I. THE CURRENT SITUATION

Epidemiology

- Pakistan does not have an official size estimate for the MSM and TG population. In 2007, 19,320 male sex workers (MSW) and 14,725 hijra (transgender/TG) sex workers were mapped. However, combined, this is only approximately 0.08% of the adult male population aged 15-49. (References: 16,27)

- In 2007, the lifetime prevalence of male same sex behavior was 3% with non-commercial partners and 1% with male sex workers. 3% of the adult male population aged 15-49 is approximately 1,279,575. (7)

- There is no national prevalence estimate for MSM in Pakistan. In 2010, the prevalence among male and hijra sex workers (combined) was 3.55%. In 2007, among male sex workers, the prevalence was 1.95% and it was 2.05% among hijra sex workers. The prevalence was higher among those aged over 25 years as compared to those under 25 years. (15,28)

- In 2008, surveillance found that HIV prevalence was 3.1% among MSW in Karachi, and 27.6% among hijra sex workers in Larkana. Earlier surveillance had found 7.5% for MSW and hijra sex workers in Karachi, 2.5% for MSW and 14% for hijra sex workers in Larkana, and 2% for hijra sex workers in Hyderabad. (1,16)

- The estimated HIV prevalence among MSM and TG sex workers was approximately 2 times higher than the general prevalence rate of less than 0.1% in 2007 (or 64 in 100,000). (15,18)

- STIs are common among MSW and hijra sex workers. In 2008, 58% of 409 hijra sex workers had STIs. 38% of these had multiple STIs. The most common were syphilis (50%) and gonorrhea (18%). (8,13,20)

Behaviour, Knowledge and Social Research relating to HIV

- In 2005-06, behavioural surveillance found that 58% of MSW and 31% of hijra sex workers in Karachi had had over 20 partners in the previous month. In Hyderabad, these figures were 97% of MSW and 8.1% of hijra sex workers. (3)

- In 2005, it was reported that 91% of hijra sex workers and 92% of MSW had ever engaged in anal sex. In 2006, 38% of MSW reported receptive anal sex and 44% reported insertive anal sex; while 87% of hijra sex workers reported receptive anal sex. In 2007, 88% of 200 hijras in Lahore had anal sex with a male in the last month. (9,14,19)

- UNGASS reports stated that the proportion of male and hijra sex workers (combined) who had used a condom at the last occasion of anal sex increased from 24% in 2007 to 33% in 2009. Other studies have found: less than 22% used condoms at last anal sex with paying clients; 22.9% of hijra sex workers used condoms at last anal sex; 18% of hijra sex workers used condoms at last anal sex with a one-time client and 15% with a regular client. (3,8,19,20,28)

- In 2008, of the hijra sex workers who had sex with non-paying clients, 89% never used condoms at the last occasion of anal sex. (8)

- In 2008, 24% of MSW consistently used condoms with male clients. In 2005 in Rawalpindi, 3.1% of MSW and 4% of hijra sex workers consistently used condoms in the past month. Second round surveillance found 7.7% of MSW and hijra sex workers (combined) consistently used condoms in the last month. (3,16,19)

- In 2007 and 2008, 7-8% of hijras had sex with a woman in the past year. (8,19)

- In 2008, over 40% of MSW paid a female sex worker for sex in the past month. (16)

- Males who sell sex to other men also buy sex from women, and hijras who sell sex to men also buy sex from male sex workers. In 2007-08, 9.5-15% of hijra sex workers paid a man for sex. (8,19)
PAKISTAN

MSM Country Snapshots – Country Specific Information on HIV, men who have sex with men (MSM) and transgender people (TG)

- UNGASS reports indicated that the proportion of MSW who had been tested for HIV in the previous year and knew the result was 4.5% in 2008 and 7.9% in 2010. The proportion for hijra sex workers was 9.1% in 2008 and 12.05% in 2010. (15,28)

- Second round surveillance showed that 13% of MSW and 13.6% of hijra sex workers knew where they could be tested for HIV. (3)

- In 2010, the UNGASS report stated that 31.35% of male and hijra sex workers could correctly identify ways of preventing sexual transmission of HIV and rejected major misconceptions, increasing from 21.15% in 2008. In 2008, 61% of MSW knew that condoms prevent the transmission of HIV. (15,16,28)

- It has been reported that many men who buy and sell sex do not believe anal sex is a form of sex, and therefore, protective measures are not needed. (18)

- In 2008, 94% of hijra sex workers could identify a condom, but 42% felt they never needed one. Only 1% carried a condom. (8)

- It has been reported that hijra sex workers have better awareness of STIs than MSW, and tend to get treated more often when they get infected with an STI. For example, in 2005 in Rawalpindi, 79% of MSW and 88% of hijra sex workers sought treatment. (3,20)

- Regarding treatment seeking behaviour, hijra sex workers went to: private clinics (51%), traditional healers (10%), pharmacies (4%) or government clinics (4%). 37% never sought care. (8)

Legal Situation and Law Enforcement Authorities

- Sex between men is illegal under Section 377 of the Penal Code. (24)

- Sex work is illegal. (6)

- In 2009, the Supreme Court ruled that TG/hijras should have equal rights. (24)

- In 2006, it was reported that MSM/TG and HIV workers face problems with law enforcement authorities. (17)

- The legal system has been classified as “prohibitive in high intensity” and “highly repressive” for MSM/TG in two UN legal reviews. (5,24)

MSM Community, other Social Research and Stigma/Discrimination

- There is very little published information about the MSM and TG community in Pakistan.

