

Thoughts, '98

April 1998

I am sitting in a park in Delhi, talking to a group of male sex workers who operate there. Using condoms? Sometimes. STD symptoms? Sometimes. What? Problems *pichche* - in the backside. What do you do? "I wash it in dettol" one says. "I go ask the pharmacist for anti-biotics" another says. "It goes away eventually", a third says. Another states that he goes to a street doctor - a quack- and gets some sort of medicine from this man.

Another park, another city. So many places across India and Bangladesh, and no doubt the same in Pakistan and Nepal. "Why don't you go to a proper STD doctor?", I ask. The response is the same. "How? How can I tell the doctor I have problems in my anus? What will he think of me? Maybe he will tell the police, or my family?"

Another common statement. "I went once and told the doctor what was the problem. He called me *harami* (a bastard), that I was a bad person, and refused to see me."

And where to go? The cost? "Who will treat me with respect?" How far away is it?

"I have never asked about anal sex of any of my patients" a doctor at an STD clinic tells me. "How can I? It is just too shameful."

"I don't know anything about rectal gonorrhoea or other anally transmitted STDs" another states. "We were never taught anything about them."

In South Asia, one of the major patterns of male to sexual encounters is that of the *khoti* and *giriya/panthi*. The penetrated and the penetrator. Some *khoti* can experience several penetrations in one day, where we have found *khoti* sex workers having anything up to 20 male penetrating partners in a day. No condoms, no lubrication, rapid penetration leading to bleeding, quick ejaculations.

But what services for STD treatment exist that cater for the specific sexual health needs of these anally penetrated males? None.

The *giriya/panthi* can always go to a clinic and blame a female sex worker for any penile discharge or other STI symptom. And many do. But for the *khoti*, whose

symptoms are primarily anal, where can he go, when anal sex is stigmatised, illegal and creates shame and dishonour, not only for the *khoti*, but also for the physician.

Recently I received a copy of the Indian National AIDS Control Programme booklet on "simplified STI & RTI treatment guidelines" for syndromic analysis. Unpleasant looking photographs of a range of STD symptoms and flow charts to indicate investigation and treatment. Nicely produced in English aimed at NGOs and clinics. working in the field of STI prevention and reproductive health.

I showed this booklet to a number of HIV/AIDS NGOs, international agencies, as well as individuals working in the field, and asked the simple question - "What is missing from this document?" Not one answered appropriately.

And what was missing? There was absolutely nothing referring to anal sex. Not one word. Nothing on rectal discharges, piles, warts, lesions. Nothing. Anal sex does not exist in India.

Not that the surrounding countries in the South Asia region are any better. Nothing exists there either.

The majority of the *khotis*, whether they sell sex or not, will be married or intend to get married. This means that not only are the *khotis* at risk from being infected with STIs/HIV through their penetration by the *giriya/panthi*, they may also infect the *giriya/panthi*, and thus infect wives with a potential impact on children yet to born. And we also know anal sex between males and females is not uncommon also!

This is not an insignificant problem either. In Dhaka, the local msm project has estimated some 5-10,000 male sex workers, with an average client range of 3-5 per day. The numbers of other *khotis* has been estimated at over 100,000. All urban centres have such male to male sex networks. Anal sex is a significant behaviour pattern not only between males, but also between males and females. And yet - silence.

In the South Asia region there are no condoms appropriate for anal sex, except perhaps those that are imported through friends or are too expensive (such as Durex Ultrasafe) for the ordinary person. There is no water-based lubricant (except KY in tubes - which is also too expensive for the ordinary person) in suitable packaging.

And amongst these male to male sexual networks involving *khotis* and *giryas/panthis*, there is no sense of community building so as to be empowering towards developing their own service provisions.

Apart from Humsafer Trust in Mumbai, Naz Foundation India Trust in New Delhi, Bharosa Project in Lucknow, Praajak in Calcutta, and Bandhu Social Welfare Society in Dhaka, and with new initiatives developing in Chennai and Cochin, nothing is being done even towards addressing the issues raised by these behaviours. In a region of some 1.4 billion people!

