

HIV/AIDS among men who have sex with men and transgender populations in South-East Asia

THE CURRENT SITUATION AND NATIONAL RESPONSES



**World Health
Organization**

Regional Office for South-East Asia

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Preface

An assessment of the current situation of HIV/AIDS among men who have sex with men (MSM) and transgender (TG) populations and the national responses was undertaken by the WHO Regional Office for South-East Asia. The countries assessed are Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

Same-sex behaviour is identified in all societies, irrespective of whether same-sex sexuality is openly acknowledged, not talked about, or actively denied. There are an estimated 4–5 million men who have sex with men (MSM) in the South-East Asia Region, while the number of those considered to be transgender (TG) is largely unknown due to limited data. MSM and TG populations in most countries of the Region are highly stigmatized, discriminated against, and often socially excluded. As with other most-at-risk populations such as people who inject drugs and sex workers, MSM and the TG populations in the Region are at high risk for HIV infection. Access to prevention, treatment, care and support services is limited compared with the share of the HIV burden borne by these vulnerable populations. This report highlights the urgent need to ensure that prevention interventions, and treatment, care and support services are put in place for MSM and TG populations.

In South-East Asia, there is a high and rising HIV prevalence rate identified among MSM – most notably in India, Indonesia, Myanmar and Thailand. The HIV prevalence rate among MSM in these countries ranges from 5.2% to 28.8%. Among the TG population, HIV prevalence has been found to be even higher in some of these countries. These rates are extremely high when compared with the overall adult HIV prevalence rate in countries of the Region, which is reported to be 0.3%. In other countries of the Region, medium-to-low HIV prevalence rates are found among both the MSM and TG populations. In all countries of the Region, a substantial proportion of the MSM and TG populations indulge in high HIV risk behaviours. Having multiple male sexual partners of all types – regular, casual and paying – coupled with inconsistent condom use with male and female partners, is closely associated with a high risk of transmission and acquisition of both HIV and sexually

transmitted infections. Despite this, a significant number of MSM in the Asia–Pacific region do not have access to HIV prevention and care services.

To ensure that the MSM and TG population have improved access to HIV and care services requires addressing the legal barriers that interfere with HIV prevention, treatment and care. Punitive laws and law enforcement practices exist in the vast majority of countries in the Region, and this has contributed towards low coverage of HIV services, and further marginalized the MSM and TG population.

All countries in the Region have a national HIV strategic plan that mentions MSM, and most countries have some form of interventions for MSM and TG populations, primarily implemented through nongovernmental organizations and community-based organizations. However, the national response in each of these countries remains insufficient, with low coverage of HIV prevention activities for MSM and TG populations. The HIV epidemic among the MSM and TG population in the Region is an urgent public health priority and the need for progress in the response is critical to the lives of millions who are at risk.

It is hoped that these country profiles will contribute towards an improved and comprehensive understanding of the issues, be useful for advocacy, and generate further responses in these South-East Asia Region countries. We hope that Member countries and partner agencies will find this report on HIV among MSM and TG useful and that it contributes towards a commitment to address the health needs of MSM and TG in the Region.

Acronyms and abbreviations

3DF	Three Diseases Fund
AEM	Asian Epidemic Model
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ATS	amphetamine-type stimulants
BCC	behaviour change communication
BRO	Bangkok Rainbow Organization
BSS	behavioural surveillance survey
BSWS	Bandhu Social Welfare Society (NGO Bangladesh)
CBO	community-based organization
CCT	Clinic Café Timor
CDC	Centers for Disease Control and Prevention (USA)
DIC	drop-in centre
FHAM	Fund for HIV/AIDS in Myanmar
FHI	Family Health International
FSW	female sex worker
FTI	Fundasaun Timor Hari’l
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B
HIV	human immunodeficiency virus
HIVOS	Humanist Institute for Development Cooperation
HSV	herpes simplex virus
IBBA	integrated behavioural and biological assessment
IBBS	integrated biological and behavioural surveillance
IEC	information, education and communication
INFOSEM	Indian Network for Sexual Minorities
KAP	knowledge, attitude and practice
KPI	key performance indicator
LGBTIQ	lesbian, gay, bisexual, transgender, intersex and questioning
MARP	most-at-risk population
M&E	monitoring and evaluation
MOPH	Ministry of Public Health
MSF	Médecins Sans Frontières

Acronyms and abbreviations (contd)

MSM	men who have sex with men
MSW	male sex worker
NAC	National AIDS Committee
NACO	National AIDS Control Organization (of India)
NACP	National AIDS Control Programme
NASP	National AIDS/STD Programme (of Bangladesh)
NCASC	National Centre for AIDS and STD Control (Nepal)
NGO	nongovernmental organization
NHAPP	National HIV/AIDS Prevention Programme
PIL	public interest litigation
PLHIV	people living with HIV
PSI	Population Services International
PWID	people who inject drugs
RFSU	Swedish Association for Sexuality Education
RSAT	Rainbow Sky Association of Thailand
SACS	State AIDS Control Society
SIDA	Swedish International Development Cooperation Agency
STI	sexually transmitted infection
SWING	Service Workers in Group
TB	tuberculosis
TG	transgender (persons)
TI	targeted intervention
TPHA	<i>Treponema pallidum</i> haemagglutination (test)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
VDRL	Venereal Disease Research Laboratory (test)
WHO	World Health Organization

Executive summary

In 2009, a situation assessment was conducted among men who have sex with men (MSM) and transgender (TG) populations in South-East Asia. The aim was to improve our understanding of HIV and sexually transmitted infections (STI), the risk behaviours, as well as the nature and extent of the national responses to the HIV epidemics among these populations. The data collected and analysed will inform current and future action in the South-East Asia Region (SEAR) to address the health needs of MSM and TG populations. This desk-based assessment used multiple data sources to review the situation in nine countries of SEAR – Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

Context

Same-sex behaviour has been identified in all societies, irrespective of whether same-sex sexuality is openly acknowledged, not talked about, or actively denied. Many countries in SEAR have long histories of males who are sexually attracted to or have sex with males, and many of these same-sex attracted males have specific indigenous terms related to same-sex sexuality. Most countries in SEAR also have long histories of gender-variant males who could be labelled as “transgender”, but in the SEAR context, indigenous terms are used. All countries under review had estimates of the number of MSM, and a few countries had a separate classification for and data on the number of male sex workers (MSWs) and TG. In SEAR, there are an estimated 4–5 million MSM, while data on the TG population were too limited to estimate a number.

Prevalence of HIV and STI

From the available data, the prevalence of HIV was high among MSM in India (7.4% national rate), Thailand (24.7% in Bangkok and 8.3% in Chiang Mai), Myanmar (28.8% national rate) and Indonesia (5.2% national rate). Medium-to-low HIV prevalence was found among MSM in Nepal (3.8%), Bangladesh (less than 1%), Timor-Leste (0.9%) and Sri Lanka (0.48%). HIV infection was not identified among MSM in the Maldives. Where HIV prevalence data were available among TG, it was mostly higher than that among MSM. In Jakarta, Indonesia, HIV prevalence among TG was 34%, while a study in five sites of Tamil Nadu, India found an HIV prevalence among TG of 12%.

STI prevalence among MSM was generally less than the HIV prevalence. In general, the prevalence of syphilis among MSM was high: in three states of India it ranged from 8.4% to 13%, and was 14.1% in Myanmar, 5% in Sri Lanka, and 15.5% in Timor-Leste. Syphilis prevalence was overall much higher among TG than among MSM populations.

Risk behaviours

HIV-related risk behaviours among MSM and TG populations were high. In almost all the countries under review, a substantial proportion of MSM had large numbers of male partners of all types – regular, casual, commercial (paid) and paying. A significant proportion of MSM also reported sex with female partners – India 12.6–69.6% (past six months) and in Timor-Leste 93.8% (past 12 months). Where data were available, it can be suggested that marriage was seen as a norm by some MSM.

One third to two thirds of MSM across SEAR reported not using condoms during last anal sex with a male partner. Among male and TG sex workers, in general, condom use was equally inconsistent. Condom use with female partners was both inconsistent and poor, particularly with regular female partners and spouses. Data on the use of water-based lubricants among MSM and TG populations were minimal and, where information was available, it showed that the use of any lubricant was not high. The proportion of MSM who injected drugs was overall small but the use of non-injectable drugs was common.

National responses

Appropriate and swift responses at the national and regional levels will be crucial to prevent escalating rates of HIV infection among MSM and TG populations and to reduce the impact of these HIV epidemics. This review found that the scale of the response by national governments does not match the overall increase in HIV prevalence and is inadequate for controlling the ongoing high-risk behaviours among MSM and TG populations in SEAR. The review also identified many challenges to scaling up responses for these populations. The lack of a supportive legal environment for MSM can be an impediment to HIV prevention activities. At present, only two out of the nine countries under review have a supportive legal environment. However, it was encouraging to note that all countries under review have a national HIV strategic plan that mentions

MSM, and many have listed this population group (some countries TG as well) as needing specific assistance and focused attention.

Most of the countries under review have some form of interventions for MSM, and sometimes MSWs and TG populations as well. The interventions outlined in national plans overall include: peer outreach education; promotion and distribution of condoms and water-based lubricants; and referrals to HIV and STI screening and treatment. Despite these interventions, available data showed that overall coverage was well short of that estimated by the Asian epidemiological model to reverse the HIV epidemic (i.e. 80%): in most countries, coverage was less than 25%.

Resources and expenditure on HIV programming for MSM and TG populations were also shown to be inadequate for implementing specific interventions and expanding the coverage. Gaps were found in strategic information, political will and legal framework, and programmes and policies. Shortages in budget allocation and funding to address the needs of the MSM and TG populations were also common. However, the assessment did show an increased awareness in SEAR to better define appropriate interventions for these population groups and to identify the role of the health sector in scaling up provision of HIV and STI prevention and treatment services.

Recommendations

Based on an analysis of the data and information, the following broad-based recommendations were made for the way forward:

1. Advocate for the creation of an enabling environment and a supportive legal framework to ensure that HIV prevention, treatment and care interventions can be implemented without hindrance to meet the needs of MSM and TG populations.
2. Rapidly scale up implementation of various essential and innovative HIV prevention, treatment and care interventions, ensure that human and funding resources are sufficient to meet the needs of MSM and TG populations, and progress towards Millennium Development Goal 6 (MDG 6) to halt by 2015 and begin to reverse the spread of HIV/AIDS.
3. Encourage, support and build the capacity of organizations to serve the needs of MSM and TG populations.

4. Expand the number of surveillance sites in national surveys beyond largely urban areas to improve estimates of national HIV prevalence, contribute towards achieving adequate coverage, and provide evidence-based responses to meet the needs of MSM and TG populations.
5. Support the implementation of social, policy and epidemiological research among MSM and TG populations.



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1. BACKGROUND

Among men who have sex with men (MSM) in Asia, there is around a one-in-five odds ratio (18.7%) of being infected with HIV.¹ To address this alarming situation, an important step forward would be to assess the magnitude of the MSM population, including those termed transgender (TG). This would assist in programme planning, evidence-based decision-making, and resource allocation to respond to the relevant issues. Synthesis of the data on the epidemiology of HIV and sexually transmitted infections (STIs), and behavioural surveillance surveys (BSS) of the MSM and TG populations in Asia will substantially contribute towards an improved understanding of various issues within these population groups.

Criminalization, cultural taboo, stigma and discrimination have hindered MSM and TG populations from exercising their full human rights, and contributed to the creation of obstacles when attempting to access health-care services and other interventions to protect themselves from HIV and STIs. Despite the ongoing high risk of and vulnerability to HIV infection, too few among the MSM and TG populations access or avail services; thus, improving the response to HIV interventions remains critical.

2. DEFINING AND DESCRIBING MEN WHO HAVE SEX WITH MEN AND TRANSGENDER POPULATIONS

Many Asian countries have long histories of males who are sexually attracted to or who have sex with males. Many of these same-sex attracted males have specific indigenous terms related to same-sex sexuality, although these terms are usually based on gender expression and the sexual role adopted while having sex with “men” (see Annex 1). The term “men who have sex with men” (MSM) denotes all men who have sex with men, regardless of their sexual identity, sexual orientation and whether or not they also have sex with females. MSM is basically an epidemiological term coined by public health officials, which focuses on sexual behaviours for the purpose of HIV and STI surveillance. The assumption is that behaviour, not sexual identity, places people at risk for HIV and STI.

Key message

The term “men who have sex with men” denotes all men who have sex with men, regardless of their sexual identity, sexual orientation and whether or not they also have sex with females.

It has been suggested that researchers and public health practitioners need to exercise caution when the term MSM is used and “to adopt more nuanced and culturally relevant language in discussing members of sexual minority groups”.^{2,3} Men who do not identify as MSM may specifically avoid venues or activities frequented by MSM, or disassociate themselves from information or media campaigns that are outwardly identified with men who present with a feminine gender expression or who identify as “gay”. This creates a challenge as those not identifying as MSM still need to access interventions to ensure that they are protected from HIV infection and STI. Policy-makers and programme managers need to understand that the label “MSM” overshadows the diversity among MSM populations and may hinder the development of subgroup-specific HIV prevention and care interventions. Working definitions such as “MSM” or “males who have sex with males” may be appropriate for HIV surveillance and outreach when treated as behavioural categories.

Transgender people continue to be included under the umbrella term “MSM”. However, it has increasingly been recognized that TG have unique needs and concerns, and it would be more useful to view them as a separate group. The term “transgender person” is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking or blurring of culturally prevalent stereotypical gender roles. Transgender people may live full- or part-time in the gender role “opposite” to their biological sex by birth.⁴ In this review, only male-to-female TG will be examined. A variety of indigenous terms in Asia are used to describe TG (*see* Annex 1).

3. EPIDEMIOLOGY

3.1 Estimates of MSM and TG populations in South-East Asia

Same-sex behaviour is present in all societies,⁵ irrespective of whether same-sex sexuality is openly acknowledged, not talked about, or actively denied. In order to assess coverage and plan appropriately for interventions, size estimation of MSM populations is needed from various sources: (1) population-based studies to identify the extent of same-sex/bisexual behaviour; (2) mapping studies to identify various subgroups of MSM, male sex workers (MSWs) and TG, as well as mapping the places where they meet to seek sexual partners or socialize; and (3) size estimations using numerical formulas based on the available evidence.⁶

Table 1. Estimates of MSM populations in select South-East Asian countries

Country	Estimated size of MSM and TG populations
Bangladesh	MSM and MSWs: 40 000 to 150 000 ⁷
India	MSM: 2 352 133 ⁸ ; MSWs: 235 213
Indonesia	<i>Warias</i> (TG) 20 960–35 300 MSM 766 800 (384 320–1 148 270) ⁹
Maldives	1600–4200 ¹⁰
Myanmar	200 000–280 000 ¹¹
Nepal	135 000 (68 000–202 000) ¹²
Sri Lanka	24 000–37 000 ¹³
Thailand	MSM 560 000; MSWs 10 000 ¹⁴ <i>Kathoeyes</i> (TG) 180 000 ¹⁵
Timor-Leste	MSM 350–2000 ¹⁶

Some countries have conducted population-based studies among men or among specific subpopulations of men (i.e. STI clinic attendees, truck drivers, students) and have documented a prevalence ranging from 3% to 13% of same-sex or bisexual behaviour.^{14,17} An unknown proportion of MSM, some of whom may engage in risky sexual behaviours, are likely to be missed in mapping and size estimation studies.

3.2 Magnitude and trends of HIV among MSM and TG populations

Various levels of HIV prevalence have been reported among MSM in South-East Asia. Overall, data on HIV among MSM are limited. In addition, differences in study methodologies, study quality and sample sizes impact upon making comparisons of HIV prevalence among MSM groups across South-East Asia. Most available data on HIV prevalence among MSM are confined to major cities and urban settings.

3.2.1 HIV prevalence and incidence among MSM populations

Prevalence of HIV is high among MSM in India, Thailand, Myanmar and Indonesia. Of concern was an increasing HIV prevalence among MSM in some sites where surveillance was done (see Box 1). For example, in 2005 and 2007 in Bangkok, it increased from 18.9% to 27.0% and in Chiang Mai from 11.4% to 15.5%, respectively.¹⁸ In 2009, HIV among MSM had decreased in Bangkok and Chiang Mai; 24.7% and 8.3%, respectively.^{19,20} In the southern states of India, HIV prevalence among MSM increased between 2003 and 2007 in the sentinel sites in Karnataka (from 10.8% to 17.6%, respectively), and Tamil Nadu (from 4.2% to 6.6%, respectively).²¹

In India, the average national HIV prevalence among MSM in 2007 was 7.4%.²¹ However, this masks the wide variation in HIV prevalence across sites in various regions of India: Karnataka (17.6%), Manipur (16.4%), Maharashtra (11.8%), Delhi (11.7%) and West Bengal (5.6%), to name some states. In Thailand, HIV prevalence ranged from 17.3% in 2003 to 30.8% in 2007.^{22,23} In Myanmar, HIV prevalence was 28.8% in 2008,²⁴ while in Indonesia, it ranged from 2.0% to 8.1% (Bandung 2.0%; Surabaya 5.6%; Jakarta 8.1%) in 2007.²⁵ In Nepal, HIV prevalence in 2009 among MSM was 3.8%,²⁶ while in Bangladesh, across several cities it remained less than 1%.²⁷ In Timor-Leste, HIV prevalence among MSM in 2004 was 0.9%,²⁸ while in Sri Lanka in 2009 it was 0.48%.¹³ In the Maldives in 2008 it was nil.²⁹

Data on HIV incidence among MSM remains limited in South-East Asia. However, data have been collected from Thailand and India. In Thailand, HIV incidence density was 5.7 per 100 person-years in a cohort of MSM in Bangkok, and 2.7 per 100 person-years among MSM attending an HIV testing clinic (2006–2007) to detect acute infection.^{30,31} In India, HIV incidence across six districts in the state of Andhra Pradesh ranged from 0.99% to 2.8% in an assessment conducted in 2005–2007.³²

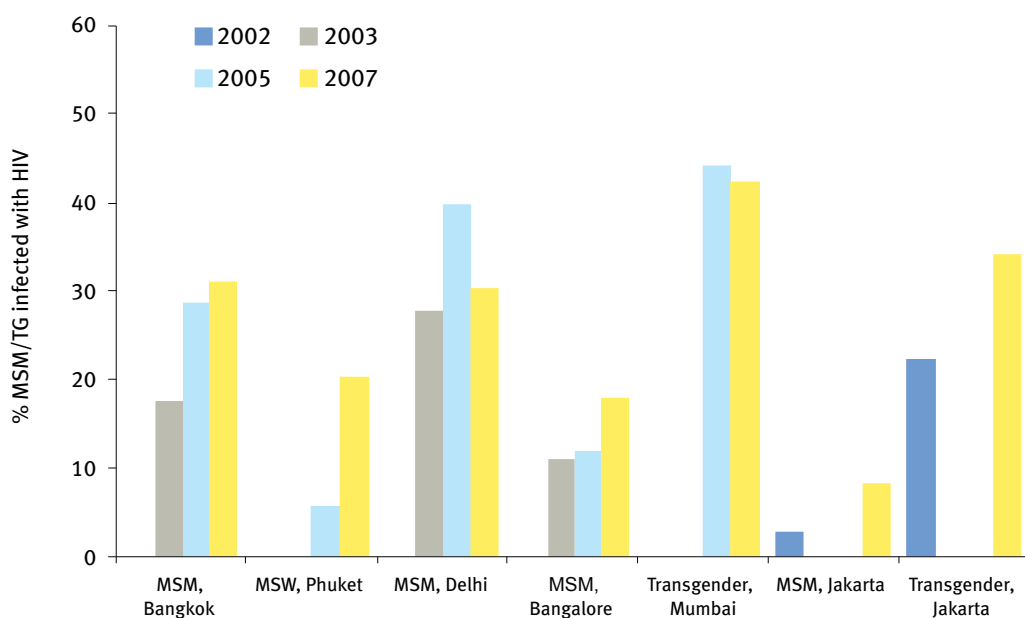
3.2.2 HIV prevalence among TG populations

Box 1. Prevalence of HIV among MSM

India	7.4%	(2007)
Thailand	8.3% (Chiang Mai, 2009), 24.7% (Bangkok, 2009)	
Indonesia	5.2%	(2007)
Myanmar	28.8%	(2008)
Nepal	3.8%	(2009)
Bangladesh	less than 1%	(2007)
Timor-Leste	0.9%	(2004)
Maldives	0%	(2008)
Sri Lanka	0.48%	(2009)

HIV prevalence data among TG populations was available only in select countries. In India, one study reported a high HIV prevalence of 42.1% among TG in Mumbai from a 2007 sentinel surveillance survey conducted by the government (Figure 1).³³ Another study conducted among the TG population in five districts of Tamil Nadu (2005–2007) reported an aggregate HIV prevalence of 12%.³² In Indonesia, HIV prevalence ranged from 14% to 34% among TG (Bandung 14%; Surabaya 25%; Jakarta 34%) in 2007.²⁵ Available data indicate that the levels of HIV prevalence are overall considerably higher among TG than among MSM, and highlight the need to conduct separate HIV prevalence studies among TG populations in South-East Asia.

Figure 1. Trends in HIV prevalence among MSM and TG populations, selected cities, South-East Asia Region, 2002–2007



Source: WHO. Regional Office for South-East Asia. *HIV/AIDS in the South-East Asia Region*. New Delhi, WHO SEARO, 2009. Available from: http://203.90.70.117/PDS_DOCS/B4400.pdf (accessed 18 June 2010)³⁵

3.3 Prevalence of sexually transmitted infections among MSM and TG populations

Among STIs, common bacterial STIs include syphilis, gonorrhoea and chlamydial infection. Viral STIs include herpes simplex virus-2 (HSV-2), genital warts and hepatitis B (HBV). All these STIs (except HBV) can produce symptoms in the urethra (urinary tract), anorectal area and mouth, depending on sexual practices. In the countries under review, STI prevalence data among MSM were more limited than HIV prevalence data.

3.3.1 Syphilis

The prevalence of syphilis (active and confirmed) among MSM in general was high in different studies (except for a couple of countries): it ranged from 8.4% to 13% in three states of India,³⁴ 3.2% to 5.6% in Indonesia,²⁵ 1.5% in Nepal,²⁶ 1% in Bangladesh,³⁶ 14.1% in Myanmar,²⁴ 5% in Sri Lanka³⁷ and 15.5% in Timor-Leste (Box 2).²⁸

Box 2. Prevalence of syphilis among MSM

Bangladesh	1%	(2007)
India	range 8.4–13%	(2005–2007)
Indonesia	range 3.2–5.6%	(2007)
Myanmar	14.1%	(2008)
Nepal	1.5%	(2009)
Sri Lanka	5%	(2005)
Timor-Leste	15.5%	(2004)

Where data were available, the prevalence of syphilis among TG populations was high, ranging from 6.5% (2006) to 7.7% (2007) in Bangladesh,^{38,39} 25.2–28.8% in Indonesia in 2007,²⁵ and 57% in Mumbai, India according to one study conducted in 2001.⁴⁰ In general, the prevalence of syphilis was much higher among TG populations than among MSM.

3.3.2 Chlamydial infection

Rates of both urethral and rectal chlamydial infection were high among the MSM and TG populations. The prevalence of urethral chlamydia ranged from 3.4% to 8.1% in Bangkok, Thailand (2006),⁴¹ 0.3% to 4.4% in India (2005–2007)³⁴ and 14.9%

(rectal chlamydiasis) in Timor-Leste (2004).²⁸ Similarly, the prevalence of rectal chlamydiasis ranged from 19.4% to 21.9% in Indonesia in 2007,²⁵ and 11.1% (MSWs) and 1.9% (non-sex workers) in Nepal in 2009.²⁶

In Indonesia, the prevalence of rectal chlamydiasis among TG in 2007 ranged from 22.7% to 34.5%, relatively higher than that among MSM (19.4–21.9%).²⁵ This may be due to higher rates of client turnover and a higher proportion of TG engaging in unprotected receptive anal sex.

3.3.3 Gonorrhoea

While a high prevalence of rectal gonorrhoea was noted in Nepal (12.5% in 2009)²⁶ and Dili, Timor-Leste (16.1% in 2004),²⁸ a relatively low prevalence (0.3–0.9%) was observed in India (2005–2007).³⁴ Data from other countries were not available.

3.3.4 Other STIs

The prevalence of HSV-2 among MSM was high and ranged from 29.1% to 48.3% in India (2005–2007),³⁴ and 29.1% in Timor-Leste (2004).²⁸ High HSV-2 prevalence was also observed among HIV-positive MSM in Bangkok (39.8% in 2006).²² HBV prevalence was high among MSM at some sites: 73.4% among HIV-positive MSM (44.8% in HIV-negative MSM) in Bangkok (2006)⁴¹ and 6% among MSM in Addu, Maldives (2008).²⁹

3.4 HIV-related risk behaviours among MSM and TG populations

3.4.1 Sexual partners – males and females

In almost all the countries under review in this report, a substantial proportion of MSM and MSWs have high numbers of male partners of all types – regular, casual, commercial (paid) and paying. The mean number of non-commercial male partners of MSM over one month ranged from 1.7 to 13.9 in India (2006),⁴² 3.9 (one month) in Bangladesh, Central Region (2003–2004),⁷ and 8.8 within 12 months (data for one month not collected) in Sri Lanka (2006–2007).⁴³ In Indonesia, the median number of male partners of MSM ranged from 2 to 10 (past month).²⁵ The mean number of commercial male partners of MSM was high in India, ranging from 3.6 to 25.2 (past six or 12 months).⁴² The TG population reported a large number of commercial and non-commercial male partners. For example, in Bangladesh, the majority had up to 20 commercial clients in the past one week during 2004–2005,³⁹ while one study

conducted in 2001 in India showed that 39% had more than 10 partners in the past one month.⁴⁰ In Indonesia, the number of partners ranged from 1 to 4 (median) in the past week.²⁵

Key messages

- » Many MSM have multiple sexual partners of all types – regular, casual, commercial (paid) and paying.
- » Many MSM have female sexual partners. Where information was available, marriage to a female was not uncommon.
- » Many TG report a large number of male partners – commercial and non-commercial.

A significant proportion of MSM in South-East Asia reported sex with female partners. The percentage of MSM who reported having had sex with females over a specified time period varied. In India in 2006, it ranged from 12.6% to 69.6% (6 months),⁴² in Thailand it was 22.3% (6 months),⁴⁴ and in Timor-Leste it was 93.8% (12 months).⁴⁵

Overall, in the countries reviewed, information on the proportion of MSM married to women was limited. Where data were available, they suggested that marriage could be seen as a norm for some MSM. In Kathmandu, Nepal (2009), 37.8% of MSM (non-MSWs) and 16.2% of MSWs were married to women.²⁶ In India, 10–55.6% of MSM were married.⁴² In many countries, MSM reported both casual and commercial female partners, which may suggest that at least some were attracted to both males and females, and would be bisexual.

3.4.2 Condom use with males and females

Inconsistent condom use with male partners during anal sex was associated with a high risk of transmission and acquisition of both HIV and STIs. One third to two thirds of MSM across the South-East Asian countries under review reported not using condoms during their last episode of anal sex with a male partner. Among male and TG sex workers, in general, condom use was equally inconsistent. Condom use appears to vary according to the type of male partner. In some countries such as Sri Lanka and Thailand, the level of consistent/always condom use with regular male partners was lower than with non-regular male partners: 26% with regular

and 46% with non-regular over 12 months in Sri Lanka,⁴³ while in Thailand it was 79.1% with casual partners and 54.4% with regular partners over the past three months.⁴⁴ In Indonesia, consistent condom use in the past month with casual male partners was 31.1%, while with casual female partners it was 11.1%.²⁵ In India, a BSS (2006) found that consistent condom use in the past six months ranged from 6.6% in Uttar Pradesh to 65.2% in Goa with commercial male partners, and from 4.8% in Uttar Pradesh to 79% in Mumbai with non-commercial male partners.⁴²

Key messages

- » One third to two thirds of MSM reported not using condoms during the last episode of anal sex with a male partner.
- » Unprotected sex with females was common, more so with regular females partners.
- » Availability and use of water-based lubricants was not high.

Condom use with female partners was inconsistent, particularly with regular female partners and spouses. The risk of transmission of HIV and STIs to female partners as well as to their future children remains high. More than two thirds of MSM in the Maldives reported having unprotected sex with women (98% in Addu; 82% in Malé),⁴⁶ while in Timor-Leste, condom use during vaginal sex was 9.1% with a regular partner, and 20.4% with a casual partner in the past 12 months.⁴⁵ In Indonesia (2007), condom use at last sex with casual female partners was 32%,²⁵ while in India consistent condom use with a female regular partner varied across states, ranging from 1.6% in Andhra Pradesh to 41.9% in Karnataka; consistent condom use with a paid female partner in the past month ranged from 23.3% in Andhra Pradesh to 78.2% in Maharashtra.⁴⁷

3.4.3 Use of water-based lubricants

Minimal data were available on the use of water-based lubricants among MSM, MSW and TG populations. Of the available data, it was found that, in general, the availability and use of water-based lubricants was not high. In Indonesia, use of water-based lubricants during last anal sex ranged from 11.6% in Batam among MSM to 23.8% among *warias* in Jakarta.²⁵ An exception was Nepal, in which a 2009

study²⁶ found that among MSM who engage in anal sex, almost all MSM (96.5%) and MSW (97.8%) study participants used lubricants (74.1% used water-based lubricants) during their last act of anal sex.

3.4.4 Alcohol and drug use

Alcohol and injection drug use has been reported by MSM, MSW and TG populations in the countries under review. In most of the countries reviewed (except the Maldives, Bangladesh and some sites in India), the proportion of MSM reporting injection drug use in the past year was small (commonly less than 5%). Data from Indonesia, Nepal and India indicate that a sizeable proportion of MSM report the use of non-injectable drugs such as marijuana.^{25,26,42} In Indonesia, 31% of MSM in Jakarta and 25% in Batam reported using drugs such as ecstasy, methamphetamines and “ice” (amphetamine-type stimulants [ATS]) in the past three months.²⁵ In Bangkok, it was found that, among MSM, the use of drugs has increased substantially, from 3.6% in 2003 to 20.7% in 2007. Of concern was the proportion using drugs during sex, which had increased from 0.8% to 6.3%.⁴⁸ Research shows that alcohol and drug use can contribute towards risk behaviours such as unprotected sex.^{49,50}

Key message

The proportion of MSM injecting drugs was overall small but the use of non-injectable drugs was common.

4. RESPONSES

The data on HIV epidemiology and risk behaviours among MSM and TG populations in the countries under review are a cause for major concern, with the potential for rapid increases in HIV prevalence in the future. Appropriate and swift responses at the national and regional levels will be crucial to prevent escalating rates of HIV infection among MSM and TG populations, and to reduce the impact of these HIV epidemics.

4.1 Policy and legal environment

The need for an “enabling environment” is discussed in the national strategic plans of most of the countries under review. Nevertheless, the overall commitment to

creating an enabling environment is not clear. Removal of all legal barriers that interfere with HIV prevention, treatment and care activities is a key aspect of an enabling environment, yet in only two countries (Thailand and Indonesia) is sex between consenting same-sex adults not a criminal offence. Other countries have criminal sanctions against “homosexual behaviour” that present substantial obstacles to HIV prevention for MSM. In 2009, the Delhi High Court ruled that consensual same-sex relations between adults in private cannot be criminalized. Soon after that judgment, appeals in the Indian Supreme court objecting to the ruling were lodged.^{51,52} In Timor-Leste, the Constitution does not specify if sex between adult males is legal or not.

It is most encouraging and praiseworthy that all the countries under review have a national HIV strategic plan that mentions MSM. Bangladesh, India, Indonesia, Maldives, Myanmar and Sri Lanka have MSM listed as among “priority groups”, “core groups”, “key populations”, “high-risk groups”, or “most-at-risk populations”. Setting targets with specific reference to MSM for intervention components such as outreach, condom distribution, HIV testing, STI referrals, and antiretroviral therapy (ART) are explicitly mentioned in the national HIV strategic plans of India, Nepal, Timor-Leste and Myanmar.

Some countries have set specific targets among MSM to either provide a service or reduce the HIV prevalence. Nepal, for example, has a specific impact-based target to reduce the HIV prevalence among MSM from 3.6% (2004) to 2.0% by the end of 2011, and an increase in condom use during last anal sex with a male from 55.9% among MSM to 80% by the end of 2011.⁵³ Setting specific targets for MSM is critical for national governments to prepare detailed action plans, to budget and fund their plans, and to make them accountable to their constituencies.

Key messages

- » Setting specific targets for MSM is critical for national governments to prepare detailed action plans, to budget and fund their plans, and to make governments accountable to their constituencies.
- » Currently, only two out of the nine countries under review have a supportive legal environment for MSM.

4.2 Interventions and programme coverage

Most of the countries under review have some form of interventions for MSM, MSW and TG populations, which are primarily implemented through nongovernmental organizations (NGOs) and community-based organizations (CBOs). Overall, interventions specific for MSWs and TG populations are not available, but some national governments do state that most MSM interventions reportedly cover MSWs and, in some cases, TG as well. Most interventions operate in major urban centres only, or one urban centre, leaving semi-urban and rural areas with few, or no, targeted interventions. Lack of data, funding and appropriate agencies to implement interventions outside urban centres remains a significant response gap.

Interventions provided in national plans include: peer outreach education; promotion and distribution of condoms and water-based lubricants; and referrals to HIV and STI screening and treatment. From the available information, only India seems to have relatively comprehensive operational guidelines for implementing HIV prevention interventions among MSM. In some countries, NGOs lack the capacity or display a reluctance to implement MSM-focused interventions. Advocacy with NGOs and capacity building will be important to develop and scale up targeted interventions for MSM and TG populations. Research shows that incarceration can result in high-risk behaviours and increased vulnerability, and there are reports of same-sex sexual activity (both consensual and forced) among prisoners.⁵⁴ However, only in Indonesia are condoms available to the inmates of some prisons.⁵⁵

Information on coverage was mainly available from the United Nations General Assembly Special Session (UNGASS) country progress reports submitted by governments to the Joint United Nations Programme on HIV/AIDS (UNAIDS) to fulfil obligations under the UNGASS meeting in 2001.⁵⁶ Coverage is determined by using UNGASS indicators: the proportion of MSM who underwent voluntary HIV testing; the proportion reached by interventions; and the proportion who reported condom use during last anal sex.* The lack of publicly available data reporting

* United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicator nine on the percentage of men who have sex with men reached with HIV prevention programmes in the past 12 months. Respondents were asked the following questions: (1) Do you know where you can go if you wish to receive an HIV test? (2) In the past 12 months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)? The numerator of the indicator is the number of respondents in the most-at-risk population group who replied yes to both questions, and the denominator is the total number of respondents surveyed.

the number of interventions for MSM, MSW and TG populations, and how many people were reached or covered through these interventions makes it difficult to assess coverage across nations, and to create accountability. Understanding the cultural context of the countries under review where same-sex behaviour is highly stigmatized, and where many men do not identify as MSM contributes towards the difficulties in aiming for greater coverage. What can be confirmed is that coverage of HIV prevention activities in Asia for MSM and TG populations is low.⁵⁷

The World Health Organization (WHO), UNAIDS and United Nations Children's Fund (UNICEF) progress report on universal access to HIV prevention and treatment (2009) indicates a median coverage rate of 24% by HIV prevention programmes for MSM in the 12 months preceding the survey in East, South and South-East Asia.⁵⁸ Coverage of MSM was well short of the 80% estimated by the Asian epidemiological model (AEM) as the target to reverse the HIV epidemic.⁵⁷ The low coverage of MSM and TG populations for receiving HIV prevention and treatment programmes indicates the need to better understand where they can be reached, using the most appropriate approach to meet their needs, and to accelerate the scale up and quality of HIV prevention and care interventions. Where information was available, high rates of HBV infection were identified, but despite this, receiving HBV vaccination is not common practice among MSM and TG populations in most Asian countries.

Key messages

- » Universal access to HIV prevention and treatment has a median coverage rate of 24% by HIV prevention programmes for MSM in East, South and South-East Asia.
- » Negative societal attitudes towards same-sex sexuality and overall punitive laws hinder MSM and TG populations from accessing services.
- » The role of CBOs and groups of MSM and TG has largely been underestimated and these groups have not been used to their full potential in formulating interventions.

Increasing the coverage of interventions for MSM necessitates a range of interventions: combating legal barriers and societal stigma and discrimination; mobilizing and allocating adequate resources; and increasing political commitment and leadership. Structural barriers to accessing and using existing services must also be addressed in order to increase coverage. Studies conducted in Asian countries highlight various barriers faced by MSM and TG populations in accessing broad-ranging sexual health services; these are commonly linked to widespread stigma and discrimination by health-care providers.^{59,60} Negative societal attitudes about same-sex sexuality, stigma associated with people living with HIV (PLHIV), and overall punitive laws hinder MSM and TG populations from accessing services. Laws, policies, societal discrimination and endemic stigma have produced systematic and ongoing barriers to accessing HIV prevention and care, often contributing towards a heightened vulnerability to HIV infection.

Coverage data were largely derived from behavioural surveillance surveys or “special” surveys conducted mainly in intervention areas. Rarely was information available on how many MSM were covered (using specific indicators that define what is meant by coverage) compared with the total number of MSM estimated in the country (denominator). Overall, there was no consensus as to what constitutes “coverage”.

Interventions are often implemented by NGOs but not managed by MSM and TG communities. It appears that the role of CBOs and groups of MSM and TG has largely been underestimated and these groups have not been used to their full potential in delivering interventions. The limited capacity of CBOs and NGOs serving the needs of MSM and TG populations arises due to various factors: lack of or limited government funding; inconsistent and unreliable funding from different international and national donors; and lack of capacity-building activities specific for sexual minority populations.

4.3 Strategic information

Several factors can escalate the HIV epidemic among MSM and TG populations, and all were found in this assessment: high or rising prevalence of HIV and STIs among MSM and TG; having multiple sex partners, both male and female; engaging in sex

work; not using condoms consistently with both males and females; having sex with male and female sex workers; not knowing one's HIV status; and widespread use of alcohol and drugs. Many Asian countries have initiated HIV serosurveillance surveys and BSS among MSM. Bangladesh, the Maldives and Indonesia conduct integrated biological and behavioural surveillance (IBBS) for HIV and STIs, which combines testing for HIV and STIs with measurement of HIV-related risk behaviours among the survey population. Nevertheless, the number of surveillance sites in the national surveys is limited and largely restricted to urban intervention sites. This leaves a gap in estimating national epidemics and achieving adequate coverage among MSM and TG populations. Only Bangladesh, Thailand and Indonesia conduct separate serosurveillance among MSW and TG populations, in addition to MSM.

Key messages

- » The number of surveillance sites is limited and largely restricted to urban intervention sites. This leaves a gap in estimating national epidemics and achieving adequate coverage.
- » Data on evidence-based HIV prevention interventions among MSM and TG populations are limited, impeding understanding of an appropriate response.

Epidemiological data on HIV and STIs is collected but additional information such as periodical updated mapping and size estimation data are needed to identify potential new intervention sites and estimate budget requirements. Improvements have been identified in this area but quality mapping and size estimation data are still not available in many Asian countries. Another major gap is the lack of HIV incidence data among MSM, which is currently available only for Thailand and India. Incidence data are required to identify which subgroups of MSM are at greatest risk and whether any decreases in HIV prevalence among MSM, if any, is due to a fall in incidence (new cases) rather than deaths of HIV-positive MSM. This review also found that data on evidence-based HIV prevention interventions among MSM and TG populations was limited, impeding understanding of an appropriate response.^{61,62}

4.4 Resources for and expenditure on HIV programming for MSM and TG populations

A 2006 policy report⁶³ indicated that investments in HIV prevention for MSM remains as low as 0–4% of the total spending on HIV programmes in the Asia–Pacific region. Little information is available on the amount of money and what proportion of the national HIV and AIDS budget is allocated for HIV prevention programmes for MSM and MSWs in each of the countries under review. Although the report of the Commission on AIDS in Asia⁵⁷ recommended that comprehensive interventions for HIV among MSM and TG populations in Asia–Pacific should be fully integrated and costed into national plans, very few countries have costed interventions for MSM and TG. This shortcoming presents extreme challenges to implementing interventions and expanding coverage for MSM and TG populations, and to holding governments accountable.

In its national strategic plan, Sri Lanka has explicitly stated that 10% of the total budget (US\$ 1 236 008) has been allocated for scaling-up HIV prevention activities for MSM.⁶⁴ In Thailand, expenditure on HIV prevention accounted for only 14.1% (Thai Baht 949 855 219) of the total HIV/AIDS expenditure for 2007, which has been criticized by civil society advocates as insufficient. Within the prevention component, only 1% (Thai Baht 8 149 570) was spent on HIV prevention programmes for MSM, despite the fact that this vulnerable group accounted for 22.4% of new HIV infections.⁶⁵

Apart from designating specific and proportional funding targets for MSM, there is a need to access both existing and new resources for funding MSM programmes in South-East Asia. Resources such as the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) appear to be overall underutilized by national governments in scaling up HIV prevention interventions among MSM and TG populations. Recently, the Global Fund has released fact sheets on “sexual minorities” as well as “community systems strengthening” to provide guidance for national governments to incorporate HIV prevention programmes for MSM and TG populations, and capacity building of CBOs working with MSM and TG populations.⁶⁶ In 2009, AusAID released a scoping exercise report to help it to focus on MSM in its new strategy for the Asia region.⁶⁷ Since late 2007, the American foundation for AIDS Research (amfAR) has provided

limited support to CBOs working with MSM and TG populations in the Asia–Pacific and other regions through a small grants programme and advocacy activities.⁶²

5. RECENT PROGRESS

In the past, most countries in South-East Asia did not have a primary focus on HIV among MSM and TG population groups or place a high priority on addressing their needs, compared with other high-risk population groups. However, with a growing amount of evidence on the rise in HIV infections among MSM and TG populations coupled with increased advocacy efforts to respond, international attention and initiatives have emerged via high-profile documents and broad stakeholder meetings. In 2008, an independent Commission on AIDS in Asia reviewed the AIDS situation in Asia, including the HIV epidemic among MSM, and made several evidence-based recommendations to scale up HIV prevention interventions among MSM.⁵⁷ In September 2008, WHO and the United Nations Development Programme (UNDP) hosted a global consultation (which included several representatives from South-East Asia) to define interventions for MSM and to identify the role of the health sector in scaling up provision of HIV and STI prevention and treatment services.⁶⁸ In February 2009, WHO, UNDP, UNAIDS and national partners held a regionwide consultation in Hong Kong on the health sector response to HIV and AIDS among MSM. Gaps in information on the epidemic among MSM and TG populations were identified. This resulted in a call to build the capacity of health providers to address the specific health issues of MSM and TG populations.⁶⁹

In May 2009, UNAIDS released its action framework to promote universal access to HIV services for MSM and TG populations. This highlights the need to respect and promote the human rights of MSM and TG and to repeal laws that criminalize consensual sexual relations between same-sex adults.⁷⁰ In May 2010, to complement the action framework, a new document identifies the priority interventions required by the health sector to meet the HIV and sexual health needs of MSM and TG persons, and highlights how national health sector partners can strengthen their response to HIV among MSM and TG persons.⁷¹

6. RECOMMENDATIONS – THE WAY FORWARD

1. **Advocate for the creation of an enabling environment to ensure that HIV prevention, treatment and care interventions meet the needs of MSM and TG populations.**
 - Governments should be encouraged to repeal laws (if they have not done so already) that impede HIV prevention activities, including laws that criminalize consensual same-sex sexual relations among adults. Ongoing advocacy and policy efforts are integral for effective HIV prevention, treatment and care for MSM and TG populations.
 - Support the implementation of measures that reduce stigma and discrimination, closely aligned with monitoring and evaluation (M&E). Such measures can be education programmes to sensitize health-care providers, law enforcement officials and the general public to minimize the discrimination faced by MSM and TG populations.

2. **Rapidly scale up implementation of various essential and innovative HIV prevention, treatment and care interventions, ensure the availability of sufficient human and funding resources to meet the needs of MSM and TG populations, and to progress towards MDG 6 to halt by 2015 and begin to reverse the spread of HIV/AIDS.**
 - Provide free high-quality condoms and water-based lubricants via outreach programmes, and from appropriate and accessible intervention sites to increase consistent condom use.
 - Intensify education on consistent condom use and HIV and STIs among MSM and TG populations. Scale up STI diagnosis, treatment and management services, as such services provide further opportunities for outreach, education, and improved sexual health and risk reduction.
 - Promote voluntary HIV testing and counselling (VCT) services among MSM and TG populations.
 - Ensure that ART is made available to HIV-infected MSM and TG populations and that appropriate linkages for referral are in place as required.
 - Introduce comprehensive HIV prevention interventions within prisons to reduce both sexual and drug use-related risks among MSM and TG populations.
 - Advocate for HIV prevention programmes for MSM to promote safer sex

behaviours with regular and commercial female partners. Information on prevention also needs to be provided to female partners of MSM.

- Address HIV risk behaviours related to non-injecting and injecting drug use among MSM and TG populations by encouraging a referral process and linkages with harm reduction and drug dependency treatment services, where available.

3. Encourage, support and build the capacity of organizations to serve the needs of MSM and TG populations.

- Advocate for and support the formation of CBOs led by MSM and TG populations to ensure community ownership, cultural competence and sustainability. Strengthen the organizational and financial management capacity of CBOs to implement HIV prevention interventions among MSM and TG populations.
- Encourage and provide incentives to existing NGOs to work with MSM and TG populations in countries where CBOs are non-existent or nascent. Build the capacity of NGOs to implement interventions among MSM and TG populations.
- Build the capacity of health-care providers to be more competent, understanding and sensitive when providing quality STI and HIV prevention, treatment and care services to MSM and TG populations.

4. Expand the number of surveillance sites in national surveys beyond largely urban areas to improve estimates of national HIV prevalence, contribute towards achieving adequate coverage, and provide evidence-based responses to meet the needs of MSM and TG populations.

- Advocate for more extensive mapping to improve the size estimation and location of MSM and TG populations.
- Ensure an adequate number of serosurveillance sites for MSM, MSW and TG populations, with identification of new sites other than current intervention sites to increase the validity and reliability of epidemiological data.

5. Support the implementation of social, policy and epidemiological research among MSM and TG populations.

- Advocate for further research on MSM and TG populations to better understand

and address the social–structural determinants of risk behaviours among various subgroups of MSM and TG, and same-sex sexual risk behaviours among other at-risk male population groups, such as drug injectors.

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Annex 1

Table 1. Indigenous sexual and gender-based identities and labels used by MSM and transgender people in some countries in South-East Asia

Country	Feminine, mostly receptive	Masculine, mostly insertive (usually labels)	Insertive and receptive (usually labels)	Transgender women who “cross-dress”
India ^{1,2}	<i>Kothi</i>	<i>Panathi (parikh, giriya)</i>	Double-decker, double, “DD”	<i>Hijra</i> (north India), <i>aravani</i> (Tamil Nadu)
Bangladesh ³	<i>Kothi</i>	<i>Panathi, giriya</i>	“Do-paratha” or “double-decker”	<i>Hijra</i>
Nepal ^{4,5}	<i>Meiti</i> or <i>kothi</i>	<i>Ta (panthi, giriya)</i>	<i>Dohori</i>	<i>Hijara</i>
Myanmar ^{6,7 *}	<i>Apwint</i> (mostly called <i>ah-chauk</i>)	<i>Tha-nge</i> and <i>apone</i>	<i>Apone</i>	<i>Nat kadaw</i> or <i>ah-chauk</i>
Indonesia ⁸				<i>Waria</i>
Thailand ^{8,9}	<i>Kathoey</i> ; “queen”	“Complete man” (<i>phuu-chaai tem tua</i>) or “100 per cent male” (<i>phuu-chaai roi poe-sen</i>); “king”		<i>Kathoey</i>
Timor-Leste [#]				<i>Behu</i> and <i>pangleru</i>

*Win Minn Than, WHO Myanmar, personal communication, January 2010

Kimbro A, WHO Timor-Leste, personal communication, January 2010

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NATIONAL OVERVIEW



Bangladesh

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

Currently, Bangladesh continues to be among the countries with the lowest HIV prevalence in South Asia. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the overall HIV prevalence in Bangladesh is 0.01% and there are an estimated 12 000 (7700–19 000) people (adults and children) currently living with HIV.¹ HIV prevalence among most-at-risk population groups in Bangladesh has remained less than 1% over the past eight rounds of serological surveillance. However, among people who inject drugs (PWID), HIV prevalence has increased steadily over the surveillance rounds, from 1.4% in 2000 to 7% in 2007, with the highest prevalence of 11.0% in one neighbourhood in Dhaka.² The National AIDS/STD Programme (NASP) of Bangladesh reports that between 2.2 and 3.9 million people are estimated to be at increased risk for acquiring HIV, including PWID, male and female sex workers and their clients, men who have sex with men (MSM) and internal migrants.³

1.2 Size of the MSM and transgender populations

There is no consensus on the number of MSM and transgender persons (TG) commonly and culturally referred to as *hijra* in Bangladesh. However, a national size estimate of MSM, including male sex workers (MSWs), ranges from 40 000 to 150 000 but disaggregated data of these two groups are not known to be available.⁴ This number is suggested to be a gross underestimate. It has been documented that the nongovernmental organization (NGO) Bandhu Social Welfare Society (BSWS) had reached some 300 000 MSM in six cities between October 2000 and December 2004⁵ but it was not clear whether this figure was the cumulative number of repeated contacts from programme data, or whether it indicated all new contacts. The size of the *hijra* population is estimated at 10 000–15 000.^{6,7}

1.3 Typologies of MSM and TG populations

For HIV serological surveillance and behavioural surveillance purposes, the Bangladesh government has categorized same-sex attracted males as MSM who do not sell sex, MSWs and *hijra*. The term *hijra* is referred to as “transgender” (TG) or “third gender” in the latest HIV serosurveillance report of 2008.

Similar to India, self-described identities such as *kothi* and *hijra* are presently used among some proportion of same-sex attracted males. *Kothis* are feminized same-sex attracted males who predominantly take up a receptive role in sex with men. Though *hijras* in Bangladesh are likely to be male-to-female TG individuals, some authors categorize them as “a complex group, and encompass several physical descriptions including hermaphrodites, castrated males, and transgender individuals”.⁸ *Panthis* are usually insertive “manly” same-sex partners and commonly the sex partners of *kothi*. Another category is *parik*, which comprises the male lovers of *kothi* but it is important to note that all *parik* are *panthis*, but not all *panthis* are *parik*.⁶ The term *giriya* is used to mean *parik*. There is another term *gaira*, which means straight males but they perform passive roles in male-to-male sex. Terms such as *do-paratha* or “double-decker”⁹ are used by *kothis* to refer to those MSM who both insert and receive when they have sex with men.¹⁰ For serosurveillance purposes, the term “MSM” usually does not include *hijras*; but includes *kothis* and *panthis*. In Bangladesh, many MSM do not categorize themselves in any of these groups and simply identify themselves as “male”.

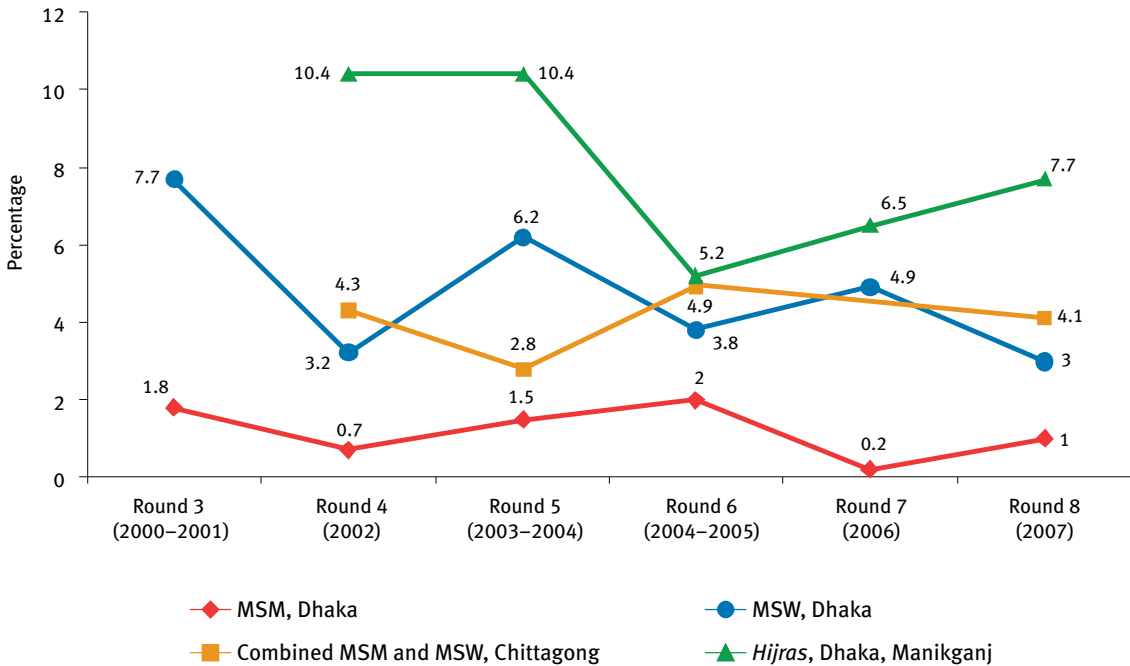
2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence and trends of sexually transmitted infections (STIs) among MSM and TG populations

Bangladesh has undertaken eight rounds of surveillance with behavioural surveillance or serological surveillance alone (note that the surveys were not combined, only the reports were combined).^{*} As part of serological surveillance, blood tests were conducted for detecting active syphilis among MSM and MSWs. Among MSM, the prevalence of active syphilis varied from 2% in 2005, to 0.2% in 2006 and 1% in 2007. Among MSWs, the prevalence ranged from 7.7% in 2000 to 3% in 2007. Among the combined MSM and MSW group, syphilis prevalence fluctuated between 2.3% and 5.6% from 2002 to 2005. Although the prevalence of active syphilis decreased among *hijras* from 10.4% in 2002 to 5.2% in 2005, an increase has once again been identified: 6.5% in 2006 and 7.7% in 2007.^{2,11,12,13,14}

* Round 1 (1998–1999); Round 2 (1999–2000); Round 3 (2000–2001); Round 4 (2002); Round 5 (2003–2004); Round 6 (2004–2005); Round 7 (2006); and Round 8 (2007)

Figure 1. Trends in the prevalence of active syphilis among MSM, MSWs, combined MSM/MSW group and *hijras* (Round 3 to Round 8)



Source: Bangladesh – Round 8 technical report (2007), National AIDS/STD Programme (NASP) (unpublished)²

2.2 Prevalence and trends of HIV among MSM and TG populations

HIV prevalence among MSM, MSWs and *hijras* has been consistently less than 1%, with no major differences in HIV prevalence among the three groups. In Round 8 (2007), HIV prevalence among all the three groups was 0.3%. Among MSM only, in Round 4 (2002) and Round 7 (2006), the HIV prevalence was 0.2%; in all the other rounds, the HIV prevalence was 0%. Among MSWs, from Round 3 (2000–2001) to Round 6 (2004–2005), none tested positive for HIV except 0.2% in Round 4 (2002). An HIV prevalence of 0.7% and 0.3% was recorded in 2006 and 2007, respectively. Among *hijras*, HIV prevalence has remained less than 1% with a lower range of 0.2% in Round 5 (2003–2004) and a higher range of 0.8% in Round 4 (2002) and Round 6 (2004–2005).^{2,11,12,13}

2.3 HIV-related risk behaviours among MSM and TG populations

Sexual risk behaviour data described are mainly from the behavioural surveillance survey (BSS) (2006–2007)¹⁵ and compared with BSS Round 4 (2002) and, when appropriate, Round 5 (2003–2004).^{11,12,16}

2.3.1 Number and types of partners

MSM: Over the years, in general, the number of sexual partners (any type) of MSM has decreased (except in Sylhet). In Dhaka, the mean number of sexual partners of MSM in the preceding month decreased from 10 sexual partners in Round 5 (2003–2004) to five in BSS 2006–2007.[†] The reason for this decrease was not known. However, the average number of sexual partners among MSM in Sylhet did not change between the different rounds. On average, MSM in Sylhet had five partners (of any type) in the preceding month.^{15,16}

Sex with paid partners: In general, the number of paid partners has decreased among MSM in Dhaka while it has increased among MSM in Sylhet. In Dhaka, the percentage of MSM who reported buying sex from males, *hijras* and female sex workers (FSWs) in the past month decreased when data from BSS 2006–2007 and BSS Round 5 were compared: males 62% and 72%, respectively; *hijras* 6.5% and 38%, respectively; and FSWs 24.8% and 57.2%, respectively. However, in Sylhet, 96.7% of MSM reported buying sex from males in Round 5, which decreased to 81.2% in BSS 2006–2007. In Sylhet, buying sex from *hijras* steadily increased from 7.2% in Round 4 to 12.2% in BSS 2006–2007. Buying sex from FSWs decreased in Dhaka and slightly increased in Sylhet during BSS 2006–2007 compared with Round 5.^{11,15,16}

Group sex: Group sex was defined as several men having sex with the same individual, one after another. Nearly a third of MSWs and around 15% of other MSM engage in group sex.⁶ Among MSWs in Dhaka, 31% among the group had not used a condom during the last group sex. Among MSM in Dhaka, 13.3% had group sex in the past month with a mean partner number of 3.6 at last group sex.¹⁵ Group sex among MSM in Dhaka showed a decrease in BSS 2006–2007 (13%) compared with Round 5 (54%). In Sylhet, however, group sex showed an increase in BSS 2006–2007 (13%)

[†] BSS 5 and serological survey 5 were conducted in the same years of 2003–2004. When BSS Round 6 was conducted in 2006–2007, serological survey 8 had already been conducted. Members from the State AIDS Committee (SAC)/ National AIDS/STD Programme (NASP) agreed to call BSS Round 6 as BSS 2006–2007 in order to avoid confusion.

compared with Round 5 (3%). Risk behaviours of MSM in Dhaka and Sylhet were much the same; in Sylhet, they have remained the same or have increased.^{15,16}

MSWs and hijras: The mean number of new clients for MSWs in both Dhaka and Chittagong showed a decline in BSS 2006–2007 (3.4 and 2.1, respectively) compared with Round 5 (8 and 2.8, respectively). The mean number of regular clients of MSWs increased in Dhaka in BSS 2006–2007 (5.5) and remained unchanged in Chittagong (1.9) compared with Round 5 (Dhaka 1.9; Chittagong 2.0). The number of both new and regular clients of *hijras* in Dhaka was high (14.8 and 14.5). The average number of regular clients of *hijras* steadily increased over the BSS rounds, from 8.3 in Round 4 to 14.5 in BSS 2006–2007.^{11,15,16}

Hijras continue to have a higher client turnover than MSWs. Most *hijras* in Round 5 (75.4%) and BSS 2006–2007 (70.2%) reported more than 20 clients in the past week compared with 8.2 clients in Round 4. However, none or insignificant proportions of MSWs in both Dhaka (0%) and Chittagong (0.3%) reported more than 20 clients in the past week over the various BSS rounds. MSWs in Dhaka have a higher client turnover than MSWs in Chittagong. On average, MSWs in Dhaka reported having 10 clients (new or regular) in the past week, while MSWs in Chittagong reported having four clients. With a high turnover of clients among both *hijras* and MSWs (comparatively more among *hijras*), the risk of acquiring or transmitting HIV is greater, with a potential for increase in HIV infections among these subgroups.^{11,15,16}

2.3.2 Condom use at last sex

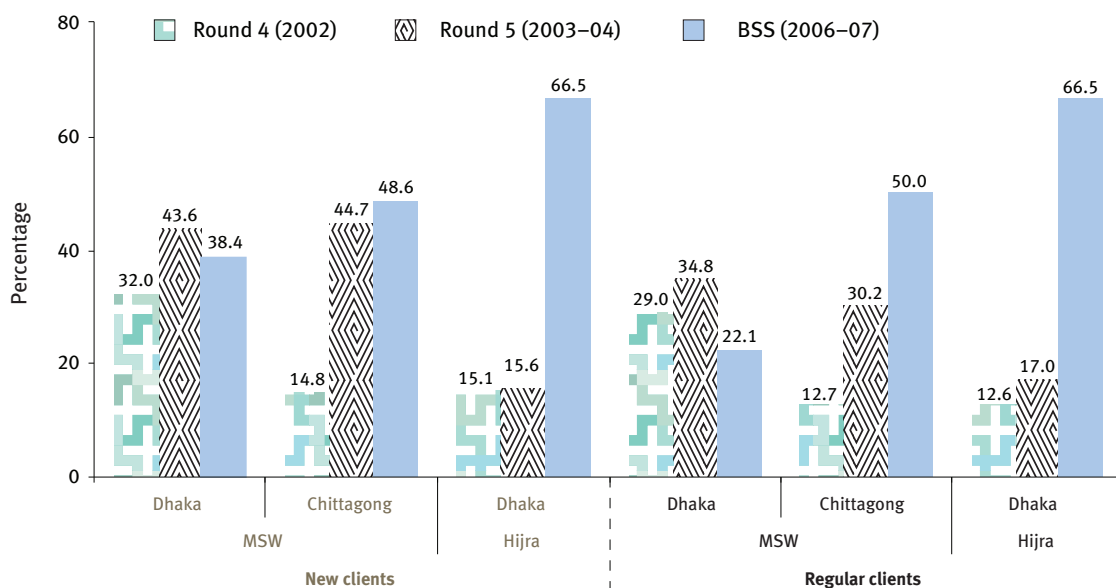
MSM: In general, the use of condoms is low and condom use at last sex has decreased over the years as identified in the various BSS rounds. Among MSM in both Dhaka and Sylhet, condom use at last sex with any group of sex workers decreased notably in BSS 2006–2007 (males 22.8%, *hijras* 7.8%, females 19.4%) compared with Round 5 (males 46.7%, *hijras* 27.3%, females 39.8%). However, among MSM in Sylhet, the percentage of MSM who used condoms with FSWs remained the same in BSS 2006–2007 (55.1%) and Round 5 (54.6%).^{11,15,16}

MSWs and hijras: Use of condoms at last sex has increased among *hijras* but decreased among MSWs. In Dhaka, the percentage of MSWs who used condoms during the last anal sex with both new and regular clients declined slightly in BSS 2006–2007 (new 38.4%, regular 22.1%) compared with Round 5 (new 43.6%,

regular 34.8%). In Chittagong, the percentage of MSWs who used condoms with new and regular clients increased in BSS 2006–2007 (new 48.6%, regular 50%) compared with Round 5 (new 44.7%, regular 30.2%). The percentage of *hijras* who used condoms with new and regular clients significantly increased in BSS 2006–2007 (new 66.5%, regular 66.5%) compared with Round 5 (new 16%, regular 17%).^{11,15,16}

Figure 2 provides an overview of condom use during last anal sex among MSWs and *hijras* from Round 4 (2002), Round 5 (2003–2004), and the BSS of 2006–2007.

Figure 2. Condom use during last act of anal sex



Source: National HIV serological surveillance 2002¹¹; Behavioural surveillance survey 2006–07¹⁵; Behavioural surveillance survey (BSS), 2006–07¹⁶

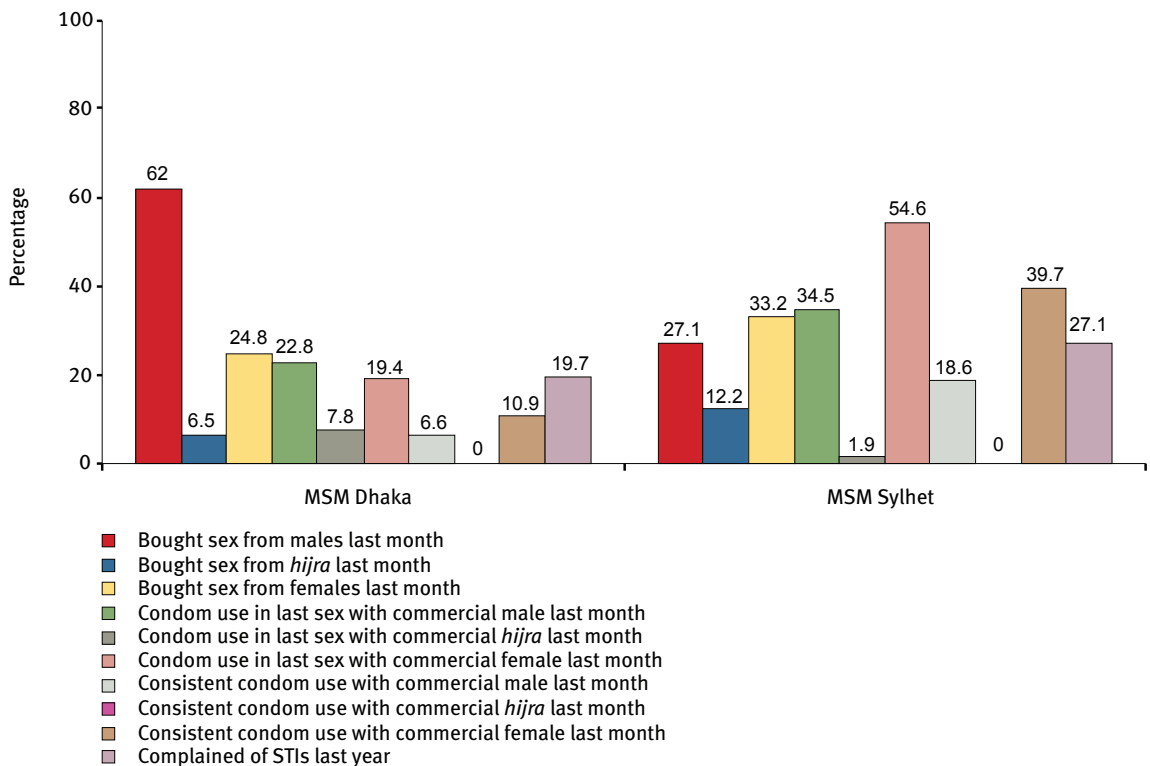
2.3.3 Consistency of condom use

MSM: Consistent condom use has generally declined among MSM in Dhaka, though among MSM in Sylhet, it has increased with male partners. In Dhaka, consistent use of condoms by MSM during sex over the past month with any group of sex workers has declined over the BSS rounds. In Sylhet, however, consistent use of condoms by MSM with *hijras* and FSWs decreased in BSS 2006–2007 (*hijras* 0%, FSWs 39.7%) compared with Round 5 (*hijras* 32.1%, FSWs 42.9%), while condom use with MSWs increased from 5% in Round 4 to 18.6% in BSS 2006–2007.^{11,15,16}

MSWs and hijras: Only a small proportion of MSWs and *hijras* used condoms consistently during anal sex with new clients in the past week. In Dhaka, consistent use of condoms by MSWs with new clients decreased slightly during BSS 2006–2007 (16%, down from 18% in the previous round), while it remained unchanged with regular clients (11%).^{11,15}

Figure 3 provides an overview of the sexual risk behaviours among MSM and clearly shows that in Dhaka and Sylhet, purchasing of sex was common and, irrespective of the type of sexual partner, condom use either at last sex or consistency of condom use over the past month was low.

Figure 3. Sexual risk behaviours and condom use among MSM



Source: BSS 2006–2007,¹⁵ Azim T et al. 2009⁶

MSM and female sexual partners: BSS 2006–2007 identified that many MSM were married. In the central area, 36.3% of MSM were married, while in the north-east 39.3% were married. Most MSM in the both the areas reported that females were regular sexual partners, and that in the past year the majority had had anal or vaginal sex with a female. Condom use during the last sexual act was low: 17.4% and 19.4% in the central and north-east regions, respectively.¹⁵

2.3.4 Injecting drug use

MSM: In both Dhaka and Sylhet, a significant reduction in risk behaviour relating to injecting drug use was noted among MSM. In Dhaka, the percentage of MSM who injected drugs in the past year decreased in BSS 2006–2007 (0.5%) compared with Round 5 (2.1%), while in Sylhet, none reported injecting drug use.^{15,16}

MSWs and hijras: In BSS 2006–2007, a slight increase was noted in the prevalence of injecting drug use among MSWs in Dhaka and Chittagong, whereas only a negligible proportion of *hijras* injected drugs. In both Dhaka and Chittagong, injecting drug use among MSWs increased slightly in BSS 2006–2007 (Dhaka 1%; Chittagong 5%) compared with Round 5 (Dhaka 0.5%; Chittagong 3.9%). In BSS 2006–2007, 24.2% of clients of MSWs in Dhaka and 17.5% of clients in Chittagong were reported to inject drugs. This clearly indicates the linkages between male-to-male sex networks and PWID.^{15,16}

3. NATIONAL RESPONSES

3.1 Policy and legal environment

MSM and other marginalized groups in Bangladesh face a variety of human rights issues including stigma, discrimination and denial of services in health-care settings. No laws or regulations in Bangladesh specifically protect most-at-risk groups from discrimination. Section 377A of the Bangladesh Penal Code criminalizes and punishes consensual sex between adult men. The law is silent on TG/*hijra* issues, which creates situations where TG face multiple forms of discrimination.¹⁷

After the first HIV Strategic Plan was reviewed in 2005, the National AIDS Committee (NAC) guided the development of the second National Strategic Plan for HIV/AIDS,

2004–2010 (NSP-II), with the active involvement of a wide range of stakeholders. The NSP-II identified high-risk populations – sex workers, drug users, MSM and mobile populations – as priority groups for HIV prevention, and recognized the need to involve these vulnerable groups in policy dialogue and formulation. Nevertheless, no specific targets were mentioned for MSM and *hijras* in relation to HIV prevention and treatment.

3.2 Interventions available

The government currently supports four major interventions among MSM and TG: the Bangladesh AIDS Programme, Male sexual health project, HIV/AIDS targeted intervention, and Health and community support for *hijras*. These interventions are supported by the United States Agency for International Development (USAID)/Family Health International (FHI), the Embassy of the Kingdom of the Netherlands, Government of Bangladesh, and Swedish International Development Cooperation Agency (SIDA)/Swedish Association for Sexuality Education (RFSU). Seven NGOs at 12 sites in Bangladesh implement these interventions among MSM and TG in which condoms and lubricants are distributed. The Bandhu Social Welfare Society (BSWS) is a key NGO involved in all the four major interventions listed above. Other NGOs or community-based organizations (CBOs) that implement these interventions include Badhan Hijra Shangha, Let there be light, Light House and Shustha Jiban.

3.3 Coverage of interventions

HIV prevention programmes are primarily targeted at most-at-risk population groups. The present coverage of prevention programmes for MSM is low. Coverage by prevention programmes during 2006–2007 declined substantially from previous years (2003–2004) with only 10–15% of MSM receiving a service. The proportion of MSWs covered by HIV prevention services in 2006–2007 was 47.9%, a decrease from 66% in 2003–2004. Among the *hijra* population in Dhaka, the coverage reported during 2006–2007 was 37%, an increase from 15.4% in 2003–2004.^{15,16} Accessing voluntary counselling and testing (VCT) services by MSM, MSWs and the *hijra* population was poor as shown by the BSS 2006–2007. Among the MSM and MSW populations, none outside of Dhaka reported using VCT. In Dhaka, among MSM, only 14.5% used the services and among MSWs it was only 1.3%. The *hijra*

community had not accessed VCT services.¹⁵ The same study found that accessing STI services offered by NGOs was low among MSWs and MSM in Dhaka: 8.4% and 8.2%, respectively. However, among *hijras* in Dhaka, it was considerably higher at 64.2%.¹⁵

By 2009, there were around 200 HIV-infected people on antiretroviral treatment (ART), which was estimated at around 3% of those who needed treatment.¹⁵ It is currently unclear as to what percentage of HIV-infected persons from most-at-risk population groups access ART. According to current information, there is a substantial decrease in the number of MSM and MSWs reached through HIV prevention interventions, posing additional challenges to scaling up prevention activities.

Table 3. Percentage of at-risk populations reached by HIV prevention programmes

Target groups	2005	2007
Male sex workers (%)	76.2	46.6
MSM (%)	77	12.7

Source: UNGASS country progress report 2008³

3.4 Current gaps in responses

The HIV prevalence among MSM, MSWs and *hijras* in Bangladesh is still low. Ongoing high-risk sexual behaviours – low condom use and multiple and varied partners – among MSM, MSWs and *hijras* underscore the need for scaling up HIV prevention interventions in Bangladesh. Yet what has been identified is a decrease in HIV programme coverage among these most-at-risk population groups. Accessing VCT and STI services is low among the MSM, MSW and *hijra* populations, and this also requires more focused attention. The *hijra* community has specific needs that are different from those of MSM and MSWs, but the service model is largely based on addressing the needs of MSM and is not really appropriate for the context of the *hijra* situation.⁶ Criminal laws against same-sex relations between consenting adults adversely impact upon an enabling environment for service delivery and this also contributes towards impeding efforts at HIV prevention interventions. The data show that having female sexual partners among MSM is not uncommon and condom use is poor. Responsive measures to prevent sexual transmission of HIV to spouses and commercial female sexual partners will need to be given increased consideration.

3.5 Recommendations – the way forward

- Urgently increase the coverage of services and expand them by encouraging more NGOs and CBOs to reach out to MSM, MSWs and *hijras*. Coverage of HIV prevention programmes for MSM and MSWs has declined substantially, and still remains overall low for the *hijra* population. Enhance coverage through outreach and offer HIV information, education, communication (IEC) and counselling services on sexual health and risk reduction. Improve access to VCT and STI services, which is low and also requires increased attention.
- Encourage the involvement of the target population in designing and implementing HIV prevention programmes so that there is a sense of ownership and participation. The *hijra* community has specific needs that are different from those of MSWs and MSM, but they commonly receive the same services as those for MSM. Encourage greater involvement of this community in the design and delivery of services.
- Ensure that the quality of services is not compromised while scaling up services. To ensure the quality of services, regular independent evaluation of HIV prevention services should be undertaken.
- Increase efforts to promote condom use and ensure easy access to condoms and lubricants for MSM, MSWs and *hijras*.
- Establish prevention programmes among MSM to promote safer sex behaviours with both regular and commercial female partners. A high proportion of bisexual behaviours among MSM, including interactions with FSWs, mean that female partners of MSM are at risk for HIV infection.
- Create an enabling legal environment by decriminalizing consensual sex between adult males. This would allow for improved access to HIV prevention services and improve the practice of safe behaviours. Targeted advocacy and provision of education is important; multiple sectors and the wider community should be involved to increase the levels of knowledge, and work towards decreasing the level of stigma and discrimination experienced by MSM, MSWs and *hijras*.
- Implement appropriate risk reduction interventions that incorporate harm reduction measures specific to PWID among MSM, and decrease sexual risk behaviours among MSM.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

In India, HIV was first reported in 1986 among female sex workers (FSWs) in Chennai. By 2007, India had the third-highest burden of HIV in the world with an estimated 2.31 million (range 1.8–2.9 million) people living with HIV (PLHIV).¹ HIV prevalence in the general population was low (0.36%); however, it was disproportionately high among FSWs and their clients, people who inject drugs (PWID) and men who have sex with men (MSM).¹ HIV sentinel surveillance conducted so far shows that the HIV prevalence was up to 10–20 times greater among high-risk groups than among the general population. In 2008, the overall picture was that of a concentrated epidemic with a high mean prevalence among specific high-risk groups – PWID (9.19%), MSM (7.30%), FSWs (4.94%) and sexually transmitted infection (STI) clinic attendees (2.46%). In 2007, the mean HIV prevalence among MSM was 7.4%.^{1,2}

India has multiple diverse epidemics occurring in different geographical areas at different time points. The predominant mode of transmission remains the sexual route, which accounts for 86% of the reported AIDS cases.³ The severity of the dual HIV epidemic in the north-east, driven by injection drug use and unsafe sex, remains unchanged. In the southern states, the HIV epidemic, which is primarily driven by unsafe sex, has begun to decline as indicated by a consistent fall in HIV prevalence among young women attending antenatal (ANC) clinics.⁴

1.2 Size of the MSM and transgender (TG) populations

The estimated size of MSM and male sex worker (MSW) populations in 2006 in India was reported at 2 352 133 and 235 213, respectively.⁵ No reliable estimates were available for *hijras* or transgender (TG) women. Some behavioural studies conducted among the “general” male populations and STI clinic attendees in different parts of India have reported a prevalence of same-sex behaviour ranging from 6% to 13%, depending upon the male population type.^{6,7,8} In one Indian study among 2910 males (15–49 years) in five rural districts of five states (Haryana, Rajasthan, Uttar Pradesh, Orissa and Karnataka), 9.5% of young unmarried men who had sex in the past year reported having had anal sex with another male. Additionally, 3.1% of

married males who had extramarital sex in the past year reported having had anal sex with another male.⁹ In another study conducted in 30 slums of Chennai, 5.9% ($N = 46/774$) reported having ever had same-sex encounters.⁶ In studies conducted among male STI clinic attendees, same-sex behaviour ranged from 7%⁷ to 13%.⁸

1.3 Typologies of MSM and transgender populations

The term MSM is an umbrella term that may be applied to various and differently self-identified subpopulations. In major cities and towns, *kothis* are relatively well organized and are a visible subgroup of MSM. *Kothis* are generally of lower socioeconomic status and some engage in sex work. *Kothis* are a heterogeneous group that includes same-sex-attracted males of all ages whose gender behavioural traits are primarily feminine; MSWs who may adopt feminine mannerisms to attract male clients; and TG or trans-sexual women. The meanings attached to the *kothi* identity may vary across India by region as well as among *kothi*-identified individuals within the same locale.^{10,11,12} A separate group of TG and trans-sexual women with a long tradition in India are called *hijras* in North India and *aravanis* in Tamil Nadu, South India. *Hijras* or *aravanis*, though biologically born as males, consider themselves as women. They are not included under the umbrella term “MSM”. *Hijras/aravanis* face distinct issues that merit more focused attention. Some proportion of *hijras* or *aravanis* may also identify as *kothis*.

Kothis and *hijras* use the term *panthi* to refer to their masculine male sexual partners or any male who is masculine and seems to be a potential sexual (insertive) partner. *Panthis* are supposed to be “real men who only penetrate”. The term *panthi*, however, is not adopted by those so named. It may also denote different types of male partners depending upon the context in which it is used: casual or paying partners or a male lover with whom a *kothi* may or may not cohabit. The equivalent terms used in different states to denote masculine insertive male partners are: *gadiyo* (Gujarat); *parikh* (West Bengal); and *giriya* (Delhi). The term “double-decker” or “double” is used by *kothis* to refer to someone who penetrates as well as receives. Though originally a label, MSM with a “double-decker” identity are increasingly becoming common, at least in select urban areas. The equivalent terms used in different states are: *DD* (Tamil Nadu); *dupli-kothi* (West Bengal); and *do-paratha* (Maharashtra).

“Gay” or “bisexual” identities are more common among same-sex attracted males who are primarily from the middle or upper socioeconomic class and who are better educated. However, the major subpopulation across any socioeconomic class is likely to be MSM who do not have a specific identity related to their sexual orientation or behaviour.¹³

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence of STIs among MSM and transgender populations

Although the majority of studies have focused on HIV infection, STIs have also been studied among MSM populations. Two community-setting studies reported a high prevalence of laboratory-confirmed syphilis among MSM: 14% (Venereal Disease Research Laboratory [VDRL]- and *Treponema pallidum* haemagglutination [TPHA]-positive) in Tamil Nadu¹⁴ and 13% (VDRL-reactive) in Chennai.¹⁵ The prevalence of laboratory-confirmed syphilis among MSM in other states was 13% in Andhra Pradesh, 8.4% in Maharashtra and 11.9% in Karnataka.¹⁴ Among TG, one study found the prevalence of syphilis to be 13.6%.¹⁴ Clinic-based studies have documented a high prevalence of syphilis among MSM in Pune and Mumbai (5.8% and 17%, respectively)^{7,16} and among *hijras* in Mumbai, one study found it was 57%.¹⁶

2.2 Prevalence and trends of HIV among MSM and transgender populations

In India, separate HIV sentinel sites for MSM were introduced in 2000 and for TG, commonly termed *hijras*, in 2005. As of 2008, there were 66 sites for MSM and one site for TG. Based on the 2008–2009 surveillance, the average HIV prevalence among MSM was 7.3% but further details were not available.¹ In this chapter, discussion about the HIV prevalence among MSM will largely be based on 2007 figures. The national HIV prevalence among MSM in 2007 was 7.4%,¹⁷ ranging from 0% (in Bihar and Himachal Pradesh) to 17.6% (in Karnataka). In the southern states of India, HIV prevalence among MSM increased between 2003 and 2007 in the sentinel sites in Karnataka (10.8% in 2003 to 17.6% in 2007) and Tamil Nadu (4.2% in 2003 to 6.6% in 2007). A decreasing trend was noted only in Maharashtra, from 18.8% in 2003 to 11.8% in 2007, where the study was conducted at the same sentinel sites.¹⁷

An integrated behavioural and biological assessment (IBBA) conducted in 2005–2007 found that in the city of Hyderabad in Andhra Pradesh, HIV prevalence among MSM was 24.7%, while in Madurai in Tamil Nadu, it was 22.3%.¹⁸ Three clinic-based studies conducted among MSM attending STI clinics in Maharashtra reported an HIV prevalence ranging from 11% to 18.9% (11% in Mumbai;⁸ 17% in Mumbai;¹⁶ and 18.9% in Pune⁷). One study also recruited members of the TG community ($N = 28$) and reported an HIV prevalence of 68% in Mumbai,¹⁶ while a study in five sites in Tamil Nadu found a prevalence of 12%.¹⁸

2.3 HIV-related risk behaviours among MSM and TG

2.3.1 Number and types of male partners

The first national behavioural surveillance survey (BSS) in 2001^{†19} was carried out in five locations: Bangalore, Chennai, Delhi, Calcutta and Mumbai. The BSS (2006), in addition to these five cities, included five other locations in five states (Andhra Pradesh, Goa, Gujarat, Kerala and Uttar Pradesh). The total number of MSM sampled in the BSS (2006) was 2638 across 10 locations.¹⁹

The BSS (2006) among MSM reported both commercial and non-commercial partners, with some variation across sites in the percentage who reported having had sex with a commercial and non-commercial male partner in the past month (Table 1).¹⁹ The median number of male partners in the past one month varied across sites, ranging from 1 to 15 (Bangalore) for non-commercial partners, and from 2 to 30 (Bangalore) for commercial partners. In Bangalore, the median number of non-commercial male partners increased substantially from 4 in 2001 to 15 in 2006.

In clinic-based studies, the number of partners reported by MSM was relatively higher. In Mumbai-based STI clinics, 45% of MSM had more than five male partners during the past six months, and 39% of TG had more than 10 male partners in the past one month.¹⁶ In Pune, 54.7% of MSM had between 10 and 99 life-time partners, and 23.1% had ever had sex with *hijras*.⁷ Community-based studies also indicated that MSM had multiple male partners: 25.9% of MSM in Andhra Pradesh reported having had sex with three to five male partners during the past one month.²⁰

[†]The BSS 2001 data are given along with those for BSS 2006.

Table 1. Different types of sexual partners (proportion and number of partners) – India BSS 2001 and 2006 (NACO)

Sites	Ever married to women (%)		Any female partner in past 6 months (%)		Commercial male partners in past 1 month (%)		Median number of commercial male partners in past 1 month		Non-commercial male partners in past 1 month (%)		Median number of non-commercial male partners in past 1 month	
	2006	2001	2006	2001	2006	2001	2006	2001	2006	2001	2006	2001
States												
Andhra Pradesh	45.6		54.8		37		6		90.4		3	
Gujarat	55.6		42.7		52.8		3		85		4	
Goa	23.7		31.4		11.8		3		96.4		4	
Kerala	32.6		30.4		51.9		4		40		2	
Uttar Pradesh	37.5		51.5		61.4		3		64.2		2	
Bangalore	41.1	29.6	16.7	7.8	64.1	36.3	30	5	48.9	89.6	15	4
Chennai	17.8	37.9	12.6	34.6	56.7	50.7	10	12	69.3	72.8	3	6
Delhi	50	46.2	69.6	51.8	68.5	65.2	2	5	56.7	74.2	1	2
Kolkata	10	24.1	19.3	25.2	50.7	17.8	3	6	85.6	84.8	2	4
Mumbai	27	28.6	25.9	32.6	8.5	7.6	2	5	84.8	73.2	4	3

Source: National AIDS Control Organization (NACO). BSS, 2001 and 2006¹⁹

2.3.2 Female partners and marital status

In both the BSS 2001 and 2006, a significant proportion of MSM reported having had sex with female partners in the past six months, and this varied across sites. In the BSS 2001, reporting a female sexual partner was highest in Delhi (51.8%) and lowest in Bangalore (7.8%).¹⁹ In the BSS 2006, it was highest in Delhi (69.6%) and lowest in Chennai (12.6%).¹⁹ It was interesting to note that the percentage had doubled in Bangalore from 7.8% in 2001 to 16.7% in 2006,¹⁹ while it showed a decrease in Chennai, Kolkata and Mumbai (Table 1). In the BSS 2001, having been married to a woman was highest in Delhi (46.2%) and lowest in Kolkata (24.1%).¹⁹ The BSS 2006 showed a decrease in marital status among MSM in Kolkata (10%), while it was highest in Gujarat (55.6%).¹⁹ In another study among MSM attending STI clinics, 82.3% had ever had sex with a female partner and 72.7% had ever had sex with female sex workers.⁷

2.3.3 Condom use at last sex with male partners

Condom use at last anal sex with commercial male partners varied across locations. As seen in Annex 1, during the BSS in 2001, use of a condom with a commercial male partner was lowest in Kolkata (18.9%) and highest in Mumbai (66.7%);¹⁹ in 2006, it was lowest in the state of Uttar Pradesh (13.1%) and highest in Goa (87%).¹⁹ In the BSS 2001, condom use with non-commercial male partners was lowest in Delhi (25.8%) and highest in Bangalore (80.7%);¹⁹ in the BSS 2006, it was lowest in the state of Uttar Pradesh (13.8%) and highest in Mumbai (88.2%).¹⁹

In a community-based study, the proportion of MSM reporting condom use at last anal sex with a paying male partner was highest in Andhra Pradesh (90.3%), followed by Maharashtra (83.0%) and Tamil Nadu (83.6%).²¹ The IBBA 2005–2007 conducted in Tamil Nadu among *hijras* ($N = 400$) showed that condom use with a regular sexual partner was 73% (last time) and 34% (every time). With a paying sexual partner, it was 93% (last time) and 50% (every time).¹⁸

2.3.4 Consistency of condom use with male partners

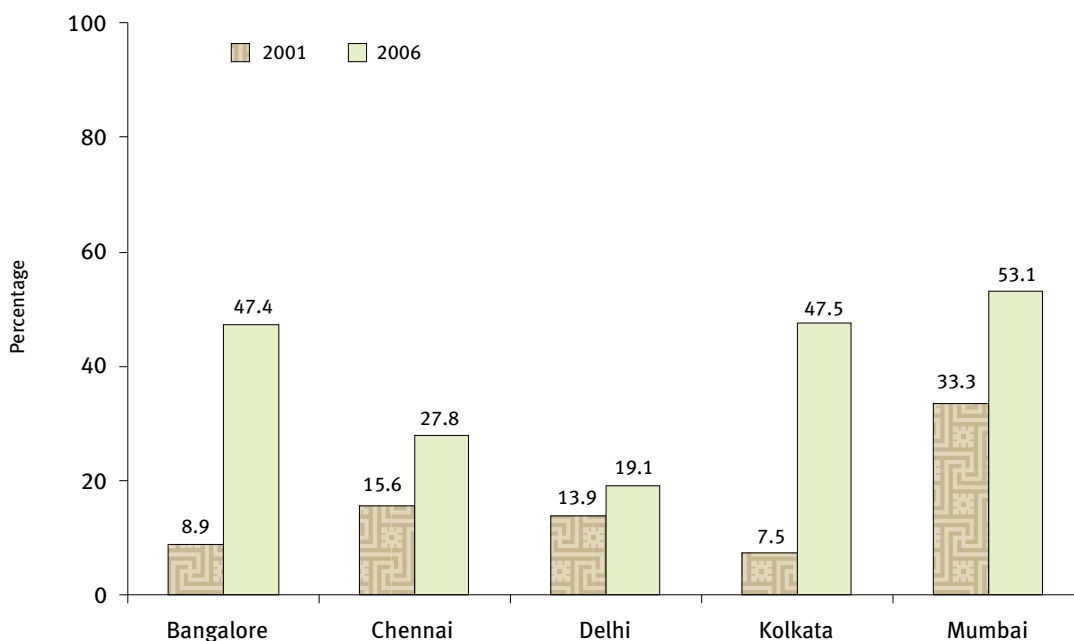
As seen in Figure 1, during the two rounds of BSS (2001 and 2006), consistent condom use in the past six months with commercial male partners showed improvements in some cities. The largest changes appear to be in Bangalore and Kolkata, and the least change in Delhi. Despite improvements in the overall consistency of condom use among MSM with commercial male partners, the majority still did not use a condom consistently.

In the IBBA 2005–2007 survey among MSM, consistent condom use (every time) was low in Andhra Pradesh at four sites (ranged from 2% to 22%) with regular partners but was higher in Tamil Nadu at four sites (ranged from 25% to 41%).¹⁸ Condom use with paying partners (last time) was found to be relatively high in both the states (range 73–92%).²¹

Consistent condom use with paid male/*hijra* partners in the past one month was highest in Maharashtra (72.4%), followed by Tamil Nadu (46.5%) and Andhra Pradesh (17.5%).¹⁸ Consistent condom use (in general) with non-regular, non-commercial male/*hijra* partners varied among states: Andhra Pradesh (13.0%), Maharashtra (57.9%) and Tamil Nadu (25.1%). Consistent condom use (in general)

with regular male/*hijra* partner during anal intercourse was highest in the state of Karnataka (76.7%), followed by Maharashtra (50.4%) and was lowest in Andhra Pradesh (9.4%).²¹

Figure 1: Consistency in condom use amongst men who have sex with men with commercial male partners during the past 6 months



Source: National AIDS Control Organization, Ministry of Health and Family Welfare. *National behavioural surveillance survey 2001 and 2006*¹⁹

2.3.5 Condom use with female partners

In the BSS 2001, condom use at last sex with a female partner was lowest in Kolkata (23.5%) and highest in Bangalore (61.9%);¹⁹ in the BSS 2006, it was lowest in Bangalore (11.1%) and highest in Delhi (69.7%)¹⁹ (Annex 1). Consistent condom use over the past six months (BSS 2001) was lowest in Kolkata (10.3%) and highest in Mumbai (25.6%);¹⁹ in the BSS 2006, it was lowest in Uttar Pradesh (5.3%) and highest in Delhi (29.8%).¹⁹ In a clinic-based study, consistent condom use (in general) with a regular female partner varied across states, ranging from 1.6% in Andhra Pradesh to 41.9% in Karnataka; consistent condom use with a paid female partner in the past month ranged from 23.3% in Andhra Pradesh to 78.2% in Maharashtra.²¹

2.3.6 Drug use

In the BSS 2006, up to a third of MSM in Delhi (30.1%) reported injecting drugs but none reported injecting drugs in the past 12 months in Chennai, Kolkata and Andhra Pradesh. At other sites, 9.1% of MSM in Gujarat and Goa reported injecting drugs in the past 12 months. Drug use among MSM was highest in Delhi (60.4%), followed by Bangalore (21.1%) and lowest in Chennai (2.2%). Cannabis (commonly called *ganja*) was the non-injecting drug used most often.¹⁹

3. NATIONAL RESPONSES

3.1 Policy environment

Section 377 of the Indian Penal Code, a post-colonial British legacy, criminalizes consensual sex between adult males. Though this law has not been broadly enforced in a direct manner, the criminality of same-sex sexual behaviour indirectly supports MSM and *hijras* being subjected to physical and sexual violence, blackmail and extortion of money by the police, and aggressive, violent and often young criminals. Several sources document that peer educators and outreach workers involved in HIV prevention services for MSM have been harassed by the police.^{11,22,23}

In 2001, Naz Foundation (India) Trust, through the Lawyers Collective, filed a public interest litigation (PIL) in the Delhi High Court to decriminalize adult consensual same-sex relationships. Relying on Constitutional law, the petition asked for a “reading down” of Section 377 (making section 377 not applicable in the context of consensual sex between same-sex adults) of the Indian Penal Code, as it posed a structural barrier to conducting outreach to MSM with HIV prevention and treatment services. In July 2009, the Delhi High Court ruled that consensual same-sex relations between adults in private cannot be criminalized.²⁴ Soon after that judgment, appeals were lodged in the Indian Supreme Court objecting to the ruling. Besides legal issues, MSM and TG face various forms of stigma and discrimination from their families, society and in health-care settings.^{25,26}

As a result of a concentrated HIV epidemic in India, the focus of the current National AIDS Control Programme (NACP-III) is on “core high-risk groups”, including MSM. The NACP-III plan explicitly articulates that more attention needs to be given to MSM. For the first time, the national plan highlights the need to focus on issues of *hijras*/TG and MSWs.

3.2 Interventions available

In NACP-III, the National AIDS Control Organization (NACO) has developed operational guidelines for implementing targeted interventions (TIs) among MSM. The main components of the MSM TIs include: behaviour change communication (BCC) through outreach education and counselling; condom promotion and distribution; referral for treatment of STI; referral for HIV testing and antiretroviral treatment (ART); building ownership of the issues through community mobilization; and creating an enabling environment in the areas where TIs are implemented. Though there is provision for buying water-based lubricants, the budget is insufficient to meet the needs of all MSM in TI sites. As of December 2009, 131 TIs work exclusively for the MSM population and out of these, 29 TIs are managed by community-based organizations (CBOs). Each specific MSM TI reaches out to a range of 400–1500 MSM. In addition, there are 200 composite TIs which provide HIV-related services to MSM as well as to FSWs and PWID.

In a mapping study, 152 organizations and networks were found to be working with MSM in India.²⁷ Of these, 53 were NGOs (including international NGOs) and 99 were CBOs. Similarly, 103 organizations and networks (that include agencies providing services for MSM) were found to be working with TG in India.²⁷ Nearly half (46/103) of these organizations were CBOs. Some of the key agencies working with TG include the Tamil Nadu Aravanigal Association in Chennai and Astitva in Mumbai.

Some key agencies that have been offering various prevention and support services for MSM and TG for several years include the Humsafar Trust in Mumbai, Naz Foundation India Trust in Delhi, and Social Welfare Association for Men in Chennai. Some of the main coalitions of agencies working with MSM, *kothis* and *hijras*/TG include: Indian Network for Sexual Minorities (INFOSEM), MANAS Bangla in West Bengal state, and Naz Foundation International's partner network. These are recognized as effective vehicles for joint policy advocacy with the government and other key stakeholders. These networks have played a key role in the formulation of the policy and operational guidelines of India's NACP-Phase III (2007–2012) on HIV TIs among MSM.

An area where HIV intervention efforts for MSM should be strengthened is inside prisons. The risk of being infected in prison through unprotected sex is high. Though same-sex sexual activity (consensual and non-consensual sex) within prisons is acknowledged, condoms are not made available.

3.3 Coverage of interventions

By late 2009, 275 000 MSM were reported to be “covered” through TIs. TIs are supported by the State AIDS Control Society (SACS) and other donor agencies. It has been reported by NACO that out of an estimated 351 000 MSM considered to be at high risk[‡] for HIV in different states of India, the coverage is 78%.²⁸ At the beginning of NACP-III (2007), only 30 TIs for MSM were established but by September 2009, there were 131 TIs exclusively for the MSM population.

Reaching a higher level of coverage will, however, be a challenge. As found in the BSS (2006)¹⁹ and reported in the United Nations General Assembly Special Session (UNGASS) country progress report of 2008, the percentage of MSM reached with HIV prevention programmes across ten states in India varied widely (17–97%).²⁹ Similarly, the percentage of MSM who had undergone an HIV test in the past 12 months and who knew their results also varied widely (3–67%). India has a free anti retroviral therapy (ART) programme for people living with HIV (PLHIV), and this is offered from 248 centres. As of August 2009, 261 806 patients were being provided free ART.² As of November 2009, the cumulative number of TG patients ever started on ART was 658, and the total number of TG patients alive and on ART was 467 (grand total numbers as found at NACO centres).³⁰ Data on ART for MSM were not found.

3.4 Current gaps in responses

The available literature shows a high prevalence of STIs among MSM and TG, and a growing increase in HIV prevalence overall. Reaching out to high-risk groups such as MSM and TG will need to be accelerated, and the provision of an adequate supply of condoms and lubricants increased. Consistent condom use with commercial and non-commercial male and female partners remains low overall, and behaviour change through information, education and communication (IEC) delivered through appropriate channels such as outreach or from TIs will be necessary. Addressing the needs of female partners of MSM through IEC appears to be missing and this will need to be given a higher priority. Information about the TG population is available but further research among this high-risk group will be required to respond to their specific needs. Stigma and discrimination against MSM and the TG community in

[‡] High risk was considered as having more than 15 partners per month.

health-care settings and society still remains a challenge, which hinders access to HIV prevention, treatment and care services.

3.5 Recommendations – the way forward

- Increase the number of TIs for wider coverage of sexual health services, including prevention, treatment, care and support for MSM and TG populations.
- Conduct ongoing monitoring and evaluation of TIs for quality, efficiency and effectiveness in meeting the needs of MSM and TG.
- Increase the provision of condoms and lubricants for MSM and TG, and provide IEC to bring about a reduction in sexual risk behaviours. Water-based lubricants need to be provided free of cost along with high-quality free condoms. As an interim measure, an adequate budget should be allocated for buying the required quantity of water-based lubricants to meet the needs of MSM and TG at TI sites.
- Encourage voluntary counselling and testing (VCT) among MSM and TG, and encourage health service providers to be more pro-active in detecting and managing STIs among MSM and TG.
- Promote safer sexual behaviours of MSM with female partners. A high proportion of bisexual behaviours among MSM means that female partners of MSM are at risk for HIV infection and points to the need for prevention programmes among MSM.
- Encourage greater involvement of the TG community in the design and delivery of services. The TG community has specific needs that are different from those of MSM but they commonly receive the same services as those provided to MSM.
- Promote and implement strategies for addressing the prevention needs of MSM and TG living with HIV.
- Encourage an increase in the formation and strengthening of CBOs led by MSM and TG community members. Where appropriate and feasible, encourage a smooth transition of TIs from NGOs to CBOs to improve community ownership and sustainability.

- Build the organizational and financial management capacity of CBOs to implement HIV prevention interventions among MSM and TG populations.
- Scale up TIs for MSM in identified “hot-spots” in various states in India through ongoing mapping and size estimation of MSM and TG populations.
- Introduce comprehensive HIV prevention interventions within prisons to reduce both sexual and drug use-related risks.
- Increase advocacy efforts to reduce stigma and sensitize the general public, police and health-care providers to the issues faced by MSM and TG. This will contribute toward the creation of an enabling environment and assist in improved implementation of services by TIs for MSM and TG populations.
- Provide ongoing advocacy and legal efforts if the Government of India does not support the Delhi High Court decision (2009)²⁴ to decriminalize consensual same-sex relations among adults.

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Annex 1. Condom use of MSM with different types of partners in India (BSS 2001 and 2006)

	Condom use with different types of partners – India BSS 2001 and 2006 ¹⁹						Consistency in condom use during past six months					
	Female partner (%)		Commercial male partner (%)		Non-commercial male partner (%)		Female partner (%)		Commercial male partner (%)		Non-commercial male partner (%)	
	2006	2001	2006	2001	2006	2001	2006	2001	2006	2001	2006	2001
STATES												
Andhra Pradesh	41.2		85.5		81.6		10.1		85.5		81.6	
Gujarat	50.8		62.1		70.4		18.9		62.1		70.4	
Goa	41.5		87		87.7		22.6		87		87.7	
Kerala	29.3		67.6		58.1		9.8		67.6		58.1	
Uttar Pradesh	18.5		13.1		13.8		5.3		13.3		13.8	
CITIES												
Bangalore	11.1	61.9	56.4	31.5	51.5	80.7	11.1	0	47.4	8.9	42.4	43.7
Chennai	17.6	48.9	49.8	63.7	66.8	58.5	8.8	14.9	27.8	15.6	21.4	19.2
Delhi	69.7	26.5	40.5	30.4	45.8	25.8	29.8	14.2	19.1	13.9	14.4	11.3
Kolkata	46.2	23.5	63.8	18.9	67.1	30.7	32.7	10.3	47.5	7.5	53.7	20.6
Mumbai	31.4	42.2	62.5	66.7	88.2	62.4	32.9	25.6	53.1	33.3	79.0	56.4

Source: National behavioural surveillance survey (BSS), 2006.¹⁹



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1. THE CONTEXT

1.1 Overview of the HIV epidemic

The HIV epidemic in Indonesia remains among the fastest-growing in Asia. The first case of HIV infection was reported in 1987. As of 2008, Indonesia had an estimated adult HIV prevalence of 0.2% and approximately 270 000 (190 000–400 000) persons living with HIV (PLHIV).¹ The HIV epidemic in Indonesia remains at a low level in the general population and is primarily concentrated among several high-risk groups that include male, female and transgender (TG) sex workers and their clients, people who inject drugs (PWID) and their partners, and men who have sex with men (MSM). In 2007, a high HIV prevalence was found among MSM (5.2%), male sex workers (MSWs, 20.3%), PWID (52.2%) and female sex workers (FSWs, 7.1%).² By 2013, it has been estimated that the number of PLHIV will be 482 800: there were 51 300 new infections in 2008 and by 2013 the figure is estimated to be 63 000.³

1.2 Size of the MSM and transgender (TG) populations

According to the Department of Health estimates in the year 2006,⁴ the number of *warias* (male-to-female TG) was between 20 960 and 35 300, and the number of MSM was between 384 320 and 1 148 270 (median 766 800). The number of clients of *waria* sex workers was between 62 000 and 104 000. There has been an increasing trend in HIV prevalence among *warias*: in 2006, HIV prevalence ranged from 3% to 17%.¹

1.3 Typologies of MSM and transgender populations

For HIV serosurveillance purposes, the Government of Indonesia classifies same-sex attracted biological males in Indonesia into two main groups: *warias* (including those who sell sex) and MSM (including those who sell sex).

The term *waria* is derived from the Indonesian Bahasa words female (*wanita*) and male (*pria*) and describes a range of identities, including TG, those who identify as male but present as female, those who identify closely as female but are biologically male, and those who imitate women in dress and mannerisms but identify as male,

and those who neither identify as male nor female. *Waria* has been variously described by different authorities using terms such as transgender, transvestites and male-to-female trans-sexuals.^{5,6}

Three “cultures” of MSM have been described⁶ as follows: MSWs; transvestites (“cross-dressers”) of various kinds; and various clusters of men who seek male sexual partners (sometimes loosely called “gay” men), sometimes as clients – local and foreign partners of MSWs.

Indigenous terms for same-sex attracted males other than *waria* are not found in the available academic literature. Some authors describe “gay”-identified individuals in urban Indonesia. However, the notion of “gay” men in Indonesia might be different from that in western countries. Some authors mention that *warias* or gay men prefer having sex with “normal” men^{6,7} or “real” men,⁶ primarily referring to masculine-looking, apparently heterosexual males, though no specific label is given for these men. However, the integrated biological and behavioural surveillance (IBBS) 2007 data indicate that *warias* call their regular male partners as “husbands”.⁵

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence of sexually transmitted infections (STIs) among MSM and TG populations

The 2007 IBBS⁵ was conducted to measure key HIV- and STI-related biological and behavioural indicators for key population subgroups. The IBBS 2007 collected biological data on the prevalence of HIV infection and STI among MSM and *warias* in three cities – Jakarta, Surabaya and Bandung (Table 1). Between 29% and 34% of MSM in these three cities had one or more rectal STI, with chlamydial infection being slightly more prevalent than gonorrhoea. The high prevalence of rectal STIs indicates a high prevalence of unprotected anal sex. The prevalence of urethral STIs was comparatively lower, and ranged between 5% and 8%. Among *warias*, the prevalence of various STIs was often much higher than those found among MSM in all the three cities. For example, rates of syphilis among *warias* were often five times higher than those among MSM (Table 1).

2.2 Prevalence and trends of HIV among MSM and TG populations

HIV prevalence among MSM rose sharply from 0.87% in 2002⁸ to 5.2% in 2007.¹ Similarly, HIV prevalence among *warias* almost doubled, from 11.8% in 2002 to 22% in 2005; and has also been constantly rising among MSWs, from 4.02% in 2002 to 6% in 2004⁹ to 20.3% in 2007.⁵ In the IBBS 2007 (see Table 1), the HIV prevalence among MSM in Jakarta, Surabaya and Bandung ranged from a high of 8.1% in Jakarta to a low of 2% in Bandung. HIV and STI prevalence was higher among MSM who had bought and sold sex.⁵ In 2002, a cross-sectional survey was conducted among *warias* (N=241), MSWs (N=250) and MSM (N=279) in Jakarta.⁸ The HIV prevalence was 22%, 3.6% and 2.5%, respectively; and syphilis prevalence was 19.3%, 2% and 1.1%, respectively. Comparing these earlier data with the 2007 IBBS⁵ data from Jakarta, there has been a significant increase in the prevalence of both HIV and syphilis among MSM and *warias* (Table 1).

Table 1. HIV and STI prevalence among MSM and *warias* in three cities

City	HIV prevalence (%)		Rectal chlamydial infection (%)		Rectal gonorrhoea (%)		Syphilis (%)		Rectal chlamydial infection or gonorrhoea (%)		Urethral STI (%)	
	MSM	<i>Waria</i>	MSM	<i>Waria</i>	MSM	<i>Waria</i>	MSM	<i>Waria</i>	MSM	<i>Waria</i>	MSM	<i>Waria</i>
Jakarta	8.1	34	21.9	22.7	18.6	29.8	3.2	25.2	32.2	42.1	8.4	25.2
Bandung	2.0	14	19.4	34.5	22.3	37.4	5.6	25.2	33.6	54.6	5.2	25.2
Surabaya	5.6	25	21.3	33.7	14.9	19.8	4.0	28.8	29.3	44.0	5.2	29.8

Source: IBBS 2007⁵

2.3 HIV-related risk behaviours among MSM and TG populations

2.3.1 Number and types of partners

The IBBS 2007 collected behavioural data from MSM in six cities – Batam, Bandung, Jakarta, Malang, Medan and Surabaya; and from *warias* in five cities – Bandung, Jakarta, Malang, Semarang and Surabaya. The median number of male partners among MSM in the past month ranged from 10 in Jakarta to two in Batam. The study revealed that 39% of MSM were also bisexual. The median number of female

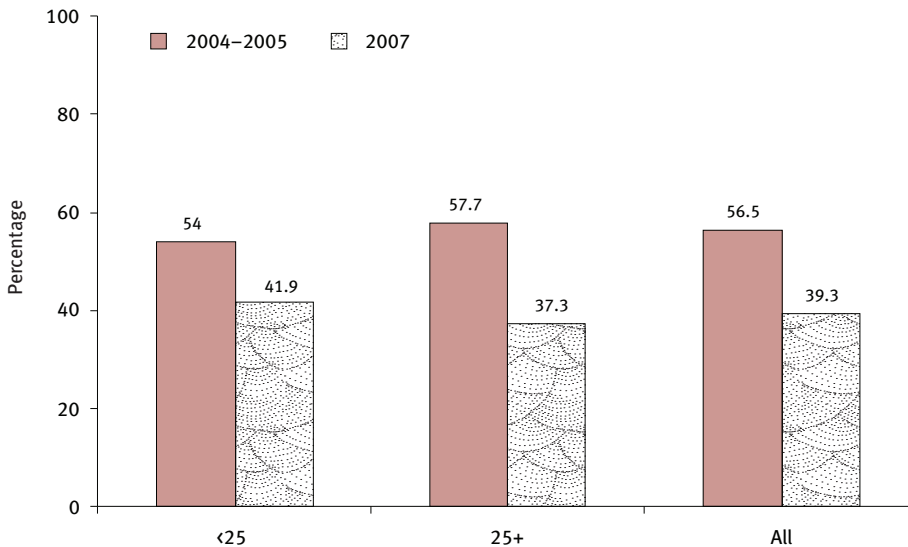
partners in the past month was one in four cities, except Surabaya and Medan where it was two. One fifth (20%) reported buying sex from males and about half (47%) reported selling sex with to males. Ten per cent reported buying sex and 14% had sold sex to female partners.⁵

Among *warias*, almost all (96% in Bandung) had sold sex in the past year and the median number of clients in the past week varied from four in Surabaya to one in Bandung. More than 90% of *warias* reported having both anal and oral sex with their male clients in the past year. In addition to clients, about 40–50% of *warias* also reported having regular male partners whom they call “husbands”.⁵ Another study¹⁰ conducted among 745 *warias* in various cities of Indonesia reported that the average number of commercial sex partners of *warias* was four per week. More than half (56%) reported having sex on average with two unpaid (regular and casual) sex partners in the previous year.

2.3.2 Condom use at last sex

Available IBBS data indicated that, among MSM, condom use at last anal sex had declined from 56.5% in 2004–2005¹ to 39.3% in 2007.⁵ However, among MSWs, condom use at last anal sex had increased from 47.5% in 2004–2005¹¹ to 72% in 2007.⁵ IBSS 2007 data indicated that condom use at last sex with females was less frequent; less than one third (32%) had used condoms with casual female partners.⁵

Figure 1. Percentage of MSM who reported having used a condom at last anal sex, 2004–2005 vs 2007



Source:

1. BSS Indonesia 2004–2005¹¹
2. UNGASS country report Indonesia¹

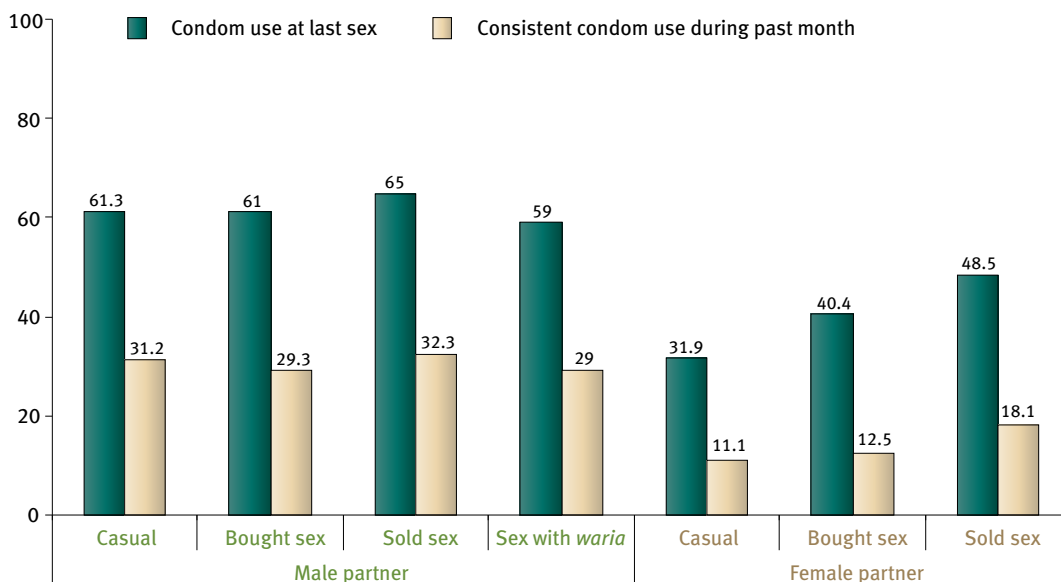
2.3.3 Consistency of condom use

The IBBS 2007 data indicated that consistent condom use in the past month was about 30% with male partners, irrespective of commercial or non-commercial partners. With female partners, consistent condom use ranged from 11% with casual partners to 18% with commercial partners.⁵

In Jakarta, 80.8% of MSM reported having had receptive anal sex in the past month, out of whom only 19.2% reported having always used condoms (highest 26.4% in Malang; least 12.8% in Surabaya). Similarly, 83.6% of MSM reported having had insertive anal sex in the past month, out of which only 21.6% reported having always used condoms (highest 28.8% in Malang; least 13.6% in Surabaya). Only 15% of *warias* in Jakarta reported having always used condoms during receptive anal sex in the past month, which was the lowest compared with other cities, the highest being 50% in Bandung. Consistent condom use during anal sex with all partners during the past month exceeded 20% in only one city – Malang (23% during insertive and 26% during receptive anal sex).⁵

A study conducted in 2008¹⁰ showed that among 745 *warias* in various Indonesian cities, 54% reported unprotected anal sex with their sexual partners.

Figure 2. Condom use during last sex and consistent condom use during past month among MSM in six cities, by type of partner



Source: IBBS 2007⁵

2.3.4 Use of water-based lubricants

The IBBS 2007 data reported that among MSM, use of water-based lubricants during last anal sex ranged from 11.6% in Batam to 21.8% in Malang. Among *warias*, use of water-based lubricants was slightly higher: 16.3% in Batam and 23.8% in Jakarta.⁵

2.3.5 Alcohol and injecting drug use

The IBBS 2007 data provide information about injecting drug use and alcohol use among MSM and *warias*. Among MSM, 31% in Jakarta and 25% in Batam reported using amphetamine-type stimulants (ATS) such as ecstasy, methamphetamines and ice in the past three months. Injecting of drugs was uncommon among MSM, with around 3% having ever injected drugs (range 1.2–3.5%). Among *warias*, the proportion who injected drugs in the past year was low (less than 4%) and the use of non-injectable drugs in the past year was low to moderate (range 3–17%). Among *warias*, 37% in Semarang and 72% in Bandung had consumed alcohol in the past three months.⁵ Another study in 2008¹⁰ among 745 *warias* in various Indonesian cities reported that 15% used illegal drugs and almost two-thirds consumed alcohol. Alcohol and drug use among MSM and *warias* poses a challenge as this can adversely impact upon the need to practise safer sex.

2.4 Potential for rapid transmission

Among MSM, STI prevalence is high, especially among those who sell sex. MSM have multiple sex partners, both male and female, and a significant proportion also buy and sell sex. HIV prevalence among MSM is increasing and consistent condom use is low. Among *warias*, HIV and STI prevalence is high and almost all sell sex to males, in addition to having regular and non-commercial male sexual partners. Available data indicate that MSM, MSWs and *warias* are at high risk for acquiring and transmitting HIV and STIs as a result of the increasing prevalence of HIV and STIs found in these population groups.

3. NATIONAL RESPONSES

3.1 Policy and legal environment

MSM, MSWs and *warias* continue to be marginalized in Indonesia. Though HIV prevention interventions for MSM are being implemented, the political environment is unfavourable. Religious conservatives continue to oppose sex education and condom promotion. Consensual sex between adult men is not illegal in Indonesia; however, under Islamic Sharia law, same-sex sexual activities are banned and punishable.

The Government of Indonesia through the Ministry of Health has launched the National AIDS Strategy and formulated the National HIV and AIDS Action Plan 2007–2009.¹² The Action Plan articulates that HIV prevention efforts will be primarily focused on certain subpopulations, including MSM and *warias*, to change their risk behaviours. The proposed activities for behaviour change include information, education and communication (IEC), promotion of healthy lifestyles, life-skills education, and training on the proper use of condoms.

The National AIDS Strategy has a priority target of reaching 80% of most-at-risk populations (MARPs) – which includes MSM and *warias* – with comprehensive HIV prevention programmes; influencing 60% of MARPs to change their behaviours; and providing antiretroviral therapy (ART) to 80% of those in need.

3.2 Interventions available

Interventions for MSM are primarily focused on behaviour change by providing IEC through outreach, and increasing the use of condoms and lubricants. Detection and management of STIs through referrals is encouraged, as is voluntary counselling and testing (VCT). The number of nongovernmental organizations (NGOs) or community-based organizations (CBOs) that provide services in the areas of sexual health and reduction of sexual risk behaviours for MSM, MSWs and TG community members is not known. The approximate number of condoms and lubricants distributed to these population groups is also not known.

3.3 Coverage of interventions

The UNGASS country report for Indonesia (2006–2007) showed that among MSM and MSWs, 32% and 52%, respectively, who had received an HIV test in the past 12 months knew their results;¹ in 2004–2005, among MSM the figure was 15.4%.⁹ About 40% of MSM and 60% of MSWs were reached by an HIV prevention programme during 2006–2007. Although there has been an apparent increase in the uptake of HIV testing from 2004–2005 to 2006–2007,^{1,11} it is not conclusive as survey methods and sample sizes differed between these periods. To reach universal access to HIV prevention and treatment by 2010, at least 80% of at-risk populations including MSM need to be covered and efforts will need to be accelerated to achieve this level of coverage. Condom programmes have largely been focused on FSWs rather than other high-risk population groups, despite the high risk of acquiring HIV through sexual transmission among MSM and TG populations.

The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) Round 4 supports care, support and treatment activities in 17 provinces. In this regard, the Global Fund has granted more than US\$ 40 million to Indonesia. The United States Agency for International Development (USAID), through the FHI–Aksi Stop AIDS (ASA) programme, focuses on STI and HIV transmission through commercial sex, MSM and harm reduction among PWID, and those in the uniformed services in eight provinces. There is no clear indication of the percentage of these funds spent for each subpopulation. USAID assistance is to reach out to about 95 000 MSM,¹³ which is less than one fifth of the estimated 766 800 (average) number of MSM in Indonesia (excluding *warias*).

3.4 Current gaps in responses

Indonesia has taken major steps in recent years to tackle the ongoing HIV epidemic and address the needs of MSM, MSWs and *warias*. The National AIDS Commission has shown a strong leadership role to ensure that there are clear targets and a costed action plan to implement the various interventions. The Indonesian Government has made a commitment that 80% of MARPs, which include MSM, MSWs and *warias*, will have access to comprehensive HIV prevention programmes. However, despite the positive responses and a serious interest in scaling up interventions, many MSM, MSWs and *warias* are still not in contact with health service providers

or HIV prevention agencies to ensure behaviour change and decrease risky sexual practices. Reaching out to these groups with IEC and encouraging a greater uptake of services for sexual health and sexual risk reduction is overall lacking. Consistent condom use with all sexual partners remains poor, and this will need to be addressed to contain the HIV epidemic.

3.5 Recommendations – the way forward

- Increase the number of sites for HIV and behavioural surveillance among MSM, MSWs and *warias*.
- Mobilize resources to fund priority interventions including for MSM, MSWs and *warias*.
- Scale up HIV prevention interventions and increase condom and lubricant use among MSM, MSWs and *warias*, given the increase in HIV prevalence and risk behaviours among these population groups. Dedicated HIV and STI services need to be expanded to increase accessibility and, importantly, should be located in settings suitable for these often highly stigmatized groups.
- Address the increasing prevalence of methamphetamine and other drug use among MSM in several cities by incorporating referrals to drug-use prevention and dependency treatment in HIV prevention programmes. Similarly, alcohol misuse needs to be addressed among *warias* through education and dependency treatment programmes.
- Conduct additional research to establish the size of at-risk MSM populations in various Indonesian cities and to better understand the sexual and social networks among MSM, MSWs and *warias*.
- Increase advocacy efforts to address the intolerance from religious conservatives, the community and family members through education and sensitization programmes to contribute towards improving societal acceptance of same-sex attracted males and *warias*.
- Provide increased training opportunities for those directly in contact with MSM, MSWs and *warias* to ensure improved HIV prevention efforts and provision of adequate care, support and treatment.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

The first case of HIV in the Maldives was reported in 1991. The latest data show that 14 Maldivians have been diagnosed with HIV/AIDS and, of these, 10 have died.¹ In addition, 243 expatriates working in the Maldives have been diagnosed with HIV, but most likely they acquired HIV infection elsewhere. HIV prevalence among resort workers was found to be 0.2% in 2008.¹ All infections were reportedly acquired through heterosexual transmission. An HIV situational assessment in the Maldives conducted in 2006 highlighted risk behaviours among female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PWID), seafarers, migrant workers and youth.² Mobility, geographically dispersed populations (across 196 inhabited islands), migration (from India and Sri Lanka) due to employment opportunities and external tourism were among the HIV vulnerability factors identified.³

1.2 Size of the MSM and transgender (TG) populations

The size of the MSM population is estimated to be between 1600 and 4200.⁴ A biological and behavioural survey (BSS) on HIV and AIDS conducted in 2008 in the Maldives recruited 126 MSM. This study also found that among PWID ($N = 276$), 4% had had sexual experiences with other men.⁵ Whether the PWID had same-sex sexual experiences in exchange for drugs could not be confirmed. The extent of male sex work and its significance in relation to HIV prevention is not known.⁶ No information is available about the TG population.

1.3 Typologies of the MSM and TG populations

Apart from the terms “MSM” and “male sex workers” (MSWs) used in government documents, no other labels or identities of same-sex attracted males are mentioned in the available HIV-related literature from the Maldives. No details are available about TG in the Maldives.

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence of sexually transmitted infections (STIs) among MSM

The BSS in 2008 focused on most-at-risk populations: FSWs, MSM, PWID, seafarers, migrant workers, resort and construction workers, and youth. MSM were surveyed at two sites – Malé (capital city) and Addu. None of the MSM tested reactive for syphilis. However, STI-related symptoms were reported by 17% of MSM sampled in Malé and 12% in Addu.⁷ A prevalence of 6% and 1% of hepatitis B was reported among MSM in Addu and Malé, respectively.⁵ The detection of hepatitis B among MSM may be a result of unprotected anal sex, sexual linkages with PWID or an involvement with injecting drug use. The BSS 2008 found all such behaviours among MSM and this may have contributed further to the risk of acquiring hepatitis B.⁷

2.2 Prevalence of HIV among MSM

The BSS 2008 indicated that the HIV prevalence among MSM was 0.0%.⁵

2.3 HIV-related risk behaviours of MSM

In 2006, a situational assessment was commissioned by the UN Theme Group on HIV/AIDS to support the Ministry of Health's Department of Public Health (DPH) in the development of a national strategic plan on HIV/AIDS for 2007–2011.² A gap that was identified at the time was the lack of an active surveillance system to provide a warning regarding the status of the epidemic in the country. Only qualitative data on MSM were available through key informant interviews. The report identified low levels of HIV knowledge and high-risk sexual behaviours among MSM who use the internet to find potential sexual partners.

In the BSS report of 2008, a high prevalence of unprotected sex was found among FSWs, MSM, PWID and youth.⁷ The reasons why MSM participants did not perceive themselves to be at risk for HIV included not changing sex partners often, always using a condom, not injecting narcotics, conviction that the partner was healthy or not having anal sex. Only 32% and 21% of MSM in Malé and Addu, respectively, perceived themselves to be at risk for HIV. Regarding knowledge of HIV in the various groups surveyed, between 67% and 80% of respondents correctly identified ways of preventing the sexual transmission of HIV, the exception being construction workers.

Among MSM, 48% in Malé and 47% in Addu reported that the chances of spread of HIV decreases by using a condom every time they have sex. The BBS in 2008 found that among all MSM participants, 48% had had sex with a male in the past month.⁷

2.3.1 Casual male sex partners

The BSS report 2008 found that most MSM had had sex with a man in the past year and, in the past month, no payment was exchanged nearly half of the time (48%). In addition, 16% of MSM in Malé reported that they had met a sex partner on the Internet (Figure 1).⁷ It has been suggested that among MSM, the potential lack of a possibility of marriage, and social recognition of a long-term commitment leads to a situation where it is more convenient to keep sexual relationships casual and have a large number of partners.⁸

2.3.2 Male sex work

The BSS 2008 reported that 44% of MSM in Malé and 18% in Addu had sold sex to another man and 29% in Malé and 18% in Addu had bought sex from a man in the past 12 months (Figure 1).

2.3.3 Condom use with men

The BSS 2008 reported that while 31% of MSM sold sex to men, 72% did not use condoms. Additionally, 58% of MSM had had sex with other men (consensual or paying) but 77% had not used condoms. A separation of the two survey sites shows that the incidence of unprotected anal sex with consensual and paid male partners was higher in Addu (86%) compared with Malé (67%). Among paying male partners it was 78% in Addu and 67% in Malé (Figure 2).⁷

2.3.4 Bisexual behaviour and condom use with women

The BSS 2008 found that a considerable proportion of MSM were married to women (29% in Malé and 26% in Addu).⁵ The study found that 75% of MSM had sex with women and 90% did not use condoms. The incidence of unprotected sex was higher with women in Addu (98%) compared with Malé (82%) (Figure 2). Many MSM had casual female partners as well as paid and paying female partners (Figure 1). More than two thirds of MSM (62% in Malé and 67% in Addu) reported having had sex with women without any money being exchanged. In Malé, less than one third of MSM (29%) reported having sold sex to women, and 49% reported having bought sex from women.⁷

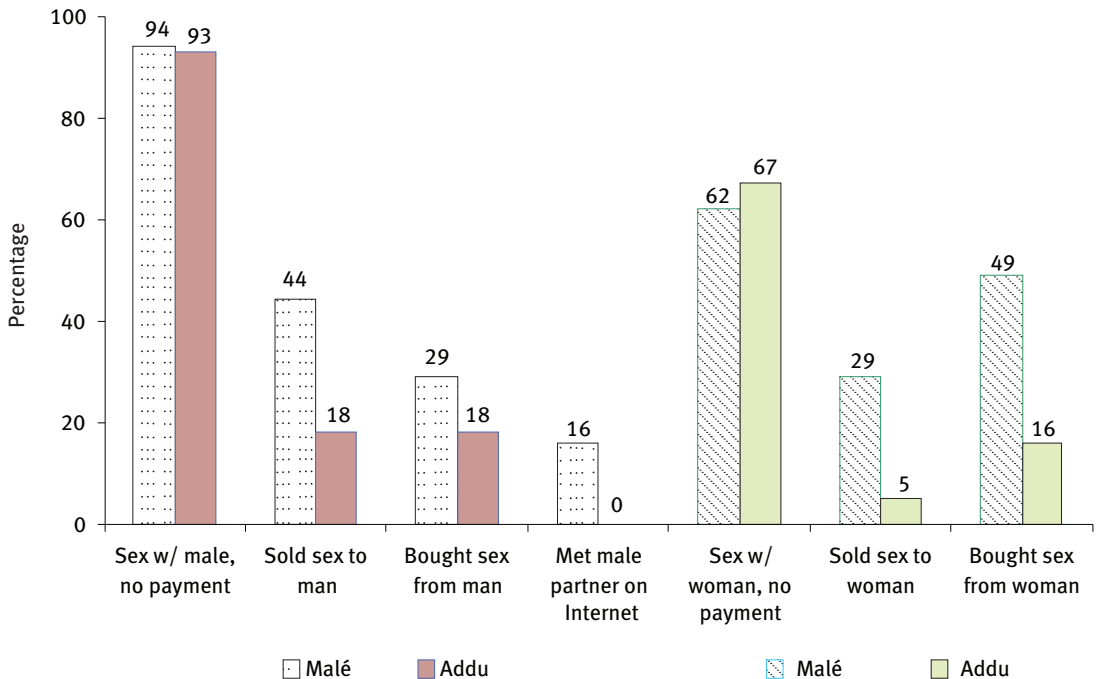
2.3.5 Injecting drug use

The BSS report 2008 shows that one fourth (25%) of MSM in Addu and 16% of MSM in Malé reported having ever injected drugs.⁷ Recent qualitative research has also found that MSM do use drugs, and often in connection with sex.⁸

2.4 Potential for rapid transmission

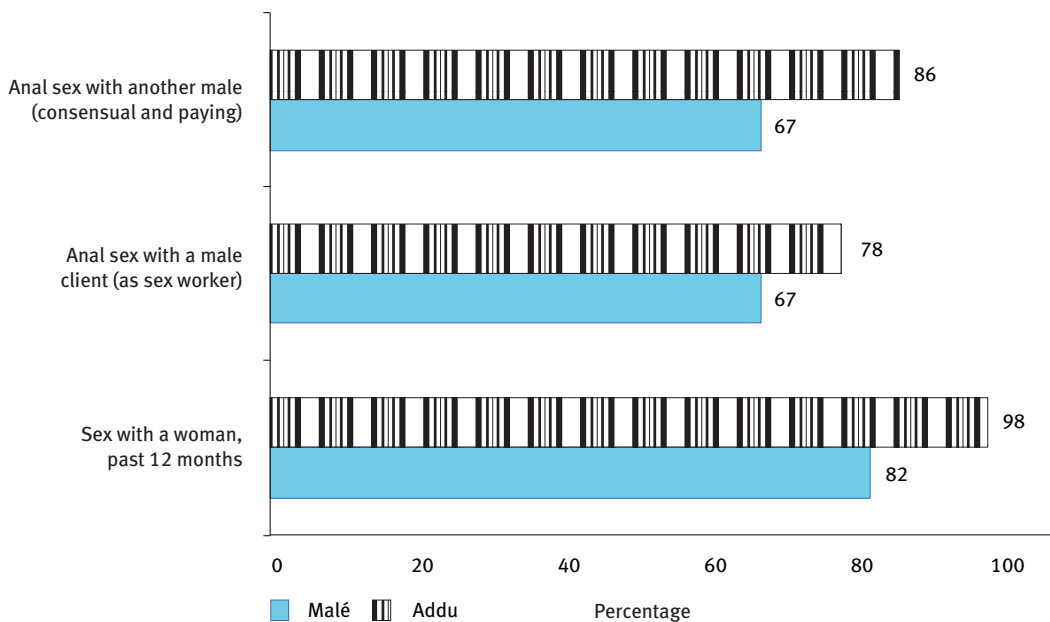
Several high-risk behaviours were found among MSM in the Maldives: high rates of unprotected sex with men and women (wife, girlfriend and FSW); selling sex to men and women; buying sex from men and women; injecting drugs; consuming drugs and having sex; and having sex with PWID. None of the MSM survey participants tested positive for HIV.⁵ However, there can be little doubt that once HIV enters the MSM population, the potential for rapid transmission of HIV across the various high-risk groups and their sexual partners is high.