- The MSM category many different identities, including: hijras, who identify themselves with the female gender and take the receptive role in anal sex; zenanas, who believe they are women trapped in men’s bodies and are often married to women; chavas, who identify with the female gender and may switch roles in anal sex; giryars, who take the role of the husband to hijras and zenanas; and maalishias are males who are masseurs by profession, sell sex to men and identify with the male gender. (18)

- MSM and hijras experience a great deal of stigma and discrimination in Pakistan. This includes: discrimination in the health system, high levels of rape and beatings, physical abuse, and sexual violence or coercion. (4,8,16)

- Stigma is cited as a key reason why working with MSM, MSW and hijra is difficult, and that the above factors limit the ability of hijras to negotiate condom use. (1,8)
II. THE RESPONSE TO HIV

Government Response

- There is a specific program line and a budget line for MSM/TG in the national strategic plan (NSP). (12)
- In 2006, it was reported that 2% of the budget was allocated for MSM/TG, but that only 42.3% had been implemented. (17)
- For MSM, the NSP includes: outreach activities, peer education, behavioural change communication, condom promotion, VCT and STI diagnosis and treatment. (12)
- The NSP sets a target of 60% of MSM accessing HIV prevention services by 2012. (12)
- Services are delivered by national and international NGOs, not by community-based organisations. (17)
- The current NSP ends in 2012. (12)
- Pakistan has received funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria, but in 2006, it was reported that no funds had been ear-marked for MSM activities. (17)
- Pakistan is also part of the successful Naz Foundation International multi-country Round 9 proposal, focusing on South Asian countries. The focus will be on strengthening existing organisational capacity to work with and advocate for MSM/TG, and then to establish 6 local CBOs. (16)
- In 2006, it was reported that the Pakistan Country Coordinating Mechanism for the Global Fund had no MSM representation. (17)
- In its UNGASS reports, the Government of Pakistan reported only on male and hijra sex workers rather than on MSM generally. (2,15,28)
- In 2006, it was reported that there was no MSM-related leadership or spokespeople in Pakistan. (17)

Community-based Response

- In 2006, it was reported that MSM are informally organised, with 2 to 3 social groups, but no community organisations or NGOs. It was stated that networks of hijras do exist. (17)
- In the Naz Foundation International multi-country proposal to the Global Fund in 2009, it was stated that there was "no real HIV-related service provision by MSM, TG and HIV-related CBOs". (16)

Strategic Information

- In 2006, it was reported that there is ongoing research on MSM and TG in Pakistan. (17)
- It was also reported that MSM are included in the surveillance system (with 9 cities in 2005) and that behavioural surveillance included MSM. (17)

III. THE RESULTS

Coverage of HIV prevention

- In 2010, 11.7% of male and hijra sex workers under 25 years old and 15.3% of male and hijra sex workers over 25 years old were reached by prevention activities. (28)
- In 2007, 2.2% of MSW under 25 years old and 4.3% of MSW over 25 years old had been reached; while 6.9% of hijra sex workers under 25 years old and 8% of hijra sex workers over 25 years old had been reached. (15)
- In 2006, the UNAIDS Global Report stated that 22% of MSM had been reached by prevention activities. (23)
- In 2006-08, it was reported that 13% of MSW had been reached. (26)

Resource Estimation and Gaps

- In 2006, it was estimated that USD $24 million would be needed to achieve 60% coverage with peer education, outreach, VCT, and condom/lubricant distribution. (11)
IV. RECOMMENDED RESPONSES

List of recommended actions

• Remove laws impeding effective HIV prevention, including laws prohibiting male-male sex and those affecting sex workers.

• National strategic plan should include a costed comprehensive response for MSM and TG.

• Advocate for the inclusion of MSM in HIV strategies at the state level.

• More systematic and regular surveillance of HIV rates, risk behaviors and MSM communities.

• Fully fund prevention programs, including condom and lubricant provision, peer education and outreach, community development, mass media, and individual counseling.

• Develop the capacity of MSM community-based organizations to provide advocacy and peer-based programs.

• Scale up MSM-friendly VCT and sexual health screening centers.

• Expand care, treatment and support facilities for HIV-positive MSM and TG.

• Address stigma and discrimination toward PLHIV in MSM communities.

• Specific prevention activities should focus on transgender people.

V. REFERENCES

All references are available at:
www.apcom.org/snapshots2010.html

Contact details of UNAIDS office in Pakistan are available at:

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