I. THE CURRENT SITUATION

Epidemiology

- It is estimated that the size of the MSM/TG population in India is 2 to 2.5 million. (References: 1,14,29)

- HIV sentinel surveillance found HIV prevalence of 7.3% among MSM in 2010, down from 7.4% in 2007. (14,29,40)

- In HSS 2008/9; HIV prevalence among MSM was more than 5% in 27 out of 60 valid sites; while in 2007 it was higher than 5% in 19 out of 37 valid sites. (45)

- Andhra Pradesh, Maharashtra, Manipur, Gujarat and Tamil Nadu have HIV prevalence of more than 10% among MSM in some sites. (45)

- In 2007, HIV prevalence estimates in MSM included: 5.6% in West Bengal, 6.6% in Tamil Nadu, 7.4% in Orissa, 7.9% in Goa, 8.4% in Gujarat, 11.7% in Delhi, 11.8% in Maharashtra, 16.4% in Manipur, 17% in Andhra Pradesh, and 17.6% in Karnataka. (2)

- In 2007, specific cities showed higher prevalence rates among MSM, including: 14% in Gujarart, 19.2% in Bangalore, 23.6% in Pune, and 32.8% in Delhi. (28)

- The estimated HIV prevalence among MSM and TG was 20.6 times higher than the general prevalence rate of 0.36% in 2007. (1,14)

- A small 2009 clinic-based study of 75 MSW in Mumbai, found HIV prevalence to be 33%. (42)

- In 2006, 41% of MSM had at least one symptomatic STI in the previous 12 months. (35)

Behaviour, Knowledge and Social Research relating to HIV

- In 2003-04, a study of 6,661 MSM in urban areas in Andhra Pradesh found that the average number of male partners in the last month was 6 men. (8)

- The same study found that in the last 3 occasions of sex with a male, 92% of MSM reported anal sex at least once. (8)

- In 2010, condom use at the last occasion of anal sex with a male was reported by 57.6% of MSM in Manipur and 48.9% in Tamil Nadu. In 2007, 50% of MSM reported this (ranging from 13% to 87%). (28,40)

- In 2007, 27% of MSM consistently used condoms in the last 6 months. When having sex with commercial partners, 41% in Delhi and 64% in Kolkata consistently used condoms in the last month. In 2009, a clinic-based study of 75 MSW, found that a third always used condoms and 53% used them occasionally. (13,38,42)

- Consistent condom use with paid male partners from BSS 2009 remains low in Karnataka at 35%; it was reported at 54% in Tamil Nadu; 72% in Uttar Pradesh and as high as 95% in Andhra Pradesh. This shows an increase in all stated compared to the previous round of BSS except for Karnataka. (45)

- In 2009, a study of 150 MSM in Mumbai found that of those engaging in insertive anal intercourse, condoms had been used in 63% of their encounters in the last month. Those engaging in receptive anal intercourse reported condom use in 95% of encounters. (41)

- In 2009, 35.9% of 210 MSM in Chennai had ever paid another man for sex. (34)

- In 2009, 46.3% of MSM in Tamil Nadu had been tested for HIV in the last 12 months and knew the result, compared to 2007, when 35% of MSM had been tested (ranging from 3% to 67%). (28,40)

- In 2009, the levels of testing for HIV according to the BSS were at 9% un Uttar Pradesh; 7% in Manipur; 54% in Karnataka; and 83% in Andhra Pradesh . (45)

- In 2010, 39.4% of MSM could correctly identify ways of preventing sexual transmission of HIV and rejected major misconceptions (ranging from 17.4% to 56.7%). In 2007, the figure was 45% (ranging from 16% to 75%). A 2010 study conducted in Mumbai, showed that although only 27% of respondents had an accurate understanding of what HIV was, they had high levels of awareness about HIV transmission routes. (28,40,43)
• The 2009 round of BSS also reported low levels of comprehensive knowledge about HIV among MSM including, 21% in UP; 30% in Manipur; 32% in Tamil Nadu; 22% in Karnataka; and 57% in Andhra Pradesh. (45)

• In 2009, a study of 210 MSM reported that psychosocial problems such as depression were related to ongoing HIV risk and HIV infection. (34)

• BSS 2009 reported levels of ever married MSMs at 45% in Uttar Pradesh; 11% in Manipur; 25% in Tamil Nadu; 34% in Karnataka and 47% in Andhra Pradesh. (45)

Legal Situation and Law Enforcement Authorities

• Sex between men became legal in 2009 when the High Court of Delhi ruled Section 377 of the Indian Penal Code unconstitutional. (26,36)

• Sex work is legal, but most related activities are illegal, such as selling, procuring, exploiting for commercial sex or profiting from the prostitution of another. (12)

• Laws that discriminate on the basis of sexual orientation are not permitted by the Constitution of India. (36)

• India does not recognise a “third gender” but there is piecemeal recognition. For example, voters can register as a “third sex” (since 2009), and female passports can sometimes be given to hijras. (36)

• Many reports of MSM, TG and HIV workers facing problems with law enforcement have been documented. A study in 2007 found that 48% of 301 kothis had been harassed by police because of having sex with males. Beatings and blackmail attempts by police have also been reported. (4,15,18,26)

• Legal reviews conducted by the UN reported that prior to the High Court of Delhi decision, India’s legal system was classified as “prohibitive in high intensity”. However, after the decision, it was classified as “moderately repressive”. (5,36)

MSM Community, other Social Research and Stigma/Discrimination

• There is very little published information about the MSM and TG community in India.

