A BASELINE UNDERSTANDING OF MSM COMMERCIAL SEX ACTIVITY AT MUMBAI TRUCK TERMINALS

A baseline study undertaken by
The Humsafar Trust
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Mumbai District AIDS Control Society

INTRODUCTION

The National AIDS Control Organization of India (NACO) estimated the number of people living with HIV/AIDS in India were between 3.82 to 4.58 millions by end 2002. The total number of cumulative AIDS cases as of February 2004 was 67,416 (as reported by NACO). Of these 49,396 were men and 18,020 were women. The route of transmission was sexual in 86. 4% of these reported AIDS cases. We are right now in the phase III of the epidemic where greater stress is needed on care and support and treatment, which is the dire need of the community.

The HIV prevalence among the MSM community in Mumbai was estimated at 20%(Source: baseline conducted during the second phase of the project by Humsafar Trust). The MSM groups are difficult to reach because of their invisibility and due to the stigma and denial attached to such behaviors. The sexual behavior of MSM is of serious concern since usually MSM have multiple partners.

Disease trends in India suggest that HIV/AIDS is best understood as concentrated epidemics, occurring in specific geographical locations and among certain populations. Therefore, rather than merely reporting 4.97 million HIV positive individuals in a country of 1 billion, it is more important to understand that 54.5% of cases in the high-prevalence state of Maharashtra are commercial sex workers (CSWs), 39.42% are intravenous drug users (IDUs), and 16.8% are Men who have Sex with Men (MSM).[1] What is the risk of infection for an individual that is *all three of these things*?

Though rarely discussed, even by those most involved in the fight against HIV/AIDS in India, understanding male sex workers' (MSWs) knowledge, attitudes, and practices can contribute to our understanding of how the epidemic is spreading in the country. Despite studies and anecdotal evidence that suggests considerable MSM (Men having Sex with Men) activity at truck stops (considered one of the 'hotspots' of HIV infection in India), descriptive quantitative data regarding the nature of this activity, which includes considerable commercial sex work, is absent

This study was designed to uncover answers regarding MSWs' knowledge regarding sexual health (with an emphasis on HIV/AIDS), factors relating to their condom and substance usage (specifically related to sex), STI treatment-seeking behaviour and VCTC utilization, and provide information regarding their sex partners at truck stops.

BACKGROUND

MSM Behaviour among Truckers

[1] National AIDS Control Organization (NACO), 2002

Lending credence to information that was already 'known' qualitatively, 23% of a random sample of 170 truckers in Mumbai admitted practicing MSM behaviour. [2] Anecdotal evidence, mainly from field outreach workers, suggests that truckers have sex with male labourers (helpers, cleaners, assistants, etc.) that ride along with them, female CSWs and MSWs.

The male labourers are often orphaned/abandoned adolescents that have left their homes, later to be picked up along the highways by truckers to serve as "helpers" by way of apprenticeship. Some truck drivers may genuinely be attracted to members of the same sex (though this does not necessarily mean they are comfortable with sexual identity labels such as 'gay' or 'homosexual'), and others may have sex with other men purely out of convenience or circumstance. Away from their wives, alone on long journeys for months at a time, truck drivers can take advantage of the obvious power dynamic they hold over their younger, less experienced 'helper.' A.R. Kavi of Humsafar Trust suggests that this phenomenon is history repeating itself as tragedy, as many truck drivers were actually once 'helpers' who had 'survival' sex with his driver before becoming one himself.

Aside from this, many Indian 'port cities', such as Mumbai, accommodate both major truck terminals as well as Red Light Districts (RLDs). This coincidence lends the option of commercial sex to truck drivers who have ample 'waiting time' between assignments and a disposable cash income. However, at this juncture it is important to note that at least in Mumbai, a trucker has one of two main options if he decides to exchange cash for sex. He can either travel to Kamathipura, Mumbai's RLD (considered the 2nd largest in the world), or save the trip across town and choose from the MSWs that operate at Cotton Green, Mulund, Wadala, and other truck terminals.

<u>The Male Sex Worker in Mumbai</u>

Deconstructing who or what defines a male sex worker in India becomes quite complicated. As Ashok Row Kavi[3] states, "…a male sex worker can hide under many labels. He can be a model, a masseur…you have to pass various barriers and stigmas to get at what they really do."[4] (AVERT STUDY RE: COMMERCIAL MSM LEVELS) Understanding the various delineations of 'Men having Sex with Men' (MSM) assists in understanding commercial MSM activity in particular.

In order to reach the programmatic purpose of serving MSM more effectively, the Humsafar Trust has carefully deconstructed the various (not mutually exclusive) sub-categories of individuals that can fall under the umbrella of 'MSM.' These sub-categories are best understood in the context of 4 main categories

Identity:	Individuals that identify as 'gay', 'bisexual' and/or local terms such as '*kothi*' (receptive partner) & '*panthi* (insertive partner)
Gender:	Individuals that are often referred to as 'transgender', in that they are biologically born male but believe himself to be female. This includes individuals referred to as the '3rd gender', or *hijras*, in South Asia.

[2] "How India's Largest Risk Behaves: A KABP Survey Undertaken at the Country's Largest Truck Terminus" presented at the 5th ICAAP by Lalita Shankar and Shilpa Merchant, Population Services International, INDIA.

[3] Chairperson of The Humsafar Trust, a leading male sexual health agency in Mumbai, India.
[4] In an interview with Nicole Rajani, published in: "Community Groups Step in Where the Indian Government Fears to Tread." *American Foundation for AIDS Research*, August 2003.

Behaviour: Individuals who do not identify with queer labels but are behaviourally homosexual or bisexual.

Profession: This includes individuals that have sex with other men in exchange for cash or kind. For example, masseurs, hotel boys, and sex workers.

The complicated thing about MSWs is that their reality lies at a cross-section of all four of these concepts. This point is further illustrated when one learns more about the individuals that are most often found to be MSWs in India:

1. *Young, middle-class urban boys*
In recent years, more news of young male 'escorts' offering their services to upper-class women in India's major urban centres has been made available. Although this is a relatively discreet form of solicitation, one cannot discount the fact that sex is often exchanged for money while such services are made available.

2. *Gay men*
As 'escorts' and as more blatant solicitors of commercial sex, *kothis* often times are categorized as MSWs. As most of these individuals are from low socio-economic backgrounds, it must be noted that commercial sex is a last-resort means to generate income to support themselves and their families. Further, as stated in a 1997 report by Naz Foundation International (NFI), "not all male sex workers are *kothis*, and not all *kothis* are sex workers." This, of course, complicates matters more as NFI seems to think Kothis are high-risk by their very definition.

3. *Transvestites/Cross-dressers*
Whether practicing heterosexual, bisexual, or homosexual behaviour, some men prefer to dress in a woman's attire. Sometimes, their cross-dressing is restricted to certain times – such as when they are on stage for performers, or when they are working as a MSW.

4. *Transgender/'Hijras'*
Traditionally, *hijras* in South Asia rely on two means of generating income: *basti*, or begging for alms, and *badai*, or receiving payment in exchange for performing and giving blessings at auspicious events (such as the birth of a child or a marriage). However, particularly as neither *basti* nor *badai* provides an individual with enough income to survive in the larger cities where news does not get around fast enough, many *hijras* have had to adopt a third means of financial survival: *pun,* or commercial sex work.
Further, contrary to popular belief, the majority of *hijras* (around 80 per cent from the two rapid surveys by HST in North-East and North-West Mumbai) are actually non-castrated, or *akwa hijras,* as they have not gone through the ritual ceremony (known as *nirwan*) that is commonly associated with the hijras of South Asia.
Therefore, when they work as commercial MSWs, some *hijras* penetrate as well as get penetrated by another male. It should be noted that 'transgender(ed)' is gender identification rather than a sexual orientation. Individuals known in South Asia as *hijras*, *chakkas*, *namardas*, etc. are part of a highly complex social construct that may incorporate the reality that, although born biologically male, they are psychologically female. Others that belong to this community, particularly those that are *nirwan hijras*, may consider themselves to be 'asexual', or of a 'third gender', as they possess neither male nor female sex organs.

MSWs and HIV

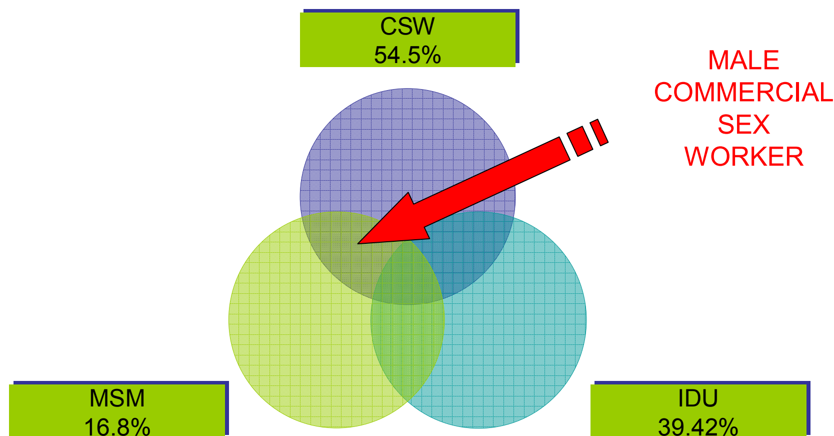
Given these complex, sometimes overlapping, delineations of individuals that may operate as MSWs, the real challenge comes in appropriately ascertaining their presumed risk of HIV infection. Akin to the female CSW population, it is assumed that the following factors play a role in exacerbating a MSW's risk of contracting HIV/AIDS:

1. High number of sex partners
2. Unprotected receptive anal sex
3. Violence exacted upon them by "police and local goons"[5]
4. Lack of support/knowledge of services
5. Substance abuse

This survey was designed and executed to determine the current prevalence of each of these factors, in an effort to describe the nature of commercial MSM activity at truck terminals. The hope is that uncovering some truths about this situation would shed some light on the risk of HIV infection for MSWs and their trucker clientele.

MALE SEX WORKERS : COMPOUNDED HIV RISK

BREAKDOWN OF HIV+ INDIVIDUALS IN MAHARASHTRA



NACO, 2002

METHODOLOGY

Rich qualitative evidence has already been collected over the period of one and half years that Mumbai District AIDS Control Society (MDACS) has funded Humsafar's intervention with MSWs and their clients. The sex mapping revealed that MSM activity is mainly found among

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[5] Narrain, Siddharth. "Sexuality and the Law." *Frontline: India's National Magazine from the publishers of THE HINDU* (Volume 20 – Issue 26, December 20,2003 – January 02, 2004).

three populations: MSM truckers, the local MSM population (consisting of college-going boys, other neighborhood males), and castrated/non-castrated MSWs.

Intervention conducted by Humsafar's field outreach workers thus far revealed that approximately 150 sex workers were spread over eight truck stops in Mumbai, and a MSW often times remains at their 'beat', hardly moving much once he has established a 'command central'. Therefore, the MSW population can be considered relatively 'static', and perhaps more accessible than the highly mobile truck driver population. Also, due to stigma around same-sex behavior it would be difficult to incorporate truckers into such a study.

A quantitative tool designed for MSWs that uncovered major assumed indicators for HIV infection would lend information about the dynamics of the MSM behaviour occurring between themselves and truck drivers. Therefore, a semi-structured questionnaire of 86 questions was designed. Field outreach workers were trained in the administration of this survey instrument, and a pilot phase of pre-testing in the field was conducted. Finally, the questionnaire was administered via a 'blanket' sampling or 'catch-all' sampling method intended to survey the entire static population of ~150 MSWs.

The following protocol details the chronological steps undertaken by program staff involved in the data collection regarding commercial MSM activity at truck stops in Mumbai:

1. The trained outreach field worker identifies a potential respondent and greets them.

2. The respondent is briefed about the study – its purpose, benefits, and risks – and asked to sign a "Consent Form" detailing these items.

3. The field worker treats the consenting respondent to refreshments (chai/snack) at a location that is a bit removed from the actual place of their business, but still at the truck terminal.