What is needed

Who should provide such services? How do we get over the shame issues? Who can the *khotis* trust? And what services should be provided?

1. education and awareness

What is the point of knowing that AIDS is a dreadful disease if you know nothing about HIV? Education programme that are cognisant of the reality of male to male sexual behaviours and dynamics are urgently need. Designed and delivered by *khotis* themselves. Peer education. Peer support. Peer mobilisation.

But education programmes should not only be for *khotis* and *giryas/panthis*. They should also be for NGOs working in the field of reproductive and sexual health, government and private institutions, policy makers, human rights agencies, street children projects, sex worker projects, schools, colleges, universities.

2. easy access to cheap and appropriate condoms and lubricants

Experience has shown in a broad range of settings that *khotis* and *giryas/panthis* do not purchase condoms at the currently available outlets to any great extent. This is due to the shame involved. And anyway, appropriate condoms for anal sex, nor lubricants, are not available.

The region needs to develop such appropriate products cheaply and in quantity and distribute them effectively. Who would be the most effective distributors? I think the *khotis* themselves would be the most appropriate personnel. They socialise with other *khotis*, they know the *giryas/panthis*, the places where males meet other males. They understand the sexual dynamics and have experience of the issues that confront their lives.

Similarly for water-based lubricant sachets. They could be indigenously produced and distributed through similar distribution networks.

Example: an NGO working with males sex workers takes condoms to a park where there are significant numbers of *khotis* and *giryas/panthis* and where they are successfully sold. BUT... it is only when they are directly available in this manner do the *khotis* and *giryas/panthis* buy them. They don't buy them outside the park. The rest of the week, these males do not access condoms. This is after 2 years of work amongst them!

3. Community building

How do we endeavour to enable regular condom usage for anal sex become a normative behaviour? What strategies are needed? Should't we be looking at increasing peer support development strategies? Enabling and empowering *khotis* to support themselves and other *khotis* within their social/friendship networks? Using the spaces already used by *khotis* to meet and socialise, and to meet *giryas/panthis*, which are primarily public environment such as park, transport terminus, and such like?

This would mean extensive development of community-building strategies. Providing access to support and socialisation mechanisms that increase self-esteem and empowerment through vocational training, savings and loan mechanisms, meeting spaces outside of sexual environments, and so on.

4. STD treatment services

Certainly the need for appropriate and confidential services are urgently apparent, but how should these be delivered? Fixed sites? Mobile services? Referrals? Ownership of the services themselves? A mixture of all of these?

And what about the wives and other female sexual partners of both *khotis* and *giryas/panthis*? How to access them should they become infected by them? Compulsory client notification? Approaching the wives of these males? Of course not. Such approaches who ensure that no-one will approach the service.

So what can be done? Perhaps educating women's sexual health projects on the issues of male to male sex and anal sex. Perhaps working closely with women's agencies in developing partnerships to work together on addressing the impact of these male sexual behaviours on women. Perhaps ensuring that education for these males deals with all issues of infection, re-infection, cross infection and treatment compliance. Perhaps all these things and more.

All this will be difficult to implement. Who wants to deal with these behaviours? How do we deal with the shame and illegality? What will happen to the family if it is found that a member is also having male to male sex? A husband, a son, a brother. An uncle, brother-in-law, cousin?

5. Advocacy

Male to male sex is prosecuted under a range of laws, including section 377 which speaks of "carnal intercourse". How to address the issues of client support, education and prevention, when we are dealing with illegal behaviours. What about blackmail? Harassment or violence committed against *khotis*? Who can they go to for support? How will human rights issues be addressed? Is distributing of condoms amongst males who have sex with males a legal activity? Will outreach workers and peer educators be harassed by police, by local thugs, by *giryas/panthis*? What can be done about this?

There are so many issues that need to be explored and addressed if effective prevention work amongst males who have sex with males is too be addressed. Work that needs to be done in its own right.

What we have discussed above is just the broad frameworks of *khotis* educating *khotis* and *giryas/panthis*. *Khoti* owned projects and services. Beneficiaries of change acting as agents of change.