

# **Knowledge, Attitudes and Practices of Male Sex Workers Based at Truckstops**

**The Humsafar Trust & Population Services International**

**By**

**Paige Passano** (Special Projects Supervisor, PSI)  
**Ernest Noronha**(Truckstop Project Manager,HST)  
**Priyamvada Todankar** (Research Manager, PSI)  
**Jamie Waltz** (Consultant)

**File path: FINAL MSW REPORT Jan 4 wed final E  
and S Edits March 3**

## Table of Contents

### Glossary of Terminology

<b>I</b>	<b>Executive Summary</b>	
	1.1	Origin of Collaboration
	1.2	Objective of Study
	1.3	Notes on Partnership
	1.4	Structure of Report
<b>II</b>	<b>Key Findings at a Glance</b>	
<b>III.</b>	<b>Introduction</b>	
	3.1	Vulnerability of MSM and Male Sex Workers
	3.2	Background on Sex Work on Truckstops
	3.3	Need for the Study
	3.4	Rationale of Study Content
<b>IV.</b>	<b>Methodology</b>	
	4.1	Study Area and Recruitment
	4.2	Questionnaire Structure
	4.3	Informed Consent
	4.4	Training of Field Investigators
	4.5	Data Collection and Analysis
	4.6	Limitations
<b>V.</b>	<b>Cultural Context</b>	
	5.1	Kothi Culture
	5.2	Social World and Peer Networks
	5.3	Types of Respondents
		a: Malishwallahs
		b: Non-Hijra Sex Workers
		c: Hijras
	5.4	Background on the Hijra Community
		a. Role of Guru
		b. Role of Gurubhai
		c. Hijra Culture and Religion
	5.5	Social Environment and Stigma
	5.6	Important Actors in Lives of MSW
		a. Panthis
		b. Customers/Cheaters
		c. Police
		d. Health care providers.

- VI. Results and Implications**
  - 6.1 Geographical Spread
  - 6.2 Types of MSW
  - 6.3 Educational Attainment
  - 6.4 Sources of Income
  - 6.5 Marital and Relationship Status
  - 6.6 Sexual Partners
  - 6.7 Condom Use
  - 6.8 Lubricant Knowledge and Use
  - 6.9 Knowledge of STIs
  - 6.10 STI Treatment Seeking Behavior
  - 6.11 Knowledge and Attitude about HIV/AIDS and VCT
  - 6.12 Knowledge of Support Services
  - 6.13 Knowledge of Specific Support Services in Mumbai
  - 6.14 Stigma
  - 6.15 Exposure to HIV Intervention
  - 6.16 Recipients of Information about HIV/AIDS
  
- VII. Priorities for Intervention**
- VIII. Areas for Further Investigation**
- IX. Conclusion**
  
- X. APPENDIX A: Survey Questionnaire**
- XI. APPENDIX B: Logical Framework for the Collaboration**
- XII. APPENDIX C: Findings of Needs Analysis of MSW and Truckers and Helper clients of MSW**

## Glossary of Terms

**Transgender:** (General definition): A person who defies expected, gender-specific norms of dress and behavior that are linked to biological sex. The defiance can occur either internally/privately or through externally rejecting gender expectations.

**Kothi:** Feminized male (to varying degrees) who is homosexual or bisexual

**Panthi:** Boyfriend or “husband” of a kothi

**Mufatkor:** Anyone who takes sex from a sex worker without paying

**Malishwallah:** Freelance masseur who often also offers sexual services.

**Hijra:** Member of the Hijra community who has been initiated under a guru

**Chela:** Novice; new initiate into the Hijra community

**Guru:** Senior hijra to whom chelas have sworn allegiance

**Nayak:** Head of one of the Hijra gharanas

**Gurubhai:** Fellow chela under the same guru

**Gharana:** House that houses a guru and chelas

**Nirvan(hijra):** Hijra who has undergone removal of all male external genitalia

**Ackwa (hijra) :** Hijra who has retains male genitalia, who may or may not be preparing to become nirvan

**Adwar:** Half of the income of a hijra that must be turned over to her guru

### Terminology Used in this Report

For the purpose of this report, the term **male sex worker (MSW)** refers to sex workers who were born as biological males but whose gender identity may range from male to female, possibly even falling somewhere on the continuum in between (or outside) the categories of male and female.<sup>1</sup> The term **transgender** will be used *in this report only* to refer to biological males who do not consider themselves male, live virtually full-time in female attire, learn ‘feminine’ mannerisms and use female gender markers. Of these transgendered persons mentioned in this study, most, but not all, have been initiated into the hijra community. Thus the term **hijra** is only used for those transgendered persons who are members of the Hijra community.

### Note on Source of Information:

The findings for this study are reported in the section entitled FINDINGS. The information in the sections entitled Background and Cultural Context did not emerge from the baseline, but rather from knowledge gained informally prior to and during this collaboration.

# **I. Executive Summary**

## **1.1 Origin of Collaboration**

The Humsafar Trust (HST) has been conducting outreach with male sex workers on truckstops in Mumbai since 2001. Population Services International (PSI), as part of a USAID -supported project entitled Operation Lighthouse, has also been working on Mumbai truckstops since 2001. Realizing the potential for synergies, PSI and HST began a collaborative pilot intervention in June 2004 with a focus on male sex workers (MSW). As part of this pilot, a baseline study was jointly conducted to gain a deeper understanding of the population. The study was limited to MSW who were based at one of 10 truckstops that make up HST's Truckstop Intervention, supported by Maharashtra District AIDS Control Society (MDACS).

## **1.2 Study Objectives**

The primary objectives of this study were to:

- Establish baseline values for the pilot collaborative project
- Better understand the barriers to health faced by MSW

## **1.3 Notes on Partnership:**

PSI's interest in the collaboration was twofold. First, despite being aware of the MSM within its targeted male populations, PSI had not yet directly addressed MSM issues. Since male sex workers based at truck stops were a group known to offer regular sexual services to PSI's primary target group (truckers and their helpers), it was felt that a more comprehensive understanding of the dynamic of sex work at the sites could result in insight that could facilitate behavior change efforts. Finally, partnering with Humsafar seemed to be an excellent opportunity to gain insight and experience in learning how to effectively reach MSM.

HST's interest in the collaboration primarily stemmed from a desire to mainstream MSM sexual health issues in order to eventually reach more MSM. Humsafar is very active in networking and supporting MSM organizations across the country, but PSI is one of the few NGOs that despite lacking an MSM community base, is still attempting to incorporate MSM concerns into existing projects. Humsafar also saw PSI's VCT clinics as a beneficial addition to their existing network of referral linkages as the clinics were conveniently located.

## **1.5 Structure of the Report**

The following report summarizes the key findings of the study, structured to maximize potential for practical for use by project managers implementing MSM projects.

## II. Key Findings at a Glance

### Demographics of Sample

- 85 % Hijras
- Rs 3000-6000: average monthly income
- 74% literate

### Multi-partner Sex:

- Average of 34 partners in a week.

### Condom Usage:

- Consistent condom use<sup>1</sup> with customers is 74 %
- Consistent condom use with panthis (boyfriends) is 40 %
- Consistent condom use with other non-paying partners<sup>2</sup> is 20%

### Lubricant Usage:

- Despite high levels of HIV awareness, knowledge of lubricant is low (33%).
- Usage of water-based lubricant is almost nil.
- The vast majority (76%) wrongly believe that packaged lubricant will increase chances of condom breakage.
- The vast majority (97%) do NOT understand risks of oil-based lubricants

### STIs:

- 47% suffered from irritable symptoms in the genital area in the last 6 months
- Of that 47% who suffered, 59 percent sought help from private doctors<sup>3</sup>
- Vast misconceptions exist about what types of partners can transmit STIs.
- More knowledge about STIs is associated with the action of visiting private doctors.

### VCT

- 92 % are aware that that HIV tests are available
- 43 % have already been tested for HIV
- 81 % believe it is very important to find out one's HIV status
- 86 % are aware that one cannot tell if a person has HIV by just looking at them
- Higher knowledge levels about VCT are associated with the action of getting tested.

### Support Services

- 92% have sought services for homosexual men
- 75% are aware of services for either HIV positive people or HIV positive homosexuals (specifically)
- 89% are aware of the Humsafar Trust, with much less awareness of other services

### Stigma

- 96 % understand there is no need to keep a distance from HIV-positive people

---

<sup>1</sup> “Consistent condom use” was defined as those who reported that they “always” used condoms as opposed to “sometimes” or “never”.

<sup>2</sup> Project staff and MSWs report that police and thugs roaming the area often demand free sex from MSW.

<sup>3</sup> It was not possible to tell if these private docs were qualified practitioners or not.

- Stigma does not appear to be a major barrier to either seeking STI or HIV services
- This group does not report any maltreatment at the hands of service providers.

#### **Exposure to the Intervention**

- 97 % spoke to an HST outreach worker in the last month on condoms
- 85% spoke to an HST outreach worker in the last month on STIs
- 94% spoke to an HST outreach worker in the last month on HIV/AIDS
- In addition to meeting outreach workers, other sources of information include:
  - **Condom use:** posters/billboards (90%), condom demonstrations (88%)
  - **STIs:** posters/billboards (58%) and leaflets (50%)
  - **HIV/AIDS:** posters/billboards (94%) and radio (60%)

#### **Recipients of Information on HIV**

- 57% are passing on information on HIV they gain to others (non-health workers)
- Main recipients of information are gurus (44%) and friends (22%)

## **III. Introduction**

### **3.1 Vulnerability of MSM & MSW**

Men who have sex with men (MSM) are an underground and underserved population whose sexual health and well-being are a matter of basic human rights. In the context of an epidemic such as India's, still driven primarily by vulnerable groups who are not being adequately reached, the health of MSM is also critically linked to the health of the overall population. Risk of the rapid spread of HIV between males is of serious concern, in addition to the vulnerability of wives and other female partners of MSM. Thus, a well-integrated, extensive effort to reach MSM marks a serious and strategic effort to minimize the devastation HIV/AIDS can bring.

The two main factors that enhance the HIV risk of MSM are high rates of partner change and the practice of anal sex, which is a highly efficient means of HIV transmission. Risk is exacerbated by widespread societal discrimination against homosexuals, forcing MSM to hide their activities and making them more hesitant to seek immediate treatment for sexually transmitted infections.

Effort towards understanding the needs and priorities of MSM and designing appropriate interventions has gained momentum in the last few years. However, until 2003, the National AIDS Control Organization's (NACO) surveillance figures did not make a distinction between different subsets of MSM (ie. Hijra and non-hijra MSM). It was not until 2004 that sentinel surveillance data for MSM were separated, revealing mean HIV positivity rate among "eunuchs"(hijras)<sup>4</sup> to be 49 %, a figure

---

<sup>4</sup> NACO's use of the word "eunuch" is a misleading label because eunuch is defined as "castrated biological male." However, (at least in the case of Mumbai) the secondary sexual characteristics of the individuals labeled as eunuchs by NACO during sentinel surveillance in 2005 were never verified. All cross-dressed MSM who were referred by the Dai Welfare Trust (a community-based organization serving transgender MSM/Hijras in Mumbai) and who consented to participate, were recruited into the study. The majority were hijras, but not all, and their castration status was not determined.

that even surpassed the positivity rates of female commercial sex workers (45 %) in Mumbai. Among IV drug users, the positivity rate was 25 % and among the broader category of MSM<sup>5</sup> it was 10 %. The rates of these four vulnerable groups range from 8 times to 43 times higher than that of the general population (1.13).<sup>6</sup>

### 3.2 Background on Sex Work at Truckstops

Deleted: ¶

As seen above, the HIV positivity rates for female sex workers and that of hijra populations is similar. The most likely explanation for this is that a large proportion of hijras in India engage in commercial sex work (also called “*pun*”) as a means to supplement their traditional ways of income generation, which are *mangti* (begging for alms) and *badai* (receiving payments in exchange for performing/giving blessings at auspicious events such as births and marriages.)

Little is known about the dynamic between female sex workers and male sex workers in areas where they share a similar pool of clients. In Mumbai, transgender sex workers tend to establish themselves in places that are not frequented by female sex workers. An exception to this is in a small number of brothels in the heart of Kamathipura, (Mumbai’s largest red light area) which cater to clients specifically seeking transgender sex workers.

Male sex workers are more commonly found soliciting clients at MSM hotspots (sex sites and pick-up points), along the highways, or at truckstops. Since truck stops tend to be exclusively male environments after nightfall, the sex work trade at Mumbai truck stops is dominated by a variety of MSW, who are both male and female identified. In the case of this study, it was primarily the latter.

PSI’s work with bisexual truckers and their helpers have revealed that while truckers are hesitant to admit a clear-cut preference for male or transgender sex workers, they openly comment on the convenience and reasonable rates for their sexual services. Based on field experience and qualitative research, young, low-income men such as helpers, who cannot afford to pay much money for sex, appear more likely to frequent MSWs, especially if their main responsibility is to guard the truck, limiting their mobility to within the confines of the truck stop.

### 3.3 Need for the Study

Data on MSW populations in India is extremely limited. The Humsafar Trust (HST) had conducted one quantitative survey of truckstop-based MSWs in December 2003.<sup>7</sup> This initial survey was conducted at most of the same sites covered by this study. However, the first survey focused primarily on sexual practices and condom use, and this study examines service utilization, lubricant use, and care and support in more detail. Based on the analysis of these data, HST and PSI hope to be able to pinpoint areas where current outreach strategies can be enhanced. The project’s log frame (**Appendix B**) aims to establish baseline values for future work with MSW, in

<sup>5</sup> In Mumbai’s Sentinel Surveillance individuals were placed into the general category of MSM who were man with same sex behavior who were not full-time cross dressers.

<sup>6</sup> Determined by women who tested positive in antenatal clinics.

<sup>7</sup> Pandya, Sapna and Noronha, Ernest for The Humsafar Trust **A Baseline Understanding of MSM Commercial Sex Activity at Mumbai Truck Terminals**. December 2003.

addition to tracking whether the collaboration between the two organizations turned out to be fruitful.

### **3.4 Rationale of Study Content**

Below is the rationale for the priority areas that were chosen for this study.

#### **Condoms**

Consistent condom use is known to be the most effective method of preventing HIV and STIs and thus a priority for all HIV programmes.

#### **Lubricant**

Lubricant use helps prevent condom breakage and tissue damage during sex. The more tissue damage there is, the greater the potential for fluid and blood exchange. Secondly, use of oil-based lubricants for anal sex is a common practice among MSM populations, which is a concern due to increased chances of condom breakage, possibly rendering condoms ineffective against transmission of disease.

#### **STI Knowledge and Treatment**

A clear understanding of the cause and modes of transmission of STIs are two essential areas of knowledge that are linked to treatments seeking behavior. Those with incomplete understanding of these two factors are less likely to take proper precautions and more likely to self medicate or to choose unqualified practitioners.

#### **VCT**

Voluntary Testing and Counselling (VCT) is not only considered to be a primary HIV preventative strategy but also an important link to essential care and support services for HIV positive people. As a prevention strategy, it gives HIV positive people an opportunity to protect loved ones from transmission of the virus as well as to protect themselves from opportunistic infections. For clients who test negative, the individualized risk reduction session helps them assess their current and future level of risk, thus hopefully leading to safer sex practices.

#### **Care and Support**

Awareness of care and support services offered and a positive attitude towards such services are crucial to enable HIV positive people to get the services they require. Availability and quality of care and support services directly affect utilization of VCT services, as people need to know that someone infected with HIV can still maintain a decent quality of life. Utilization of STI, VCT and care and support services are also heavily affected by the attitudes of service, especially for marginalized populations.

#### **Sources of Information / Adequate Reach**

It is essential to know whether the target group is being adequately covered by the intervention. This ranges from ensuring the regularity of day-to-day contact to checking coverage of key topic areas. As far as HST and PSI are aware, the sex workers in this sample were not covered by any other formal intervention. However, other sources of information, particularly within the peer group, are very influential. Thus, these final questions were an attempt to determine the various channels through which MSW gain information and with whom they share this knowledge.

## IV. Methodology

### 4.1 Study Area and Recruitment

Although the HST/PSI collaboration targeted both MSW and their clients, this baseline study was limited to MSW. The rationale for this decision was that the MSW population is very well defined and the behavior of the sex workers is more important from an epidemiological standpoint. Thus, only those participants were recruited who **exchanged sex for money as their primary mode of income** on one of the following 10 sites where the intervention was taking place:

- Cotton Green                      Sanpada
- Reay Road                              Juhinagar
- Mulund East                              Dahisar
- Mulund West                              Vashi
- Masjid Bandar                              Mankhurd

### 4.2 Questionnaire Structure

The research instrument is a structured, quantitative and qualitative questionnaire of 107 questions (**Appendix A**), designed jointly by PSI and HST. It was adapted from the aforementioned survey of MSW that was conducted by HST in 2003. However, the focus was shifted from cataloging sexual behavior and condom use to an intensified focus on the psychological factors hindering preventive behavior and prompt service utilization. Thus, the primary objective of the current survey was to assess the triggers and barriers among MSW for: condom use, STI treatment-seeking behavior; utilization of VCT services; and utilization of care and support services.

### 4.3 Informed Consent

The following steps were taken by investigators to gain informed consent.

1. The investigator identifies a potential respondent and briefs him/her verbally about the study – its purpose, benefits, and risks – after which the respondent is invited to sign the Consent Form. (**Appendix A**) Consenting respondents are told they would be compensated for their time.
2. The interviews are conducted either at the truck terminal or at a neutral place. The process is stopped mid-way if the respondent requests to discontinue.

#### 4.4 Training of Field Investigators

Four outreach workers on the project were trained as research investigators by PSI's Research Manager to administer the survey. The questionnaire was pre-tested on site and adapted during the pilot phase of the study. Questionnaires were conducted in Hindi and all responses were recorded by the investigators under the guidance of three trained supervisors.

The questionnaire was administered using a non-randomized, "take-all" sampling method intended to cover the majority of the MSWs on the 10 sites. Sample size cluster were predetermined for each site, depending on the target population size available on the site. The desired sample fell between 60 and 84 -- and the achieved sample was 72 MSW. This sample is considered sufficient considering the universe of MSW (on the 10 sites) is approximately 150 MSW (based on estimates from sex site mapping conducted by HST).

#### 4.5 Data Collection and Analysis

The data collection period was 21 days. The responses from the 72 completed forms were then entered into a database and coded by PSI's Research team. SPSS™ software was used for descriptive statistical analysis.

### V. Cultural Context

#### 5.1 Kothi Culture

The word *kothi* is a complex term because it is used as a community marker, gender marker, and sexual role marker. Across most states of India, the word *kothi* is utilized by a diverse population of males with feminine mannerisms and attributes. Some *kothis* consider themselves to be men and some do not. *Khada kothis*, a group who generally dresses in male attire, do not dispute their maleness but use the term *kothi* to indicate their affiliation with other *kothis* as well as to indicate their choice in sexual partners. Other *kothis* are transgender, considering themselves to be a woman trapped in a male body. Though these *kothis* may wear male clothes in public, most of this sub-category of *kothis* would prefer to dress in female attire, if they could do so without facing extreme discrimination. A third category of *kothis* are those who dress almost full time in female attire, and consider themselves to be either female, neither male nor female, with a minority utilizing the term: "transgender"(see section below on the Hijra community).

*Kothi* is also a common term to indicate a person's preferred sexual role as the receptive partner. In Mumbai, *kothis* generally use the term "*panthi*" to refer to their partners, who are expected (or assumed) to take the insertive role. However, some *kothis* assume both the insertive role and the receptive role interchangeably. While in some *kothi* circles there is considerable stigma associated with taking the insertive role, in other groups it is quite acceptable.

Within the *kothi* community, it is common to refer to other *kothis* using female gender markers, even if they are not transsexuals. The use of the female gender markers in

speech is flexible and many *kothis* are accustomed to utilizing both male and female gender markers, depending on the context they find themselves in.

Despite the complicated gender politics of the term *kothi*, from a public health perspective, all kinds of *kothis* fall under the term “MSM” because their biological sex is male (or in rare cases, intersex) and their sexual behavior is primarily sex with other biological males. Furthermore, while some *kothis* do engage in peno-vaginal sex with female partners, they primarily engage in sexual relationships with men. Thus, the kind of risk behavior they engage in is similar to that of any MSM sub-population.

## 5.2 Social World and Peer Networks

To complement this baseline study and as part of this collaboration, PSI/Humsafar recognized the need to gain a fuller understanding of the social and sexual networks that influence MSWs. This information was gathered through the following methods:

- needs assessment of MSW at truckstops
- discussions with HST outreach workers
- anecdotal reports from both PSI and HST outreach teams
- qualitative research findings from prior PSI studies

## 5.3 Background on Respondents

### A: Malishwallahs

*Malishwallahs* are a small subgroup of MSM that constituted four percent of our MSW sample. Most Indian cities have *maalishwallahs*, who also frequently offer sex for a little more than the cost of regular massage. In some cases the offer of sex is covert, where at some point during the massage the client comes to know that sexual services are also available. For others, the massage is simply a cover the sex work.

Some *malishwallahs* are employed in establishments such as health clubs, gyms and salons. Others, such as most of those in this study, are self-employed entrepreneurs who offer massage (and sex) to clients they independently seek out and solicit.

The *malishwallahs* at truckstops usually move along truck routes, offering massage to truckers, cleaners and other transport workers either inside their trucks or in a solitary place.

### B: Non-Hijra Sex Workers

Eleven percent of our sample fell into the category of “Non-Hijra Sex Workers.” By definition, *malishwallahs* could also be included in this category, but they were separated based on the assumption that their lifestyle and identity might set them apart. Non-hijra sex workers included two main categories, *khada kothis* (explained above in Section 5.1) and transgender sex workers who are not part of the hijra community.

From the perspective of the general population, any male who is seen wearing a sari and traveling in the ladies compartment of trains is presumed to be a hijra. However, there is a significant population of sari-clad MSM who have not been initiated into the hijra community, and as a result their life experience is likely to be considerably different from hijras. Some of these MSW may cross-dress only for business

purposes and change into male attire during non-working hours. Unfortunately, it was beyond the scope of this study to probe deeply into the lifestyle of this group.

### **C: The Hijra Community**

The majority of our sample (85%) belongs to the hijra community, a complex hierarchical society in which community members form a bond based on gender identity, socio-cultural links, and economic interdependence. While outsiders tend to assume, based on external appearance, that the hijra community is inherently different from the *kothi* community, in most parts of India, hijras and non-hijra *kothis* use the same, simple term '*kothi*' to identify themselves. There are numerous other terms as well, some of which are chosen by the community members themselves, such as the term *Aravani* in Tamil Nadu, and others which are either neutral or derogatory based on the context in which they are used ( such as *ali* (Tamil Nadu) , *kojja* or .5 (Andhra Pradesh), *chakka*, *gud*, # 6 , *hijri* (Maharashtra and beyond).

In order to join the hijra community, an initiate must devote oneself to the service of the guru. The guru initiates each *chela* (novice) into the community in a ritual ceremony referred to as *reet dalna*. This ceremony formalizes and institutionalizes the bond between guru and *chela* (or mother and child) after which the guru will teach the initiate the ways of the community, including how to assume the role of a woman.

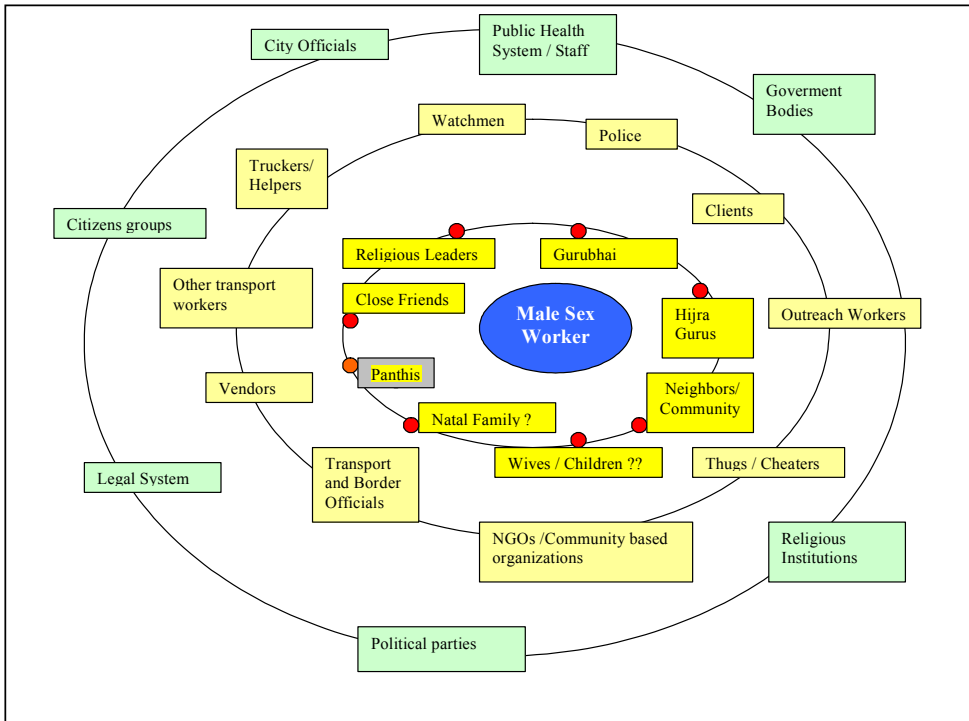
Contrary to public opinion, emasculation (or any other bodily changes) is not necessarily to complete this initiation ceremony. Emasculation is an optional procedure some hijras opt for after taking initiation. Once a *chela* has been initiated, it is understood that the guru will protect her and the *chela* is expected to serve her guru for life. In many ways, this ritual also marks the permanent break between the *chela* and her natal family, as she has now been accepted into a new family.

The assertion of femaleness (or of being part of a third gender) occurs frequently in association with joining the hijra community.<sup>8</sup> Self-identification as female is not dependent on whether one has undergone emasculation (complete removal of male external genitalia) or not. However, the feeling that one is a true female often becomes stronger once a person has become *nirvan* . At that point, a hijra is considered *asli* (real) in the sense of being “a real woman/hijra” and acquires a greater status within the community.

---

<sup>8</sup> This is also true for other transgender individuals or transsexuals who are not part of the hijra community.

**Chart 5.1 Social Network Map**



The above diagram illustrates the types of actors that may make up the social network of the male sex workers based at Mumbai truckstops. The three concentric circles represent degrees of closeness and influence on the lives of MSW. If the MSW happens to be a hijra, the role of guru and *gurubhai* will be very prominent, and if not, this would not be applicable. The role of a MSWs natal family depends on the degree of contact she has with her family. In the case of this particular study sample, only two percent of the sample originated in Maharashtra, but is not known if the MSW migrated to Mumbai accompanied by family, or alone. Similarly, only 13 % of our sample reported that they were married to a woman, so the role of wife and children is not applicable for many. There is some overlap in the terms, such as clients, who are also often truckers and helpers, police, or thugs. Similarly, friends could include any of the above people (MSWs may consider gurubhai, police, thugs, watchmen, vendors, etc. as friends, or enemies!)

**5.5 Background on the Hijra Community**

**A: Role of the Guru**

Because they are situated at the top of the hijra hierarchy, gurus hold immense power over their *chelas*. Most gurus take half of their earnings (referred to as *adwar*) while others take a smaller proportion. In general, a guru assumes the right to live off the earnings of her *chelas* and thus counts on them for support in old age. To avoid

having to turn over such a large percentage of one's earnings, some hijras elect to live independently.

### **B: Role of Gurubhai**

Hijras who are part of the same *gharana*, devoted to the same guru, are called *gurubhai*. *Gurubhai* are important influences in the peer group because many aspects of a *chela*'s daily life are shared with the other initiates. For example, if a person needs to be taken to the doctor, it is often the *gurubhai* who will accompany her. The concept of family bonding is very strong; with *gurubhai* providing financial, emotional and social support to each other. At the same time, tensions between *gurubhai* exist as they would in any closed community. However, for those who have been rejected by their families and communities, the *gurubhai* are the primary source of emotional and practical support.

### **C: The Hijra Community and Religion**

By taking initiation into the hijra community, regardless of one's religious upbringing, the initiate becomes a Muslim. From that time onward, it is obligatory for that individual to cover her head with the edge of her sari or dupatta during *azan* (call for prayer). Some hijras choose to adopt Muslim rituals such as doing *namaz* (prayer to Allah), observing *roza* (fast during Ramzan) or reading the Holy Qu'ran. Many others, however, who were Hindus by birth, continue to worship Hindu gods and goddesses and do not adopt Islamic practices.

Interestingly, despite the Qu'ran's harsh stance towards homosexuality, there is an unusual degree of tolerance within Islam in relation to hijras and other cross-dressing males. This tolerance does not extend to non-cross dressing *homosexual* men or to anyone who speaks openly about homosexuality. Historically, Ajmer Sharif Khwajah Garib Nawaz, one of the major Islamic saints, took a benevolent stance towards hijras, and as a result hundreds of hijras from across the subcontinent visit his tomb annually to offer obeisances. According to one source, "Certain medieval Muslim missionaries in India are claimed to have been 'especially kind towards hijras' and the hijras reply to this with affectionate love up to this day. This is one of the many reasons why the hijras can be found easily at Muslim shrines. [Furthermore,] those who are able to acquire the considerable savings required to make the pilgrimage to Makkah - are treated with a special respect by other pilgrims."<sup>9</sup>

Islam is not the only religion that has a rich history related to gender-crossing males. The Maharashtra-Karnataka state boundary is home to a large Devdasis/Jogta community dedicated to the goddess Yellamma/Renuka. Sex work is an important part of this community's history. Members of such groups can be seen in saris begging at traffic signals or other public spaces with a basket containing the goddess on their heads.

## **5.6 Social Environment and Stigma**

---

<sup>9</sup>Hijras and Islam in India. <http://www.geocities.com/leylasuhagi/hijraislam.html>. Accessed Dec 26, 2003.

A large proportion of the MSWs from this study live in slum colonies. According to Humsafar's outreach team, the discrimination MSW face within these low-income neighborhoods is much less than what they encounter from middle-class communities. Possible reasons for this greater tolerance were believed to be the following: those living in slums have more exposure to each other's lives, the poor are more accustomed to adjusting to situations (and neighbors) beyond their choosing, and the poor have a stronger belief in the genuine power of hijras to bless or curse.

Thirteen percent of MSWs in the sample reported living at home with their parents. According to Humsafar/PSI outreach workers, in many cases the parents are unaware of that their son is selling sex for a living. However, some parents of MSWs *are* aware of their son's occupation and despite this, accept his lifestyle (mainly) because of the financial support he offers to the family. However, the support tends to evaporate the minute the money stops coming in. This can be disastrous for those MSWs who become sick and can no longer maintain their previous income to support themselves and their families.

This multiple stigmas faced by MSM and their families includes:

- Appearance (if their appearance reveals a visible identity, (eg hijra/effeminate)
- Occupation (if it is known that they are sex workers)
- Marital status (particularly if they are unmarried or divorced)
- HIV status (if it comes to be known)

## 5.6 Other Important Actors in the Lives of MSW

### A: Panthis

*Panthis* is a broad term that can be loosely translated into "real man" or "the one who penetrates." It is also used by *kothis* to mean "my husband" or "my man." The men who become *panthis* to MSWs are usually a former customer who turns into a regular customer, following which a deeper relationship develops. Some MSWs live with their *panthis*, but in this study, only 13 percent of the respondents reported such a living situation.<sup>10</sup> As mentioned in Section 5.1, although it is common for *kothi*-identified MSW to take the receptive role in anal sex, this is not always the case. This implies that some panthis occasionally take the receptive role as well, though they may not like to admit it. Evidence suggests that MSWs who are willing (and able) to penetrate clients are sometimes able to earn more money for this 'extra' service. This could include any MSW who are not *nirvan*.

The average MSW-Panthis relationship is a complex, negotiated exchange of emotional, sexual and financial needs. In a concurrent needs analysis conducted by PSI / HST with the same target population as this current study the most frequent response to the following three questions was, "my *panthis*."

- What is the most important thing in life? ( 55 % )
- Who do you spend most of your time with? ( 62 % )
- What is the biggest threat to your life and work? (33 %)

---

<sup>10</sup> Since 85 % of this sample was part of the Hijra community, it is no surprise that over half of the respondents reported living with their guru.

The answer to the third question was somewhat surprising, and further explanation for this response is required. Humsafar outreach workers claim that it is common for *panthis* to exploit MSWs in various financial, emotional, and physical ways as they are the power holders in the relationship. However, financial arrangements vary, and in some cases, *panthis* are the ones who give MSWs money and gifts. If this is the case, MSWs usually opt to retain several *panthis* from whom they can elicit various benefits and favors.

The biggest public health concern related to *panthis* is that once the relationship is properly established, condom use drops or declines significantly. This is despite the fact that in most cases, both partners understand the fact that neither of them are monogamous, as the MSW relies on customers for survival and her *panthi* is considered to be the kind of man who reserves the right to have sex with anyone, male or female, as the need arises. One limitation of this study was that reasons for low condom use with *panthis* were not explored in enough depth. However, outreach workers report the following commonly cited reasons related to low / no condom use with *panthis*:

- a. **Mera pati hai, uskesaath condom kaise istemal karte hain?** (*He's my husband. How can I use a condom with my husband?*)
- b. **Maza nahin aata hain** (*There is no pleasure with condoms*)
- c. **Dusron ke saath condom istemal karte hain, iskesaath koi zarurat nahin**(*I use condoms with all others so there is no need to use condoms with him*)
- d. **Man nahin karta.** (*I don't (or he doesn't) like wearing condoms*)

## **B: Customers and Cheaters**

Customers of MSWs cut across the socio-economic spectrum, however the majority of customers of MSWs based at Mumbai truckstops are either truckers/transport workers or men from the general population who frequent the truckstop at night. Clients also include thugs and “cheaters” who threaten MSWs and profit from forcibly extracting money and/or sex from them, thus they often fall into the category of *mufatkor* (person who takes free sex.)

## **C: Police**

The police are well connected with the MSWs at Mumbai truckstops. They regularly extract *hafta* (weekly bribes) from the MSWs and because of this regular supplement to their income, they don't generally harass the sex workers for money or threaten to take them to the lockup. Some police establish friendly relations with MSWs and even provide a measure of protection from thugs and cheaters, but they also feel entitled to have free sex with MSWs. Thus, there is some overlap between the police and the category of *mufatkor*.

## **D: Health Care Providers**

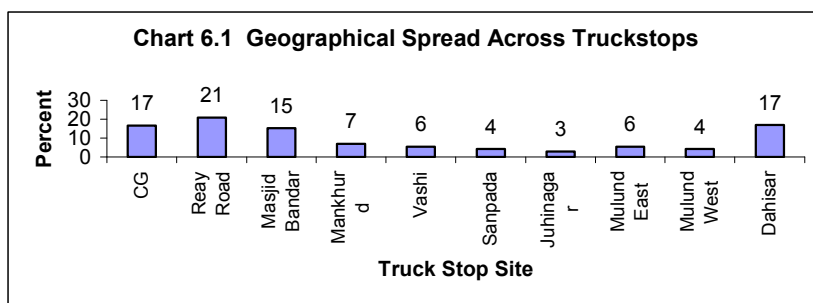
Most health care professionals (both in the private and public sector) are not sensitized or trained to work with the health concerns of sexual minorities, especially transgender people. Discrimination exists in the denial of care or provision of sub-

optimal care, verbal abuse/humiliation and neglecting to ask appropriate questions when taking sexual history.<sup>11</sup> The health care system is also extremely insensitive to the important issue of alternate family structures and the rights of visitation of non-blood relations. Though the problems of accessing care did not emerge from this particular baseline, more extensive qualitative research would uncover a more realistic picture that shows major barriers to accessing timely health care.

## VI. RESULTS AND IMPLICATIONS

### 6.1 GEOGRAPHICAL SPREAD

- Respondents for the survey were recruited from the following ten sites, which are spread over a huge geographical area from Masjid Bunder in South Mumbai to Dahisar in North Mumbai to Juhi Nagar in New Mumbai.



- The majority of MSW reported that they were born outside of Mumbai (82%). The following illustrates the place of origin for MSWs.

**Table 6.1 Place of Origin**

State	%
Andhra Pradesh	48
Tamil Nadu	25
Calcutta	10
Karnataka	8
Madhya Pradesh	3
Delhi	2
Maharashtra	2
Uttar Pradesh	2

### Implications

- Since the largest concentration of MSW can be found at four interstate trucking hubs Reay Road, Dana Bunder, Cotton Green and Dahisar truck stops, additional outreach workers could be placed on those beats.
- With 73 % of the sample from Andhra Pradesh & Tamil Nadu, and with 10 % from West Bengal and 8 % from Karnataka, recruitment of outreach workers with

<sup>11</sup> Put Venky's website address

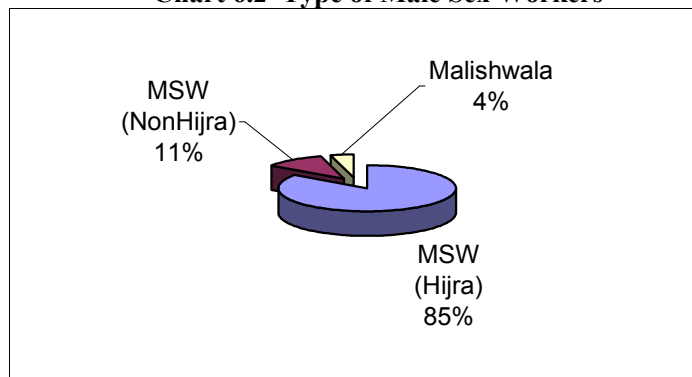
appropriate language skills should be considered. Utilization of IEC materials in Telegu, Tamil, Kannada and Bengali may be more appropriate and could result in increased impact.

- Networking with CBOs serving MSWs in Andhra, Tamilnadu, West Bengal and Karnataka, to share strategies and learnings would also be fruitful.

## 6.2 TYPES OF MSW

- There are three types of MSWs: hijras, non-hijra MSM, and *malishwallahs*. (See Section 5.3 for detailed descriptions.) The majority of MSWs in this study considered themselves part of the hijra community.

**Chart 6.2 Type of Male Sex Workers**

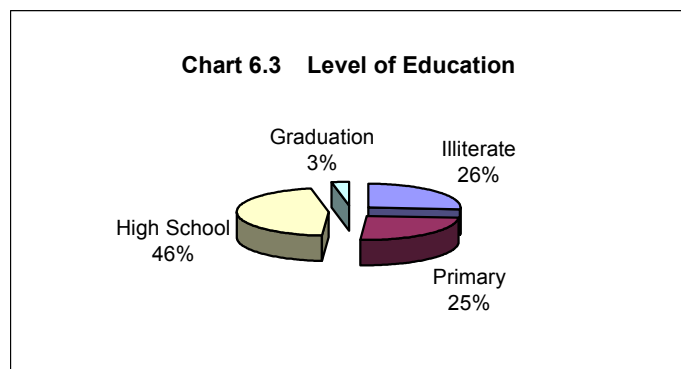


### Implications:

As 85 % of the MSW are hijras, a better understanding of the community's social structure, views towards safer sex practices, and preferences in terms of health facilities would be beneficial.

## 6.3 EDUCATIONAL ATTAINMENT

**Chart 6.3 Level of Education**



- Although 26 % reported they were not able to read or write their own name in their own language, 74% of the respondents were literate.

## 6.4 SOURCES OF INCOME

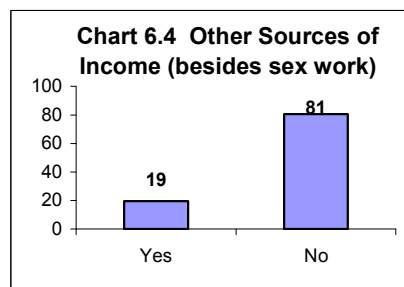
93 % of the MSWs sampled report having a monthly income less than Rs. 6000.<sup>12</sup>

**Table 6.4 Average Monthly Income**

Income in Rs.	Percent
Less than Rs. 3000/-	39
Rs. 3000/- to 6000/-	54
Rs. 6000/- to 12000/-	6
Rs. 12000/- to 15000/-	1
<b>Total</b>	<b>100</b>

- Eighty-one percent of the respondents have no other source of income besides sex work. Of the 19 % who reported another source of income, nearly 60 percent of those reported *mangti* (begging) as the other occupation. A negligible proportion had other jobs such as carpentry or part-time work as a watchman.

### Implications



- The other reliable sources of income are very scarce, which most likely translates into near total dependence on income from sex work. Those MSWs who for various reasons (visible signs of poor health, age, etc) are not able to secure enough clients in a day would be in a weaker position to reject clients who refuse to use condoms

### 6.5 MARITAL AND RELATIONSHIP STATUS

- Only 13 % of respondents stated that they were married to a woman.

**Table 6.5a Marital Status**

Married to a Woman?	
Yes	13 %
No	88 %

- Over half the respondents stated that they live with their guru, followed by parents or “with my panthi.”

<sup>12</sup> This question did not capture how many dependents they are supporting on their income, or whether this figure is reported before or after the guru is paid.

**Table 6.5b Living Situation**

Living with...	Percentage
Guru	53
Parents	13
Panthi	13
Alone	11

**Implications**

- Since 53% of the MSW report that they live with their guru, there are strong reasons to scale up advocacy efforts and community based efforts with the gurus and *gurubhai* in the residential areas where they stay.
- Though it is difficult to reach *panthis* as they are generally not on the truckstop, effort should be continued to learn more about them, interact with them, and encourage MSWs to refer *panthis* for treatment and testing.

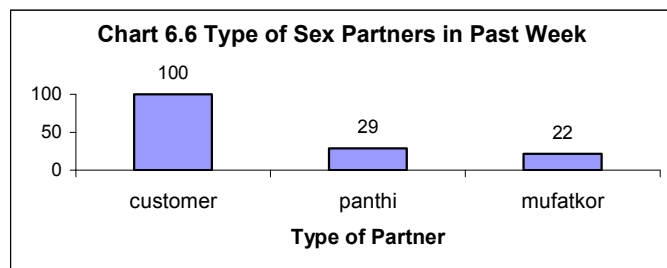
**6.6 SEXUAL BEHAVIOR & CONDOM USE**

- MSWs reported an average of 34 different sexual partners per week. The following depicts the different types of partners they reported having in a week.

**Table 6.6: Number of Partners**

Mean Number of Partners per Week	
<b>Customer</b>	29
<b>Panthi</b> (boyfriend)	2
<b>Mufatkor</b> (takes free sex)	3
<b>Total</b>	34

- To gain knowledge about frequency that the MSW met the different partners, survey participants were asked which kinds of sexual partners they had in the last week. All 72 MSWs reported having had sex with clients in the last week. Twenty nine percent reported having been with their *panthi*(s), and 22 % reported having had sex without getting paid (with someone besides their

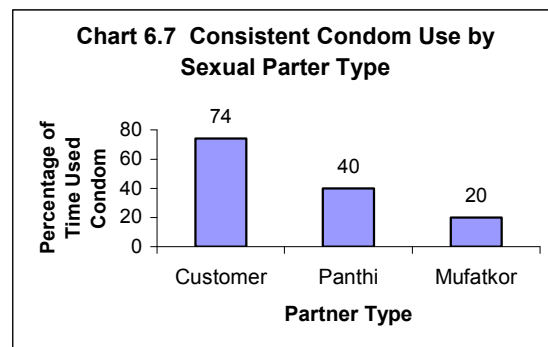


*panthi*)

## 6.7 CONDOM USE

**Condom use at last sexual encounter with a customer: 93 %**

- Ninety-three percent of respondents stated that the last time they had sex with a customer, they used a condom. Since not all respondents had sex with *panthis* or *mufatkor*s in the past week, the sample was too small to obtain an accurate number for “condom use at last sexual encounter” for the other types of partners.



- The question used to determine consistent condom use was: “How often do you use a condom with “x” type of partner?” The following chart shows the proportion of MSW who responded: “I always use a condom.”
- Therefore, although 91% reported using a condom with their last customer, consistent with customers is much lower at 74%. The marked drop in consistency with the other partners is dramatic: only 40 % for *panthi* and 20 % for *mufatkor*.

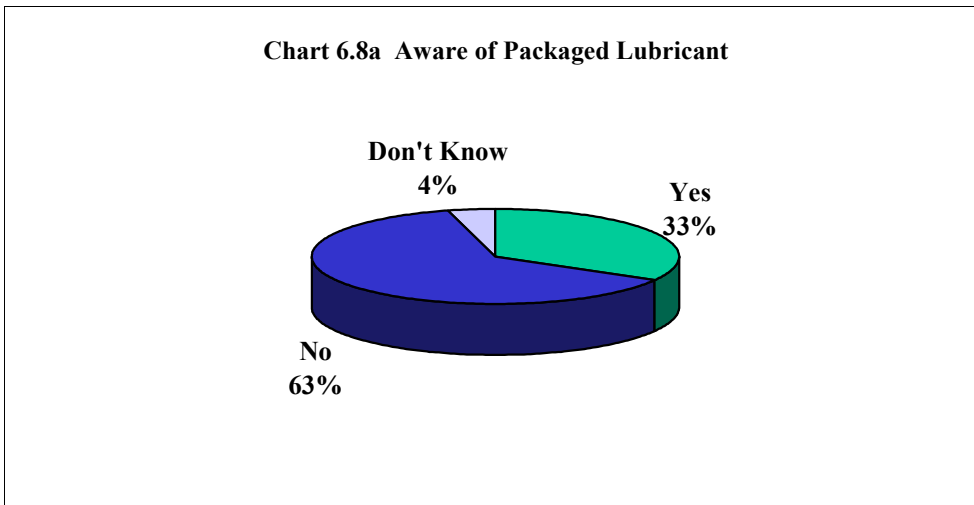
### Implications

- These data confirm the hypothesis that most MSW have more than one *panthi*.
- Even if consistent condom use with customers is high at 74 %, the fact that MSW are taking an average of 29 customers a week indicates that the effort to continue increasing consistency of condom use is still required.
- Condom use among *panthis* and *mufatkor*s indicate that both MSWs and their non-paying partners are at extremely high risk for HIV infection. As both types of partners are hard to reach and to convince, intensive work with MSWs and negotiation skills may be the best way to ameliorate this problem.

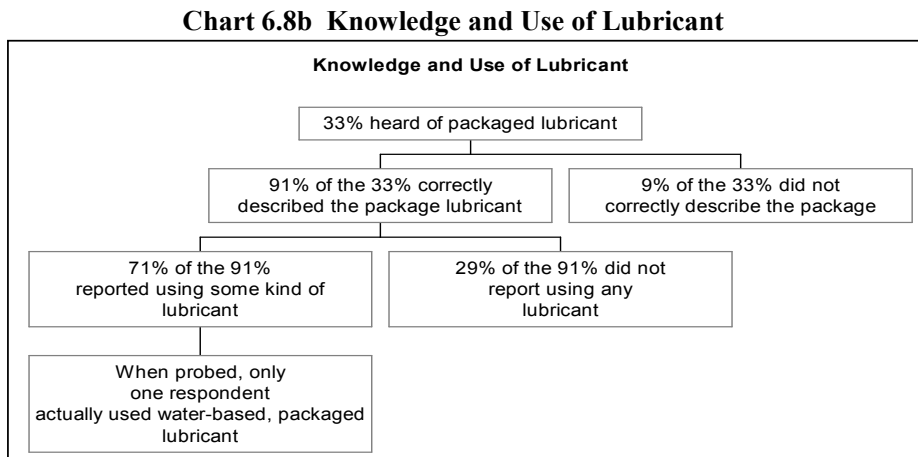
- Not enough is known about the circumstances in which the *mufatkor* demands free sex. In order to address this issue, more investigation would need to be done to find out if these sex acts are completely non-consensual, which would indicate an alarming weekly incidence of rape on the truckstops, or if free sex is an agreed upon between MSWs and *mufatkor*s as a form of payment for some kind of favors.

## 6.8 LUBRICANT KNOWLEDGE AND USE

- All 72 participants were asked if they had ever heard of some kind of packet containing lubricant (local terms: *chiknai* and *jelly* were used) Only 33% (n=23) said that they had heard of it.



- Of the 33 % that had heard of it, 91% (n = 21) could correctly describe the correct packaging. Among those with the correct knowledge, most of them reported using some kind of lubricant, but when probed further, only one respondent reported using a packaged lubricant.



Concern over the prevalence of the use of oil-based lubricants led to the addition of the following two questions in the survey. These question were used to check the target groups understanding of appropriate lubricants to be used with condoms.

**Table 6.8 Misconceptions about Lubricant**

Statements about Lubricant:	% who gave the <b>correct</b> answer	% who gave the <b>incorrect</b> answer
Using oil and cream as a lubricant will increase chances of condom breakage	3 (yes)	97 (no)
Water-based lubricants will increase chances of condom breakage	24 (no)	76 (yes)

### Implications

- Much work is required to increase awareness of proper lubricant, make it available at a reasonable cost, and encourage its use.
- Responses to the last two questions (above) revealed widespread misunderstandings. The target population needs to be informed of the increase chance of condom breakage as a result of using oil-based products as a lubricant.

### 6.9 KNOWLEDGE OF STIs

Knowledge:

- All respondents said that they believe it is important to get STI treatment from a qualified practitioner.<sup>13</sup>
- Only 44% of respondents correctly answered both of the following questions on STIs: **1)** If you forget to take a few pills in the treatment course, your STI will not get completely cured; and **2)** One must complete the course of medicines even if the symptoms vanish before the course is complete.
- Overall, less than half of the respondents correctly answered the questions related to modes of STI transmission. This question was asked to the 50 respondents who had heard of STIs or were familiar with the symptoms of STIs.

**Table 6.9 Knowledge of STI Transmission Routes by Partner Type**

Sexually transmitted infections can be passed from...	% of respondents who <b>correctly</b> responded to the statement
Men to women	32
Women to men	42
Men to hijras	54
Hijras to men	32
Men to men	38

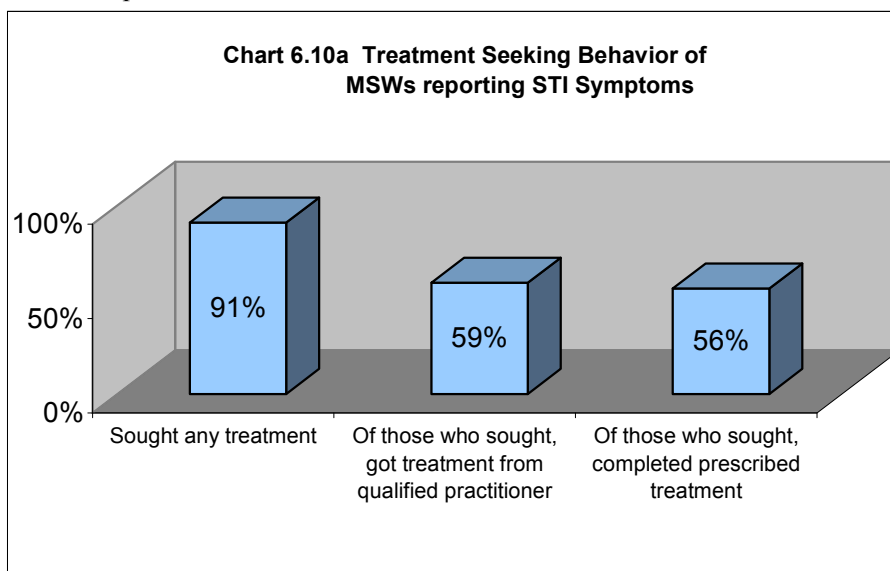
<sup>13</sup> A qualified practitioner was defined as a doctor who has undergone training in a medical school.

## Implications

- Responses to the question on modes of transmission in relation to different types of partners is puzzling and requires further investigation, especially when the overall level of knowledge appears to be high among this group.
- For those who do seek STI treatment from qualified doctors, it is vital that outreach workers spend time discussing the importance of antibiotic treatment completion to reduce chances of resistance.

### 6.10 STI TREATMENT-SEEKING BEHAVIOR

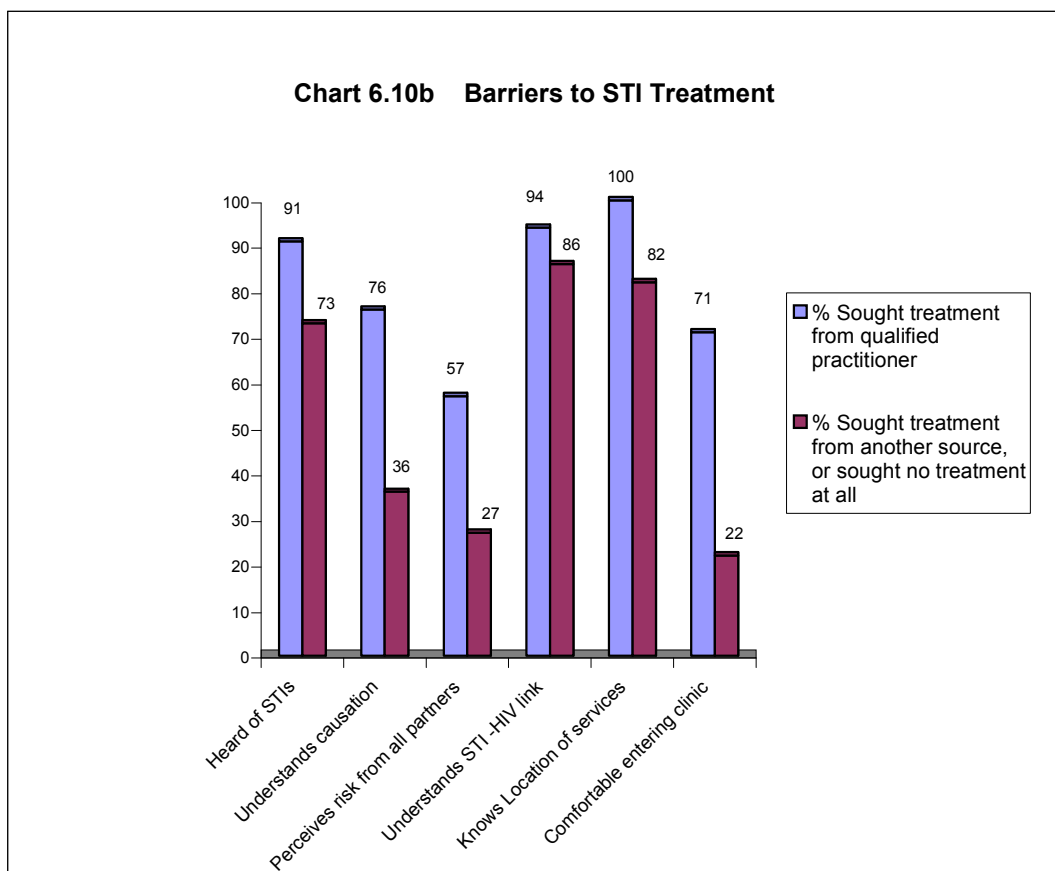
- Forty-seven percent of respondents reported suffering from some kind of uncomfortable symptom(s) in the genital/anal area in the last 6 months. This was used as a proxy measure for having an STI.
- Of those reporting symptoms, 91% reported trying to do something to treat the problem. This group included home remedies, over the counter medications and seeking help from unqualified practitioners. Of that group, only 59% sought treatment from a qualified practitioner and 56% stated they completed the prescribed treatment.



- There were very few open-ended responses given by those who did **not** seek treatment from a qualified practitioner. Those replies included:
  - I felt shy
  - My guru gave me medicines
  - There was no time

### Implications

- Without clinical data it is difficult to come to any conclusions other than the fact that this population frequently experiences irritable symptoms in the genital/anal area. With almost half of the target group reporting (probable) STI symptoms in the past six months, doubts can be cast on actual consistency of condom use.
- MSW seem to understand the need to go to qualified doctors. However, actual health-seeking behavior shows a considerable amount of self-medicating for STIs as well as advice-seeking from unqualified persons (chemists, roadside doctors, and friends) More effort is required to encourage MSW to choose reliable doctors.



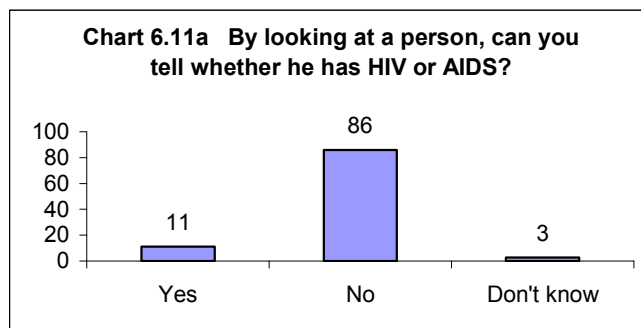
- Knowledge and attitude indicators of those who had not sought STI treatment from a qualified doctor were noticeably different than knowledge and attitudes of those who had chosen qualified doctors. This is most dramatic in two knowledge areas: knowledge that one acquires STIs through the sexual route and knowledge that one can get STIs from any type of partner. There is also a dramatic difference in comfort levels related to entering STI clinics among those who seek proper treatment and those who do not.

### Implications

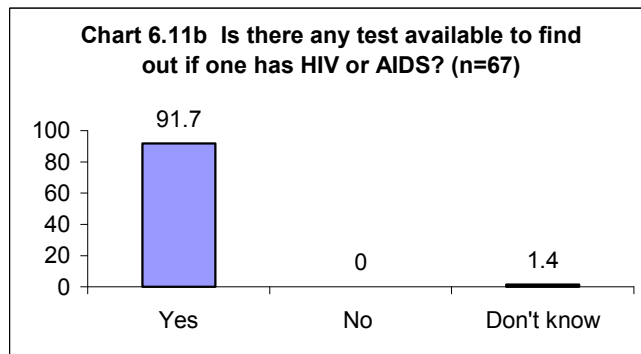
- Energy invested in clarifying misconceptions about STIs seems to pay off as higher knowledge levels seem to be associated with appropriate treatment-seeking behavior.
- An ongoing effort will be required to reduce inhibitions and discomfort related to seeking STI treatment and creating services that are genuinely friendly to MSM and transgender clients.

### 6.11 KNOWLEDGE AND ATTITUDES ABOUT HIV/AIDS AND VCT

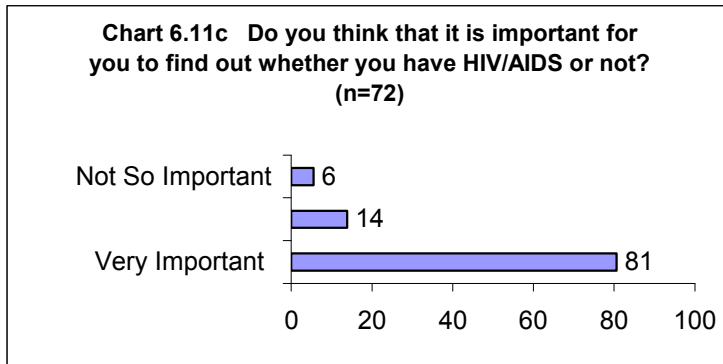
- When asked if one could tell by looking at a person if they have HIV, the majority (86 %) correctly answered “No.” Fourteen percent said either “Yes” or “I don’t know.”



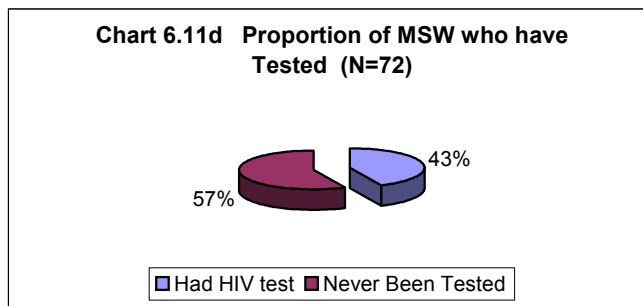
- Almost all respondents were also aware of a test that one can take to find out if one has been infected with HIV.



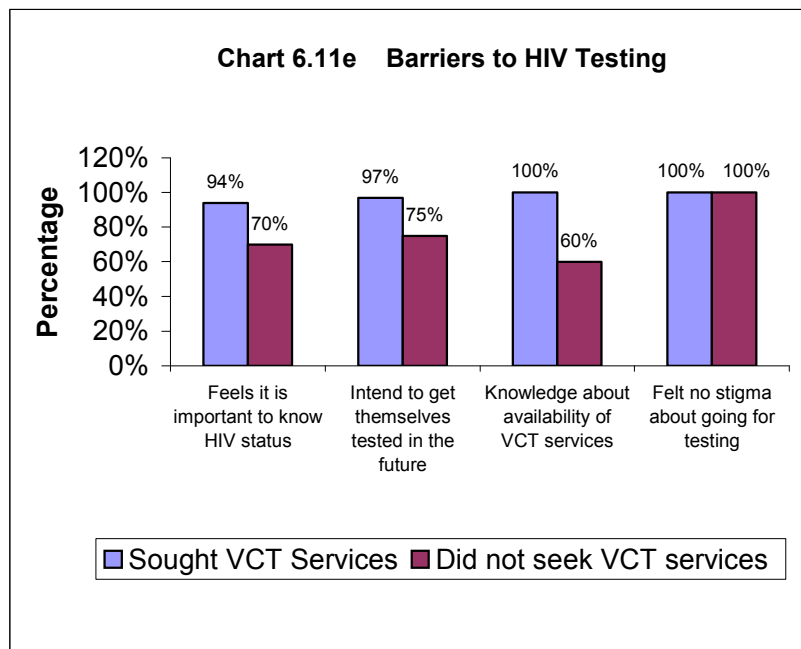
- Eighty one percent of the respondents also felt knowing one’s HIV status is very important.



- Forty-three percent of respondents reported having had an HIV test.



- Of those reporting having had an HIV test, 70% said that they were pleased with the quality of the services in terms of cost, waiting time, and nature of the workers. Places listed where tests were taken include: The Humsafar Trust; PSI; and private hospitals.
- Significant differences are seen in attitudes towards VCT, intention to get tested and knowledge of location of VCT between those who had been tested before in the past and those who had never been tested.



### **Implications:**

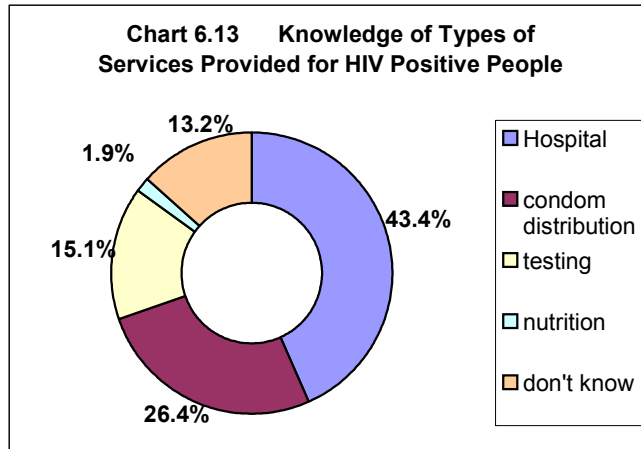
1. Knowledge and attitude levels are in accord with behavior change communications goals.
2. Understanding of the asymptomatic nature of HIV is high among MSW
3. Knowledge levels about HIV testing is high and a significant proportion have been tested. Those who have tested are reporting a higher likelihood to retest than those who have never tested.
4. VCT is perceived to be personally relevant to the target population but more effort should be made to enhance felt demand for VCT.
5. Energy must be spent to ensure that all MSW know **where** VCT is available as this knowledge appears to correlate with getting tested.

### **6.12 KNOWLEDGE OF SUPPORT SERVICES**

- Ninety-two percent of respondents stated that they have sought services for homosexual men.
- Seventy-five percent of respondents positively when asked if they knew of organizations that help either HIV positive people **or** HIV positive *homosexual* men.

### **6.13 KNOWLEDGE OF SPECIFIC SERVICES IN MUMBAI**

- Spontaneous knowledge about location of services for care and support provided by **The Humsafar Trust** was high (89 %).
- Spontaneous mention of **Dai Welfare Trust**, a community based organization serving the Hijra community, was 6%.
- Participants had to be probed further to find out if they had ever heard of **Safe Sailors' Club** (a branch of Humsafar serving HIV positive MSM) and **Sion Hospital** (one of Humsafar's main public hospital linkages.) After probing, 29% of respondents said they had heard of Safe Sailors' Club and 45% had heard of Sion Hospital.
- When asked what types of services these organizations provided for HIV positive people, respondents listed the following (n=53):

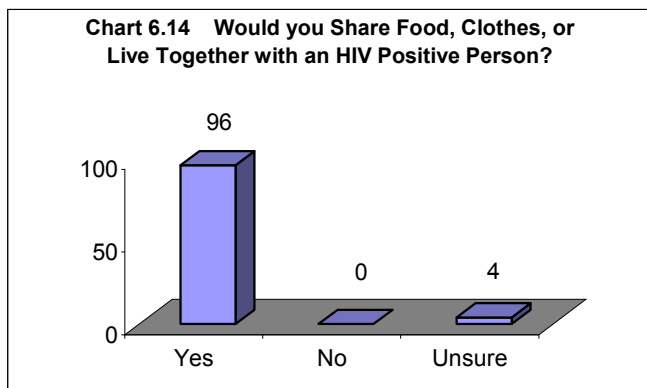


**Implications:**

- With 89 % of the sample claiming they were familiar with services available for homosexual men, it indicates that word of mouth among closed communities is working effectively to link MSM with services.
- Awareness of The Dai Welfare Trust was lower than expected since Dai claims to work exclusively for the Hijra community.
- Respondents show a fairly accurate understanding of what Care and Support organizations offer (hospitals, condoms, testing) but there is no mention of medicines/ARVs and awareness of nutritional support needs to be bolstered.

**6.14 STIGMA**

- Ninety-six percent of respondents reported that if they came to know that a friend were infected with HIV, they would not have any problems sharing food or clothes with him or staying together. The remaining 4% said, “I don’t know.”



- When asked why they felt comfortable about close proximity to positive people, respondents made comments such as:

- Because this disease is spread by unprotected sex and not by eating food.
- Because I know how HIV passes and how to protect myself from it.
- This disease doesn't spread through touch.
- We don't get AIDS by having food together.
- Because he is also a human being.
- Because he is known to me.
- Because if we discriminate against our own people, so will the society.
- Because today he has, tomorrow I may get.

**Implications:**

- The MSW in this study show a remarkable level of clarity and lack of stigma vis-à-vis HIV positive people. This can be used to the benefit of any program seeking to promote care and support services, voluntary testing and counseling, or build peer education programs.

**6.15 EXPOSURE TO HIV INTERVENTIONS**

- MSW seem to be regularly accessing information related to condom use, STIs, and HIV/AIDS by Humsfar Trust outreach workers.

**Table 6.15a Exposure to Information on HIV**

	Topic Areas		
	Condom	STI	HIV/AIDS
Discussed with (Humsafar) health workers in last month	97	85	94

- The following charts illustrate the various types of exposure respondents have had to messages on condom use, STIs and HIV/AIDS:

**Chart 6.15b: Condom Messages Received in Last 6 Months**

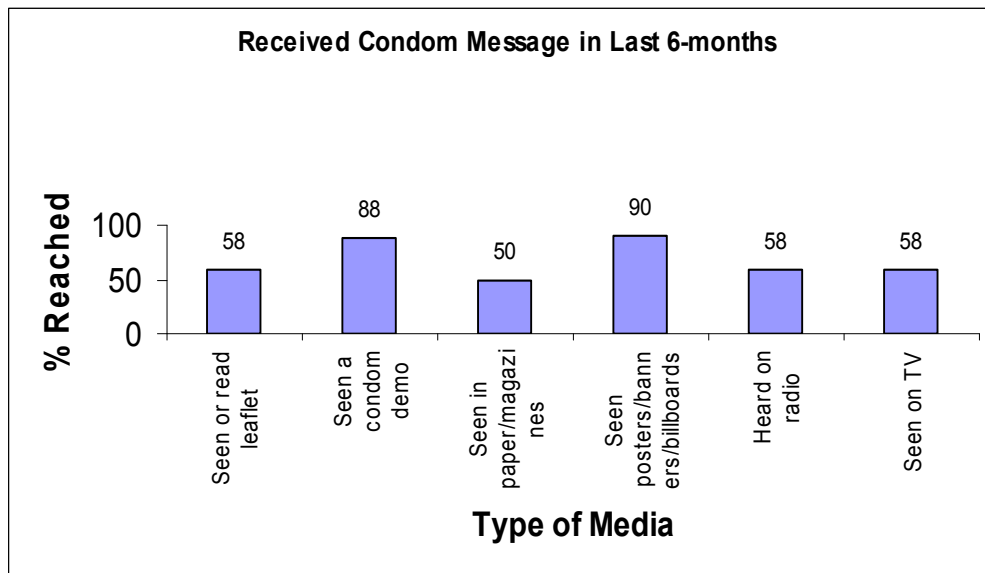


Chart 6.15c: STI Messages Received in the Last 6 Months

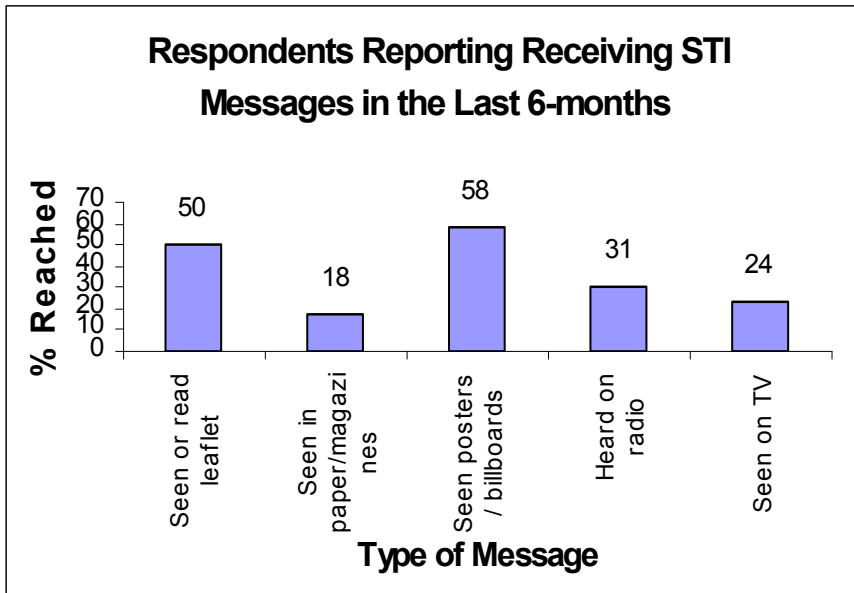
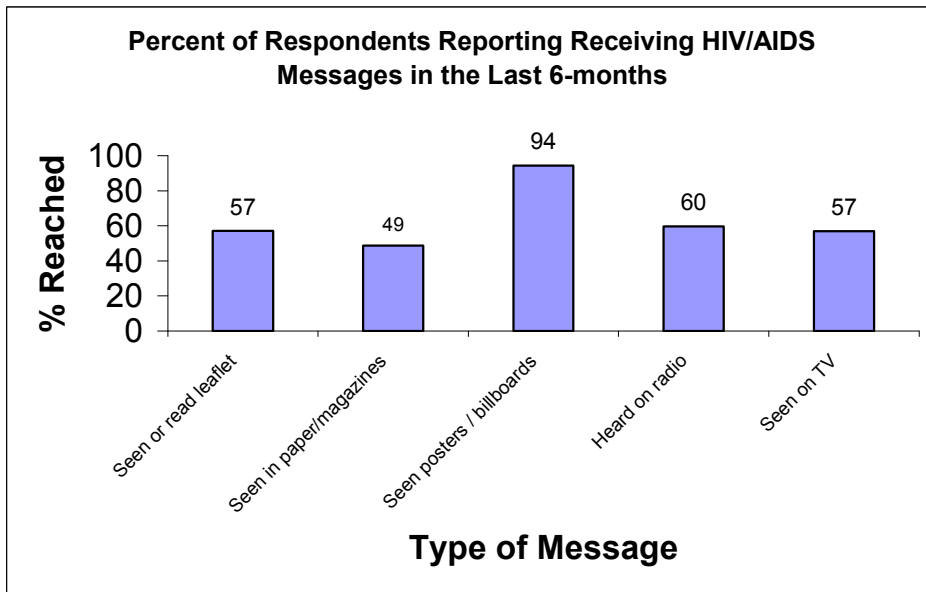


Chart 6.15d HIV/AIDS messages received in the last 6 months

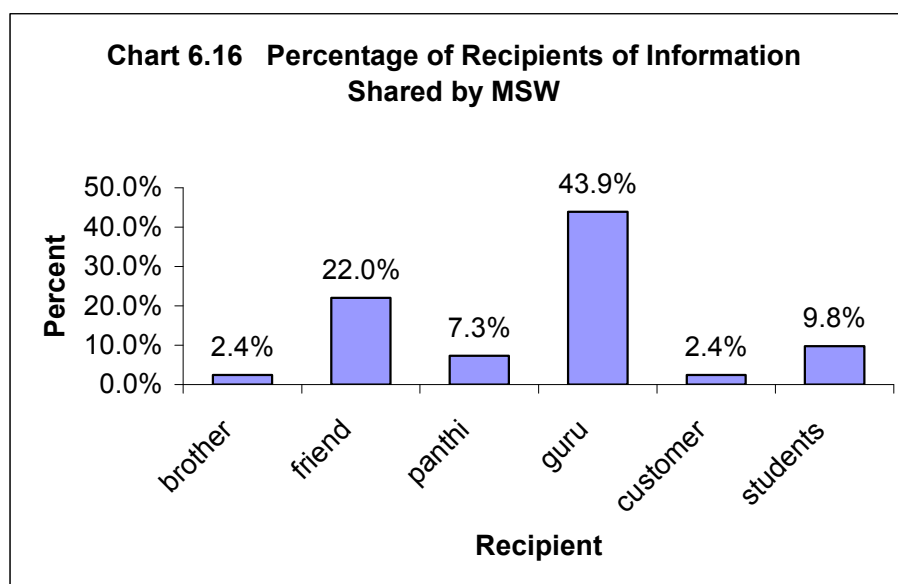


### Implications:

- Outreach should continue as before, as it is probably the most important method of gaining information and getting personalized questions answered.
- Posters and Billboards are the most commonly reported medium through which sexual health messages are reaching the target population. Radio and TV are other important channels, with radio slightly surpassing TV.

### 6.16 RECIPIENTS OF INFORMATION ABOUT HIV/AIDS

- When respondents were asked if they shared any information that they learned about HIV/AIDS with others, 56.9% (41) said they had shared information. Of those who have shared information, the table below indicates with whom they shared that information.



### Implications:

- Gurus are the main recipients of informal HIV/AIDS information from the MSW, a surprising finding considering their seniority over the MSW. However, since gurus are not accessible by most NGOs, it is understandable that they may need information.
- Information passed by social networks is an important channel that must be taken into consideration, demonstrating a need for a well-supported peer education program.

## VII. PRIORITIES FOR INTERVENTION

The top priorities emerging from this study are as follows:

**Condom use**, despite being reported as very high between MSW and customers, still needs to be vigorously promoted due to extremely high partner turnover. (34 partners/week) Of particular concern is the very low reported condom use between MSW and their *panthis* and *mufatfors*, who tend to emerge from the same pool of men as the customers.

Knowledge of **water-based lubricant** is extremely low, so outreach workers will need to spend more time and energy promoting it and making it readily available. MSW seem to be at the very early stages of behavior change with regards to lubricant, as opposed to high levels of acceptance of condoms. **STI knowledge** is generally high, but more emphasis needs to be placed on clarifying causation and the fact that STIs can be passed via any type of partners. **STI treatment seeking** is a priority that requires more attention, primarily to promote qualified practitioners and to discourage self medication or going to untrained providers. Establishing the understanding that untreated STIs increase risk of HIV is perhaps one way to encourage prompt treatment.

In the area of **Care and Support**, updated information about services and medications available should be disseminated and discussions can be opened up about the practicalities of seeking help.

## VIII. AREAS FOR FURTHER INVESTIGATION

- Condom negotiation with customers
- Variation in condom use depending on partner and type of sex
- Panthi-MSW relationship and condom use
- Context Panthi-Mufatkor relationship. Is it forced or negotiated non-paid sex?
- How to replace demand for oil-based with demand for water-based lubricants
- Barriers and triggers for actual utilization of care and support services among MSW?

## IX. CONCLUSIONS

The findings of this study, particularly if examined along with the Humsafar Trust's December 2003 survey on male sex workers, helps paint a more complete picture of the world of sex work conducted on truckstops. One of the things that emerged from these two studies is that this particular group of MSWs has an extraordinarily high level of knowledge related to HIV/AIDS. They have clearly accepted the need to use condoms and are serious about protecting themselves. In addition, many of them seem to understand the value of VCT as and even pay regular visits to VCT centers.

Their self-protective behavior is of vital importance as most of them have no other alternative source of income

me to enable them to survive. Furthermore, with 34 partners a week, their professional life is akin to a game of Russian roulette. Their partners, particularly those men who refuse condoms, are also at very high risk, as these sex workers will most likely to continue seeing clients as long as their health status permits.

As opposed to many other high risk groups, in this sample there is no denial about the severity of HIV. While knowledge is high related to HIV, prompt and professional care of STIs is an area that needs more attention. Despite knowing that one should visit qualified doctors, the tendency to try to address the problem using quick-fix solutions remains a barrier. Currently it seems that STIs are viewed, as they are by most sex workers, as a simple occupational hazard.

The level of awareness and compassion for people living with HIV/AIDS strikes a positive note in contrast to the irrational fears and hostility that is commonly found related to PLHA.

MSW make up a group that has been hit brutally by HIV/AIDS. Their support system is primarily their own tightly-knit community that holds onto itself when the rest of the world is hostile or indifferent to their existence. The comment “Today he has, tomorrow I may get” reveals an acute awareness of the personal threat HIV poses to an individual in this line of work. Everything that can be done to help strengthen this community and support its members in their struggle for survival and maintenance of good health should be done.

- X. APPENDIX A: Survey Questionnaire**
- XI. APPENDIX B: Logical Framework for the Collaboration**
- XII. APPENDIX C: Findings of Needs Analysis of MSW and Truckers and Helper clients of MSW**