• Few MSM in India use the Western “gay” identity. They more commonly identify as hijra (transgender), kothi (feminine and sometimes cross-dressing MSM), or as straight men. The kothi call the “straight” men who have sex with men panthi. (6)

• MSM and TG experience stigma, discrimination, harassment and violence. (39)

• A 2010 study of 274 MSM in Mumbai indicated that only 10% would break off a relationship if one partner was diagnosed with HIV. (43)

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) 2006-2010. (15)

• As of January 2010, 132 targeted interventions for MSM/TG are contained in the NSP (10% of interventions), along with another 220 composite interventions. The National AIDS Control Organisation planned to allocate USD $30,000 for each targeted intervention. (15,44)

• By Year 5 of the NSP, it aims to reach 1.15 million MSM, or 50% of MSM at “particular risk of acquiring or transmitting HIV”. (29)

• The NSP does not discuss improving the capacity of MSM CBOs, and does not address stigma and discrimination. (29)

• The current NSP ends in 2012. (15)

• India has received funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2006, it was reported that no Global Fund funds were ear-marked for MSM. However, in the Round 9 Global Fund proposal, there is a strong emphasis on building MSM CBO capacity and increasing coverage to MSM/TG. This will include setting up 90 new drop-in centers, conducting peer outreach, responding to violence, behavioural change communication, life skills, STI referrals, support groups and condom distribution. (14,15,29)

• India is also part of the successful Naz Foundation International multi-country Round 9 proposal, focusing on MSM in South Asian countries. The focus will be on strengthening the Naz Foundation International India to improve and scale up, as well as develop behavioural change communication and advocacy materials. (29)

• In 2010 and 2008, the government reported on all 5 of the UNGASS indicators directly relevant to MSM. (1,40)

• In 2006, it was reported that there is local MSM-related leadership and spokespeople in India. (15)

Community-based Response

• MSM are formally and informally organised, with CBOs, programs and social networks. (15)

• Nationally, it has been reported that there are approximately 90 to 100 MSM or TG CBOs. (14,15,36)

• In 2009, the Global Fund Round 9 proposal identified a further 110 areas where MSM CBOs are needed. (14)
• MSM/TG CBOs conduct a wide range of HIV-related activities and services, including: peer outreach and education, drop-in centres, condom and lubricant distribution, social marketing, health counselling, community awareness events, advocacy, peer support for PLHIV, VCT clinics, and STI clinic and VCT referral. (3,15,35)

Strategic Information
• There is ongoing research on MSM in India, conducted by academics, the government, NGOs and CBOs. (15)
• MSM are included in the surveillance system. (45)

Health System
• It is not clear if there are MSM-specific clinics run by the government.
• The Humsafar Trust runs MSM-friendly VCT and STI clinics. (35)

National and International Networks
• India has more than one network at the national level for MSM/TG: the India Network for Sexual Minorities (INFO SEM), the National MSM and HIV Policy, Advocacy and Human Rights Network, and Voices Against 377. (36)
• India is included in the South Asian MSM and AIDS Network. (36)

III. THE RESULTS

Coverage of HIV prevention
• There are a range of coverage estimates. In 2009, the government reported that the 90 existing MSM CBOs cover about 16% of the MSM population and the 2009 BSS Manipur showed coverage of 18.1%. The overall BSS showed a range of 1.8-63.4% coverage. (14,40)
• Other estimates include: 4% of 950,000 MSM in 2005; 45% in 2005-06; 57% in 2007 and 78% in 2010. (1,27,28,33,44)
• In 2009, 25.8% of 210 MSM in Chennai had participated in an HIV prevention program. (34)
• NACO reported that by January 2010, 78% of their targeted MSMs (275,000 out of 351,000) have been reached. (45)

Resource Estimation and Gaps
• In 2006, it was estimated that USD $175 million would be needed to achieve 60% coverage of MSM with peer education, outreach, VCT, and condom/lubricant distribution. (25)

Effectiveness of prevention efforts
• In a study of 210 MSM in Chennai, it was reported that participating in an HIV prevention program increased the likelihood of using condoms for anal sex. (34)
IV. RECOMMENDED RESPONSES

List of recommended actions

- 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 India are available at: