 'open' relationships. And though the counsellor alienated Arvind by addressing him as a fellow Indian woman, in doing so she was arguably satisfying her job description as a 'peer' counsellor. Vikram recounted a similar experience, perhaps with the same person. "The peer counsellor you expect to talk to you in such a way that the person does not get hurt, be calm, be normal," he said. "She wasn't with me – she's a TG, transgender – and she was like, *why did you not use a condom?!* She got very emotional: *Why didn't you?*" Vikram deemed both her tone and tactic - instilling fear of HIV – inappropriate. "*You're my counsellor*," Vikram recalled thinking, "*not my*

mother!" He requested to be seen in the future by someone he described as "some basic-quality guy", suggesting that, though his counselling abilities were unexceptional, at least he was an actual peer on account of being male and gay.

The peer educator is the cornerstone of the policy of targeted interventions. As Chaitanya Lakkimsetti (2020) explains, the qualification for this role is not one's level of health awareness but one's degree of access to the communities that need to be reached, and the inclusion of "true peers" is considered the golden standard of effectiveness. Vikram and Arvind drew attention to the differences between them and the counsellor. Though these differences are articulated as a split between "MSM" and "TG", class and caste likely also play their part. The client and the counsellor may belong to the same "community", but they live in altogether different social worlds, ones that rarely overlap outside the space of the clinic. And because high fun as seen as a 'rich gay' phenomenon (despite, as I demonstrated in Chapter 4: Organizing Logics, the participation of people from across the socio-economic spectrum), the failure to reach men who have developed a problematic relation to it brings this tension to the fore, as we will see shortly.

High fun troubles the risk-based biomedical classifications that underpin the system of targeted interventions in a rather more obvious way, too. Suppose Arvind, Faisal and Vikram *did* feel comfortable reaching out to Humsafar Trust for High Fun-related support, what service would the targeted intervention be able to provide? "I would refer you to mental health," said Krishna, an openly HIV-positive gay man that manages the HIV linkage services at Humsafar Trust and also acts as a counsellor, when I presented him with this hypothetical situation. "So you can talk more and we listen – what kind of support does he have near him?" Other than in-house counselling and identifying trusted relatives and friends, staff at Humsafar Trust can do little in the way of harm reduction. "We can't deal with that because it is not our department," explained Prakash, tellingly figuring the target population (MSM/TG) and the targeted route of transmission (sexual) as a subdivision. As a sexual health intervention targeted to gender/sexual minorities, needle exchange or de-addiction treatment are not in Humsafar's remit. Even if harm reduction was within its mandate, the staff at NGO are not necessarily equipped to deal with de-addiction: Prakash described finding it incredibly difficult to deal with men into high fun, who in his experience can get very aggressive when in withdrawal. "We have to refer them to Sankalp or rehabilitation," he explained. "We divert them."

I arrived to Sankalp half an hour late, having gotten off at the wrong South Mumbai train station. "You're lucky," said Eldred Tellis, the organization's director. "My 11.30

appointment was cancelled. He was suddenly sick – withdrawal, I'm guessing. Though it would have been interesting for you to meet him: he's into chemsex." The client is one of two men who have approached Sankalp for high fun-related support. "His sister is very sceptical," Eldred continued. "She wasn't impressed by the building, wanted to know where the counsellors got their degrees, etcetera. They're middle class I suppose." We settled into the interview, which turned into a discussion between the director and his much younger assistant about the wisdom of setting up a referral mechanism with Humsafar Trust. "It would be better if Humsafar Trust have their own services and we help them with that," opined Eldred, "because at Sankalp we deal with the lowest strata of society. Most of the gay men are not ready to associate with those down-and-out, street-based guys. They don't identify as addicts or injecting drug users." He looked at me for confirmation, as if to see if he's understood this 'new' phenomena correctly. Prior to our meeting, I had sent him a paragraph on high fun for the Sankalp newsletter, as requested, and Eldred told me he had found it very informative. "They're just having *fun*, correct?"

Although he claimed to know little to nothing about high fun, Eldred had hit the nail on its head. Several interlocutors told me they thought the euphemisms of "fun" and "stuff" obscure the kinds of drugs taken in high fun. Moreover, some of them drew attention to the way in which their social status enabled what they reflected on as a denial about the nature of their relationship to drugs. "I've never been told to leave a bar or anything," Rounak explained during one of our conversations, "but then I also look a certain way, if you know what I mean?" "Not like an addict," I asked. Rounak nodded and proceeded to tell me the story about the seemingly impoverished man who took him to a cowshed, related in Chapter 4: Organizing Logics. "When I found myself in that shed with a few chicken and this random desperate guy and a bunch of cow dung I was like… *damn*! If this is not addiction, then what is?" Similarly, Anthony recalled the depictions of heroin-addled "junkies" in the Doordarshan serials of his childhood to explain his cognitive dissonance. The stereotype of the destitute drug-user passed out on the pavement pervades the popular imagination of drug addiction, and his gender (male) and socio-economic status (underprivileged) combine to make him legible as a *junkie*. It is this "community" – street-based, poor, and more likely to use heroine or crack cocaine rather than MDMA or crystal meth – that organizations like Sankalp service, and that many queer men into high fun define their drug use in opposition to.

Defined with reference to the risk of blood-based transmission through sharing needles, the boundaries of the "IDU" category itself are contested. When I asked Eldred what his main recommendation to NACO would be, he suggested that the "I" should be taken to

stand for ‘injectable’ rather than ‘injecting’ or ‘intravenous’. “So if someone is smoking heroin they should also be given OST, oral substitution treatment,” he explained. “Now you have to have be injecting for minimum 3 months. That’s wrong, because you may be chasing, but you’re chasing for 6, 7 years, and tomorrow if you don’t have the cash somebody could inject it.” During high fun too, different modes of administration may be used throughout a ‘session’ by different people, or at different stages in one’s high fun career. Eldred also explained that women drug users are often not reached by harm reduction efforts, reflecting the implicit gendering of “IDU” as male critiqued by one of the speakers at the World Aids Day event described in the previous chapter. This male is punitively heterosexual – or, rather, his drug use is not understood in relation to his sexuality. While Eldred was clearly open to helping queer men who are into chemsex, his preferred option would be an arrangement with Humsafar Trust where they take the lead, since he does not consider himself familiar enough with queer sexuality. This admission chimes with David Stuart’s observations that before there were chemsex-specific services in London, many of his peers sought support from de-addiction services “where the gay sex elements of their drug use were not addressed with any cultural competency at all” (2019, 6).

High fun thus exposes several contradictions and tensions in the conceptualization of “community” in the context of targeted interventions. First, it seemed that the more involved interlocutors were with ‘community’, the more apprehensive they were about utilizing community-based services, lest their good reputation or sexual/romantic prospects were spoiled, to echo Goffman (1963), by the interlocking stigmas of HIV and high fun. This problematizes the assumption that community-based services are “safe” spaces free of judgement. Second and relatedly, their experiences of being judged by peer counsellors complicates the “true peer” concept, which elides the fault lines of gender, class, caste and language that divide the targeted community. Third, high fun exposes the gap between services for “MSM/TG” and those for “IDU”, with staff at both Humsafar Trust and Sankalp saying they lacked the mandate and the expertise to provide harm reduction services for men who are into high fun. As such, high fun troubles the conceptualization of “communities” as discrete, mutually exclusive populations while also posing a challenge to the assumption of intra-community solidarity.

None of this is news to service providers. “We need a holistic, non-judgemental approach,” reflected one employee at a major INGO in New Delhi that funnels donor money to smaller NGOs or community-based organizations across India. He listed several blind spots in targeted interventions, including differing degrees of intra-community vulnerability,

a lack of shared identification between gay men and transgender women, and people's engagement in multiple, overlapping risk behaviours. Although "NACO acknowledges this, it does not understand what it looks like," the project manager said. The INGO's latest project sought to re-vamp and up-date targeted interventions for MSM/TG by addressing some of these issues, with the aim of reaching men who are into high fun and under under-served groups in Indian cities and towns, including Bengaluru. But this, it turned out, was easier said than done.

Targeting the "party/drug crowd" in Bengaluru

"TIs are dying," the programme director of the large INGO told the staff of a smaller NGO in Bengaluru where I was doing participant observation. We had all gathered in the main room of the office, a modest affair on the second floor of a residential home, to welcome Sanjay, who had flown in from New Delhi that morning. "The model is twenty years old, and we need to pump new energy into it." The vessel for this new energy was Shakti, a series of "community-*led*, not based" clinics that the INGO was setting up in seven Indian cities and towns with partner organizations, including the NGO in Bengaluru. Although the implementation of the project was severely hampered by the Covid-19 public health measures that came into effect in India on 25 March, in this section I offer an ethnographic account of the training session and the project's first phase, paying particular attention to the construction of men who are into high fun as a high risk *population* distinct from the segments of community usually reached by targeted interventions.

"Not to brag," Sanjay began his training, "but the entire concept of Shakti is mine. And I'm gay, and after that the line manager is TG." Because of this, Shakti is community-led rather than *based*. In the latter, Sanjay explained, 'community' refers to the outreach staff– "MSM reaching MSM, TG reaching TG" – and sometimes to counsellors, but not management. "So *led* means not only the outreach, but the strategy, evaluation, analysis comes from the community. If I do sex work, it is not community – I *am* community, but a different community." He then asked us each whether we were community or not community, clearly meaning MSM/TG as opposed to CSW (commercial sex worker), or IDU/PwUD (injecting drug user or person who uses drugs), although some of us had likely been paid for sex and/or used drugs at some point. The team assigned to the Shakti project comprised Swapna, who was formerly employed as a counsellor on a government-run harm reduction intervention, Tanu, a *hijra* with some experience of peer outreach, Joseph, an inexperienced but ambitious project manager who identifies as queer, and me, a foreign gay

man whose utility wasn't immediately obvious. For fear of being mistaken as heterosexual I confirmed that I was indeed community, despite being so obviously an outsider. Only Swapna wasn't. "If it's less than 80% community staff," Sanjay specified, "it's community-based, not led." With five of us in the team, we had just about managed.

Shakti's emphasis on this distinction reflects the importance of "community" as a source of credibility in HIV/Aids governance since the adoption of the GIPA principle (Chan 2015). Indeed, when applying for funding on behalf of the organization, I made sure to emphasize that half our board members and many of our staff were belonged to a gender or sexual minority. But a problem soon arose. Between the two of them Tanu and Swapna spoke four or five languages with some degree of confidence, but not English. Yet this was language in which Sanjay had chosen to deliver his upbeat talk, with some Hindi thrown in for good measure. Probably used to rote learning during what little formal education they had enjoyed, Tanu and Swapna kept offering up random HIV/Aids jargon in response to Sanjay's prompts, crying 'high risk!' in a panic when the question concerned confidentiality, which bothered Sanjay greatly. It didn't help that Sanjay had chosen to deliver his upbeat talk in English, with some Hindi thrown in for good measure, a language of which Tanu and Swapna had little grasp. The tension points to a contradiction in the function of community in HIV/Aids governance: "As a newcomer among the traditional elite structures," writes Chan, "the community needs constantly to re-legitimize itself to prove its value, but it cannot do so without relying on the frames of reference from the dominant power systems" (2015, 190). Although the clinic would be community-led, this leading would have to happen in the acronym-ridden language of global HIV/Aids governance.

Language was both symptomatic and symbolic of a larger issue, namely the gap between traditional targeted intervention constituents and staff – mainly working class, Kannada-speaking gender/sexual minorities cruising in public spaces - and the 'new' target populations of young students and professionals from all over the country using apps to find sex and romance. "Because many of them are from other parts of the country, they know either English or Hindi," argued Sanjay, although it was not just an matter of linguistic and regional diversity. "They'll be annoyed if there is no English - even if they speak Kannada they won't speak it." Sanjay was perhaps extrapolating from his experiences of outreach in Delhi, where certain people responded to messaging in Hindi aggressively, as if the use of the language were an insult to their intelligence or status. Making explicit these fissures in 'community', Sanjay suggested that the staff speak "your Kannada" with the *hijras* and *kothis* in hamaams [bath houses frequented by truckers], but English with the others sub-groups.

Sanjay hypothesized the rate of infection among "TG" (transgender) and kothis has plateaud, because they have been targeted for decades now. The director agreed that the populations his NGO has historically worked with during outreach in parks, theaters, at bus stops and other cruising areas are "no longer testing positive". The term used to index this is reactivity rate, e.g. the percentage of positive tests among a certain group. The rate is a measure of a targeted intervention's effectiveness: if it is low, this is seen as indication that the people 'most at risk' are not being reached. This emphasis on reactivity rate is part of a new prevention rationale in HIV/Aids policy in the aftermath of the 2008-2009 financial crisis focused on identifying segments of key populations imagined to be "hidden" and targeting them for testing, in the hopes of meeting ambitious testing goals (Monteiro et al. 2019, Mora et al. 2019, De Cock et al. 2019). As Thomann and colleagues explain, the preoccupation with reactivity rate "that measures HIV test results like it would a rate of return, is fed by technocratic logics that drive the development of cost-effective ways to identify the "undiagnosed" while diverting attention from more comprehensive approaches to prevention" (Thoman et al. 2022, 1). With the renewal limited funding hinging on a project meeting expected outcomes, the survival of an intervention depends on its ability to meet expected outcomes. Shakti's target, Sanjay clarified, is a reactivity rate of 5%. "If we don't meet that, the program is over."

All this was brought into sharp relief when, over a lunch of sambar, rice, and fiery hot chicken cooked by one of the staff members, Joseph told Sanjay proudly that he had already tested thirty-three people in Cubbon Park, one of the city's main cruising areas. Sanjay was not impressed.

S: How many reactive?
J: There weren't any
S: Then your entire intervention is wrong. If you were catering to at-risk people, you would have at least gotten 2%. No reactive is not possible, then you're targeting the wrong population. If it is less than 3%, it is not a population.Why did you test them, why did you think they were at risk?
J: Because they are sex workers. They do not belong the privileged segment of the population.
S: What is privilege?
J: Their awareness is nihil, they don't have access to services.
S: They don't use condoms?
J: They don't have any understanding of disease.
S: Are you *sure*?

As Sanjay saw it, Joseph's assumptions crystallized the problem with targeted interventions and why they were becoming "out-dated". They reflect a historic focus of the organization, and many of its sort, on those sexual and gender minorities assumed to be most at risk of police violence and HIV infection on account of their lack of information and privilege. But these populations have since been saturated with HIV messaging. "Our entire work has been with working class sexual minorities", conceded the NGO director, "but what we're realizing is that a lot of middle class gay men do not have much information about HIV, and reaching them will be a bit challenging."

Sanjay's insistence that "if it [reactivity rate] is less than 3% it is not a population" also points to a subtle distinction between community and population, with the latter promising a high "yield" of positive test results (De Cock et al. 2019). Someone had informed Sanjay there is currently a 12% reactivity rate among MSM – far higher than the officially reported rate - and that new infections are mainly among "urban gays". "There are many ifs and buts, but this is my hypothesis," concluded Sanjay. "There is another population that we are not reaching, and we don't know how they are accessing services."

This is where high fun comes in. "Bangalore is known as party city," Sanjay explained, since Swapna and Tanu were clearly unfamiliar with the phenomenon. "At parties what happens [is], there's guy with room, he orders biryani, plays porn and have people over. We need to find those people." The omission in this list of an ingredient arguably more characteristic than biryani – 'stuff'– notwithstanding, this group was henceforth described as the "party/drugs crowd". Joseph enthusiastically described this as an "untouched area" where HIV intervention has not yet reached. The organizations carrying out targeted interventions compete for populations, I was frequently told. "If you do it, the TI [targeted intervention] will come to you, because you are the pioneer," Sanjay told the NGO staff, referring to reaching out to men into high fun. "We have to tap this population. Someone will come take Bangalore populations from you if you don't take it." These metaphors of territorial virginity and pioneering bring to mind the efforts by colonial enterprise like the East-India Company or Dutch VOC to secure monopolies on profitable goods at new frontiers, understood as sites where crises encourage new strategies for profit (Patel and Moore 2018). If chemsex is configured as the new frontier of HIV/Aids prevention, the profit it promises is a high reactivity rate.

This reflects, and is perhaps influenced by, global funding priorities. The day after Sanjay's training, a delegate from the British organization funding Shakti came to visit the NGO's office. It was an officious occasion: the entire staff and a few people I'd never met

before sat in a circle in the main bit of the office, dressed in their nicest sarees and shirts. There was none of the usual chatter and gossip. In turn, everyone said their name, gender/sexual identity and role in the organization, with those unfamiliar to me introduced by the director simply as 'community'. He translated as the delegate asked them what the hook-up scene is like these days. After a while the director brought up the "party/drug crowd", admitted that the organization so far had failed to reach this "population". He explained that the NGO originated in 1999 in an attempt to address what it saw as a lack of working class representation in emerging queer spaces, which were and continue to the domain of English-speaking gay men. This focus on low-income groups has meant that middle and upper class gay men have not been reached though the organization's targeted interventions. The delegate's interest was piqued by the mention of chemsex. When he asked the director to translate his follow-up questions, the director instead diverted them to me, explaining I was conducting research on the topic.

Quite understandably, the delegate was not very interested in my observations about the 'erotic economy' of drugs and desire, preferring to hear instead from the Indian staff. Yet I was much more proximate to high fun scenes than the more "authentic" community members present, not just on account of my research but because I moved more easily through the on- and off-line spaces used by middle to upper class gay and bisexual men. I was part, in other words, of a socio-sexual network (Race 2015) that excluded most other people in the room. The ceremony was something of a microcosm of the HIV/Aids Industry (khanna 2016) in that it brought together the Western donor, the large INGO intermediary set up to "support a transference of governance from distant donors to affected communities" (Chan 2015, 90), the local NGO/CBO representing community, and the HIV/Aids researcher. One of Chan's main contestations is that the professionalization of Aids activism has reduced it to a form of grant-seeking, in which "community" is an important resource. Yet the community present at the meeting could not speak authoritatively on the "party/drug crowd" - and I could of course not speak on behalf of community.

In any case, 'tapping' into this new population was easier said than done, it turned out. In the weeks that followed, Joseph would routinely complain to me about his difficulties in reaching men into high fun for testing. "They all just want to come have a party here," he sighed during a cigarette break one afternoon. "I have no qualms inviting them home and pricking them, but a lot of guys want to invite two, three people. Where do they get the energy?!" There was definitional ambiguity, too. "There is so much confusion about poppers," Joseph continued. I nodded. "So many guys are like – poppers aren't drugs…" I

nodded again, though I also don't think poppers qualify as 'chems' as such, and use them routinely. "It's quite amazing! People always find ways to justify their behaviours to themselves." When I set up a meeting with an interlocutor who had begun coming out about his chemsex experiences to raise awareness, Joseph again appeared judgemental. "He is into drugs?" he said, feigning indignation. "I'm not surprised to be honest. He looks like he would be." When my facial expression betrayed shock at this statement, Joseph quickly assured me they "just speaking his mind", as if to draw a distinction between their private morality and his professional neutrality.

Clearly, Joseph's personal views on high fun – as irresponsible and incomprehensible risk behaviour – informed their approach as peer outreach worker and community clinic manager, from his mission to lure men to his house on false pretences to "prick" them to his notion that men into high Fun fook a certain way. My point here is not to discredit Joseph or the intervention he led, but rather to highlight again the challenge high fun poses to the assumption that "community-based" (or led) interventions are *by definition* confidential and non-judgemental. Insofar as Joseph defined his own sexual identity in opposition to the men who are high fun, he may have been more 'triggered' by it than Swapna, the working-class heterosexual woman who had worked in a government intervention for injecting drug users, would be. Then again, Swapna may not have had much understanding of the sexual contexts in which these gay and bisexual men consume drugs.

Despite the ambition of targeting the "party/drug crowd", Shakti also serviced people who appeared to me at low risk of contracting HIV. This was related to a tension between programmatic and popular definitions of "community." Who exactly was included in community became a topic of some debate when Joseph explained the risk assessment form to me, Swapna and Tanu a day before we were to conduct a health camp at a pride fundraiser event. The first row asked us to identify the 'client group' as MSM, TG, or Hijra, below which we would specify a 'primary identity', with a list of options given and a blank line for identities not listed. Did *kothi* go under *Hijra* or MSM, someone asked, a question explored in more detail in Aniruddha Dutta's study of the impact of HIV/Aids classifications, and the programmatic split between "TG" and "MSM" in particular, on gender and sexual minorities in West-Bengal (2013). And when Joseph manually added 'lesbian', Tanu asked whether this meant F-to-M ("female to male"), prompting another transgender staff member to explain the difference between F-to-M (as transition) and F-to-F (as sexual orientation). But why do lesbians need to get tested, Tanu wanted to know. "They are also community," insisted Joseph. He then went on to guide us through the rest of the form, which of course was

premised almost entirely on penetrative sex involving a penis, sending ripples of laughter through the room as we rehearsed the 'proper' pronunciation of *anal* with Tanu and Swapna. At the health camp the next day, a stall at the upscale mall where the fundraised was held, the clientele comprised many lesbian and bisexual women and non-binary and transmasculine people. They struggled to fill out the risk assessment form- understandably so, given that the questions were of little relevance to their sexual practices and anatomy. There were no 'reactives' among them, and at the end of the day a worried Joseph asked whether I could please send some of the HIV-positive guys I had interviewed his way, or at very least do a test myself.

Meanwhile, we struggled to find a place that could host the intervention and realize it as a clinic – precisely because, Joseph and the director suspected, it was by and for "community". Agreements with landlords would fall through at the last minute, often for spurious or unspecified reasons. A week or so after a space was finally secured and the clinic opened, P.M. Narendra Modi declared a lockdown to stop the spread of the novel coronavirus. It is therefore difficult to assess how effective the intervention was in reviving the approach of targeted intervention and reaching men who are into high fun. But its early phase revealed several contradictions in the construction of "community" that underpins such interventions. First, while "community" is an important source of legitimacy in the global economy of HIV/Aids funding, community-led or based targeted interventions are only legitimate if they are conducted in the highly specialized language of global HIV/Aids governance, rather than locally-salient idioms. Second, the groups that traditionally comprise the constituents and staff of community-led/based organizations are not the same groups that need to be targeted. Third, men who are into high fun - conceptualized as the "party/drug crowd" emerge as a distinct *population* promising a high "yield", e.g. the proportion of positive results among those tested (De Cock et al. 2019, Thomann et al. 2022), which would legitimate the intervention and help secure its continuation. Yet staff members felt they could exclude women and other people identify as LGBTI+ but are at low risk of contracting HIV, thus revealing a tension between programmatic and socio-political interpretations of community. This becomes particularly problematic when the pressures of this target-driven approach encourage strategies that compromise consent and might encourage data fudging[15]. Moreover, the emphasis on HIV reactivity rates is at odds with the prioritization of risks

[15] The only antidote to which is, according to Sujatha Rao, "that the primary worker understand the meaning and implication of the data being collected and feels her input is valued" (2017, 221).

detailed in Chapter 5: High Risks, and detracts from a more holistic approach to harm reduction in high fun contexts.

Recovering together

Men who are into high fun are, of course, not passively waiting for targeted interventions to start reaching them. In the absence of adequate institutional harm reduction responses to high fun, during the period of my fieldwork there were two nascent efforts at organizing a grassroots response. One was a semi-public discussion aimed at "breaking the silence" about high fun in Bengaluru, held during the city's "Namma Pride" in November. Although everyone could attend, the event was only advertised in queer circles and was hosted in a discrete, closed space. It centred on an informative presentation by someone who reflected on his own experiences with high fun, which was followed by an informal discussion about high fun's potential harms, the problem with stigmatizing it, and whether or not PrEP protected against blood-based transmission of HIV. I joined planning meetings in the capacity of volunteer at the Bengaluru NGO, whose director wanted to support the effort but was unsure how to do so.

In an unrelated development, men in other parts of the country had begun informally organizing a network of people recovering from high fun-related drug dependency. They held their first meeting in New Delhi in December 2019, when I was in the city for the World Aids Day celebration analysed in the previous chapter. After some back and forth over email with Anthony, one of the organizers, I was given permission to join on the condition that I attended in a personal, e.g. non-research capacity. As Anthony would later explain during our interview in Mumbai, there had been considerable discussion about the question of who should and should not be allowed to attend the meeting. Should it just be men who are into high fun, or everyone – queer *and* straight? –concerned about the potential harms? Given my promise not to comment on the event itself, in this section I instead briefly detail Anthony's reflections on this initiative, which I suggest might contain lessons for HIV policy makers and staff at targeted interventions of the sort described above.

Like the other interlocutors in Mumbai cited in the first part of this chapter, Anthony did not approach Humsafar Trust when he started feeling like he needed support. Anthony explained that although he has personal differences with Humsafar, he thinks they do "amazing work with the community", not least because they are a relatively well-funded organization. But when Anthony saw a video Humsafar made about high fun some two years prior to our conversation, he was not impressed. "I remember watching it while I was using

and thinking, this is not how it happens," he explained. "They didn't seem to have the right information, and it was very dramatic, very Bollywood-esque and sensationalist. It was not geared towards people who were using but towards those who were not, because there were too many gaps in the understanding of how things actually are." Anthony felt the video risked reinforcing stigma around drug use in the community – the same stigma that was stopping people like him from utilizing Humsafar Trust's services.

Instead, Anthony started attending Narcotics Anonymous, the peer support group modelled on Alcoholics Anonymous and its 12-step program. Initially Anthony felt uncomfortable talking about the high fun aspect to his drug use. This, he said, "makes our experiences very particular, because it's not just the drug, its drugs plus sex." Yet once Anthony opened up about this aspect, he was surprised by the response. "It seemed the floodgates opened because there were others who I'm assuming are straight men who also wanted to talk about using drugs in the context of sex and what that did to them," Anthony recalled. "And I thought only gay and bi men had this problem, and that meth is maybe specific to us." Although there is still a lot of the "sexual stuff" that Anthony does not talk about in the meetings, they challenged his assumptions about the uniqueness of queer sexualized drug use.

NA also taught Anthony that "only an addict can help another addict", and it was with this in mind that he and a few other friends started talking about creating an informal platform to share experiences about high fun. Initially, he wanted the network's first meeting to be for "users" only. But he realized this would mean attending the meeting would amount to coming out as such. "And then I was reminded of going to queer meetings or gay meetings in the 90s or 2000s and if you came to the meetings, you were *gay*, you weren't there to explore or say hi," Anthony explained. In the end, the meeting was open not just to queer men who did not identify (yet) as users, but also to straight people and queer women who had supported a friend through their struggles with addiction, and one female psychologist whose expertise was queer mental health. Proximity to "high fun", rather than an identification with it or with the label "user" or "addict", was what the people attending the meeting shared.

Journalists were not welcome. "We've always been very aware of trying of trying to protect the community," Anthony explained, "because once the media steps in, the police might step in." The need to raise awareness about high fun and demonstrate the need for resources for harm reduction is thus at odds with the concern about punitive approaches. This reflects a larger historical tension, explained in Chapter 1 and elaborated upon in the previous chapter, between the state's punitive and biopolitical approaches to the groups associated

with HIV/Aids risk (Lakkimsetti 2020). Yet while homosexuality has been decriminalized and a repeat of the 2001 "Lucknow arrests" of MSM outreach workers is unlikely, drug use is still very much illegal. Moreover, as Anthony explained, "there is a very conservative government in place that can really fuck things over if they wanted to." His dilemma was one I shared when I published about high fun in an Indian magazine, and one I discussed frequently with my editor. At the same time, Athony and his peers feel the network should take a more "ACT UP"-style approach – confrontational and political – by highlighting and protesting the human rights violations (shock therapy and assault) that happen in de-addiction centres. In this respect too, the initiative contrasts to targeted interventions carried about by NGOs and CBOs, which, as we saw the previous chapter, are under increasing pressure not to bite the hand that feeds them.

Whether or not these two organic, grassroots attempts at harm reduction will be able to make a difference to men who feel they need high fun-related support remains to be seen, but Anthony's reflections contain interesting contrasts to the target-driven approach that narrowly approaches men who are into high fun as a "population" promising a high yield of positive HIV test results. First, addiction, not HIV, was the main focus, reflecting the risk prioritizations of interlocutors explored in Chapter 5: High Risks. Second, the "intervention" engaged people with proximity to high fun rather than targeting those who identify with it, which may help mobilize and enhance community-based systems of support. Third, Anthony's insistence that "only an addict can help an addict" suggests this network might be able to provide a more genuine and effective form of "peer support" than the targeted interventions have been able to, and that interventions should be led or shaped by people with direct experience of high fun. Such an approach might help remove some of misconceptions and judgemental attitudes that compromised the attempt to reach men who are into high fun in Bengaluru.

Conclusion

In this chapter, I argued high fun exposes several contradictions in "community" as it is constructed for the purposes of targeted intervention. The risk taxonomy that underpins HIV/Aids classifications produces communities as discrete populations whose behaviours and identities do not overlap. As a result, services for men who are into high fun fall in the gap between harm reduction services for injecting drug users and sexual health services for men who have sex with men. Not only do HIV/Aids classifications suggest these categories are mutually inclusive, they are also implied to be internally coherent. This makes it hard to

attend to the barriers men who are into high fun might face when approaching services for "MSM", including the stigma on drug use and HIV. Moreover, it is precisely because they are run by "community" that men like Arvind, Faisal and Vikram avoid such services: their worries about confidentiality and gossip challenge the assumption that community-based services are free of judgement and stigmatization.

High fun also confronts staff in targeted interventions for MSM with the limits of their reach. Reflecting the global emphasis on test-and-treat targets and the resultant focus on identifying "hidden" and undiagnosed segments of key populations (Monteiro et al. 2019, Mora et al. 2018), men who are into high fun are figured as a new "population" promising a high yield of positive HIV test results. This population is seen as distinct from the segment of community traditionally reached by (and comprising the staff of) targeted interventions, suggesting that simply targeting "community" is no longer sufficient. This is related to a difference in programmatic and socio-political interpretations of "community": as Sanjay put it, people can be community without being a *population*. Yet the pressures of this target-driven approach and its narrow focus on HIV risk might compromise the development of ethical and holistic approaches to high fun. I suggested that paying attention to grassroots efforts at collective harm reduction might help us conceive of alternative approaches. These might begin with de-mystifying and de-stigmatizing high fun within the "community", not least because stigma on drug use both prevents men from utilizing existing services and compromises attempts at reaching men who are into high fun. Moreover, such interventions should involve people who know "how things actually are", as Anthony put it, since high fun raises the question of who counts as a true peer in the context of targeted intervention.

Chapter 9: Interlude for Stigma

The notion of stigma is arguably one of social science's most well-travelled and taken-for-granted concepts. At once a popular term and an analytic category, the common-sense understanding of stigma as prejudice and discrimination based on certain "abnormal" characteristics is reflected in much HIV policy discourses and research. The UNAIDS guidance note on reducing HIV-related stigma and discrimination defines stigma as referring to "the negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people" (UNAIDS 2014, 2). It implies a mutually-reinforcing relation between prejudice against people with HIV and prejudice against the groups associated with the epidemic, including gay men and other "MSM". Believed to stop people from knowing their HIV status and/or seeking and adhering to treatment, stigma is identified as a major barrier to achieving the 90-90-90 goals and ending the epidemic (UNAIDS 2014), including in India (Ekstrand et al 2018).

The UNAIDS definition echoes sociologist Erving Goffman's (1963) influential description of stigma as a "discrediting attribute" containing the potential to spoil's one's social identity in the eyes of the so-called "normals". But the reification of HIV stigma as a set of negative attitudes that has resulted from this conceptualization fails to account for the wider contexts of political, social and economic marginalization in which processes of stigmatization and discrimination take place, anthropologists have argued (Parker and Aggleton 2003, Castro and Farmer 2005). Building on these interventions, the following two chapters attend closely to interlocutors' experiences of – or anticipation of – "HIV stigma" in an attempt to complicate the ways in which the concept is invoked both in policy and scholarly discourses, and to contribute to the body of anthropological literature demonstrating the persistence of stigma despite HIV's medical normalization (Philbin 2014, Mc Grath et al, 2014, Villaamil 2014, Moyer & Hardon 2014). In particular, I ask what a more thoroughly "intersectional" approach to stigma might look like, and, conversely, what HIV stigma as experienced or anticipated by gay and bisexual men in urban India might teach us about intersectionality. But first, in this theoretical framework I briefly survey some of the literature on HIV/Aids stigma in India and relate this body of work to the aforementioned

anthropological critiques.

HIV/Aids stigma research in India

India is described by most researchers as a country where HIV/Aids stigma remains widespread. In a comprehensive report for UNAIDS titled *India: HIV and AIDS-Related Discrimination, Stigmatization and Denial* (2001), prominent stigma researcher Shalini Bharat, Peter Aggleton and Paul Tyrer identify the realms of health care, the domestic sphere, the workplace, insurance, education, and post-death services as contexts in which people with HIV/Aids confront stigma, with the health care sector described as "perhaps the most conspicuous context for HIV/AIDS-related discrimination, stigmatization, and denial" (Bharat, Aggleton, and Tyrer 2001, 3). Drawing on a sample of 31 people living with HIV in Mumbai and 13 in Bengaluru recruited through private and public hospitals, the authors list some of the forms discrimination takes in these contexts, ranging from refusal of medical services to expulsion from home and community and termination of employment. The authors emphasize the gendered distribution of HIV/Aids stigma, which is often related to a sexual double standard (van Hollen 2013, for critique). They explain that their efforts to recruit gay men to the study were unsuccessful,

Precisely because HIV-related discrimination is so prevalent, Indians with HIV devote much of their energies to avoiding it. As a result, the study of stigma may take the form of the study of its anticipation. In a paper whose authors include many leaders in the field, Wayne T. Steward and colleagues develop what they describe as a multi-component framework in an attempt to adept the theory of HIV-related stigma to the Indian context (Steward et al. 2008). They define stigma as referring to the "devalued status that society attaches to a condition or attribute," (2008, 1225) incorporating critiques of usages of the stigma-concept that obscure its relational nature (Link and Phelan 2001, Herek 2007). Drawing on interviews with 16 HIV-positive people, the authors distinguish between four different forms of individual stigma experiences: enacted, felt normative, internalized, and vicarious. While the first component captures interpersonal actions, and specifically instances of discrimination based on someone's perceived seropositivity, the second and third component refer to intrapersonal processes. Felt normative stigma is the degree to which PLHIV perceive stigma to be normative in society, and internalized stigma refers to the degree to which they themselves accept the validity of this stigma. The former may be informed by what the authors term vicarious stigma, meaning knowledge of instances of

discrimination and prejudice faced by people who share their predicament.

Building on a study of self-disclosure among 68 people with HIV in South India (Chandra, Deepthivarma and Manjula 2003), the authors hypothesize that felt normative stigma (with or without its internalization as shame) leads to "behavioral modification" in the form of non-disclosure. This was born out by the first part of their study: "Participants had strong expectations about the prevalence of normative stigma (felt normative stigma), which led them to limit disclosure of their infection," and this was especially so after learning about other people's experiences ("social learning") (2008, 1228). As a result, instances of reported enacted stigma were relatively low. Yet this, the authors stress, comes at psychological toll. The second part of their study measures the different stigma components and their effects: participants are asked to rate the extent to which they agree with a statement they are presented with, and these scores are related to participants' stated mental well-being. This metric analysis confirmed the authors' hypothesis that non-disclosure (linked to felt normative stigma) correlates to higher levels of depression, likely by isolating people from social support and other resources.

The tendency to dismiss HIV/Aids as a problem of sex workers and other "bad" women in early responses to the epidemic has in resulted in the gendering of HIV/Aids stigma, with women often blamed and expelled by in-laws following the death of a deceased husband. Cecilia van Hollen suggests the gendering of HIV stigma cannot be explained by invoking the gendered double standard, or sexism, alone. Drawing on research with fifty HIV-positive women in Tamil Nadu between 2002 and 2004, van Hollen contextualizes the stigma they face in cultural constructions of the gendered body, and argues that stigmatization is often driven by economic motivations for disenfranchising a daughter-in-law (2013). In this way, stigma draws on and reproduces gendered inequalities.

The relation between HIV stigma and sexual identity remains underexplored in the Indian context. "A vital gap in the existing stigma/discrimination measures is the lack of attention to assessing compounded or layered stigma," points out Shalini Bharat in her review of HIV stigma research in India, "which is stigma experienced both on account of seropositive status and due to other forms of marginalisation" (2011, 148). This is especially true for HIV-positive gay men. In the UNAIDS report she co-authored with Peter Aggleton and Paul Tyrer, Bharat suggests that the difficulties of coping with two stigmatized identities in a "closed, homophobic society" (2001, 56) makes this group particularly hard to reach for research purposes. Having failed to recruit gay men to the study despite her best efforts, Bharat spoke to gay activists instead. They confirmed that "gay HIV-positive men were a

hidden population" (2001, 56), in part because being diagnosed with HIV led men to withdraw from gay community spaces and caused some men to go through life as heterosexual instead.

The few studies examining HIV stigma among gender and sexual minorities tend to focus on the poor and working class segments of "MSM" who are typically reached by HIV/Aids programming in India. For example, Laura Thompson and colleagues have studied HIV stigma among *kothis* involved in an Avahan mobilization in Karnataka (2013), and Venkatesan Chakrapani and colleagues (2008) recruited HIV-positive *kothis* through community agencies. Sunita Manian (2019), who includes HIV-positive men who sex with men and transgender women in her study of HIV/Aids in Tamil Nadu, explains the gender and sexual minorities most at risk of HIV are those on who are also poor, given that they are disproportionately exposed to sexual violence by the hands of police or clients. This is borne out by Deepika Ganju and Niranjan Saggurti's study of HIV vulnerability among transgender women in sex work in Maharashtra (2017, 904). Yet, as I demonstrate in the next two chapters, paying attention to the experiences of relatively affluent gay and bisexual men with HIV might yield new insight into the relation between HIV stigma and forms of inequality more generally.

Problematizing the stigma concept

HIV stigma research is marked by an enthusiasm for scales and indexes. The most well-known of these is the Berger HIV Stigma Scale (HSS), which is based on a 40-item questionnaire that uses a four-point Likert scale with responses ranging from 1 (strongly disagree) to 4 (strongly agree). The higher the score, the greater the experiences of "stigma", defined as a "deeply discrediting attribute" (Saine et al. 2020). The scale has been validated and adapted for use in South India by Jeyaseelan and colleagues, who suggest their "culturally validated, abridged HIV-Stigma scale can be used in busy clinical settings" (2013, 434). While doubtlessly useful for the purposes of justifying the need for psychosocial support by providing a seemingly objective description of the problem of "stigma", such scales offer little in the way of analysis. Not only do the psychometric properties selected impose categories of experience on the survey-taker, they arguably isolate these experiences from the wider contexts in which they take place. Even when adjusted for "cultural appropriateness", such scales tend to reinforce the notion of stigma as something that happens in the minds and actions of individuals, rather than as a process related to the reproduction of social difference and inequality more generally.

In their influential critique of stigma research, Richard Parker and Peter Aggleton suggest such individualizing tendencies in HIV/Aids research are related to a misinterpretation of Erving Goffman's *Stigma: Notes on the Management of a Spoiled Identity* (1963). In it, the sociologist argued that 'stigma' has a discrediting effect on the social identity of the person possessing the attribute, who is "reduced in our minds from a whole and usual person to a tainted, discounted one" (1963, 12). Goffman identified three different kinds of stigma: abominations of the body (physical deformities), blemishes of individual character (like homosexuality or mental illness), and tribal stigma associated with belonging to a reviled social group (such as belonging to a minority religion). In their different but related ways, these stigmas create a discrepancy between people's virtual, or perceived, and actual identities. When this discrepancy becomes apparent, it "spoils" the person's social identity (1963, 30). In the case of an individual who "in effect or by intent passes" (1963, 95), the embarrassing revelation of the stigma looms as a threat. This may cause them to self-isolate so as to avoid "mixed contacts" - e.g. contact between a stigmatized person and the people Goffmann describes as 'normals' – or, if possible, hide their discrediting attribute. Indeed, this is the strategy identified as dominant among people with HIV in India by Steward and colleagues, and it is one that has become increasingly viable with the availability of ART and the reduction of visible side effects. In addition to concealment, Goffman identifies defiance and irony as modes of "managing" (the threat of) a spoilt identity. Biohazard and other tattoos signalling a seropositive status are examples of such "self-stigmatization" (Brouwers 1998). (Although they are, in my experience, far more common in Euro-American contexts than in India, one interlocutor sported a tattoo depicting Poseidon fork emerging from the iconic red ribbon. The fork represented, he explained, his anger at the person who infected himself as well as at "the stigma".)

Despite his characterization of stigma as a "deeply discrediting" attribute possessed by the stigmatized person or group, however, Goffman proposes a "language of relationships, not attributes, is really needed" (1963, 3). Many of the 'notes' are descriptions of the different forms these relationships can take: they are accounts of mixed contact. This qualification notwithstanding, in research within the field of social psychology "the stigma or mark is seen as something *in the person* rather than a designation or tag that others affix to the person," Bruce Link and Jo Phelan have observed (2001, 266). Building on this critique, Richard Parker and Peter Aggleton argue that social-cognitive approaches to stigma suffer from an individualistic bias: they tend to focus on the perceptions of individuals and the consequences of these on social interaction, treating stigma as negative emotions arising from an

individual's lack of information or their 'cultural' beliefs (2003, 15). There is, for example, a tendency in literature on HIV/Aids stigma in India to focus on attitudes, misconceptions, perceptions, and feelings: there is research on the "perception of AIDS" among low-income communities in Mumbai (Bharat 2000), the relation between "gender-based attitudes, HIV misconceptions and feelings towards marginalized groups" (Bharat et al 2014) and HIV stigma and that between "HIV misconceptions" and support for coercive measures (Ekstrand et al. 2012), and the "attitudes towards HIV-infected persons" of health care workers (Mahendra et al. 2007), etc. As a result, stigma is treated as a static attitude rather than a "constantly changing (and often resisted) social process" (Parker & Aggleton 2003, 14) rooted in wider social and economic structures.

Parker and Aggleton propose that "to move beyond the limitations of current thinking in this area, we need to reframe our understandings of stigmatization and discrimination to conceptualize them as social processes that can only be understood in relation to broader notions of power and domination" (2003, 16). They put Goffman in conversation with Michel Foucault and Pierre Bourdieu (1984) to suggest that processes of stigmatization and discrimination are part and parcel of the cultural (re)production of difference by signalling social distinctions among individuals and groups. Thus placing stigma at the intersection of culture, power, and difference, the anthropologists argue it both draws on and reinforces existing social and social and structural inequalities. In other words, the relations that are at the core of Goffman's analysis are relations of power that occur in, and reproduce, specific symbolic fields. Seen in this way, "it becomes possible to understand stigma and stigmatization not merely as an isolated phenomenon, or expressions of individual attitudes or of cultural values, but as central to the constitution of the social order" (Parker and Aggleton 2003, 17). The forms stigma takes, then, is determined by its historical and cultural context. Conversely, HIV stigma might offer a privileged window into the principles that organize social life in a given cultural setting.

Building on this critique of cognitivist explanations, Arachu Castro and Paul Farmer (2005) propose structural violence as a conceptual framework for understanding Aids-related stigma. Not only do forms of structural inequality shape risk of infection and rate of disease progression, they also determine who suffers from HIV/Aids-related stigma and discrimination. Just as it can be expected that people of colour with Aids will be more stigmatized in societies marked by profound racism, "in highly sexist settings, the disclosure of HIV infection is more likely to provoke stigma and threat of domestic violence than in environments where women enjoy gender equity," the authors suggest (2005, 55). This is

borne out by the research on the gendering of HIV stigma in India, where women suffer a disproportionate amount of the blame for infection and disease at the hands of in-laws (van Hollen 2013). Similarly, HIV researchers in India stress that the “marginalized groups” associated with the epidemic – sex workers, injecting drug users, migrants and homosexuals – suffer HIV stigma more intensely on account of their “double” marginalization (Bharat, Aggleton and Tyrer 2001). More recently, the lens of intersectionality has been used to describe the way in which “HIV stigma intersects with other stigmas, such as stigmas associated with race and sexuality, to create unique and sometimes new oppressive conditions and experiences” (Earnshaw et al. 2021, 413, see also Abukari et al. 2021). Whitney Rice and colleagues (2018), for example, suggest that racism and sexism may worsen the effects of HIV stigma among women living with HIV in the U.S. South. Yet despite this growing acknowledgement of the importance of intersectionality in understanding HIV stigma, there is little consensus on how to analyse the way in which these different sources of stigma interact (Earnshaw et al. 2021, Turan et al 2019).

Whereas the aforementioned authors suggest the individualistic bias in most accounts of stigma is due to misinterpretations of Goffman’s stigma theory, Veena Das (2001) lays the blame for this with the centrality of the notion of “spoilt identity” in it. The emphasis on (individual) identity, she argues, makes it difficult to recognize both forms of collective resistance to stigma *and* the ways in which the everyday management of it becomes a problem of families and communities. According to Das, the way in which disability and disease stigma becomes a problem of “connected body-selves” in the Indian context is in part due to their association with sexual transgression. This insight is particularly relevant to HIV/Aids, which in India was initially framed by government officials and scientists as a disease of moral degeneration that would not affect the country’s general population due its superior family values and rigid sexual morality, as detailed in Chapter 1. These values have historically served to uphold the caste-based social order through the principle of endogamy, as queer and feminist analyses of the relation between caste, gender, and sexuality have taught us (Abraham 2014, Rao 2020, Upadhyay 2020) – which, according to Das, is what makes the suggestion of sexual transgression so problematic. Yet caste is a conspicuous absence in the literature on HIV/Aids stigma. Caste is mentioned not a single time in the 72-page UNAIDS report on HIV/Aids stigma in India (Bharat, Parker and Tyler 2001) or in Shalini Bharat’s review of HIV/Aids research in India (2011). And while van Hollen (2013) mentions that most of her participants come from impoverished Dalit communities, it is unclear if and how their caste and class location shapes the form gendered HIV stigma takes

in these women's lives.

The following two chapters respond to Parker and Aggleton's call to analyse HIV stigma in relation to the reproduction of the social order more generally. In Chapter 10, I draw on their critique of the framing of HIV stigma as a problem of individual knowledge deficit to challenge the notion that Undetectability will "eliminate" HIV stigma by radically reducing fear of transmission. Instead, interlocutors described a dynamic whereby viral suppression enabled them to justify ethical non-disclosure, such that Undetectability contributed to the further "closeting" of HIV. In this way, TASP discourses may exacerbate the dynamic described by Steward and colleagues (2014) by making the option of concealment even more viable, particularly for those with privileged access to treatment, viral load testing and related discourses. Chapter 11 moves beyond experiences or anticipation of stigma within the gay community and in hook-up contexts to explore a different aspect of the "double stigma" of being gay and HIV-positive, namely anxieties around "coming out again" at home. I suggest that his anxiety relates not just to the way in which HIV stigma may reinforce parental homophobia, but also to the way in which a positive HIV status threatens to undermine a family's standing in the caste and class-based social order. In an effort to understand how and why this is so, I try to develop an intersectional approach to HIV stigma that moves us beyond the point of intersection with other identities.

Chapter 10: Undetectability

"Once I'm undetectable," asked Santosh, a sales manager in his mid-twenties when we met over iced coffee in Bengaluru. "And I just want to hook up – because you do need to hook up from time to time – do I need to disclose I am [HIV-]positive and undetectable? Because there is so much stigma attached to it. Especially in India, the environment is not very friendly."

My conversations with thirty HIV-positive gay and bisexual men in Mumbai, Bengaluru, Chennai and New Delhi kept circling back to this question. In the past decade, a scientific consensus has emerged around the fact that those with suppressed or 'undetectable' viral loads cannot pass on HIV through sexual routes (CDC 2020). The message that "Undetectable = Untransmittable'', popularized in a campaign launched in 2016 by the U.S. based Prevention Access Campaign, is invested with hopes of eliminating HIV stigma by decreasing fear of transmission (Prevention Access Campaign 2020). As explained in Chapter 1, it is at the heart of the current paradigm of treatment-as-prevention (TASP), according to which the HIV epidemic can be ended by reducing forward transmission through biomedical means. In addition to viral suppression, treatment-as-prevention technologies include Pre-Exposure Prophylaxis (PrEP), in which antiretroviral medication (emtricitabine/tenofovir disproxil, branded as Truvada) is taken preventatively, and Post-Exposure Prophylaxis (PEP), a course of antiretroviral medication taken after HIV risk exposure.

There is nothing new about undetectable viral loads, as Kane Race's (2001) analysis of the 'power effects' of the medical technologies associated with HIV, particularly antibody testing, antiretroviral treatment (ART) and viral load testing, reminds us. As viral load tests measuring the rate of viral replication became more sensitive, doctors began using the phrase 'undetectable' to describe viral loads below 500 RNA copies of the HIV virus per ml blood[16], which signified patient compliance and was seen as a "fairly reliable, but not infallible, measure of infectivity" (Race 2001, 168). In the past decade, however, the emergence of a scientific consensus regarding the effect of ART treatment on forward sexual transmission (CDC 2020) - combined with the diminishing problem of treatment toxicity - has led to a re-conceptualization of viral suppression as a matter of epidemiological surveillance and control rather than merely individual patient care. As Kane Race explains in a more recent article,

[16]The threshold for Undetectability is now typically between 20 to 50HIV RNA copies/ml. Viral suppression is defined as less than 200 copies of the HIV virus per millimetre blood, at which point HIV cannot be transmitted through sexual routes (Prevention Access Campaign 2020).

> HIV-positive individuals have long used viral load test results in attempts to reduce the risk of unprotected sex (see Race, 2001, 2003; Rosengarten et al., 2000). But the appearance of undetectability as an explicit identity mobilized to mitigate any alarm associated with HIV positivity – that is, as a prevention identity *in itself* – is a relatively recent development; one that connects with discourses of Treatment as Prevention and recent clinical trials that suggest the reduced infectiousness of HIV-positive individuals on treatment.[8] The emergence of this term as a prevention identity demonstrates how the field of sexual practice is directly and indirectly informed by biomedical discourse, though not in the ways necessarily expected or readily acknowledged by policy-makers. (Race 2015, 256)

In 2019, U.S. Chief Medical Advisor Dr Fauci declared that "the concept of U = U [Undetectable = Untransmittable] is the foundation of being able to end the epidemic" (Prevention Access Campaign 2020). Undetectability is thus key to the turn to "biomedical triumphalism" (Kenworthy, Thomann, and Parker 2018) that marks current HIV/AIDS discourse. At the risk of overstating its novelty, I use capital-U 'Undetectability' in this thesis to refer to this contemporary yielding of what in more formal HIV jargon is known as Undetectable Viral Load (UVL) as a form of *treatment-as-prevention* (as opposed to treatment-as-treatment) (TasP).

As Eileen Moyer and Anita Hardon have pointed out, claims of reducing stigma have been "a common justification for medicalizing the disease throughout its 30-year history" (Moyer & Hardon 2014, 267), and are often invoked by proponents of scaling up TasP strategies. Yet the effects of treatment-as-prevention discourses are anything but straightforward. Researchers have mobilized the Foucauldian frame of biopolitics and governmentality to draw attention to the ways in which TASP enables and encourages novel forms of subject-formation (on the part of the HIV-positive person) and surveillance (on the part of the state) (Krellenstein and Strub 2012; Persson 2013, Guta, Murray, and Gagnon 2016, Persson et al. 2016). Kane Race's prescient analysis regarding the way viral load testing helps situate the HIV-positive person as the "natural delegate of risk management" through a process of responsibilization (2001, 179) is borne out by social scientific research on the impact of new biomedical prevention technologies on queer men in the Europe, the U.S., and Australia. Drawing on Paul Rabinow's (1996) conceptualization of 'biosociality', researchers demonstrate that new biomedical prevention technologies do not reduce HIV stigma in any straightforward way, but are instead mediated by generational, serological and geographic identities, and may give rise to new forms of marginalization in (Grace et al. 2015; Young, Flowers, and McDaid 2016; Girard et al. 2018; Young et al. 2019). Survey data

measuring the impact of PrEP on Australian gay and bisexual men's willingness to sleep with HIV-positive partners similarly problematizes the assumption that TasP discourses and technologies eliminate stigma (Holt et al. 218). Yet while this emerging body of scholarship illustrates the need for "focused examination of particular biomedicalization processes, situated in their specific – but globalised – contexts" (Young, Flowers, and McDaid 2016, 413), its scope is limited to the context of queer communities in the Euro-American world, with the exception of a study exploring the impact of viral suppression on HIV-positive queer men in Singapore (Tan, Lim, and Chan 2020).

In this chapter, I offer an ethnographic examination of the impact of Undetectability on the way in which HIV-positive gay and bisexual men in urban India navigate sex and romance. As previously explained, these men come from predominantly middle to upper class backgrounds. Most though not all of them access treatment privately, and therefore have easier access to viral load testing technologies and to the discourses of Undetectability that circulate on English-language websites and social media online than their less privileged HIV-positive counterparts who access treatment for free at ART centers in public hospitals. While NACO introduced bi-annual viral load testing into its treatment protocol in 2018, issues around access persist, and the agency has stopped short of endorsing the message of U = U despite otherwise embracing treatment-as-prevention strategies and discourses (NACO 2022).

Challenging the assumption that Undetectability will dismantle HIV stigma, I argue it instead gives rise to novel ways of navigating the question of responsibility for risk management in sexual contexts, including ethical non-disclosure in the face of perceived social risk. Name-and-shame Grindr profiles vilifying people with HIV is one of the ways in which interlocutors become aware, vicariously, of these risks, although they also draw on their own past perceptions of and attitudes towards HIV-positive men. In this way, the discourse of Undetectability may intensify the dynamic described Steward et al. (2008), who argue, as explained in the previous chapter, that a high degree of perceived stigma ("felt normative stigma") leads people with HIV in India to adopt a strategy of disclosure avoidance. I suggest that one of the consequences of this closeting of HIV is the perpetuation of a serological divide in terms of access to TasP discourses, such that few HIV-negative or untested men encounter the discourse of Undetectability. However, even if this barrier were to be overcome, it is doubtful that knowledge of Undetectability alone will end HIV stigma, which I argue, echoing Parker and Aggleton (2003), is not a problem of ignorance/knowledge alone.

Navigating responsibility

Raj and Vinay messaged me on Grindr from separate accounts, both inviting me to their shared two-bedroom apartment in a leafy Bengaluru neighborhood for a conversation about my research. "Maybe don't launch into the interview straight away," Raj cautioned as he picked me up from outside the compound. He explained that though he himself is comfortable with his status, his partner Vinay only got diagnosed when the two of them started dating the previous year. After disclosing his own status on their first date, Raj suggested he and Vinay visit a diagnostics center together. Vinay, who is 26, had never been tested before.

But within minutes of my arrival, Raj and Vinay were locked in discussion about the ethics of non/disclosure and the question of responsibility for risk management, arguing in the playfully adversarial way of couples with few actual disagreements. Raj's policy is to disclose his status straight away when speaking to a potential sexual partners - not because he feels he has a moral obligation to, but to protect himself from the fall-out of non-disclosure. "They do so much emotional drama," the thirty-year-old software professional explained. "*Why didn't you tell me before, why did it take so long?* Even though it's not about you, it's about *me* – *I* have to live with this!"

By way of illustration, Raj shared an experience he had on a dating app recently. After telling a 'match' that he is HIV-positive, Raj was chastised for not putting his status on his profile, demonstrating the way dating apps and their different formats for prompting HIV status shape norms around sexual negotiation (Race 2015*). I would have had a chance to weed you out*, the match explained. Raj replied that that it is not his problem, and told me he suspects his match was just anxious about having had unprotected sex himself. "I understood him, his problem was, *Oh God! I did so many things.* But if he's not aware of his own status, that is *his* responsibility!"

Implicit in Raj's explanation of his match's response is a theory of HIV stigma as cycle of fear and avoidance. Writing with reference to gay male Latino communities in the U.S., Rafael Díaz (2006) used the phrase 'displaced abjection' to refer to the way his interlocutors project their own disproportionate HIV risk - emerging from the intersections of poverty, homophobia, and racism - onto their peers, thereby giving themselves an illusion of safety. Raj opined that instead of "taking it out on someone who is just talking to your virtually'', his match should get tested, and that if he still wants to have condom-less sex, he should get on PrEP. In doing so, he explicitly rejected the unequal distribution of responsibility for both traditional and biomedical forms of risk management.

Paul Flowers (2001) and Kane Race (2001) have historicized this asymmetry, which they argue is the product of certain knowledge regimes enabled by the antibody and viral load tests. Whereas the identification of a 'gay lifestyle' as the main risk factor in the early days of the U.S. epidemic meant "the responsibility and blame for HIV risk management were distributed evenly across all gay men and were, to a great extent, met by solidarity," (Flowers 2001, 53) the development of the antibody test in 1985 shattered this homogeneity by producing the HIV-positive person as ''a new site for the inscription of [HIV/AIDS] stigma" (Race 2001, 174) Race argued that this process of 'responsibilization' intensified with the advent of HAART in 1996. "While the designation of 'undetectable' status exempts the subject from the status of abject," explained Race more than a decade before the *U = U* consensus, "it also implants an imperative around individual self-surveillance upon which the subject's capacity to retain that (non-contaminate) status depends" (2001, 177-178). This explains the 'doubleness' of Undetectability as it is experienced by Raj and Vinay.

Not only did Raj challenge the unequal distribution of responsibility for risk management, he recognized and rejected the stigmatizing trope of the criminally contagious HIV-positive person that underpins it. "I know what I went through," he said, his voice tinged with indignation,

> and I know I'm not going to make someone else go through the same. So this whole playing with the guilt feeling doesn't really work. I'm *undetectable*, and I'm using a condom, or just fucking blowing someone. *So I don't really need to come out*, and I don't think I should feel guilty.

Raj invoked his suppressed viral load alongside traditional forms of safer sex to counter the normative notion that HIV-positive people must always disclose their status. Undetectability allowed him to reason that he is already doing his bit for risk management by maintaining a suppressed viral load, and therefore need not feel guilty for non-disclosure or delayed disclosure.

Although this conflation of taking responsibility for *individual* and the *public* health by taking ART is not new (Race 2001, 179), it has recently been amplified in North-America by campaigns with titles like 'HIV STOPS WITH ME' (Guta, Murray, and Gagnon 2016). Raj's rejection of guilt hints at the way this logic overlaps with that of the criminalization of people with HIV. In 2012, Canada's Supreme Court upheld laws criminalizing HIV status non-disclosure including when condoms are used, but exempted those with undetectable viral loads. As Sarah Schulman (2016) points out, Canadian activists are wary of celebrating the exemption, because making the legal requirement to disclose contingent on viral load does

not challenge the logic of criminalization itself. Rather, it exemplifies the way "viral load surveillance becomes increasingly implicated in HIV criminalization" (Guta, Murray, and Gagnon 2016, 98) by facilitating the framing of those who refuse treatment or fail to maintain an unsuppressed viral load as resistant, risky and in need of surveillance and intervention (Shulman 2016, 128).

Where does that leave someone like Vinay, who was conflicted about starting treatment? Knowing himself to be forgetful and messy with medications, Vinay worried that starting treatment early might undermine his health in the long run. Perhaps in recognition of the fact that "minimizing adherence challenges in order to emphasize the benefits of treatment as prevention for public health purposes has been equated with violating core principles of medical ethics vis-a`-vis the individual patient: to *do no harm* and to *respect autonomy*" (Guta, Murray, and Gagnon 2016, 88; Krellenstein and Strub 2012), Vinay's doctor at the local government ART center supported his decision to postpone treatment. When I went to meet him, the former ART consultant to the WHO stressed the need for proper counselling before starting treatment, but endorsed the principle of TASP. He spoke to me between treating patients, who lined up outside the cubicle in which we were sat. One of them was man with syphilis who had failed to show up for his penicillin shot. "If he was HIV positive," the doctor said indignantly after scolding the patient, "how many people would he have infected in the five months he was not treated?"

Vinay is, in his own words, "really horny", and would like to be able to have sex with people other than his boyfriend without having to disclose his status. "I was speaking to this doctor on Grindr who was *desperate* to sleep with me," he told me, cracking up Raj. "And I figured that since he's a medical professional, it should be okay with him, he should have a better understanding." Vinay was quickly disabused of the notion that medical professionals are less likely to stigmatize people with HIV. "Why are you on Grindr?", the doctor replied. "Don't you feel ashamed? Why are you even speaking to people like this, what if you pass it to someone?" In a U-turn, Vinay told the doctor that he was just kidding, not because he wanted to sleep with him, but because he wasn't sure ''what he would do next''.

The contrast between Raj's confident righteousness and his boyfriend's experience of being shamed back into the proverbial closet demonstrates the doubleness of Undetectability. On the one hand, it enables Raj to challenge to unequal distribution of responsibility for risk management and disclosure. But although it became clear during the course of our conversation that he opposes all forms of HIV criminalization, Raj's invocation of viral suppression to absolve himself of feelings of guilt is structurally homologous with

contemporary forms of HIV criminalization that exempt people with Undetectable viral loads from the requirement to disclose, raising concerns that "those categorized as virally unsuppressed by this new form of classification will be marked as increasingly dangerous" (Guta, Murray, and Gagnon 2016, 98). According to these entangled medical and judicial logics, even the mere presence of someone like Vinay on a dating app can be construed as a criminal wrong, as the doctor he chatted with implied.

Undetectability thus has both de-marginalizing and marginalizing potential, as Australian researchers have pointed out (Persson et al. 2016). It enables new ways of navigating the question of responsibility for risk management and disclosure, most notably ethical non-disclosure. Yet the casting of Undetectability as a form of taking responsibility risks marginalizing those refusing or failing to maintain a suppressed viral load by further positioning the HIV-positive person as the natural delegate of risk management (Race 2001). By intensifying the moral imperative of viral containment, TasP discourses deepen this unequal distribution of HIV risk management even as it promises to normalize HIV. Instead of resolving the problem of stigma, Undetectability gives rise to new ways of managing it, most notably by enabling those on treatment to weigh the risk of transmission against the social risks of disclosure.

Social risk

"Actually, I'm undetectable," said Bilal when Gautam asked him about PrEP in a WhatsApp conversation a few days after they had sex. "What do you mean you are *undetectable*?" asked Gautam. He "flipped out" when Bilal elaborated. The links he sent to webpages explaining *U=U* did little to temper Gautam's anger. ''I wish you had told me so I could have at least had a say. And why didn't you use a condom?!?'', he wrote. Although Gautam uses condoms in theory, this preference rarely survives the first joint.

"I didn't tell you because of *this*," Bilal replied. "This is exactly the kind of stigma I'm talking about. Why don't you put yourself in my shoes for a second?" Gautam used to get tested for HIV so frequently that the staff at his local lab started to recognize him and, Gautam worried, speculated about the reasons for his obsession. When one of these tests came back positive, and then the follow-up ones did too, Gautam "just wanted to go stand in the middle of the road and die," as he put it to me. Unsure who to turn to, Gautam unblocked Bilal on WhatsApp to send him a slew of questions, but refrained from telling him about the diagnosis. "In 2019, you don't ask someone who is HIV-positive to explain everything to you," came the reply. Gautam shot back: "In 2019, you should have the ethics to inform

someone before you have bareback sex with him."

The message exchange illustrate what researchers in the U.K. describe as a serological divide in terms of who accesses TASP discourses, and how TASP discourses are received (Young, Flowers, and McDaid 2016). Gautam's response to Bilal's status disclosure was a demonstration of the stigma that stopped Bilal from disclosing without being prompted in the first place. Crucially, his undetectable status gave rise to contestations over responsibility for risk management, disclosure and education rather than resolve the problem of stigma. Gautam only internalized its meaning after testing positive himself, when he, as he explained to me, "understood where he [Bilal] was coming from''.

Although I never met Bilal, many of the people I interviewed shared his position on disclosure:

> Nobody wants to hide, put on a mask. But if you disclose, guys not only stop talking to you, they will spread rumors about you. They might do anything, actually. (Karan, 35, Mumbai)

> I have to keep it private because it is stigmatized. I don't have a problem telling people if they react normally. It's like [being] LGBT: I can tell you I am homosexual, but people should be able to take it, right? I shouldn't be traumatized by your response, right? And then you'll go and tell a hundred other people who respond in a hundred other ways… that's very hard to take, no? If you judge me, discriminate me, I can't take it, right? I also need to have safety. (Karthik, 25, Chennai)

> Why should I cause them a panic attack if I know I am not posing any risk [because of being undetectable?] (Sri, 39, Bengaluru)

> I will keep it to myself. It will not be met with compassion. (Arvind, 34, Mumbai)

> *U = U* is okay, but the way the message is put forward is very important. In a country like India, you can't expect people to disclose and be safe. (Amit, 26, New Delhi)

These comments turn the idea of "safety" in the context of HIV on its head by hinting at the considerable *social risk* involved in status disclosure, ranging from reputational damage to physical violence. The common comparison to queer "coming out" drives home the way in which HIV continues to be experienced as a secret that requires closeting (and disclosure) rather than a manageable chronic condition like any other. Indeed, the tension between the universalizing medically-normalized construction of HIV implicit in the Undetectability discourse is contrasted to situated lived experience, in particular the specific and less-specific social risks of disclosure "in a country like India".

Sometimes this social risk takes the form of Grindr profiles that are made to name and

shame an allegedly HIV-positive person. “What I see happen is that when people come out clean saying they are positive, pictures are spread on groups with messages saying ‘stay away from this person, he’s positive”, explained Santosh, elaborating on the apprehension about disclosure with which I opened this chapter. “Without even realizing that that person can’t really transmit anything if he is undetectable, or without giving any attention to the fact that person wanted to be upfront and honest with you.” Rather than offering insurance against being maligned in this manner, “coming out clean” makes one vulnerable to vilification. Crucially, Santosh anticipated that Undetectability would not make disclosure any less of a damned-if-you-do-and-damned-if-you-don’t scenario. Indeed, I once received threatening messages on Grindr from someone who had spotted me at Mykonos, a gay sauna in New Delhi, a few days earlier. Having learned from my profile that I am ‘Positive, undetectable’ - one of the answer options for Grindr’s voluntary HIV-status prompt - he wanted to know how I could dare come to such a place, as if my very presence was infectious. In contrast, the friend I had gone to the sauna with struggled to get people to agree to him putting on a condom: if you’re *clean*, his partners protested, then why do we need to use one?

As a recently-diagnosed interlocutor in Delhi who chose the pseudonym “Cher” explained, “there is this image of people with HIV as bad because they go around trying to ruin other people’s lives, and I don’t want to be that person.” Cher’s awareness of this trope is an example of what Steward and colleagues (2008) describe as vicarious stigma. They draw on psychologist Albert Bandura’s social learning theory (1977), which posits that we learn from observing the experiences of others, to suggest that their research participant’s high degree of “felt normative stigma” was informed by their knowledge of other people’s experiences. In the case of the name-and-shame profiles, one does not need to personally know the individual targeted: very existence of these profiles seem to demonstrate the prevalence and intensity of HIV stigma. We “see it happen”, to use Santosh’s words.

Indeed, having come across several such profiles during my fieldwork, I feared become the object of one myself, and adjusted my disclosure strategies accordingly. On July the 29th of 2019, I wrote in my fieldnotes that I was worried someone I had hooked up with might find out about my status and start telling people I’m some sort of villain trying to spread the virus. “I saw a profile like that in Delhi,” I wrote, “warning people in full caps of a gay who was positive but didn’t disclose.” But whereas I decided to start disclosing more consistently, since I was anyway at least partially “out” due to my research, Santosh and many other interlocutors resolved to consistently *not* disclose.

In one case, an HIV-negative interlocutor explained he became the target of a name-

and-shame profile after he had revealed the marital status of his friend's lover. This suggests that such profiles feed on and flourish in a wider culture of secrecy and suspicion: "Gossip only happens when people are having secrets," Bora theorized. "You judge if someone is closed. [You ask yourself,] *What are they hiding?* When you're open and aware, there is less scope for gossip." Just like Bora had shared information about his friend's partner with the intention of shielding him from heartbreak, name-and-shame profiles and rumour about HIV status more generally can be understood as a form of warning that circulates – alongside credible stories of blackmail, deceit, overdose and violence - in an otherwise largely unsupported queer community. And insofar as they create an environment that discourages voluntary HIV status disclosure, their logic is self-perpetuating: since people are keeping their HIV status a secret, they must be "exposed," just as Bora had exposed his friend's lover, who in turn threatened to expose Bora's friend to the police for carrying drugs (they were planning on doing high fun). Understood this way, rumour may "have to do not so much with the transmission of necessary news as with the refinement of necessary skills for making, testing, and using unrationalized and provisional hypothesis about what kinds of people there are to be found in one's world" (1990, 23), as Eve Sedgewick suggested in *Epistemology of the Closet*. HIV gossip should thus be understood as part of a wider culture of discretion and suspicion among a community that was, till recently, criminalized, and remains vulnerable to a host of dangers.

Bora's example also demonstrates that such profiles bear little relation the actual serostatus of the target. I once got a distress call from someone who thought he might need PEP, because the flatmate of the guy he had just hooked up with claimed this person was HIV-positive. My acquaintance and his hook-up had had an open conversation about serostatus before having unprotected sex, so I suggested the flatmate was probably just jealous. All this is reminiscent of Van Hollen's (2013) claim that the "stigma" faced by HIV-positive women at the hands of their in-laws is often related to economic motives, rather than reflecting moral judgements alone. Except in the case of the gay community in Bengaluru, the motives seemed to be of an emotional nature – related to feelings of jealousy, revenge, or rejection. (Although some interlocutors expressed fears of extortion and blackmail (they had a "vicarious" experience of it), this has happened to none of them.)

"Fraud HIV guy," claimed the handle of one profile, its display picture featuring someone I had interviewed just weeks ago about being on PrEP. "Guys be safe," warned the profile bio, "this profile is fake he is using my friends pics dnt share ur details with this dog he is a son of randi [prostitute] and a HIV guy make him viral to all if u know him let me

know or contact any police station." The suggestion that people who know my interlocutor should contact the police to stop him from making everyone 'viral' explicitly aligns the sentiment behind such campaigns with the logic of HIV criminalization. For Sarah Schulman, the way status non-disclosure has come to be conceptualized as a criminal wrong, even when no transmission takes place and even when condoms are used, is symptomatic of a more general tendency to deliberately misrepresent *conflicted* situations as abusive ones. This absolves one party of all accountability while punishing the supposed perpetrator, usually by empowering the state and its law enforcement. By framing non-disclosure as aggravated assault, rather than promoting safer sex as a matter of mutual responsibility, the "state of being HIV-negative has been recast by the Canadian courts as one of potential victimhood" (2016, 121). Aside from being most counterproductive from a public health point of view in that it dissuades people from getting tested (Mykhalovskiy 2011), the Guilty/Innocent binary of criminal justice comes to replace an earlier queer ethos of solidarity and shared responsibility for safer sex communication (Flowers 2001). HIV criminalization scapegoats as dangerous the party who is actually *endangered* and in need of protection.

In India, the HIV AIDS (Prevention and Control) Act 2017 does exactly the opposite, in theory if not in practice (Bathini 2020). Drafted by the Lawyers Collective – the organization whose harassment by the government was detailed previously - over a decade prior to its approval by the Rajya Sabha (the upper house of India's Parliament), the Act not only safeguards confidentiality, but also prohibits the propagation of hatred against people with HIV. Yet the trope of the HIV-positive person as criminally contagious has a lot of traction. In an attempt to contextualize what was overtly stigmatizing behavior towards me during sex[17], an HIV-negative friend told me he had been harassed by someone whom he later found out (through rumour) to be HIV-positive, collapsing in his narrative the threat of sexual assault and that of HIV infection. Of course people *do* contract HIV through rape – but what my friend's apology hinted at is the way in which status non-disclosure is figured as a fundamental breach of consent. At the same time, "known" HIV-positive people are (sexually/romantically) avoided by most, leaving people with HIV in the double bind described by Santosh.

As a result, while the Indian government has long abandoned its initial harsh punitive approach to the epidemic with a human rights-based one, Schulman's use of the word

[17] This was in spite my having told my new friend in detail about Undetectability, as we, ironically enough, had been speaking about this particular strand of my research.

"endangered" (2016, 127) to describe the impact of criminalization on people living with HIV resonates with the sense of social precarity described by many of my interlocutors. In lieu of a legal framework for prosecution[18], Grindr profiles like the one above function as a form of vigilante criminalization by mobilizing social risk.

As explained at length in Chapter 2: Methods, Ethics and Poz/itionality, apprehension about disclosure presented a significant methodological challenge. Throughout my two-hour long interview with Faisal, which features prominently in Chapter 4: Organizing Logics, Faisal maintained he was lucky that at least he hadn't picked up HIV. "People say stuff like – *oh, he must be HIV positive from all that high fun*", he said bitterly, hinting at the interlocking nature of HIV and high fun stigma. "Even though I've been on PrEP for I don't know how many years." After two hours or so, the interview gave way to a more reciprocal exchange. "I'll be honest with you," Faisal interjected when I began telling him about the HIV diagnosis I received a few months before starting fieldwork. "I've been positive for six years. But I don't want it to be talked about." PrEP helped Faisal side-step what he called the "major stigma" associated with HIV, while Undetectability provided the justification: "I was put on medication straight away, so I knew I wasn't infecting anyone." TASP thus contributes to the closeting of HIV in more ways than one.

There, of course, important exceptions. Sunny, a returned expat in Mumbai who used to run workshops with a sexual health clinic abroad, told me he discloses his status on Grindr because he feels he has a responsibility to educate "the community". "But there are times when I remove it from my profile," he explained, "when I just can't be bothered to go through that whole thing. Since I'm not putting anyone at risk, they don't *need* to know." Because of the absence of transmission risk, disclosure (for Sunny) becomes a social service rather than a moral obligation, further illustrating the way Undetectability itself may militate against the exposure of HIV-negative or untested people to the gospel of *U = U*.

Even when HIV-negative or untested people do encounter Undetectability, their engagement with it is mediated by stigma. "It doesn't matter whether you are undetectable or not," said Arvind in Mumbai. "People are like, *I just don't want anything to do with it*." His words were echoed by Santosh: "Whether it's PrEP or Undetectability, people just don't want to talk about anything related to HIV, because they know there is a risk they're taking if

[18] Although the Indian Penal Code pertains two Sections, 269 and 270, regarding the spread of infectious diseases that have been used to criminalize heterosexual HIV transmission on at least fifteen occasions (HIV Justice Network 2021), it is unlikely that gay men, until recently themselves acutely vulnerable to police blackmail and harassment, would take legal action in a case of non-disclosure.

they're hooking up every day." This resonates with researchers' observation that focus group participants in Scotland "were concerned that existing forms of HIV-stigma would preclude those not affected from HIV from engaging in this critical 'new' information about HIV-risk" (Young, Flowers, and McMaid 2016, 418). Several interlocutors internalized the resulting serological divide through a before/after comparison. "I don't blame people who freak out," said Karthik in Chennai, "because before testing positive, I didn't know HIV is not AIDS, I didn't know about Undetectable." This also suggests that the high degree of felt normative stigma was related not just to vicarious stigma, but also to the reflection on interlocutors' own past attitudes towards guys with HIV.

Gautam told me he is still angry at Bilal, reflecting the tenaciousness of dominant norms around status disclosure that he himself – because of social risk – cannot not live up to. His decision to block Bilal on WhatsApp illustrates the mechanism of avoidance particularly well. On Grindr too, chats have a way of disappearing - a sign one is blocked - once a seropositive status is disclosed, leaving the HIV-positive person with little opportunity to explain the science behind *U = U*, even as dating app formats for prompting HIV-status may have de-stigmatizing potential elsewhere (Race 2015). Indeed, Gautam's failure to place himself in Bilal's shoes until he himself tested positive is evidence of existence of a serological divide that mediates both access to Undetectability and its interpretation. His reluctance to disclose in the face of intense social risk related to the preservation of his family's social status demonstrates the way in which Undetectability contributes to the closeting of HIV, rather than its de-stigmatization, thereby foreclosing widespread engagement with it.

This contrasts to developments in North-America, Australia and Europe, where scholars remark with some optimism that "people are becoming more open about their viral loads" (Guta, Murray, and Gagnon 2016, 97) even as they worry the increasingly salient suppressed/unsuppressed binary and the "new elite status of undetectable" (Grace et al 2015, 346) may lead to forms of in-group stigmatization (Schulman 2016, Persson 2013, Persson et al. 2016). Although a marker of privileged access to health care and viral load monitoring, it would be a stretch to describe Undetectability as in any way 'elite' in the context of same-sex male dating in India. Indeed, interlocutors often emphasized the context-specific nature of the forms of social risk they faced, which they sometimes contrasted explicitly to the universalism of the *U = U* campaign's promise of normalization. Their insights suggest that the effects of TasP preclude the forms of solidarity on which it relies for widespread engagement by further privatizing and individuating the experience of living with HIV, a

process that has been underway since 1996 (Flowers 2001). Yet it would be naïve to assume that overcoming the resultant serological divide is all it takes to dismantle stigma (Prevention Campaign Access 2020), as TasP discourses suggest.

'#ScienceNotStigma'

The aim of the *U = U* Campaign is to disseminate the scientific consensus regarding the effectiveness of treatment as a form of prevention, both by lobbying prestigious institutions and persons to publicly endorse the validity of *U = U* and through social marketing campaigns. Its premise is that knowledge of Undetectability will translate into reduced fear of transmission, thereby "dismantl[ing] the HIV stigma that has been destroying lives and impeding progress in the field since the beginning of the epidemic" (Prevention Access Campaign 2020). Underlying this assumption is a common conceptualization of HIV stigma as an individual's negative attitude resulting from ignorance or cultural beliefs about HIV/Aids (Parker & Aggleton 2003, 13). It follows that if only people had access to 'correct', up-to-date information about HIV/Aids and its routes of transmission, the problem stigma would be solved. #ScienceNotStigma, one of the hashtags accompanying the U = U campaign, summarizes this position.

Interlocutors often related the perceived prevalence of HIV stigma in India to a lack of awareness among both general and "key" populations (but especially the former. "Basically the stigma is also that if an HIV person is there, he is usually very sick and not able to go around," Sri explained. "Not healthy, walking and talking. They're like: *this guy has HIV, oh he doesn't seem like* it! And I'm like, well, *are you expecting a zombie?*" This assumption that people with HIV look a certain way is factored into attempts at what Australian researchers term 'sero-sorting', or selecting partners based on presumed or disclosed serostatus as a safer sex strategy. An HIV-negative acquaintance in Bengaluru told me he was sometimes mistaken to be HIV-positive because of his petite frame– and when someone he had slept with was later rumoured to be positive, this person's skinniness was invoked as proof. Conversely, Faisal told me 'bottoms' often take off the condom on the rare occasions that he does try to use one because they assume his muscular physique means he must be HIV-negative. And when I was invited by Azim Premji University's queer-straight alliance to give a talk about my research, the woman organizing the event warned I better start by explaining the difference between HIV and Aids.

This conflation may be a legacy of early representations of HIV/Aids in India. Health communication scholar Ravindra K. Vemula explains that during NACP-I (National AIDS

Control Programme-I, the first phase of HIV/Aids programming which ran from 1992 to 1999), the dominant message was that HIV/Aids was a "guaranteed death sentence". This reflected mainstream medical discourse emanating from the West, which was that HIV would always lead to AIDS and thus untimely death. Although the advent of triple-combination therapy (ART) in 1996 meant the progression of HIV into Aids was no longer inevitable, the unavailability of the new treatments for the vast majority of HIV-positive Indians - and indeed their counterparts in other Global South countries - rendered this fact almost irrelevant as far as public health messaging was concerned until treatment was rolled out in 2004. Moreover, since the public was not seen as scientifically literate enough to understand Aids, HIV was construed as a "deadly disease" rather than as an immune deficiency syndrome with a long (and, in a small number of so-called "elite non-progressors", perpetual) stage of latency. The main strategy, according to Vemula, was to instil a sense of danger and fear in the general population, something both he and interlocutors suggest contributed to stigma. Storylines about HIV/Aids in mainstream cinema didn't help clarify matters, since there was a tendency to ridicule people with HIV as suffering from a no-cure disease that they had brought upon themselves (Vemula 2019). "So people see these movies and think if he's *poz*, he's going to die," explained Sri. In Delhi, Amit echoed his conclusion. "It creates this negative image," he said. "I mean, everyone dies, but you stop when it's happy! So why is it different with poz?"

Interlocutors also pointed out that people remain confused about modes of transmission. This despite posters on 'how HIV does and does not spread' that listed sitting and living together, social interaction, mosquitos and bed bugs among the things that do not transmit HIV (Vemula 2019, 92). Most memorable in terms of public awareness campaigns regarding modes of transmission was actress Shabana Azmi's clarification in a public service ad broadcasted on Doordarshan in the late 1980s that *chhoone se AIDS nahi hota hai, chhoone se sirf pyar phailta hai* (you don't get Aids from touch, only love spreads through touch) (Raghavan 2017). Yet, as Kaushik in Bengaluru said, "people still think it's like in the [19]80s and it can't be treated and somehow if I touch you it'll be weird." Some interlocutors associated a lack of knowledge about modes of transmission with rural populations through anecdotes. Arjun [name] in Bengaluru, for instance, told me that somewhere in middle Karnataka, an HIV-positive person had committed suicide by jumping into a well, "and then [the people in] that crazy village, they drained the whole pond!" While they may very well be true, such anecdotes play on more general tropes of rural ignorance and backwardness, producing the non-urban space as stigma's proper location (Meghani 2021). But when I told

someone about my research over for drinks at an upscale bar in Bengaluru's Indira Nagar neighbourhood, the college student urgently wanted to know whether "it" spreads through mosquitos or not.

Some of the ineffectiveness of public health communications around HIV/Aids and its modes of transmission may be a by-product of an initial policy of denialism. "The Government of India was reasonably comfortable while telling the people how it did not spread," writes Vemula, "but had a tough time talking about the sexual route of transmission" (2019, 82). Early messaging focused on blood-based transmission and the dangers of sharing injection equipment, but skirted around the issue of sex, still "a strict no-no" (ibid). This was related to the prevailing notion that since India was a conservative, family-oriented society with a rigid sexual morality, there was no need to mention the sexual route – at least not to the so-called general population. Even when this assumed proved inaccurate and the government was forced to exit denial mode, NACO struggled to address the sexual route with any degree of detail. Posters in the first phase warned against "unprotected sex with an infected person" - but what constituted un/protected sex remained unclear, "because it was forbidden to talk about sex and sexuality so boldly" (Vemula 2019, 86). The emergence of the sexual health concept enabled NACO to discuss sex and sexuality in later years, and the prevention of sexually transmitted diseases – including HIV - through condom usage was central to NACO's second phase of programming - even if its material also promoted abstinence and the "right age for sexual debut" (Vemula 2019, 100)[19]. Nonetheless, one of the Azim Premji University students rhetorically asked how we can talk about HIV/AIDS when "we [Indians] can't talk about the S, only the TD." An educational program co-designed by NACO caused political controversy in 2007 and was banned in several states, and in 2014 Harsh Vardhan, who was then the BJP's health minister, said "so-called 'sex education'" should be banned altogether (Jha 2014).

In short, there is much evidence to support interlocutors' claims that ignorance about HIV – what it looks like today, and how it is transmitted – is the cause of much of the stigma they experience or anticipate. If misconceptions about HIV are so prevalent and damaging, might the discourse of Undetectability reduce stigma, as campaigners claim? Gaurav, a public

[19] This was both because the promotion of abstinence was a requirement imposed by international donors like then U.S. President's George Bush's PEPFAR, and because of aforementioned moralistic notions of Indian sexuality. As Vemula writes: "ABC [abstinence, be faithful and condoms] has become little more than an excuse to promote the Indian government's long-standing agenda regarding people's sexual behaviour and the kind of sex education they should receive – A for unmarried people, bolstered by advocacy for B, but for most people, 'anything but C' (Cohen 2003)" (Vemula 2019, 101).

health professional in Delhi, is invested in this message in more ways than one. As a trained medical professional and consultant to NACO through its Technical Resource Group mechanism, Gaurav understands the agency's apprehensions about endorsing U = U. "Most people with HIV in India are from a lower socio-economic background with limited literacy," he explained, "and we fear that if we tell them that they're undetectable, they might stop taking their medication." At a more personal level, Gaurav is enthusiastic Undetectability. He told me he cannot hide his status from sexual partners "in good conscience", despite understanding himself to not be posing any transmission risk. When I asked whether he believes one must always give the other person the option of evaluating the evidence-base of the *U =U* consensus for themselves, Gaurav turned the question on its head in an act of romancing biomedicine. ''If they accept the science," he said, "they accept me."

But what does it mean to accept the science? In Pune, I visited another gay medical professional, this time an HIV-negative one. We had arranged an interview to discuss the uptake of PrEP in India, which Pranab prescribes in the capacity of a private physician. As explained in Chapter 5: High Risks, PrEP and PEP are unavailable at government hospitals except in cases of heterosexual rape and occupational hazard. PrEP/PEP exemplifies the uneven nature of biomedicalization (Clarke et al. 2003), stratified in the case of India along domestic socio-economic fault lines because it has not been made available for free. "It's wealthy, privileged, upper middle to upper class guys who are educated," said Pranab when I asked him about the demographic on PrEP in India, echoing the findings of a 2017 survey (Patel et al. 2018). "Most gay men [in India] don't even know PrEP exists." Yet even though PrEP awareness might function as something of a class marker among middle to upper class gay and bisexual men, it is working class sexual and gender minorities who are reached by the NGOs and CBOs carrying out studies to gauge willingness for PrEP uptake, as the one I volunteered with in Bengaluru was in the process of doing.

Like Raj, I am cautiously optimistic about PrEP's ability to democratize risk management (Schubert 2019), in part because of my own experiences in London. Yet existing research suggests PrEP does not eliminate HIV stigma in any straightforward way. For example, a survey of gay and bisexual men in Australia found over half of those taking PrEP were still uncomfortable having condomless sex with HIV-positive partners with an undetectable viral load (Holt et al. 2018, 3617). Despite being on PrEP himself, Pranab explained he would not sleep with an HIV-positive person because "there is still that 1% change." He told me that he always asks people about their HIV status and requests what he, perhaps in a Freudian slip, called a "clean" (as opposed to clear) lab report to prove it.

Pranab looked a little surprised when I asked what he does when people say they are positive and undetectable.

> P: I've never had anyone tell me that they were positive. I kind of weed profiles off. You don't put too much time into conversations when you know there is something about it that just doesn't click with you. So I haven't had that. I have had someone tell me that they were undetectable a couple of times, but I didn't engage in any of those interactions. I kind of let them whither way as politely as possible.
>
> C: Can you describe how that filtering works? Like, what are the markers?
>
> P: [laughs] Well, you can sort of tell from a person's profile, their level of… understanding of just general things. You know, the way they structure their sentences, the things they write about, you can tell whether you will be able to have a same wavelength as them to [be able to] converse with them, or whether you're coming from completely different worlds. And if that's the case it's gonna be *awkward*, you won't know what to talk about, how to communicate…
>
> C: And you think that's linked to the likelihood of them being HIV-positive?
>
> P: I think there's definitely a knowledge gap. And that's where the problems are, where you're just completely *ignorant* and unaware – not bothered to learn about the problems as well.

Pranab's risk management is a blend of biomedical methods and more intuitive forms of risk reduction, according to which certain kinds of people are more likely to have HIV than, for instance, a white researcher. (I did not disclose my status during our conversation, opting to privately savor the irony instead.)

Anthropologists and cultural theorists have long known that "new knowledge and information about perceived sexual risk will always be interpreted within the context of pre-existing systems of meaning" (Parker 2001, 167), with biomedical discourses but one strand of a what Paula Triechler (1999) termed an "epidemic of signification''. Richard Parker and Peter Aggleton (2003) point out that much research on HIV stigma comprises of public opinion polls and surveys of knowledge, attitudes and beliefs that seek to establish a correlation between stigmatizing attitudes towards people with HIV and misconceptions about modes of transmission. "'Correct' as opposed to 'incorrect' beliefs thus become the defining cause of stigmatization in relation to people living with HIV and AIDS, as well as of those perceived to be associated with the epidemic in a variety of different ways," they write (2003, 16). Indeed, this resonates with my interlocutors' suggestion that HIV stigma derives from misconceptions about the difference between HIV and AIDS and the virus's modes of transmission. Yet this overly individualistic approach 'desocializes' stigma, Parker and

Aggleton continue, by obscuring its relation to what they describe as the social workings of inequality. Building on their intervention, Arachu Castro and Paul Farmer point out that there is a wealth of information regarding people's knowledge and attitudes, but that these are "decontextualized from larger social processes that are both historically rooted and linked to persons and processes that are not visible to the survey researcher", which they argue hinders the advancement of a "theoretically sound understanding of stigma" (2005, 53).

My conversation with Pranab demonstrates the way social meanings of HIV shape the people make sense of its medical facts, including Undetectability. In Pranab's case, these systems of meanings involved a set of value judgements and assumptions that combined to relegate HIV to what he a sees as a "completely different world''. Clicking with someone, wavelengths, awkwardness, syntax, communication, the ability to converse in English, being educated – these are all euphemistic ways to express a preference for partners from privileged backgrounds, as Rohit Dasgupta (2017) also suggested in his analysis of online of gay male dating in India. Although Pranab subscribes to scientific rationality, his re-formulation of a common prejudice about the poor as ignorant and lazy through the medicalized HIV jargon of "knowledge gap", as well as his conflation of a clear and a "clean" lab report, blur the lines between the social and the biomedical. Pranab's invocation of the knowledge gap is somewhat ironic, since working class sexual and gender minorities who have been relentlessly targeted by HIV prevention efforts for the past two decades may have better knowledge of HIV risk than their more privileged counterparts, as we learned in Chapter 8: Targeted Intervention. Evidently, his judgement about the relatively "safety" of partners is informed by diagnostic as well as social criteria.

The issue, in other words, is not (only) whether Pranab beliefs there is risk of HIV transmission or not, but rather that he would not want to have anything to do with *the kinds of people* that (he thinks) contract HIV in the first place. This resonates with the implicit message identified by Niranjan Karnik in his analysis of early constructions of HIV/AIDS in India: "the warning to these [middle to upper] classes is that they should reduce or limit contact with lower-class people (such as prostitutes who are more likely to service foreigners) and also avoid taking on Western behavioral mores [e.g. homosexuality]" (2001, 330). While Pranab valorized the West as a place of knowledge and rationality (including about HIV), he seemed to have taken the former part of the warning to heart.

This partially explains the avoidance that was a recurrent theme in my interviews and my own experiences, and which I argued forecloses widespread engagement with Undetectability. The U = U campaign is undeniably empowering for someone like Gaurav,

who, much like me and like his peers elsewhere (Tan et al. 2020), has invested it with hopes of finding love and acceptance. This makes sense, given the way in which the legacy of early fear-based messaging around HIV/AIDS and out-dated tropes continue to shape popular conceptions about the condition, not least because of the lack of contemporary general awareness campaigns and the culture of denialism lamented by Dr Sam Prasad in Chapter 7: Communities Make the Difference. Reducing fear of transmission by making available up-to-date information may therefore reduce stigma. Yet the assumption that knowledge of Undetectability translates into acceptance of people living with HIV removes from view the context-specific forms of social inequality that structure and texture HIV stigma everywhere. The reliance on biomedical, individuating solutions is a marked shift away from an earlier understanding that combatting stigma entails empowering the already-stigmatized communities affected by HIV/AIDS, a truism that influenced Sujatha Rao's interpretation of NACO's mandate when she was the agency's Director General (Rao 2017, Lakkimsetti 2020). We might then wish to replace the convenient assumption that scientific fact will solve the problem of stigma with the undoubtedly more complicated and more politically sensitive effort to promote an ethos of #SolidarityNotShame.

Conclusion

As Paul Flowers (2010) has pointed out, the introduction of effective treatment enabled people living with HIV in the U.K. to re-engage with the world in ways that were previously unimaginable, including by forging new sexual and romantic relationships. Yet insofar as this brought with it new challenges, the medical normalization of HIV intensified rather than removed the problem of stigma management and what Flowers describes as the "identity imperative". In this chapter, I have suggested Undetectability has introduced a similar dynamic. My argument is not that it has led HIV-positive gay and bisexual men in India to stop disclosing, since non-disclosure has long been a popular strategy for stigma management among people living with HIV in the India (Chandra, Deepthivarma and Manjula 2003, Steward et al. 2008). Rather, precisely because Undetectability – along with the medical normalization of HIV more generally - enables gay and bisexual men living with HIV to continue hooking up, it confronts them with the question of stigma in sexual contexts and how to deal with or avoid it. I argued that while Undetectability enables those on effective treatment, like Raj, to challenge the unequal distribution of responsibility for risk management and disclosure, Undetectability risks rendering those who are not virally suppressed, like his boyfriend Vinay, as irresponsible and dangerous. Insofar as it further

places the onus of prevention on the HIV-positive person (Race 2001), TasP discourses thus shore up the logic of criminalization even as they purports to normalize HIV. Moreover, as the exchange between Gautam and Bilal illustrated, by enabling ethical non-disclosure in the face of social risk, Undetectability may contribute the closeting of HIV rather than its de-stigmatization – thereby precluding the forms of solidarity on which TasP relies for widespread engagement.

In their explanations of the perceived prevalence of HIV stigma, interlocutors related it to ignorance and misconceptions, particularly regarding the difference between HIV and AIDS and routes of transmission. This suggests that greater awareness of Undetectability may reduce stigma by reducing fear of transmission and correcting the outdated image of HIV/AIDS as a deadly disease. It might also help people counter the vilification of HIV-positive men as vengeful villains trying to spread the virus, if potentially at the cost of further marginalizing those who are unable or unwilling to start and adhere to treatment. Yet my conversation with Pranab suggested that, as anthropologists have previously pointed out, HIV stigma is about more than a knowledge deficit alone. His risk calculus, while rationalized in scientific terms, relies on classist and casteist tropes about the poor as uninformed and diseased. This hints at the way in which HIV stigma is shaped by and reproduces broader structures of inequality (Parker & Aggleton 2003). In the next chapter, I elaborate on Gautam's story and ask why he was so scared of his HIV status being revealed in an attempt to develop a more thoroughly intersectional approach to HIV stigma.

Chapter 11: Status Anxiety

Getting HIV was Gautam's "worst fear", as he told me straight away when we met at the outside seating area of a café in a leafy part of Chennai. "This might sound odd, but it's almost like I willed it to happen. I'd been so paranoid about testing positive that for three years I would go every month, every two months to get tested. The lab staff started recognizing me and even they were like – why are you coming every month, haven't you got anything better to do?"

Gautam had tested 12 times for HIV in the span of a year until in June 2019, he finally got a positive. This was around the time that the 26-year-old was due to start work in Canada for the large international corporation he was employed with. "I had spent all my savings on the visa procedures and had a very high score for Canada," Gautam explained, referring to the country's ranking system for long-term visa applicants. "My friends were all very jealous – none of them got that high a score. So I just couldn't fathom I would be positive." Canada, Gautam knew from his anxious research, has immigration restrictions for people living with HIV. "I called the lab and set – *listen, I tested two months back, how is this possible, you have to do it again.*"

Gautam got several tests, including one a governmental hospital. He had never been to one before because "you wouldn't even want to use the toilets there". When these confirmed the positive serostatus, Gautam "just wanted to go stand in the middle of the road and die," as he told me. Oscillating between despair and disbelief, Gautam started ART free-of-cost at the government hospital, having spent all his savings on visa procedures.

Gautam told his therapist about the diagnosis, who connected him to at an HIV/Aids NGO. "Yes, there is stigma attached to it," the physician working there told Gautam, "but consider it like diabetes: just take your medication and you'll be fine."

But Gautam didn't feel fine, and was struggling with the psychological side-effects of the medication and the diagnosis in what appeared to be a self-imposed isolation. "I've cut myself off completely from friends, from social media," he said, "there is no point, nothing interests me anymore." This extends to dating and casual sex. Gautam feels like a "fraud" not informing partners of his diagnosis, but, as explained in the previous chapter, does not feel like disclosure is an option. "Why would a negative guy accept me, even if I'm undetectable?" he asked me. "Does love like that really exist?"

Moreover, Gautam was worried news of his status would spread. "We're just that kind of people," he said of the gay community, "bitchy, gossipy." Periodically someone will

tell Gautam that this or that guy is positive, and he has seen several of the name-and-shame profiles discussed in the previous chapter. “So I don’t trust anyone,” Gautam concluded, “and my family is well-known in Chennai, so I can’t risk that.”

When I asked whether he is planning on telling his parents about his serostatus, Gautam explained his coming out as gay was “not easy”, despite his family’s profile. He said he raised in a “very non-Indian, Westernized manner”, and that the family conducted itself in English at home despite all speaking Hindi. Though his coming out was “very drastic”, Gautam and his parents eventually reached an unspoken compromise: he doesn’t bring up his sexuality, and they don’t pester him about marriage.

“But I think,” Gautam continued, “because I chose this lifestyle, I got it. Because gay men are more prone to getting HIV.” Although he wondered who “gave it” to him, Gautam mostly blamed himself for his infection, which he saw as a punishment for not using a condom - despite his constant anxiety about HIV risk. “This would kill them, my parents,” Gautam anticipated, explaining that as the first-born male son, he was always the “apple of their eye”. “Disappointing them is the worst part. Because of my selfish deeds, my family would never go back to normal.”

*

In the previous chapter, I drew on Gautam’s and other interlocutor’s stories to explore how HIV-positive gay and bisexual men navigate disclosure in hook-up and romantic settings. Gautam’s narrative confirms several themes that emerged in that chapter: the concern about gossip, fear of rejection, the doubt that “undetectability” would make a difference, and the resultant self-isolation. But it also demonstrates how these concerns are eclipsed by the worry that Gautam’s parents might find out about his status. This worry, and the related fear of being a disappointment, was shared by other interlocutors and dominated conversations about “HIV stigma”. This was in part because many of them were able to hide their status, and so experienced few instances of “enacted” stigma. Stigma thus manifested as anxiety rather than discrimination - and much of this anxiety, as I will show in this chapter, was focused on the impact of intentional or accidental status disclosure on interlocutors’ family.

Of the three modes that Erwin Goffman identified as ways of managing a ‘spoilt identity’, concealment was by far the most popular among my interlocutors, as is evident from the previous chapter. In the era of medical normalization, a positive HIV status is

relatively easily hidden – especially for men and people with privileged access to treatment (Steward et al. 2014). This is unlike the past, when opportunistic infections manifested as a variety of *stigmata*, from the purplish lesions that characterize Kaposi's Sarcoma to unrelenting diarrhoea. Early treatments often had side-effects like lipodistrophy that could give away an HIV-positive person's status to those in the know (Flowers 2010). Today, on the other hand, viral suppression renders the virus 'undetectable' socially too. As I showed in the previous chapter, U=U enables interlocutors to refrain from disclosing to gay and bisexual peers, who they worried would reject, ostracize and possibly malign them. My interlocutors are thus "discreditable" (1963, 57), rather than discredited, by their HIV. For Goffman, there was little value in studying someone who is not aware of their stigma, such as an undiagnosed leprosy patient. "Where the stigma is nicely invisible and known only to the person who possesses it, who tells no one," he continued, "then here again is a matter of minor concern in the study of passing" (1963, 93). In this chapter I challenge this notion by attending closely to interlocutors' anxieties about the possible effects of status disclosure, particularly in the domestic realm, and by asking what these tell us about HIV stigma's relation to the operation of power more generally.

The fear of intra-community rejection detailed in the previous chapter is one aspect of what is often referred to as the "double stigma" of being HIV-positive and belonging to one of the groups associated with HIV risk, including men who have sex with men (Bharat 2011). As explained in Chapter 9: Interlude for Stigma, researchers use this frame to describe the way in which HIV/Aids stigma and the marginalization of the groups associated with the epidemic – including "MSM" – compound and reinforce each other (Bharat, Aggleton, and Tyler 2001, Steward et al. 2008). This chapter both validates and complicates this notion. In the first section, I suggest the concept resonates with interlocutors, as evident from the way in which many of them –like Gautam – describe or anticipate informing their parents of their HIV status as a kind of "second coming out". Yet the concept of "double stigma", valid though it may be as a description, tells us little about how these two sources of stigma (homosexuality and HIV) interact. Returning to Gautam's story in more detail, I suggest HIV stigma derives its strength not from homophobia per se, but from the disease's association with sexual transgression more generally. Because HIV infection implies a violation of what Gautam referred to as "the rules of the world" – particularly as they pertain to the reproduction of the (caste-based) social order – it undermines the social status of not just the infected individual but that of their family too. In the final section, I explore the implications of this for attempts to develop an intersectional approach to stigma.

Coming out again

Gautam was not alone in bringing up his parents and the impact that his HIV status might have on them, which was the main focus of his HIV-related anxieties." People aren't scared of getting HIV," an HIV-positive friend from Delhi once claimed. "They are scared of *having to tell their parents* they got HIV." My interlocutors described this, like Gautam did, as a second "coming out". By using the queer idiom of the closet, these interlocutors implicitly and explicitly linked HIV stigma to that associated with homosexuality. Yet their descriptions of the relation between the two, and their strategies for navigating it, were diverse. These descriptions both validate the concept of "double stigma", which clearly resonates with interlocutors, and hint at its limitations.

When Gautam said he thought he got HIV because he chose "this lifestyle", he was invoking the trope of HIV as a punishment for homosexuality. This trope dates back to the earliest constructions of the epidemic soon after the New York Times reported a "Rare Cancer seen in 41 Homosexuals" in 1981 (Altman 1981). In the absence of an identified aetiological agent, there was much speculation about which aspect of the so-called homosexual 'lifestyle' was causing the disease cluster (Flowers 2010). "That a concept of "gay cancer" could have ever existed is painfully illustrative," writes author and Aids historian Sarah Schulman (2021, 16), of the homophobia that informed medical discourse on the illness. The fact that it was named Gay-Related Immune Deficiency (GRID) before it was termed acquired immune deficiency disorder (AIDS) in September 1982 betrayed a conceptualization of homosexuality as *itself* a pathology, such that even lesbians were initially suspect (Schulman 2021). Public figures explicitly called Aids God's punishment for homosexuality, and nurses in New York are said to have used the phrase Wrath of God Syndrom (WOGS). "In contrast to cancer, understood in a modern way as a disease incurred by (and revealing of) individuals," wrote Susan Sontag in *Aids and its Metaphors*, "AIDS is understood in a premodern way, as a disease incurred by people both as individuals and as members of a 'risk group'-that neutral-sounding, bureaucratic category which also revives the archaic idea of a tainted community that illness has judged" (1988). In other words, the fact that "gay men are more prone to getting HIV" - as Gautam put it – leads some to believe not only that they deserve it, but that the disease provides moral justification for their marginalization.

Whereas Gautam seemed to have internalized this idea, Fran in Mumbai had not. He worried, however, that his HIV status would reinforce his parents' homophobia. Though Fran is from a Catholic background, his family were never particularly religious. It was Fran's

coming out that triggered his mother's spiritual rebirth, and his sexuality that became the object of her newfound healing powers. "Whenever she sees me, she'll randomly put her hands on my head and start praying the gay away," explained Fran, laughing wryly. "So telling her would just prove her right. She would see it as my punishment." Santosh's mother, on the other hand, responded well when he told her he was gay. Yet though they are very close, Santosh told me he would refrain from telling her about his recent HIV diagnosis when we met in Bengaluru. "I don't want them to associate the condition with the kind of *lifestyle* I have," he explained, "I don't want her to have that thought that if he were straight, this wouldn't have happened at all." Perhaps unwisely, I told Santosh that this is roughly what happened when I told my parents I was positive: though she had always accepted my sexuality, my mother struggled to comprehend that I might be the kind of gay man who gets HIV, and blamed herself for failing to teach me about love and monogamy. It was my gay lifestyle – and not being gay – that was the problem. Santosh nodded. "And I think they've always had this image of me in their head," the marketing professional continued, "of the perfect child who could do nothing wrong. I don't know how my mother would perceive me."

In New Delhi, Amit echoed these worries. "HIV is like coming out again in the worst way possible," the 26-year-old said when we met at a coffee shop in Connaught Place. "Why should I have another problem if I already have one? So the solution is that being gay is no longer a problem – but you need to fix *that* first before you can fix the HIV stigma." Like Gautam and Santosh, Amit invoked his family's status and his own status as the doted-on son to contextualize his fear of being a disappointment:

> I don't want to disappoint then. See, you have to understand, I'm from a very middle class kind of family – and for my parents I was a kind of poster boy. They have high hopes for me and big expectations. So coming out was a big thing – they accepted it eventually, but it was a big thing. And to be honest, I'm not sure how they'll deal with the HIV shock. The fear of making my parents sad was always much bigger than the fear of dying.

Amit's reference to himself as a "poster boy" of his family underscores the way in which his family's status is linked to his success. Another interlocutor similarly explained that since he was his parent's favourite son, "the spoilt one", he did not want to disclose his status to them: "They're always going on about how I'd make such a great dad, so I don't want to add this to it since I've already broken their heart with being gay."

In contrast, two interlocutors chose to confront the "double stigma" of homosexuality

and HIV by coming out as both at the same time. “Atom Bomb, Nitrogen Bomb, *dono dal do,*” Sri told me he reasoned, “throw both!” In this imagery, Sri’s sexual identity and HIV status were sources of devastation in their own right, yet also related. His mother tried to disassociate the latter from the former. “She asks me nowadays, *are you really sure you got it through sex*?” Sri laughed. “I tell her I did my fair part, but I can’t be certain. *So there’s still a change you didn’t get it through sex?* [she asks,] *Is there any way you can find out?*” Sri decided to let his mother believe he got “it” – the virus is never referred to by name in the family home, “like Voldemort” - through a dirty needle at a lab. Severing the link between (homo)sexuality and HIV made Sri’s diagnosis more bearable to his mother Similarly, one HIV-positive kothi interviewed by Venkatesan Chakrapani and colleagues told the researcher that his father “could tolerate that I was HIV positive but asked me not to tell others that I got it through by having sex with men!” (Chakrapani et al. 2007, 355) In both these cases, parents attempt to reduce the risk of the HIV diagnoses “flushe[ing] out an identity that might have remained hidden from neigbors, jobmates, family, friends,” as Susan Sontag (1988) wrote Aids threatened to do. Yet Sri’s mother no longer pesters her son about marriage, and seems to have tacitly accepted his relationship with a man – someone Sri met through the support group for HIV+ gay and bisexual men he helped create. In this way, his HIV status helped Sri’s mother come to terms with his homosexuality – even if only by making heterosexual marriage all but impossible for reasons I will get to shortly.

Raj denied his parents this concession. “I told my mom: *I’m gay, I’m positive, I got it through sex with a man,*” he recounted when we met at his apartment in Bengaluru. “And she said – *okay, is there any problem to your life?*” Raj said there wasn’t and that he had been undetectable for two years, and explained what this meant. It took his mother longer to accept his being gay, something Raj ascribes to his being from a small city in Tamil Nadu. “She used to cry but that’s the Indian mom thing, or probably any mom, so that’s okay. Now, after coming out to them, I don’t have to put up this façade of getting married and all.” Like Sri, coming out as an HIV-positive has relieved Raj of the pressures to conceal his homosexuality, and implicit his insistence that he got it through male-on-male sexual transmission is both a recognition of the mutually-reinforcing nature of these stigmas *and* a combative refusal of them. “I think I loved that I came out as HIV-positive, not as gay,” he reflected, exemplifying the defiance identified by Goffman (1963) as one of the ways of managing stigma.

Raj was quick to add that his case was exceptional: most people he knew through his informal counselling of recently diagnosed queer men and boys, including his boyfriend, are

not "out" about their status at home. I asked Raj whether, given his own experience, he thinks HIV-positive people should follow the visibility strategy on which the U.S. gay movement was based ("Gay brothers and sisters," activist and San Francisco politician Harvey Milk is supposed to have implored his peers, "you must come out!" (Gevisser 2021, 311), and which has in recent decades come to define queer politics in India too, particularly in the urban centres. "Will it work if it happens," asked Raj rhetorically. "Yes. But should we do it? No. Because gay men already have a lot of mental issues. So I don't think we should put one more stress on them and force them to come out."

This notion of "one more stress" resonates with the common conceptualization of 'double stigma' as occurring when HIV stigma is "layered over" another form of stigma, in this case that of homosexuality (Bharat 2011, 143). Ekstrand and colleagues point out that HIV stigma, defined as shared perceptions about the devalued status of people with HIV/Aids, often combines with pre-existing social prejudices the groups associated with the epidemic in India. They refer to these as "compounded stigmas" (2012, 701) and use rating scales to measure "how much their [the respondents'] personal moral beliefs and their feelings towards different groups, including men who have sex with men, hijras, injection drug users, male and female sex workers, influence their opinions about HIV/AIDS" (2012, 702). But while a correlation can thus be established between "pre-existing" prejudices and HIV stigmatization, the frame of double stigma does not give us the tools for analysing the interaction between these, or the way one is folded into the other. Nor does it explain why interlocutors whose parents appeared not to be prejudiced against gay men were so worried about coming out as HIV-positive.

Take, for example, Arvind's case. As explained in Chapter 5: High Risks, Arvind's parents considered themselves liberal and forward-thinking, and his mum had joined him at Mumbai Pride. But the copywriter told me he didn't plan on telling his parents about his seroconversion, which happened in the context of high fun: "They'll know I was doing drugs. And it'll be like, because I'm gay I *had* to get HIV. It's like coming out all over again." Arvind also worried the news would reinforce his parent's Islamophobia, since they would likely blame Arvind's late partner Aziz for being a corrupting influence. Here, the stigma associated with drug use is folded into the "double stigma" of HIV and homosexuality (in which the former is presented as an inevitable consequence of the latter) – and, more subtly, tied up with the communalist trope of the nefarious, criminal Muslim male. In other words, for many of my interlocutors, HIV created a discrepancy between their "virtual" identity as

respectable ambassadors of their middle class families - despite being gay - and their "actual" identity of being not just gay, but deviant, to use Goffman's phrasing (1963, 30).

When Susan Sontag (1988) made her observation about illness flushing out a previously concealed identity, she was referring to the way the physical signs of Aids risked outing someone as homosexual. But while this was the case for some interlocutors who had not come out to their parents as gay, most appeared concerned instead that their HIV diagnosis would reveal them to be the wrong *kind* of gay. This contrasts to the findings by Chakrapani and colleagues, whose participants told them that their being HIV-positive might be more acceptable than being gay (2007, 355). While the *kothis* they interviewed a decade and a half ago likely came from poor or lower middle class backgrounds, the parents of my interlocutors predominantly belonged to middle or upper class families who consume media in which acceptance of homosexuality is increasingly equated with liberalism and globalized modernity (Sircar 2017). Indeed, the increased visibility and mainstreaming of homosexuality as a result of the 17-year long challenge against Section 377 might explain why the observation that Bharat and colleagues' observation in 2001 that "there is a far greater stigma attached to homosexuality than to AIDS in India" (Bharat, Aggleton and Tyler 2001, 56) does not resonate with the majority of my interlocutors. Yet as I suggested in Chapter 1, this greater mainstream visibility is premised on a certain projection of middle class respectability (Sircar 2017), which HIV seems to undermine.

For Amit, this inability to tell his parents about being HIV-positive is why he rejects the discourse of medical normalization, which he associates with the Global North. "I see a lot of comparisons to diabetes in articles from the West," he said. "But okay, my dad is diabetic – will I tell my mother, look, I have this thing, dad has diabetes, it's no big deal? *Of course not!* Sex is seen – and gay sex in particular – as bad. Again, it's that stepping stone, so getting to HIV – just saying [sex] happens is bad enough." Amit appeared to be suggesting that it is HIV's association with sexuality in general, as well as with homosexuality, that makes it so problematic. In the following sections, I explore the implications of this insight with reference to my interview with Gautam. I suggest that while the concept of "double stigma" helpfully describes the way in which the stresses of homophobia and HIV stigma can compound one another, it does not offer us the analytical tools required to understand HIV stigma's relation to the social-moral order more generally.

Rules of the world

Gautam was the only one of my interlocutors who decided, following his HIV

diagnosis, to try and stop being gay altogether. “Sometimes I think it’s a blessing,” Gautam continued after taking a break from speaking to attend to his cappuccino. “It showed me not the be an absolute whore. I never thought promiscuity was wrong, but now I understand the rules of the world, why everyone values marriage. It doesn’t justify it, but I see where people are coming from.” He explained he feels a bit ashamed of “being a homosexual”: “maybe subconsciously I never fully accepted it. Outwardly, yes – I was going to the parties, had friends etc., but internally, I need the stability.” His HIV was a wake-up call, God’s way of telling Gautam that his life was not going in the direction it should. “If I was negative, maybe by 35 I’d have continued this way and I’d be screwed up, but now I know that’s not what I want to do.”

At a recent visit to his ART centre, the nurse there had suggested Gautam “settle down”. She offered to connect him with another patient, a Christian girl from an educated family. “Do you mind that?” she asked, referring to the girl’s religion rather than her gender. Keen to emphasize that HIV-positive people can have children, she also asked him whether, as an ‘MSM’, he would be able to have sex with her. Gautam replied that he’d had a few girlfriends in college, and that though it would require some effort, he thought he could do it. But, as Gautam explained to me, he didn’t want to disappoint his parents by marrying a Christian. Gautam made explicit his privileged caste background and explained he was “the first born on my father’s side, next in line on my mother’s, so there’s a lot of pressure to get married.” Gautam immediately clarified that he is “all for inter-caste marriage, I love inter-caste marriage, but my family won’t be happy about her being a Christian.” Nonetheless, Gautam accepted the nurse’s offer, which had briefly lifted his spirits. “I felt some hope that my life would have some substance, that I wouldn’t just be lonely.”

Unfortunately, the girl had misgivings of her own. During Gautam’s next visit to the ART centre, the nurse informed him the girl only wants to marry men who contracted HIV through blood-transfusions or at birth. “She’ll well-educated and got it from her parents,” the nurse explained, adding that the girl was a little hot-tempered. Gautam told the nurse he could deal with the temper, but not with the hypocrisy, the “weird” requirements: “Why is she judging?” The nurse told him being honest will not always get him what he wants: “Sometimes you have to tweak the story a bit.”

Gautam’s experience, though unusual, shows us four interrelated things about the operation of HIV stigma in the Indian context and its relation to what he described as the “rules of the world”. Firstly, it demonstrates the tendency to associate HIV with deviancy. Gautam’s interpretation HIV as evidence of the unviability of his lifestyle conflates

promiscuity, homosexuality, loneliness and HIV risk. These are contrasted to the "stability" and "substance" promised by compulsory heteronormativity. Gautam figures his HIV infection both as the result of deviation from the norms – the rules of the world – and as a lesson about their importance. We might understand this simply as "internalized stigma", referring to the extent to which the stigmatized person agrees with the validity of normative stigma (Steward et al. 2014). In their study of HIV-positive *kothis* involved in HIV community mobilisations in Karnataka, Laura Thompson and colleagues (2013) suggest the psychological frame of internalized stigma deflects attention from the social, cultural, and moral processes that condition their interlocutors' negative attitudes towards their own sexualities. Similarly, Gautam related the validity of the stigma of HIV to heteronormativity and the unfeasibility of being gay – at least, as he stressed, in the Indian context. Moreover, Gautam reprimanded himself for having been "an absolute whore", echoing early responses to HIV/Aids in India that suggested the disease would remain limited to numerically insignificant deviant segments of society - and sex workers in particular – since the general population would be protected by a rigid and puritan sexual morality characteristic of Indian society proper (Das 2001, Karnik 2001).

The construction of Aids as divine punishment for homosexuality analysed by Susan Sontag (1988) has historically been less salient in India, since the very existence of Indian homosexuals was initially denied. As Siddhartha Dube explains in his memoir *An Indefinite Sentence*, "in the half decade since HIV had emerged in India, the unrelenting focus on women sex workers had spared us [queer men] blame and persecution for carrying the ''gay plague" (2019, 126). Yet Gautam's conflation of homosexuality and sexual promiscuity more generally demonstrates that even though he a respectable gay man whose social location is far removed from the sex workers who tested positive in his city in 1986, he is indirectly impacted by this history of stigmatization. Moreover, Gowri Vijayakumar (2021) has argued, the focus on key populations -including MSM- in the ensuing decades left in tact the notion that HIV/Aids control was a problem of the governance of deviant or non-normative behaviour. Gautam's discourse of self-blame can thus be related to the well-known double bind of targeted intervention: while targeted resources conform with epidemic's differential impact on different groups are necessary, they can re-inforce the identification of HIV/Aids with deviancy (Patton 2002, Chan 2015).

Secondly, stigma is contagious. Like Amit and other interlocutors, Gautam was more worried about the potential impact of his HIV status on his family than he was about his health or romantic prospects. This resonates with findings from on a study based on

interviews with 68 people with HIV in South India, which identified fear of bringing disgrace to family as one of the main reason participants avoided status disclosure (Chandra, Deepthivarma and Manjula 2003). As Veena Das explains in her conference paper on disease stigma, “the stigma of disability, impairment and body disfigurement is not treated as an individual affair in societies that place less importance on the individual as a locus of value, instead it is treated as a matter of connected body-selves” (2001, page unknown). Das’s argument is in part based on ethnographic studies of leprosy in India, and particularly Hanne Bruin’s (1996) insight that stigma arises from the perception that the leprosy-affected person has violated the sexual and reproductive norms of caste hierarchy. Similarly, Surabhi Tandon (1999) found that leprosy patients in Delhi and Utter Pradesh spend a great deal of time worrying about what moral taboo they must have inadvertently broken to incur this punishment. “The entire discourse of anxiety that surrounds the stigma of deformed bodies thus is about reduction of sociality, exclusion from moral community as well as subjective feelings of guilt and shame,” summarizes Das (2001, page unknown).

Although Gautam, like most HIV patients on effective treatment, shows no visible signs of disease, his narrative was fraught with these themes and feelings. His seemingly hyperbolic worry that news of his diagnosis would “kill” his parents is suggestive of the social death that stigmatized diseases, according to Das, are capable of causing families. Indeed, some interlocutors were worried their siblings might struggle to get married if their status became known, and it is not uncommon for entire families to relocate once it has become public knowledge that someone in the household is HIV-positive. Das argues we should pay attention to “the drawing of boundaries within the domestic and its immediate environment of kinship and village or neighborhood community” (2001, page unknown) aimed at preventing such a situation. When someone I met at Bengaluru Queer Film Festival told me about an uncle who had died of AIDS, he seemed hyper-conscious he was (for the first time in his life) breaking this boundary, which ran right through his family. Shivam and his mother used to drive to a different district to pick up medications for his uncle lest the local pharmacist would put one and one together. They told other relatives the diagnosis was tuberculosis so as to “prevent the stigma from “spread[ing]” to the whole kinship group”, as Das (2001, page unknown) puts it.

While this brings to mind Dumont’s (1979) argument about the porosity of the Indian “dividual” self, Das is careful not to reinforce simplistic divisions between “individual-centered societies and socio-centric societies”. Her aim is to problematize the individualism of stigma theory - a result, she argues, of Goffman’s emphasis on “spoilt identity” and a

reflection of the centrality of the individual subject in liberal epistemology more generally. Although it may be true that, as Parker and Aggleton (2003) suggest, this bias makes our theorization of stigma particularly unsuitable to contexts where family ties are valued highly (such as India), these limitations apply outside such contexts too. In a clear example of boundary-drawing, when I “came out” as HIV-positive to my parents, my mother asked me to refrain from telling anyone else in our village. And upon learning about my status and research at a Pride celebration in London, a white English friend tipsily shared that several of his relatives were HIV-positive, but that this had always remained a secret. Similarly, a Costa Rican woman once told me she and her family had never been able to properly grief the death of relative in the 1990s, because its cause – Aids - could not be spoken. As was the case with Shivam, in both these conversations my own disclosure prompted people to break a boundary (for the first time) aimed at containing the spread of stigma. It made me wonder how many such family secrets exist, and how these silences work to reinforce the notion that HIV/Aids does not affect the “general” (non-deviant) population.

Thirdly, since a family’s social status is closely tied to the question of marriage, this becomes a key domain in which people with HIV experience or anticipate stigma. The right of people with HIV to get married has been repeatedly questioned, and was indeed briefly suspended by the Indian Supreme Court in 1998 in a judgement that described HIV infection as the product of undisciplined sexual impulse (Sanjay 1998). Though the right to marry was affirmed in 2003, the existence of HIV-positive match-making websites (Kabra 2013), self-help groups arranging marriages between people with HIV (Root 2018), and informal match-making services at ART centres such as the one encountered by Gautam reflect the difficulties of HIV-positive people face in finding a partner through conventional means. When I asked Sri what the main concerns were among the gay and bisexual HIV-positive men in the WhatsApp support group he moderates, he said it was finding a spouse. A few of the group’s members had found (female) partners through informal match-making services of the kind encountered by Gautam, which Sri thought had started around 2016 or 2017. “And the rest of us,” he sighed, “well, we have each other, and that’s it.” Based on some of the messages from strangers I received after joining the group, one of its primary (if unintended) functions appears to be as a database for the telephone numbers of potential partners. Sri himself had met his boyfriend through the group.

Gautam’s appreciation of the “value” of marriage was triggered by his infection with a virus that made finding a spouse that might please his parents near-impossible. Aware of this irony, he was willing to compromise by agreeing to meet the Christian girl. Yet she

rejected Gautam on the grounds of his having contracted HIV through (homo)sexual means, reflecting a hierarchy among PLHIV based on route of transmission. Precisely because of the association with deviancy and the transgression of sexual taboos, the assertion of innocence becomes central to HIV-positive people's self-representation. "The collective narrative tried to carve out a space of innocence from which patients could separate their own affliction from those whose AIDS was blamed in the popular culture on personal behaviour such as unsafe sex, or IV drug use," writes Das (2001, page unknown) about networks of HIV-positive people in India. "The very process of fighting stigma in such cases reaffirms the way in which personal affliction is made to fold into the stigma of belonging to marginal group." "Double stigma" is thus experienced not just as marginalization within the gay community, as explored in the previous chapter, but may also manifest as judgement or, in the case of sex-workers, blame within PLHIV networks. (None of the men I spoke to were involved in such networks, which they associated with heterosexuals if they even knew about them.) The nurse's attempt to contextual the girl's pickiness with reference to her "good" background reflects her awareness of the way in which the emphasis on the "innocence" of the route of transmission works to mitigate the impact of seropositivity on a family's social status.

This brings us to our fourth insight, which is that HIV undermines class and caste privilege in a way that homosexuality alone, for many of my interlocutors, does not. This explains why so many of the men I spoke to expressed a fear of being a disappointment, usually invoking their middle class background and the hopes invested in them as a male child by way of contextualization. As previously explained, the groups blamed for the epidemic's arrival to India tended to belong to lower-caste groups, whose deviant sexuality was implicitly contrasted to that of "general population" imagined to be dominant caste and middle-class (Vijayakumar 2021). Elites, on the other hand, were seen as at risk of emulating amoral Western behaviours such as homosexuality (Karnik 2001). If, as Navaneetha Mokkil (2019) argues in her study of configurations of female sexuality in Kerala, class, caste and community status are key to the operation of sexual morality and respectability, HIV has in India been constructed as the antithesis of middle class respectability. And since Gautam is, as he stressed, from a well-reputed and well-known family, the stakes are high. Whereas Gautam's homosexuality could still be folded into his family's self-image as open-minded and modern (as signified in Gautam's narrative by the emphasis on speaking English at home), albeit with difficulty, Gautam anticipated his HIV status would pose a more fundamental threat to their social status.

The apparent isolation resulting from Gautam's concern with concealing his status

contrasted starkly with the sense of togetherness demonstrated by two *hijra* activists I interviewed the next day. When, after switching off the recorder, it became clear I am HIV-positive, the women hugged me and switched into peer counsellor mode. Without missing a beat, Anya and Saumya reassured me in near-unison that "we are here for you, and so is God, and you will live a long and beautiful life, and don't listen to what anybody else says" - all while holding my hands and maintaining eye contact. They invited me to Marina beach, where, as they explained, *hijras* and other transgender women with HIV get together to talk, "share sorrows," drink generous amounts of beer, dance, and eat mutton or chicken biryani prepared in advance by Saumya. Unlike Gautam, Saumya was not concerned about disappointing her family, since they had cut her off a long time ago. Not finding a husband wasn't a worry either, since men, as she complained "take everything from us but won't introduce us to their families". It seemed to me that since Anya and Saumya were already outside the pale of societal respectability as epitomized by marriageability, they were able to accept and – crucially – share their HIV status in a way my far more privileged interlocutors were not. "I don't think that I am alone," Saumya said after explaining that none of her relatives answer her phone calls. "God is there, our people are there, [and] HIV patients are there."

To suggest that *hijras* are less affected by HIV stigma because they have already broken with the "rules of the world" would be to ignore the way in which hierarchies of "izzat" (respect) among hijra communities, informed in part by the ideal of sexual ascetism (Reddy 2005), interact with HIV stigma. "You look at a *hijra* household, if someone is infected with HIV, the way you treat them, the way you make them sit, there is this stigma," explained the director of the NGO I volunteered with in Bengaluru. "But there is also solidarity." This kind of solidarity is foreclosed, along with other forms of support, when young, privileged gay men like Gautam decide to protect their family from stigma by keeping their diagnosis a secret. Indeed, our conversation validates the correlation between non-disclosure and isolation and depression identified by Steward and colleagues (1014). In this limited respect at least, Gautam might thus be worse off than the two *hijras* who, in a standard intersectional analysis, might be expected to suffer greater HIV stigma due to their oppressed class and/or caste position and their status as *hijras*/transgender women. "Already I am community," explained Anya, meaning transgender. "That's the first discrimination. Second discrimination, I am HIV-positive." But this "double stigma" was also the source of solidarity and support.

How, then, might we develop an analysis of HIV stigma and its relation to other forms of social difference that moves us beyond the point of intersection?

Intersectionality and HIV stigma

Researchers have in recent years drawn on the concept of intersectionality to produce more complex accounts of HIV stigma. "Intersectional stigma," write Abubakari et al (2021, 2) "occurs when an individual or group experience(s) multiple stigmas that are not only overlapping but also co-constitutive. It denotes the synergistic effect produced by systems of oppression at the intersection of these stigmatised identities, behaviours and/or conditions on well-being and health." This approach enables more fine-grained analyses of the ways in which multiple forms of structural violence interact to create certain health outcomes than the 'double stigma' frame. In a study of HIV-positive people transitioning out of prison in South Africa's Gauteng Province, for example, the authors observe that having a criminal record had an adverse effect on socioeconomic stability, which in turn negatively impacted medication adherence. Anticipated HIV stigma also decreased adherence, and was reinforced by sexual shame: "Male participants expressed concerns that disclosing their HIV status would lead others to assume they had engaged in sexual activity while incarcerated" (Woznica et al. 2021, 202). In this way, the convergence of incarceration stigma, HIV stigma, and homophobia all contribute to negative health outcomes (Woznica et al 2021).

At other times, stigma continues to be located at the intersection of marginalized identities. For example, in a study of sexual health of women on opioid substitution treatment in England, a Venn diagram is used to illustrate the overlap of the stigmas associated with 'female gender', 'drug use', 'homelessness', 'transactional sex', and 'STI/BBV status' [blood-burn virus], with the central circle labelled Intersectional Stigma (Medina-Perucha et al. 2019). While it is clear that these sources of stigma overlap, it is less obvious how interact with each other. In contrast, Valerie Earnshaw and colleagues (2019) stress the co-constitution of different identities in their study of internalized stigma among Black gay and bisexual men living with HIV in the U.S.. "Due to the interconnectedness of identities," they write, "the development of HIV/STI internalized stigma may be shaped, or influenced, by existing race and/or sexual orientation internalized stigma" (Earnshaw et al. 2019, 3). Elsewhere, Valerie Earnshaw and colleagues point out that while the lens of intersectional stigma is increasingly popular among HIV researchers, researchers have struggled to operationalize it. They stress the multidimensional nature of intersectional stigma – meaning the ways in which "multiple, interlocking dimensions of stigma" (Earnshaw et al. 2021, 414)

shape HIV and health outcomes - and discuss various quantitative measures for capturing it. They also emphasize the need for a multilevel approach, such that analyses of individual (internalized) and interpersonal (discrimination) stigma are contextualized with reference to the socio-political systems that reproduce heightened HIV risk among, for example, Black and/or queer people in the United States. "Ambiguities embedded in how to use intersectionality make it a flexible tool that is popular across disciplines," explain Janet Turan and colleagues (2019, 5) in their review of intersectional stigma research, but this also means there is little consensus on approaches and methods when applying the concept to stigma research.

Kimberlé Crenshaw (1989) coined the term intersectionality in her analysis of the way in which anti-discrimination legislation failed to address the issues faced by Black women in the U.S. In an interview with the legal scholar for The Guardian, the concept is summarized by the journalist as the idea "that different forms of discrimination – such as sexism and racism – can overlap and compound each other" (Mohdin 2020), and this, indeed, is how the concept has been understood and applied by many, as Anna Carastathis has pointed out disapprovingly (2014). Building on Carastathis' review of critiques of recent iterations of the concept, and in particular of the way in which these reinforce essentializing notions of identity, Rahul Rao (2020) suggests the 'additive' mode of intersectional analysis arises from a misreading of Crenshaw's traffic intersection metaphor. This metaphor was intended to convey that just as one cannot always determine which driver was at fault if an accident happens at the intersection of cars coming from different directions, it is often impossible to tell what form of discrimination (sexism or racism) creates a given experience of marginalization. Rao contends that this image has resulted in a tendency to understand 'intersectionality' as that which happens, literally, at the crossroads of different identities or forms of discrimination, as if these 'roads' "*have nothing to do with one another prior to or after their crossing*" (Rao 2020, 15, italics in original). Instead of thinking of intersectionality in terms of 'separable analytics', Rao proposes we attend to the ways in which different categories are always already mutually implicated.

To illustrate his argument about the inseparability of categories, Rao draws on the Bhimrao R. Ambedkar's analysis of the relation between gender and caste oppression in a speech written in 1936 for a conference of caste-reformers in Lahore, but considered too controversial by be delivered (Ambedkar and Anand 1990). The pre-eminent Dalit scholar and leader argued that the practices of sati, compulsory widowhood, and child marriage all

work the enforce caste endogamy, which is (according to him) the essence of caste. Therefore, the regulation of women's sexuality through said practices is *identical* with caste. "By collapsing the distinction between ends and means," writes Rao,

> Ambedkar takes us away from the base-superstructure imagery of orthodox Marxism. The relationship between caste and gender cannot be visualised as the separate layers of base/superstructure, as the separable axes of a crossroads, or even as the mutual constitution produced by the strands that make up a rope, each of which takes its contours from the other. Instead, rather like a Mobius strip, caste *is* the regulation of gender, which *is* caste. The philosopher Elizabeth Grosz uses the image of the Mobius strip to point to the ways in which 'while there are disparate "things" being related, they have the capacity to twist one into the other.' (Rao 2020, 15)

Intersectionality, then, is not just about the "double stigma" or compounded oppression of being a Dalit and a woman, but also about the way in which caste hierarchy functions through gender norms, and vice versa. Together, these norms governing gender and sexuality form what Gautam referred to as the rules of the world and uphold the caste-based social order. Indeed, Ambedkar's conclusion that inter-marriage was the only way to "annihilate" caste finds echo in Gautam's disclaimer that he loves inter-caste marriage, which might be understood as a form of self-reflection on the way in which the logic of endogamy persists in his desire to fulfil filial duty and partner preferences. Insofar as HIV infection suggests a deviation from the norms that uphold the social order, it has the power to render its subject abject in Kristeva's sense of the word as that which disrupts meaning, order, and identity (quoted in Kagan 2018).

In addition to the co-constitution of categories, Rao is interested in the possibility of intersectionality as "historical path dependency", or the way in which contemporary forms of oppression might be structurally dependent on historic ones. "Just as racism forges the discursive structures in which subsequent queerphobic moral panics take shape," he writes, "caste oppression does something similar in the South Asian context" (2021, 177). He is inspired in part by Shamira Meghani's analysis of the relation between HIV stigma, homosexuality and caste in her reading of Onir's *My Brother… Nikhil* (2005) and two other texts. *Brother…. Nikhil* (2005) fictionalizes the true story of Dominic D'Souza, the Goan swimmer who was fired and incarcerated in a medical ward after manifesting the first HIV case reported in the coastal state. Much of the discrimination faced by Nikhil is represented through caste metaphors, some coded and some overt. When Nikhil jumps into the pool, his peers evacuate it instantly. Even his doctor treats him "like an untouchable", according to Nikhil's boyfriend. As Anjali Gopalan recalled in conversation, this analogy used to be quite

common, with her and her peers referring to HIV-positive people or people with AIDS as "the new untouchables" in the 1990s. The analogy is used in journalistic and scholarly writing on HIV in India too, with one article on HIV jurisprudence in India framing this as a question of the "rights of the new untouchables" (Krishnan 2003) in its title.

But likening HIV-positive people to untouchables elides the actual intersections between caste oppression, queerness and HIV vulnerability, argues Meghani:

> The film metaphorizes 'untouchability,' layering it through social codes that engender stigma for the specific gaze of its middle-class and caste-conscious viewers. 'Untouchability,' that supposed remnant of Indian 'tradition,' appears atavistic: stigma belongs in the past, and its solution is 'moderntiy.' But this elides the persistence and mutability of caste, and its 'already-stigmatised' subjects, as the conceptual sources of stigma. (2017, 8)

Indeed, analogies like "gays are the new blacks" imply both that racism – for example – is no longer an issue *and* that it remains enough of an issue to function as a ground for comparison, as Rao points out. Such statements also obscures the possibility of being gay and black, or Dalit and HIV-positive, because "analogical reasoning invites us to juxtapose and compare categories, placing them side by side as if they were separable" (Rao 2020, 178).

At the same time, Meghani stresses that "caste is deeply relevant to the stigmatisation of the wrong bodies in complex ways" (2017, 5). She draws on Sundar Sarukkai's analysis of 'untouchability' as serving conceptually and socially as an important rubric through which Brahmins construct themselves in relation to non-Hindu communities in South Asia, such that the stigma of 'untouchability' has a broader role in shaming. "Sarukkai's conceptualization of untouchability as hereditary, embodied, outsourced burdens indicates its wider and more foundational social role: the disburdening of bodily shame onto 'untouchables'," summarizes Meghani. "HIV stigma and 'untouchability' may then derive from this framework and will of course intersect with it: some of the 'already stigmatized' – perhaps especially sex workers – are also lower-caste" (Meghani 2017, 5). Meghani's analysis thus directs us to the way HIV stigma not only intersects with caste oppression, which it very well may, but is also *inflected by* its grammar, as Rao (2021, 177) puts it.

How do we attend to these entanglements ethnographically? In a lecture later posted to her blog, Sara Ahmed has provoked us to be sensitive to stigma's "proximate histories" beyond just their point of intersection in, for instance, the bodies of queer people of colour ("it can be tiring to be the point!") (Ahmed 2013). But these are difficult to tease apart. "Everything is inter-linked and messed up," explained a non-binary interlocutor who works

as a peer counsellor in Delhi, and is also HIV-positive. “Till date people think that the person [who gets HIV] is doing sex work. And it’s mostly because the first cases were found in sex workers in India. And there are still notions that you can’t eat alongside a person with HIV, treating them as untouchables…” This explains why one of Nithin’s colleagues at a Mumbai law firm stopped sharing his lunch tiffin after he came out as HIV-positive. The colleague said he was being careful because he and his wife were trying to conceive, though Nithin had explained U = U – demonstrating once again that knowledge alone does not solve the problem of stigma. And when during a visit to an affluent, progressive household in Bengaluru my HIV status came up just as dinner was being served, the timing seemed particularly awkward. This discomfort may of course have been the product of projection or paranoia on my part, but the centrality of commensality in narratives of HIV stigma in India demonstrates the interconnectedness of HIV stigma and caste, even in “liberal” urban settings, the relegation of caste to the rural realm in the mainstream, middle-class imagination notwithstanding (Meghani 2017).

Yet neither Nithin nor me could be said to be experiencing the “double stigma” of caste and seropositivity: he was of a middle class and what I presumed to be a dominant caste background, and I a white foreinger. In contrast, the sex workers I met during a focus group at the NGO in Bengaluru were, I was told, mainly from Dalit backgrounds. They complained of doctors’ refusal to touch them despite the insistence by Aids campaigns that HIV/Aids doesn’t spread through touching, which presumably the doctors would have learned in their medical education. Whereas their mistreatment by the hands of medical staff may be attributed to the intersection of caste, gender, and their status as sex workers, Nikhil’s exclusion from workplace commensality was not related to his caste status. Yet he is impacted by caste-ism – and, arguably, by the epidemic’s historical association with lower-caste sex workers and their clients - insofar as this shapes the form HIV stigma takes in the Indian context.

Stigma’s proximate histories are not confined by national borders. Take, for instance, the shattering of Gautam’s Canadian dream. Gautam’s high score in the immigration metric reflected his desirability as a highly educated, English-speaking migrant from South Asia, e.g. a “deserving” migrant. Yet despite his merit, Gautam now belonged to that most unwelcome class of migrants, the HIV-positive ones. Although Canada’s residency restriction for HIV-positive people is rationalized with reference to relative burden on the country’s public health system (the threshold for which was recently raised), the country’s criminalization of non-disclosure is justified through highly mediatized moral panics about

HIV-positive migrants, particularly heterosexual Black African men. As one activist explains to Sarah Schulman, “the trope of the sexually predatory diseased black immigrant helped marshal racism to harden public opinion behind HIV criminalization” (Schulman 2014). This illustrates how HIV stigma, at least in the North-American context, is intractable from the history and present of anti-Black racism and xenophobia, starting of course with the stigmatization of Haitian immigrants to the U.S. as “Aids-carriers” during the early years of the epidemic (Farmer 1999). This racism in turn functions through stereotypes about black or “African” hyper-sexuality (Geary 2014). Even though Gautam – as middle-class, educated South Asian migrant - occupies a very different position than African foreigners in the imagination of multi-cultural Canada, he is impacted by the racialized anxiety that informs Canadian HIV/Aids laws.

These observations challenge us to expand our analysis of intersectional stigma in HIV research. Instead of focusing only on the intersection of different marginalized identities and HIV, we might also ask how HIV stigma is “always already” shaped by the histories of marginalization that have given rise to these identities. Just as we cannot understand gender norms without paying attention to the history of present of racism, colonialism, and/or casteism, so too should we approach HIV stigma as intractable from the relations of inequality that create other forms of social differences. This kind of ethnographic “sensitivity to stigma” (Ahmed 2013) might also contribute to on-going queer and feminist theorizing on intersectionality, which this chapter has only begun to acknowledge. After all, as Patricia Hill Collins reminds us, “despite the widespread belief that intersectionality has arrived (…) it is important to stop and recognize that this way of looking at and living in the world constitutes a new area of inquiry that is still in its infancy” (quoted in Carasthatis 2014, 312).

Conclusion

In this chapter, I have tried to attend ethnographically to HIV stigma as experienced by a people who, in the main, avoid its manifestation through non-disclosure. I argued that in the absence of enacted stigma, HIV stigma is experienced as a form of status anxiety, not least because of its ability to undermine the forms of class and caste-based privileges that many of my interlocutors enjoyed. I suggested this insight calls for an approach to HIV stigma that moves beyond merely describing its intersection with other forms of oppression, without denying the significance of this point of intersection. Interlocutors validated the notion of “double stigma” by describing disclosure of their HIV status to parents as a “second coming out”. The queer idiom of the closet was not just a metaphor, as interlocutors stressed

the way in which HIV and the stigma of homosexuality reinforce one another.

This resonated with me personally: when I was first diagnosed, I told a regular sexual partner that I felt like such a stereotype. "That was me five years ago," my friend said, revealing that he too was positive. For him, he added, the feeling of being a cliché was exacerbated by his ethnicity (black) and the fact that he was doing sex work at the time. In my friend's case the stigma is not "double" but quadruple - which in part explains why concealment is his preferred strategy of stigma management. Similarly, an interlocutor from New Delhi explained that his HIV diagnosis initially intensified what he described as his "complex about caste" while dating. Yet merely identifying these areas of overlap and acknowledging their impact on individual experiences of HIV stigma by labelling it double, layered or intersectional stigma does not tell us much about how HIV stigma, racism, anti-sex work sentiment/sexism and caste-ism interact with and are shaped by one another.

Drawing on Rahul Rao's critique of the additive mode of intersectional analysis, I have tried to attend to HIV stigma's inseparability from other histories of oppression. Echoing Veena Das, I argued that HIV stigma arises not just from homophobia, but from the virus's association with the violation of sexual norms more generally. And insofar as these have historically served to maintain the caste-based order, as Ambedkar and feminist scholars have argued (Abrahams 2014), HIV stigma can be said to be "always already" about caste – even when it affects people who, like the majority of my interlocutors, are not from oppressed caste backgrounds. Indeed, it is precisely because of their relatively "high" social status that the anticipation of HIV stigma manifests as a form of status anxiety. Moreover, HIV stigma is inflected by the grammar of caste, as evident from the concern with touch and commensality both in efforts to combat HIV stigma and in people's experiences of it. And if, as Parker and Aggleton point out, "stigma always has a history which influences when it appears and the form it takes" (2003, 17), in the Indian context female sex workers – many of them from Dalit or other oppressed caste backgrounds – are the protagonists of this history, not gay men. Yet the scapegoating directed at them during the second half of the 1980s finds echo on the emphasis on deviancy in Gautam's narrative, as when he blames himself for being "an absolute whore".

It is difficult, but not impossible, to attend to these connections ethnographically. Doing so involves challenging the individualism built into the concept of stigma as it is used in both social science research and popular discourse, and involves challenging the separability of our categories of analysis and identification. Yet ethnography, perhaps like no other method, allows us to attend to the subtleties and contradictions in people's experiences

of stigmatization or anticipation thereof. I have tried to do so with reference to Gautam's story, which at face value reads as an example of internalized HIV stigma and homophobia. Though this may well be the case, it also contains insight regarding the relation between these and the "rules of the world," particularly as they pertain to marriage. In this way, I have tried to contextualize HIV stigma as part and parcel of the reproduction of the social order and the operation of power, as Parker and Aggleton (2003) ask us to do. In turn, attending "sensitively" to HIV stigma in this way might contribute towards an intersectional mode of analysis that does not reify and homogenize categories of experience and identification, and might contribute to on-going attempts to develop an intersectional approach to sexual politics in the Indian context (Sircar 2017, Upadhyay 2020, Rao 2020).

Conclusion: Ethnography in the treatment-as-prevention era

At the International AIDS Conference of 2012, then-U.S. President Barack Obama called on the attendants to let the "science" lead the HIV/Aids response (Kenworthy, Thomann, and Parker 2018). In the intervening decade, HIV/Aids discourse and governance has become thoroughly biomedicalised. Building on Eileen Moyer and Anita Hardon's (2014) rough distinction between "prevention-era" and "treatment-era" modes of anthropological engagement with the epidemic, in this thesis I have tried to ask what an anthropology of the treatment-as-prevention era might look, and why it matters. It was divided in three parts, focusing on risk, policy, and stigma respectively. These parts provided different windows into the landscape of HIV/Aids in India today, and challenged some of the key concepts and assumptions that inform both HIV/Aids policy and research.

Chapter 3: Interlude for Chemsex, Chapter 4: Organizing Logics, and Chapter 5: High Risks offered an in-depth, if partial, exploration the "high fun" or chemsex scenes that have emerged in urban India in recent years. Although there are no equivalent studies to those establishing a correlation between HIV infection and chemsex in Europe and other contexts in the Global North, sexualized drug use is anecdotally linked to new HIV transmissions among men who have sex with men in India. Confirming or contesting this hypothesis was beyond the scope of this thesis, based as it is on qualitative research with a small number of men (some of whom do trace their HIV infections to their involvement in high fun). Instead, I demonstrated that understanding changing transmission dynamics requires continued social scientific study of the messy realities of sex, beyond just labelling chemsex as risk behaviour. Indeed, ethnography provides an alternative to the biomedical, positivist styles of research that predominate in chemsex literature (Bryant et al. 2018, 243). Both public health research on chemsex and more critical approaches to sexualized drug use among queer men focus almost exclusively on gay communities in the urban centres of Europe, Australia, and the U.S. (Møller & Hakim 2021). My ethnography of "high fun" offers an important contribution in this regard, limited though it is for reasons explained in Chapter 2: Methods, Ethics, and Poz/itionality.

By approaching high fun anthropologically as a (sub)culture with its own internal logics, I challenged the assumption that sexualized drug use is a "rich gay" phenomenon. Indeed, its inclusivity is one of high fun's most distinct and appealing features, not least because of the perceived rigidity of social and sexual hierarchies in gay male communities more generally. Yet a closer look at the social organization of high fun suggests this

inclusivity hinges – at least some of the time – on what I described as an erotic economy of drugs and desire, in which erotic capital is an important for of currency alongside the ability to purchase "stuff" (drugs) and/or host. Although I spoke to men on both sides of this equation, the perspectives of working class and poor men – as well as those of *hijras* and other gender non-conforming people – are missing from this thesis due to the class and language bias in the sample. How do they navigate high fun's erotic economy and expectations of reciprocity? Do they experience high fun as a place where "everyone is welcome", as one of my interlocutors claimed, or do they face forms of class and/or caste discrimination? What kinds of support and services, if any, do they access after the party is over?