4. The field worker completes the questionnaire with the respondent, without stopping the interview process mid-way unless the respondent requests to leave. In the case of this occurring, the questionnaire would be voided and not considered in the final analysis.

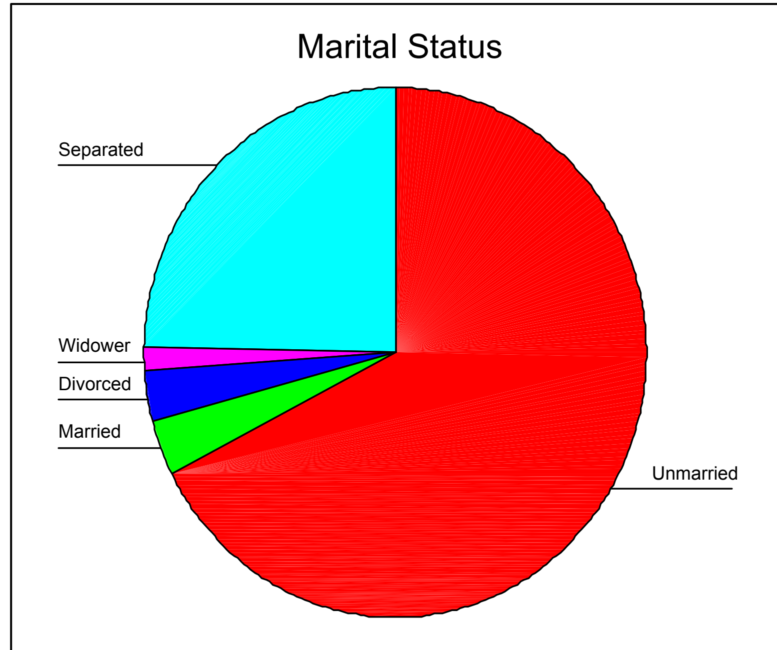
5. The field workers return completed questionnaires to the Project Officer.

The responses from the 141 completed forms were then entered into a database and coded. SPSS™ software was used for descriptive statistical analysis, resulting in data tables and graphs for variables that did not have a sufficient number of missing responses.

KEY FINDINGS

Part I: Demographic Profile

This survey reveals that a little over half of MSWs are between the ages of 25 and 30, one-third are illiterate, and two-thirds are unmarried.



Further to this, MSWs earn between Rs. 3000/- and Rs. 6000/- monthly, though it should be noted that 40% have a simultaneous alternate profession of *mangti* (aka *basti*, or begging).

While approximately 40% of MSWs are native to Mumbai, many also come from other regions of India. Most prominent among these other states are Karnataka (5%), Andra Pradesh (9%) and West Bengal (6%).

A disturbing demographic trend is that the majority of MSWs reside alone, as detailed in the table below. Though they may have a social support system in other fashions (particularly if the individual is a *hijra*, and belongs to a *guru-chela* order), it would be of interest to further explore the psychological effect of this residential situation and its effect on vulnerability for HIV infection.

Stay

	Frequency	Percent	Valid Percent
With parents	9	6.4	6.4
With friends	5	3.5	3.5
With male spouse	10	7.1	7.1
Alone	93	66.0	66.0
With guru	24	17.0	17.0
Total	141	100.0	100.0

Part II: Knowledge regarding HIV/AIDS

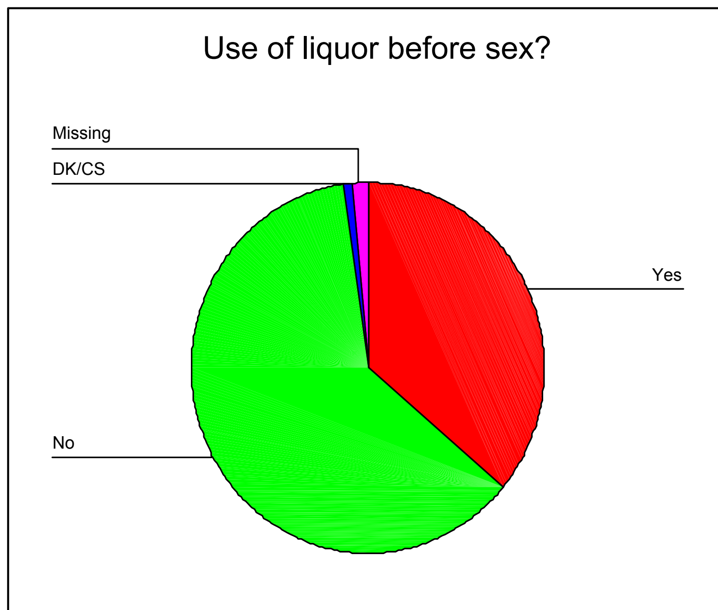
Findings suggest a satisfactory understanding of HIV transmission, with some believing in commonly mistaken routes, i.e. mosquito bites (36.7%), sharing a toilet (26.5%), and sharing utensils (22%) with an infected person. Three-fourths of MSWs identify correct definitions of HIV, and nearly all can identify appropriate means of preventing HIV infection.

Can you tell me how HIV transmission can be prevented?

Avoiding penetrative sex	Yes	92.6%
	No	5.8%
	Can't say	1.7%
Using condoms during penetrative sex	Yes	92.4%
	No	6.8%
	Can't say	.8%
Using sterilized needles/syringes	Yes	100%
	No	-
	Can't say	-
Avoiding pregnancy if a woman is discovered to be HIV+	Yes	95.8%
	No	.8%
	Can't say	3.4%

The majority of MSWs believe that HIV and AIDS means sure death and they are not aware if cures exist for either.

Part III – Substance use



Over one-third of MSWs admit to consuming liquor (alcohol) before sex. Close to 40% of these individuals consume liquor with every sex act and over half consume liquor 'sometimes' prior to sex. Further, it was revealed that the types of liquor consumed by most MSWs are *desi daru* (local liquor) and beer.

Almost half of respondents state that they always or sometimes use some intoxicant prior to sex. Most popular among MSWs is *gutka*, or flavoured chewing tobacco (37%), *paan*, or betel nut (25%), and 'plain' tobacco (25%).

Fortunately, data reveals that almost none of the MSWs use needles for injecting drugs (92.9%).

Part IV: Sexual Partners[6]

On average, MSWs have sex with 22.5 male partners (including clients) per week. When asked a similar question, regarding number of male partners in a day, data reveals a slightly elevated average than can be deducted from this number; MSWs have an average of 5.3 male sex partners in a day.

[6] Altered from the subject heading used on the survey instrument for further clarity

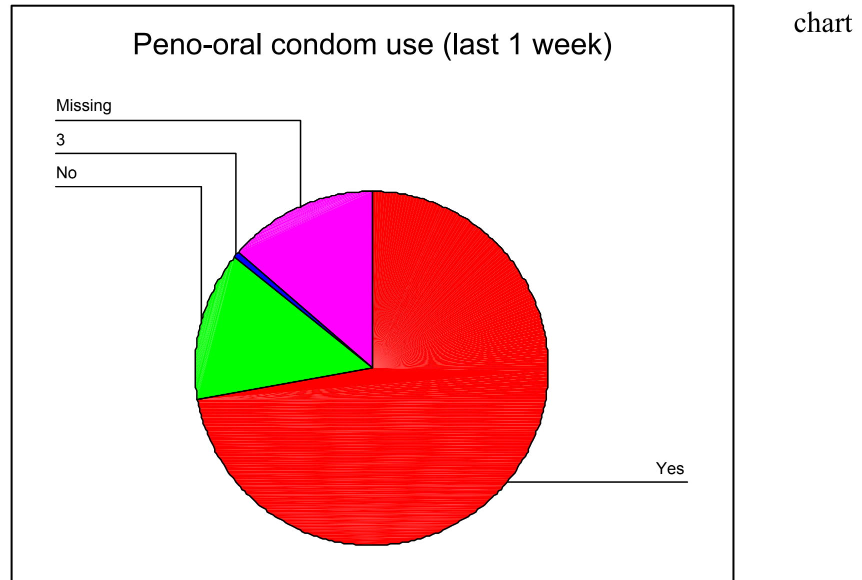
It should also be noted that 15% of MSWs also admit to having sex with females, though the majority of these individuals stated that this happens only "rarely." Of those that have female partners, the majority are non-spousal sex partners (77.3%).

Part V: Practices pertaining to sex

When asked about wet kissing, close to 40% of MSWs responded that saliva was exchanged approximately two to four times (sometimes) in the week preceding the time of interview. Mutual masturbation appears to be rarely practiced among this population, as nearly 70% of respondents stated they have not done so, even once, in the last month.

Part V.a. : Peno-oral sex with male partner

The majority, or 83.6%, of MSWs had peno-oral sex with their partner in the month preceding the time of interview. MSWs have oral sex with an average of 7 clients in a week. Among these acts, just over half of MSWs admit to sucking/licking another person's penis more than 5 times in a week's time. About 80% of MSWs state that their male partner uses condoms (most often with *each* oral sex act) as illustrated in the pie chart below.



However, of the 25% of MSWs that admits to being penetrative oral sex partners during commercial sex activity (allowing their client to suck/lick their penis), three-fourths (74.7%) never wear a condom during this act.

Part V.b. : Oral-anal sex with male partner

Of the MSWs surveyed, only 16.7% had oral-anal sex with their client in the week preceding the time of interview, making this the least prevalent sex activity that occurs.

Due to the small number of those engaging in oral-anal sex, there was an insufficient sub-sample size to further analyze the details of this activity. However, the trends suggest

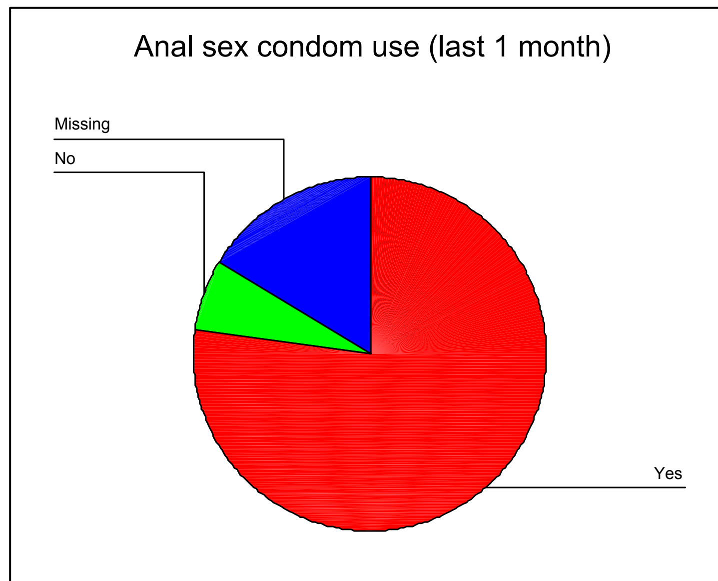
half of MSWs state that their partner uses protection (condom dam) while being receptive to oral-anal sex.

Close to 13% of MSWs allow another person to lick their anus, and trends suggest that almost all of these individuals do not use protection during this activity.

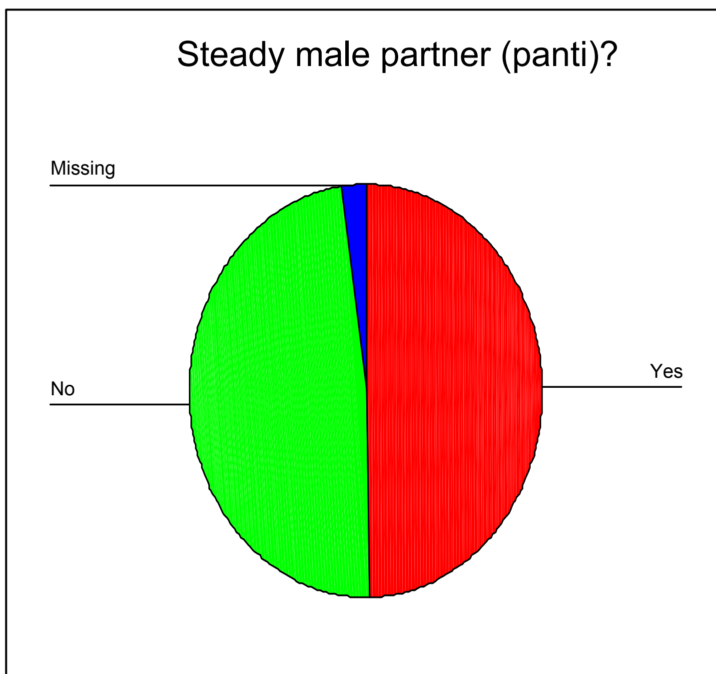
Part V.c.: Anal sex with male partner

The majority, or 83.2%, of MSWs had peno-anal sex with their client in the week preceding the time of interview. On average, respondents have anal sex with slightly over 6 clients per week. The majority of MSWs that have anal sex state that their client inserts his penis into their anus (i.e. MSWs act as receptive partners) at least 5 times in the last one month. It is comforting to note that the majority of respondents use condoms during this act, as is illustrated in the pie chart below. There is still some gap in condom use during receptive sex that should be addressed with follow-up interventions.

Perhaps one of the most interesting findings of this survey is that approximately 15% of MSWs admit they are penetrative partners, in that they insert their penis into their client's anus. This lends credence to the anecdotal evidence that a number of *hijras* that engage in commercial sex are non-castrated (*akwa)*.



It was observed that over half of MSWs are the recipient of inter-femoral (*Chapti)* sex from their clients, and about one quarter insert their penis in between a client's thighs.



Part VI: Regular partner and spouse profile

Along with non-regular male clientele, half of MSWs also have a steady partner, referred to as their *panti* (term used for insertive partner with regard to MSM

sexual behaviour). Despite a large number missing, it can be gleaned from the data that several main reasons prevent MSWs from using a condom when they have sex with their panti: inability to negotiate condom use ('because my *panti* says no'), condom availability ('I don't know where to get a condom from' or 'I don't get a condom while having sex') and trust in their *panti*. Interestingly, these barriers parallel the barriers found among female CSWs with regular male partners/clients in Mumbai.

The majority of MSWs do not go outside their locale for sex work (75.9%), but if they do then they go to another truck stop. When prompted to name which truck stops, Wadala and Kalamboli were the most popular responses, though there is insufficient data to make reasonable conclusions regarding this finding.

Conforming the basis upon which this study was designed, when asked to characterize the clients they have in Mumbai, nearly all mentioned 'trucker,' oftentimes in conjunction with 'cleaner' or 'labourer.' A few MSWs also mentioned that their clientele is composed of college students.

Inter-femoral sex

A discrepancy was discovered during a review of the major findings with regard to inter-femoral sex. When asked in a previous section, few MSWs admitted to allowing their client to insert his penis in between his thighs. However, when asked later, the data reveals that MSWs have inter-femoral sex with an average of 7.3 partners in a week. This is a point that should be looked into more closely with follow-up focus groups and/or surveillance.

Further, it should be noted that while nearly all MSWs can correctly identify 'oral sex with a condom' and 'anal sex with a condom' as definitions of 'safer sex practices', very few mentioned 'inter-femoral sex with a condom'. This lack of knowledge could have tremendous health consequences, particularly with regard to certain STIs that can be contracted via skin contact with an infected individual.

Part VII: Sexual Health

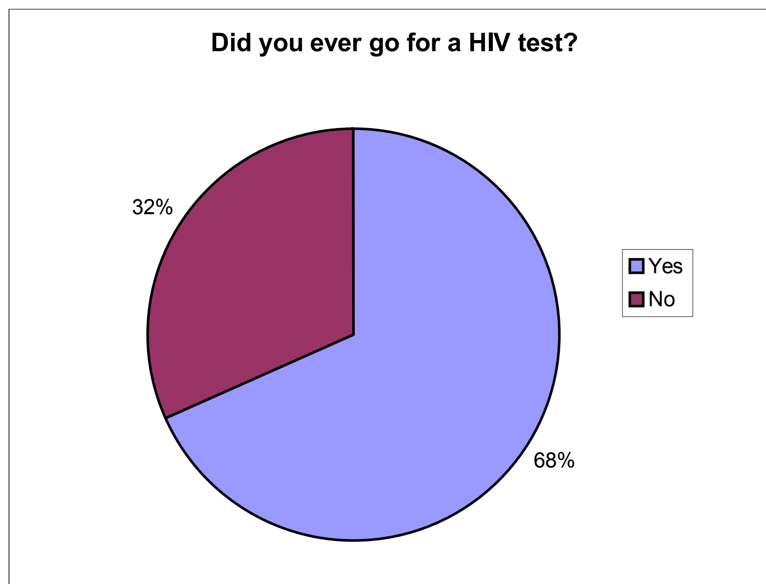
Despite a fair amount of individuals that did not respond, it is important to note that nearly one-third (31.4%) of MSWs have suffered from a STI in 6 months prior to the time of interview.
Of these, the two chief symptoms they experience are blisters and ulcers on/around their penis and greenish-yellow discharge. These symptoms are consistent with herpes/chancroids (blisters and ulcers) and trichomoniasis/gonorrhoea/chlamydia (discharge) but diagnostic tests would obviously have to be conducted to accurately characterize the appropriate infection.

Although almost all respondents take medical treatments to alleviate their symptoms, it should be noted that about one-third of MSWs rely on home remedies, and almost 30% self-medicate. The key findings are summarized in the table below.

What treatment did you take (for STI symptoms)?

Home remedies	35.8%
Self-medication	29.9%
Treatment from an allopathic (western medicine) doctor	32.8%
Treatment from a *vaidu* or *buva*	1.5%

While the majority of MSWs have gone for a HIV test prior to the time of interview (68%), those that had not yet gone mention embarrassment, ignorance about testing centers, or cost as reasons for not getting the HIV test done. A little over half that had gotten tested did so at a NGO facility, and the majority (73.7%) did collect their reports. Those that had not only mentioned fear (86.8%) and loss of referral slip (13.2%)as reasons for not collecting their HIV test report.



It is encouraging to observe that nearly all MSWs find it easy to access condoms (94/1%). This is no doubt due to the intensive intervention efforts of dedicated Humsafar field outreach staff. Data confirms that the majority of MSWs mentioned 'NGO' or 'paan shop' as the place they procure condoms. Chemists, general stores, and hospitals were also often mentioned.

PROGRAMMATIC IMPLICATIONS

While this study remains a modest initial attempt to characterize commercial MSM activity centered at truck stops in Mumbai, several interesting observations were made. These observations, detailed in the preceding 'Key Findings' section, lend suggestions to program planners that are concerned with the MSW population in this metropolis. The following are by no means 'conclusions,' but rather implications that should be incorporated when designing intervention efforts to this population:

- While overall HIV knowledge and condom usage is high, there is a need to address misconceptions regarding route of transmission.
- A comprehensive program for MSWs must incorporate the issue of substance abuse among this population.

- Abysmal rates of current condom usage while MSWs are recipient oral sex partners must be addressed. Knowledge regarding STIs that can be transmitted via peno-oral sex needs to be shared.
- Also disconcerting is the fairly large proportion of MSWs that are insertive anal sex partners. Addressing condom use and STI detection among this sub-population is paramount.
- Similarly, the fair proportion of MSWs that have non-regular female partners must be noted and incorporated into an intervention strategy.
- The importance of receiving STI treatment from a trained medical professional must be emphasized. Further, outreach workers could be educated in assisting MSWs with recognizing warning signs for STIs common in this group, so that they might seek care more urgently as well.
- While many MSWs are going in for HIV testing, efforts to reduce the barriers (namely embarrassment and awareness of free testing facilities) must be made.
- The observation that half of MSWs have regular male partners (*pantis*) is significant. *Pantis* should be included in outreach efforts as regular male partners are included in outreach to female CSWs. This could improve condom negotiation and trust issues, which are currently acting as barriers to condom use among MSWs.

Finally, subsequent studies with larger sample sizes (perhaps achieved by widening the study area) must be conducted. In particular, determinants of risky sexual behaviour need to be identified following this baseline assessment, in order to more effectively profile (and subsequently provide outreach to) MSWs and their clientele at Mumbai truck stops.