The uneven relations of reciprocity engendered in high fun have implications the distribution of HIV and other risks, although these are anything but straightforward. Chapters 4 and 5 were an attempt to put "risk" in context, not least by attending closely to how interlocutors made sense of and navigate it. They emphasized the entangled interpersonal and structural relations through which a variety of riseks – including, but not limited to, that of HIV infection, emerge. In doing so, interlocutors challenged the individualism that inform dominant notions of "risk behaviour" as a matter of individual choice. In contrast to the atomizing approach to risk that prevails in behavioural literature on chemsex, I reproduced stories such as Arvind's in as much detail as possible to highlight the profoundly relational nature of HIV, addiction, and mental health risks, as well as their inter-relatedness. I was unable to pursue all the connections Arvind and other interlocutors drew attention to: future ethnographic engagements with high fun might locate it more firmly in relation to the history and present of drug policy and rehabilitation in India, for example. By challenging the individualizing and atomising notions of risk behaviour that underpin much public health research on chemsex, I extended anthropological critique of the dominance of biomedical paradigms in HIV/Aids governance to the underexplored context of middle class gay and bisexual men in India.

Chapter 6: Interlude for Community, Chapter 7: Communities Make the Difference, and Chapter 8: Targeted Intervention contextualized the failure to provide harm reduction services to men who are into high fun with reference to the decline of India's celebrated approach of targeted intervention. Insofar as this decline can be attributed to the shift from community-based prevention to treatment-as-prevention, these chapters explored the effects of the biomedicalisation of HIV/Aids policy and the withdrawal of international donors on the "communities" credited with having helped curb the Indian epidemic. As such, they form

an important update to scholarship on the Indian HIV/Aids response, which tends to be based on fieldwork conducted during the heyday of the community-based approach in the late noughties (Lakkimsetti 2020, Vijayakumar 2021). Drawing on Aniruddha Dutta's (2013) prescient insights, I argued that the sense of abandonment and exploitation expressed by community HIV/Aids workers reveals the necropolitical dimension of HIV/AIDS programming. Although the struggles that led to recent legal gains won by sex workers and sexual and gender minorities have their origins in the HIV/Aids prevention effort, the neglect of populations previously seen as "key" partners now that a generalized epidemic is no longer worry points to the limits of biological citizenship.

This is not to polarize biomedical and social approaches to HIV prevention, which, as Susan Kippax and Niamh Stephenson (2012) remind us, can and do in fact work in tandem. For example, the organization I was embedded with was conducting a PrEP awareness campaign among *hijras* and other transfeminine populations. Although it could not provide the preventative antiretroviral medications, NGOs and community-based organizations of its kind are well-placed to do so in the future, as several interlocutors who were concerned by the lack of counselling and monitoring around PrEP pointed out (indeed, future research might explore in more detail than I have the uptake of PrEP by gay and bisexual men using prescriptions from private physicians or illegal over-the-counter purchases). But interlocutors also expressed concern TASP might provide cover for a government whose ideology seems incompatible with the pragmatism underpinning the community-based approach, and whose hostility to civil society impacts negatively on HIV/AIDS organizations. As legal scholar Ratna Kapur explains, "the Hindu nationalists, key players in the movement to purge India and Indians of sexual agency and sex talk, are intent on degrading sexuality and banishing any overt expression of it outside the model of the good Hindu wife and heteronormative arrangements" (2015, 125). High fun is about as far away from the norm of the good Hindu wife one can get.

This is all the more worrying given the gradual demise of NACO's autonomy since the withdrawal of international donors a decade ago (Rao 2017). The agency ignored repeated requests by both me and an editor at *The Caravan* for comment – an example, perhaps, of the non-responsiveness and indifference alleged by HIV/Aids workers and activists – and other research might produce a more fine-grained and balanced analysis of its present approach to HIV/Aids communities. But what was evident from my research was that HIV/Aids activists worried that test and treat targets provide a way of addressing – or being seen to address – the HIV/Aids epidemic without talking about any of the behaviours and structural issues driving

it. As Paul Flowers suggests, "the messy complexities of addressing people in a holistic sense, with their social interactions and meaning-laden sexual conduct seems a far less attractive, less measurable, and increasingly arduous, and unrelentingly political, option for policy makers and government alike" (2010, 110) compared to test-and-treat strategies. For this reason too, ethnographic engagement with the changing contexts of HIV transmission, of which high fun is but one example, remains essential.

High fun demonstrates the importance of integrating community-based or social and biomedical strategies, rather than swapping the former for the latter. Reducing risk in high fun contexts would require a holistic approach to harm reduction that does not isolate HIV risk from addiction and related mental health problems. At the same time, high fun reveals several contradictions inherent in the conceptualization of "community" that underpins the ailing system of targeted interventions. Not only does it expose the gap between services for men who have sex with men and injecting drug users, it also foregrounds tensions and contradictions internal to the "MSM/TG" category. Citing fear of stigma and gossip, interlocutors avoided targeted interventions precisely *because* they were community-run - even as they acknowledged the need for harm reduction services sensitive to the (homo)sexual contexts of their drug use. Indeed, harm reduction services for "IDU" cater to a very different demographic, and not everyone who does high fun is an *injecting* drug user.

In this way, high fun challenges us – anthropologists and policy makers – to think of alternatives to the "queer paradigm" (Patton 1990) that continues to inform biomedical risk classifications beyond just acknowledging that there might be overlap, for example, between "MSM" and "IDU". The focus on gay and bisexual men in my research was informed by and reproduced these taxonomies. Future research might go further in challenging the taken-for-granted categories of HIV/AIDS than I have by, for example, centring sexualized drug use and include the whole cast of characters involved – gay, bisexual, and putatively straight men into high fun, *hijra* sex workers getting "high" on cheap booze before or after meeting clients, drug dealers and peddlers of a variety of sexual leanings, service providers, therapists, staff at de-addiction centres, worried best friends, queer couples comprising lesbians, transmen or non-binary people experimenting with drug-enhanced sex, etc.

Shifting gears again, Chapters 9: Interlude for Stigma, Chapter 10: Undetectability, and Chapter 11: Status Anxiety focused on the effects of treatment-as-prevention discourses and technologies on gay and bisexual men living with HIV, and explored the gap between the medical normalization of HIV and people's lived experience of it. As Eileen Moyer and Anita Hardon write, "the persistence of stigma in the face of increasing biomedicalization

seems to confound the expectations of public health planners and medical practitioners, as well as activists, many of whom seem to believe that the process of biomedicalization through treatment should depoliticize and desocialize the disease" (2014, 264). The discourse of "Undetectable = Untransmittable", for example, is invested with hopes of eliminating stigma. Instead, it helps people justify non-disclosure in the face of intense social risks. It enables people like Gautam and the majority of my HIV-positive interlocutors to deal with their status in a way that is both discrete (in the sense of not disclosing it) and discreet (in the sense of keeping it separate from other realms of their lives).

As such, treatment-as-prevention discourses complete the privatization of HIV/AIDS described by Paul Flowers in his analysis of "HIV transitions" in the U.K. (2010). Where its social and physical visibility previously made HIV/AIDS a public and political crisis, the introduction of ART turned its management into a private affair between the patient and their physician (in the countries where treatment was available, that is). While it is helping some people communicate their positive HIV status more confidently in places like the U.K., the U.S.A., and Canada (Guta et al. 2016), including by selecting "Positive, undetectable" under Grindr's voluntary prompt for HIV status, in the Indian context Undetectability appears to shore up the popularity of the already-common strategy of concealment (Steward et al. 2014). This is particularly true for people who, like Gautam, have the luxury of a private cupboard in which to hide their medications, or who can afford to live by themselves. While this may shield people with HIV from stigma and discrimination, it comes at the cost, I argued, of support and solidarity - both among HIV+ people and across the serological divide. The increasing social "undetectability" of HIV/AIDS thus makes continued attention to what is sometimes described as the psycho-social needs of people living with HIV, including through ethnographic engagement, more rather than less important.

Despite its scientific universalism – which is to say, the universal applicability of the message that viral suppression eliminates risk of transmission – the discourse of Undetectability thus has different effects in different contexts. At a U = U Summit in Montreal, where this year's International AIDS Conference was held, Dr Benjamin Bavinton presented the findings of a large survey of gay and bisexual men in five Asian countries (Indonesia, Japan, Malaysia, Thailand and Vietnam) that revealed only just over a third of the sample were aware of U = U (Samuel 2022). Although no such survey has, to the best of my knowledge, been conducted in India, I suspect the findings would not raise this average. But my argument is not only that biomedicalisation is an uneven and stratified process, as demonstrated by these global gaps in awareness of U =U and the fact that NACO has stopped

short of endorsing the message, but also that it interacts in unpredictable ways with context-specific factors that shape the lived experience of people with HIV and their HeIV-negative or untested counterparts. Processes of biomedicalisation should thus be “situated in their specific – but globalised – contexts” (Young, Flowers and McDaid 2015, 412). In doing so, I contributed significantly to scholarship on the impact of treatment-as-prevention discourses and technologies, which tends to be based on research with gay communities in Euro-American and Australian contexts (Guta and Gagnon 2012; Krellenstein and Strub 2012; Persson 2013; Guta, Murray, and Gagnon 2016) or with heterosexuals in East and Southern Africa (Ngure et al. 2016, Bond et al. 2016, Ngure et al. 2020).

In the absence of enacted stigma, the anticipation of HIV stigma takes the form of a kind of status anxiety implicating not just the HIV-positive individual, but their family too. Countering a tendency in HIV research to approach stigma as a problem of stereotyping that can be measured using stigma scales, I tried to relate HIV stigma to the operation of power more generally by attending closely to the anxieties of my interlocutors. Some of these focused on the way in which “coming out” as HIV-positive to parents might reinforce their homophobia or undercut hard-won acceptance, attesting to the existence of what researchers commonly describe as “double stigma”. But I suggested an intersectional approach to HIV stigma should move beyond the area of overlap by paying attention to the way in which HIV disrupts what Gautam described as the “rules of the world”, particularly as they pertain to marriage and the reproduction of the (caste-based) social order. By raising the spectre of sexual transgression, and because of its historical association with poor or working class and oppressed caste groups, HIV poses a threat to an individual and their family’s social standing in a way that homosexuality in and of itself might not. HIV thus remains, despite its medical normalization as a chronic condition “like any other” (Moyer & Hardon 2014), profoundly social, with interlocutors like Amit explicitly challenging the universalism implied in biomedical discourses that compare the condition to diabetes.

In these final chapters I have tried to contribute to both the literature on HIV/AIDS stigma in India, in which the experiences of middle to upper class gay and bisexual men are largely absent, and attempts in anthropology to improve our conceptualization of “stigma” (Parker and Aggleton 2003, Castro and Farmer 2005). Although “eliminating stigma” is increasingly included in TASP discourses as a condition to the achievement of the test-and-treat goals, addressing stigma in all its context-specific complexity requires exactly the kinds of fine-grained analyses and social approaches that the biomedicalization of HIV/AIDS threatens to foreclose. As Paul Flowers explains,

> whereas in the past, the unimpeded action of virus facilitated a host of psychological and sociocultural understandings and responses to HIV, the effective action of medication upon the virus has rendered the positive body as mere 'setting' for action. Critically, within these kinds of construction, the HIV positive person is reduced to a disease vector within prevention, and adherence and the work of managing side effects becomes relevant only as the mechanism by which the medication can work its wonders (2010, 110).

In the face of these developments, anthropology becomes an all the more important for its ability to engage people living with HIV as just that: people going about their day-to-day lives as they navigate the physical, mental and social impact of a virus they happen to have contracted. Ethnography is crucial if we are to engage people with HIV as complex and sometimes contradictory individuals, rather than mere settings, as I hope I have done.

Final reflections in another pandemic

At 8pm on the 24th of March, P.M. Narendra Modi appeared on television to announce what would be referred to in the international media as the world's biggest and strictest lockdown. As the author Arundhati Roy (2020) detailed, the sudden suspension of transport sparked an exodus of now-destitute migrants from India's metropoles, with thousands trying to reach their native villages by foot at risk of starvation, police harassment and death-by-truck. Meanwhile, affluent people wondered whether it was safe to let mAids and other domestic workers enter the home, since the difficulties of isolated in India's crowded slums and lower-income neighbourhood rendered the members of the service class suspect. Months before the racialized health inequalities on which the Covid-19 pandemic feeds would receive due attention in places like the U.S. and the U.K., India's lockdown had put a spotlight on the country's great class divide.

It also effectively put an end to my fieldwork: although, in retrospect, I could have continued conducting interviews with HIV-positive men or people with experience of high fun over the phone or via conference call, given the difficulties of building trust detailed in Chapter 2: Methods, Ethics, and Poz/itionality, I was reluctant to do so. And although I managed to do a few such interviews with HIV/AIDS activists, most public health activists and NGO workers had more urgent matters to attend to. The community-led clinic that I was poised to start "observing" would be closed to the foreseeable future, having finally opened just two weeks prior to Modi's announcement. (Instead, the NGO directed its efforts towards delivering food stuffs to trans and cis-gender sex workers across Karnataka who were now, of

course, out of business.) Inconvenient though all of this was, I was lucky to have returned, just in time, to an airy apartment I rented in a leafy, middle class neighborhood of Bengaluru. Alternating between its three balconies and a rooftop terrace, I counted my blessings and started writing.

But I also counted my pills. My visit to Bengaluru was meant to be brief, and most of my stuff, including three months' worth of medication, was still in Mumbai. Postal services were limited to medical equipment and operated via airports, which I could not reach, so I tried to figure out a way for the private physician I interviewed once to transport raltegravir and a tenofovir/emtricitabine combination to my part of the city. As I googled things like *Does UberEats accept prescription medication?*, messages trickled into the WhatsApp peer support group I was part of describing far more dire situations. Members who lived in (or were stranded in) rural areas of the country were unable to pick up their medications at ART centers, which tend to be located in the hospitals of larger towns and district centers. Some had outed themselves as HIV-positive to local police officers in order to gain the required permissions for even the most basic forms of travel. While the newly-emboldened police officers helped some of them, Loon Gangte from the Delhi Network of Positive People reported others were humiliated (Chattopadhyay 2020). More generally, the lockdown exacerbated issues of treatment access and stock-outs at government hospitals (Chattopadhyay 2020).

Despite these intersections, many of the think-pieces that mentioned HIV/AIDS in first few months after Covid-19 was declared a global pandemic took the form of comparison, invoking the former as a past epidemic from which lessons can be learned regarding how to respond to our current one. "Fear, bigotry, and misinformation," the HIV-positive author Edmund White (2020) wrote in *The Guardian*, "this reminds me of the 1980s AIDS Pandemic." The parallel irked some ACT UP veterans, who felt two epidemics were too different in epidemiological character to be compared. I myself was frustrated by the way in which think-pieces like Mark Schoofs' *I lived Through The AIDS Epidemic. Here's How To Live Through Coronavirus* relegated the HIV/AIDS epidemic to the past, dovetailing with "end of AIDS" narratives and obscuring the way in which Covid-19 would impact, for instance, global funding for HIV/AIDS. "But," as Mathew Rodriguez (2020) noted, "in the way that they affect the body politic, the citizenry, they [the HIV/AIDS and Covid-19 pandemics] have dusted up many of society's worst impulses: the need to blame, to criminalize, to lock each other up."

From where I was standing on my Bengaluru rooftop, it was evident blame and

bigotry were in no short supply. Within weeks of first reported Indian cases, the mainstream media (now commonly referred to as P.M. Modi's 'lapdog') had spun a narrative that pinned the source of the spread on a religious conference held by a Muslim sect, Tablighi Jamaat, in New Delhi in March – despite the fact that the Capital's authorities had at that time not yet imposed any restrictions (Sharma and Gupta 2020). A BJP MLA warned of Muslim vegetable sellers spitting on their wares to spread the virus, and one of the Hindi media articles I was translating in an effort at self-improvement alleged Pakistan had sent Covid-19-infected agents across the Line of Control bifurcating Kashmir. According to a WhatsApp message that was forwarded to me, Shivaji Nagar – a predominantly Muslim vicinity nearby– was burning, because its residents were resisting quarantine. Meanwhile some in the online LGBT groups I had joined complained about the continuation of high fun parties, where people were now, supposedly, spreading not just HIV but also Covid-19. Indeed, these and other rumours were reminiscent of the "geographies of blame" constructed during the early years of HIV/AIDS epidemic (Farmer 1992).

More subtly, the emphasis on personal responsibility in the response to Covid-19 was another commonality with HIV/AIDS. In the U.K. as in many other countries, the Covid-19 response was characterized by an intense focus on risk behaviours, which included anything from doing groceries to hugging a friend. While this was understandable given the nature of Covid-19 transmission, there was a noticeable lack of more structural interventions, such as making up for years of under-investment in the National Health Service, increasing ventilation in schools, or addressing the inequalities causing discrepancies in infection and morbidity rates domestically and globally (for example by supporting the patent waiver for Covid-19 related medical technologies called for by India and South Africa). The response exhibited the same biomedical individualism that has characterizes HIV/AIDS discourse and policy, anthropological critique notwithstanding. As Adam Geary (2014) explains in his analysis of the relation between state racism and HIV/AIDS in the U.S., this tendency to isolate the virus both from the social, political and economic contexts that enable its spread *and* from the bodies on which it acts - and the resultant emphasis on individual risk behaviours - deflects attention from the way in which material factors, such as poverty and incarceration, condition health. Indeed, as Steven Thrasher has pointed out more recently (2022), it tends to be the same or similar groups of people who are disproportionately impacted by pandemics like Covid-19 and HIV/AIDS, such that we might speak of a "viral underclass" rather than (merely) about "high risk groups" or high risk behaviours. Yet, as the authors of *Empire's Endgame: Racism and the British State* point out, in the U.K. "any

mention of the disproportionate number of deaths suffered by Britain's black and Asian communities during this crisis has been dismissed as 'divisive,' or, perhaps more perniciously, as attributable to genetic difference" (Bhattacharyya et al. 2021, 178).

The individualism underpinning biomedical responses to viral pandemics like HIV/AIDS and Covid-19 is ironic given the way in which contagion reveals our interconnectedness. During an on-line lecture hosted by the Whitechapel Gallery and British Library during the summer of 2020, Judith Butler argued Covid-19 pushes to the fore the question of relationality. Not only does the highly transmissible respiratory disease remind us we are not the bounded individuals many of us think we are, the health measures with which the outbreak was met exposed our dependency on others (devalued low-wage workers were suddenly recognized as "essential"). Butler saw this as an opportunity to re-think the notions of vulnerability and harm: "Vulnerability is usually understood as the condition of being potentially harmed by another. It also means, however, the porous and interdependent character of our bodily selves and our social lives" (Verso 2020). They went on to emphasize that the dependency that marks our emergence into the world does not cease with adulthood: we continue to be impressed upon by our environments and social worlds, though the doctrine of individualism works to obscure this impressionability and porosity. What does it mean, Butler asks, that "when another breathes out, I breathe in, and that something of my breath can and does find its way into another person, that we are interlaced or interlocked in this way?"

Contagion, in other words, ruptures the myth of the self-contained individual. In *The Mushroom at the End of the World*, anthropologist Anna Tsing (2015) traces the notion of the self-contained individual to the "twin master sciences of the twentieth century," namely neoclassical economics and population genetics. Where Richard Dwarkin's "selfish gene" theory proposed that self-interest propels evolution, the frame of *homo economicus* presupposes a rational man who makes choices to maximize his own interest.

> The assumption of self-containment made an explosion of new knowledge possible. Thinking about self-containment and thus the self-interest of individuals (at whatever scale) made it possible to ignore contamination, that is, transformation through encounter. Self-contained individuals are not transformed by encounter. Maximizing their interests, they use encounters – but remain unchanged in them. *Noticing is unnecessary to track these unchanging individuals*. A "standard" individual can stand in for all as a unit of analysis. (2015, 28, italics mine)

In contrast to this strategizing individual, matsutake mushrooms – the unlikely protagonists of Tsing's monograph – emerge through mutualistic relationship with the trees. They are the fruiting bodies of an underground fungus that derives its carbohydrates from the roots of certain trees, for whom the fungus forages. As such, mushrooms depend on their host trees to the point of being, quite literally, inseparable from it; conversely, pines rely on the mushrooms to live in infertile soils (2015, 40). Tsing refers to this enabling entanglement as an example of contamination as collaboration, or – more poignantly for the purposes of our discussion here - contaminating relationality.

This thesis has been an attempt at, and an argument for, the science of *noticing* – ethnography – at a time when biomedical optimism threatens to marginalize social scientific engagement with the epidemic. Insofar as the treatment-as-prevention discourses reflect a more general individualism in our understanding of health, such ethnographies are of vital importance as we become increasingly vulnerable to the sorts of viral pandemics from which we are just now emerging. Narratives such as Arvind's and those of the other interlocutors featured in the preceding chapters are, in essence, stories of encounter through transformation. The interviews in which they were produced were, in turn, encounters that transformed me and my relation to HIV. I began this thesis by explaining, in the preface, that the animating question grew out of my own disorientation and anguish following my HIV diagnosis. Over the course of the research, "the more stories I heard the less space my own suffering seemed to take up," as Arthur Frank writes in his preface to the second edition of *The Wounded Storyteller* (2013, xi). Like Frank, I felt less alone. At a time when the biomedicalization of HIV renders it an increasingly private, and, I argued, isolating experience, ethnographies can help "widen the circle, to amplify and connect the voices that [are] telling tales about illness, so all of us could feel less alone," (Frank 2013, xi) as I hope this thesis has done.

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