Figure 1. Sexual partners of MSM, Maldives, 2008



Source: Biological and behavioural survey on HIV/AIDS – 2008⁷

Figure 2. Unprotected sex (%) among MSM in Malé and Addu, Maldives, 2008



Source: Biological and behavioural survey on HIV/AIDS – 2008⁷

3. NATIONAL RESPONSES

3.1 Policy and legal environment

Sex between same-sex adults remains criminalized in the Maldives. According to Section 15, clause 173 (8a) “Sexual activity with a member of the same sex”, under the “Rules of adjudication”, the punishment is to be lashed (*tha’zeer*) between 19 and 39 times and banished or imprisoned for a period of between 1 and 3 years, depending on the severity of the offence.

The HIV situational assessment reports that Maldivian MSM are constantly afraid of disclosure and largely maintain two strictly separate lives.⁹ In the Maldives, as in many other societies, issues surrounding sexuality, especially same-sex sexuality, and sex work are not openly discussed.

The National Strategic Plan (2007–2011) indicates that a comprehensive package of HIV prevention services will be offered for MSM.¹⁰ It is reported that, by 2011, a target of 80% of MSM will receive comprehensive HIV prevention services.

The United Nations Development Programme (UNDP) has reported that there are few nongovernmental organizations (NGOs) in the Maldives. Those that are active provide HIV educational services through weekly radio programmes, peer education and seminars.⁶ The World Health Organization (WHO) and United Nations Population Fund (UNFPA) have provided funding and technical assistance for HIV/AIDS awareness and prevention programmes. Few civil society organizations and basically no known networks and self-help groups of affected communities, such as PWID, MSM or sex workers, are found in the Maldives.

3.2 Interventions available

The National Strategic Plan notes that the capacities of NGOs and governmental institutions will need to be built to provide comprehensive HIV prevention services for MSM. These include outreach activities for HIV education including peer education, and behaviour change communication (BCC); condom promotion; HIV testing; and STI diagnosis and treatment. However, the specific number of targeted interventions for MSM is not mentioned. It is possible that after the BBS 2008 findings of high-risk behaviours, targeted interventions for MSM would be initiated. The United Nations Office on Drugs and Crime (UNODC) supported a sensitization programme for prison officers on drug use and HIV.¹¹ UNDP, with support from the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), conducted sensitization programmes for law enforcement officers, including prison officers. Both the activities by UNODC and UNDP are not MSM specific. However, MSM-related issues are discussed in the programmes, highlighting the country situation in relation to MSM, mainly to minimize stigma and discrimination. Similarly, FSW- and PWID-related issues are also discussed in the programmes.

3.3 Coverage of interventions

According to the BBS 2008, 16% of MSM in Malé and 2% in Addu had tested themselves for HIV.⁷ Information on those who were tested and received the results was not known. In Malé, 48% of MSM and in Addu 21% had received information on HIV/AIDS/STI in the past 12 months. In the absence of targeted interventions, HIV and STI information was received mainly through the television, radio, newspapers and magazines. Despite the apparent lack of targeted interventions, the BBS in 2008 reported that condom distribution was highest among MSM compared with

the other groups that were surveyed: 65% in Malé and 72% in Addu.⁷ It is not clear whether condoms were distributed to MSM by some NGOs. Information was not available on the distribution of lubricants or the detection and management of STIs among the MSM population.

3.4 Current gaps in responses

Despite the fact that HIV infection has not been detected among MSM, a high level of sexual risk behaviours within the MSM population and their sexual relations with women are a cause for concern. The lack of targeted interventions for MSM remains largely unaddressed. The widespread lack of condom use with all types of sexual partners shows a lack of information, education and communication (IEC) and counselling services on sexual health and ways of reducing risk behaviours. Lack of capacity among existing NGOs to implement targeted interventions with the MSM population was identified, as was the lack of community groups of MSM to serve their broad-based needs. Criminal laws against consensual same-sex relations and negative societal attitudes are also important structural barriers that need to be examined further and addressed.

3.5 Recommendations – the way forward

- Ensure that periodic HIV serosurveillance and behavioural surveys are conducted among MSM, and consider expanding the number of sites.
- Intensify efforts at bringing about behaviour change through IEC among MSM in order to promote consistent condom use with both male and female partners. Expand substantially the provision of condoms and lubricants for MSM to complement the message of behaviour change.
- Increase condom use among MSM with female sexual partners to decrease the risk of sexual transmission of HIV. Greater attention should be focused on the needs of spouses and female partners of MSM.
- Increase monitoring for and raise awareness of drug injecting and other drug use among MSM as an increase in drug use, specifically drug injecting, has the potential to escalate an HIV epidemic among MSM.
- Increase the detection and management of STIs and, where possible, provide education and hepatitis B vaccination to all MSM.

- Advocate for increased access to health-care services by MSM, particularly those related to men’s sexual health. This will involve advocacy and sensitization of health-care providers and the local community, including religious leaders. This will contribute towards raising awareness of the issues and potentially improve the overall HIV prevention response.
- Strengthen the capacity of NGOs to work with MSM populations, including adopting appropriate outreach programmes by NGOs to meet the sexual health needs of all men, but ensure that there is a specific awareness of and focus on services for MSM.
- Review and, where required, improve Internet-based HIV educational interventions designed to reach MSM in the Maldives.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

The first case of HIV in Myanmar was detected in 1988. In 2008, there were an estimated 236 000 (range: 160 000–370 000) people living with HIV (PLHIV).¹ Adult HIV prevalence in Myanmar has seen a slow downward trend from 0.7% in 2000 to 0.63% in 2008. A majority of reported AIDS cases (68%) are attributed to sexual transmission,² with a male-to-female ratio of 2.4:1.³

Myanmar has a concentrated HIV epidemic among men who have sex with men (MSM), female sex workers (FSWs) and people who inject drugs (PWID). There is a rising concern regarding the HIV epidemic among MSM, with the HIV prevalence in 2008 reported to be 28.8% – the second highest among the three most-at-risk groups.⁴ This was substantially higher than the national HIV prevalence (0.63%) among adults aged 15–49 years. The highest HIV prevalence (37.5%) was found among PWID. Among FSWs, HIV prevalence was 18.4%. It is important to note that the findings of HIV prevalence among MSM should not be considered as a national overview as 400 participants were sampled from only two sites.^{2,4,5}

1.2 Size of the MSM and transgender (TG) populations

The number of MSM in Myanmar was estimated to range between 200 000 and 280 000.⁶ The number of MSM living with HIV was estimated to be 30 000 in 2006–2007.⁷ Data on the estimated number of transgender persons (TG) were not known to be available.

1.3 Typologies of MSM and TG populations

Limited information is available on the typologies of same-sex attracted males in Myanmar. The emergence of “gay”-identified men in Myanmar, although they are mostly hidden, is a recent phenomenon.⁸ Three types of MSM were self-defined in the integrated biological and behavioural survey (IBBS):⁹ *apwint*, commonly more open and mostly called *ah-chauk*; the hidden type known as *apone* and referred to as *ma'cho*; and *tha-nge*, the partner of *apwint* and *apone*, commonly referred to as an “ordinary” male who has sex with males or females and does not admit to being gay.

In Myanmar, TG are termed as *ah-chauk*. This population group could have a career as *nat kadaw*, also known as “ritual specialists”, and as beauticians. The TG population is commonly involved in same-sex relations and is usually accorded great esteem and important roles in both urban and rural areas in Myanmar. Among MSM, those who have sex with *ah-chauks* are considered as heterosexual men since *ah-chauks* are seen as feminine and some *ah-chauks* may even live with their male “husbands”.⁸

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence of sexually transmitted infections (STIs) among MSM and TG populations

Data on STIs among MSM are limited. A recent unpublished report of a study conducted among 828 MSM found that 26.2% reported ever having had an STI; and 11.8% reported STI-related symptoms in the past three months. In the 2008 HIV serosurveillance survey, syphilis prevalence among MSM was reported at 14.1%, the highest among all the most-at-risk population (MARP) groups. Among FSWs, it was 5.5%, the second highest.^{4,5} Data on STIs among TG were not available.

2.2 Prevalence and trends of HIV among MSM and TG populations

The most recent data from 2008 showed an HIV prevalence among MSM of 28.8%.⁴ In 2007, it was reported to be 29.2%.⁶ Data collected on MSM from Mandalay in 1996 showed that the HIV prevalence was 33.3%.¹¹ The available data do suggest that the overall HIV epidemic among MSM has shown a slight decline but primarily the problem has remained uncontrolled over the years.

2.3 HIV-related risk behaviours among MSM and TG populations

In Myanmar, a behavioural surveillance survey (BSS) was conducted in 2008 among high-risk groups such as FSWs, PWID, out-of-school youth and truck drivers.¹⁰ An integrated biological and behavioural surveillance (IBBS) was conducted for the first

time among MSM in 2009 by the National AIDS Programme in Yangon and Mandalay, with 275 respondents participating in each city. The findings will be disseminated to stakeholders soon.⁹

Same-sex sexual risk behaviours have been reported among some specified male groups. In a study on out-of-school youth in 2008, it was found that a total of 2.3% (82/3495) young men reported having ever had sex with another man; 1.6% (55/3495) young men reported having had sex with another man in the past 12 months; this proportion varied from 0.2% in Monywa and Lashio to 3.1% in Yangon. The median number of partners was one (range: 1–10). Of young men reporting sex with another man in the past 12 months ($N = 55$), 56% always used a condom and 5.5% almost always used condoms.¹²

2.3.1 Types of partners among MSM

A BSS conducted in 2008 among 828 MSM shows that MSM have sex with paid as well as casual male and female partners. However, disaggregated data on the number, frequency and gender of the sexual partners are not available.¹⁰ Nevertheless, this information does indicate that MSM are sexually active with both males and females. More comprehensive data on risk behaviours among MSM are needed.

2.3.2 Consistency of condom use

In a study conducted in 2008,¹⁰ a relatively high level of consistent condom use was found with paid partners compared with regular partners. Among 828 MSM, including TG and male sex workers (MSWs)* in Mandalay and Yangon, 53% of MSM and TG reported using condoms consistently† during anal sex with male paid partners, and 78% during vaginal sex with female paid partners. The same study found that 52% used condoms consistently during anal sex with casual male partners and 19% during vaginal sex with casual female partners.¹⁰

Condom use among MSWs (including TG who sell sex) was similar: 52% with one-time male clients, 48% with regular male clients; 45% with a male paid partner, 69% with a female paid partner, 43% with a casual male partner and 21% with a casual female partner.¹⁰ Future studies should address some of the gaps in understanding the risk behaviours of various subgroups of MSM and MSWs.

* Numbers from each group were not provided but participants included TG who sell sex.

† Time frame for measuring consistency was not mentioned.

3. NATIONAL RESPONSES

3.1 Policy and legal environment

In Myanmar, sex between men is punishable by death or lifelong imprisonment (Penal Code of 1882–1888). A proportion of MSM, however, are reached through nongovernmental (NGOs) and community-based organizations (CBOs). A further challenge is the problems faced by civil society groups in Myanmar in registering their organizations. As was stated by the board of the Three Diseases Fund (3DF) for Myanmar: “It would also be helpful if the Government could recognize the key role local NGOs and CBOs can play in reaching marginalized and remote populations.”¹³

Although the HIV sentinel surveillance system has been operational in Myanmar since 1992, MSM were not part of HIV surveillance until 2007.¹⁴ From 2000 to 2006, seven population groups were followed as sentinel groups: male STI patients, PWID, FSWs, pregnant women, blood donors, new tuberculosis (TB) patients and military recruits. In 2007, two sites – Mandalay and Yangon – were added as MSM sentinel surveillance sites.

Myanmar’s National Strategic Plan on HIV and AIDS (2006–2010) aims to reduce HIV transmission and vulnerability, particularly among at-risk populations, and to improve treatment, care and support.² Target populations include PWID, sex workers and their clients, MSM, partners and families of PLHIV, prisoners, mobile populations, uniformed services personnel and youth.

The National Strategic Plan explicitly states that MSM are among the key populations (others being PWID and sex workers) at highest risk for and vulnerable to HIV in Myanmar, and that prevention focusing on these populations will be of “the utmost priority and will rely on high-intensity, sustained and focused effective interventions”. Specific time-bound targets in relation to reducing HIV prevalence and increasing condom use among MSM are outlined in the Strategic Plan (Table 1).²

The Myanmar National Strategic Plan acknowledges that HIV prevalence differs among MSM with different identities and behaviours, and that there is a need for formal data. The Plan also states the need to conduct a situation analysis of the dynamics of MSM interactions to develop an appropriate strategy, and to identify new geographical sites for interventions, in addition to Mandalay and Yangon.²

Table 1. Myanmar National Strategic Plan on HIV and AIDS, Operation Plan 2008–2010: reduction in HIV-related risk, vulnerability and impact among men who have sex with men

Standard indicators	Denominator	Baseline or latest figure	Targets		
			2008	2009	2010
Impact/Outcome targets					
% of MSM who are HIV infected	240 000	33% (1996)	31%	30%	29%
% of MSM who have an STI (syphilis)	240 000	35.12% (2005)	30%	28%	26%
% of men reporting the use of a condom the last time they had anal sex with a male partner	240 000	67%	75%	77%	80%
MSM reached by package of BCC prevention and STI prevention/treatment	240 000	28 566 (2006)	45 000 (19%)	50 000 (21%)	55 000 (23%)
Number of MSM accessing VCT	240 000		15 000	18 000	21 000

Source: National AIDS Programme

In general, there has been an increase in funding from both national and international sources for HIV programmes in Myanmar. In 2004, an estimated US\$ 18 million was spent on HIV and AIDS activities by concerned government agencies and NGOs in Myanmar. The bulk of the funds (52%) went to prevention-related activities, followed by AIDS programme costs. No details were available on what proportion of the prevention-related funding was spent on HIV prevention interventions among MSM.

In 2007, grants amounting to US\$ 21 million were provided by the 3DF to Myanmar to deliver and scale up provision of health services to address TB, malaria, and HIV and AIDS.¹⁵ No details were available on how much of these funds were allocated for HIV prevention and care activities among MSM.

3.2 Interventions available

HIV prevention efforts for MSM are relatively recent in Myanmar, with few NGOs

providing services until recently. Between 1 April 2004 and 31 March 2005, 16 projects were supported by the Fund for HIV/AIDS in Myanmar (FHAM) to directly address the prevention of HIV via sexual transmission through the provision of services to the general population, as well as high-risk groups including MSM. The funding available has contributed towards two key outputs of the Joint UN Programme on HIV/AIDS (UNAIDS) in Myanmar: increasing access to condoms, and improving the capacity for prompt and effective management of STIs. However, more needs to be done. In 2008, there were 13 organizations reaching out to the MSM population primarily through outreach, distributing condoms and lubricants, and providing information, education and communication (IEC) for risk reduction and behaviour change. The international NGO Population Services International (PSI) was the main agency reaching out to 29 970 MSM with intervention services in various parts of the country.¹⁸

Provision of condoms and lubricants for MSM and TG remains of critical importance but the quantity of these items distributed specifically to this population group is not known. The number of condoms distributed free by various NGOs and the National AIDS Programme in 2008 was 16 276 396 in total. The social marketing of condoms by PSI witnessed the distribution of 17 862 263 condoms in 2008. Voluntary counselling and testing (VCT) is an important service but the extent of uptake of this is not known. Provision of antiretroviral therapy (ART) for those HIV infected within the MSM and TG community is an important intervention but the extent of accessibility and availability of ART for this specific population group is not known; however, is expected to be small in number. Detection and management of STIs in this population is considered an important intervention for HIV prevention but the numbers receiving this service are largely unknown.

3.3 Coverage of interventions

In 2005, 22 000 MSM (less than 10% of the national estimate of MSM) had received health education, and this was mostly through peer education and outreach programmes delivered by NGOs.¹⁷ In 2006, an estimated 28 000 MSM, constituting only 11.6% of the estimated MSM population (240 000) in Myanmar, were accessed through outreach¹⁸ and 10.2% among them accessed VCT.¹⁹ Increasing the coverage of interventions remains an ongoing challenge. An estimated 16% of the total

estimated MSM population was reached in 2008 and, of those reached, only around 11% of MSM accessed HIV testing and counselling services.¹⁶

There are services for MSM in several townships but a comprehensive package of services is available only in a few townships. Where it is offered, a drop-in centre (DIC) is operating. It is reported that most MSM are reached in Yangon, Mandalay, Ayeyarwaddy and Bago divisions, where DICs exist. Only 4097 MSM accessed VCT services in 2008, which fell sharply compared to the numbers reported in 2007 (13 180 MSM): the target for 2008 was 15 000 MSM.¹⁹ The coverage of services for TG remains unknown.

In 2005–2006, it was reported that only 4.4% of all people with advanced HIV infection were receiving anti retroviral therapy (ART).²⁰ At the end of 2008, 20.5% of HIV-infected persons needing ART received it. Out of all the patients on ART ($N = 15\ 191$), 8066 were male.¹⁹ Data on HIV-infected MSM receiving ART has been not recorded.

3.4 Current gaps in responses

The major critical gaps that have been identified are broad-ranging. The number of serosurveillance and behavioural surveillance sites for MSM and TG are inadequate. Studies that estimate the population size of MSM and TG in other areas of Myanmar are lacking. The findings from such studies can impact upon the scope of the response. Coverage is low and, consequently, the MSM and TG population reached with condoms and lubricants, IEC on sexual health, behaviour change and issues surrounding HIV testing and counselling is less than adequate. The concerns regarding STIs cannot be underestimated, particularly the high rates of syphilis. Yet, broad-ranging detection and management of STIs appears to be low and consequently will require scaling up. Information about the TG community is poor, which impacts upon the delivery of a service suited to their needs. A lack of financial support for MSM programmes is one area that needs to be addressed to strengthen the response, and meet the health needs of the MSM and TG community.

3.5 Recommendations – the way forward

- Expand HIV serosurveillance sites beyond the two main urban areas of Mandalay and Yangon. Improve estimation of the size and location of MSM populations in order for interventions to be better informed, planned and budgeted.
- Scale up HIV prevention interventions and increase condom and lubricant use among MSM and TG, given the increase in HIV prevalence and risk behaviours among these populations. Dedicated services for HIV and STI need to be expanded to improve accessibility and, importantly, need to be located in settings suitable for these often highly stigmatized groups.
- Encourage MSM and TG to utilize available VCT services and explore any potential barriers as to why such services are not being accessed.
- Make efforts towards decriminalizing consensual sex between adult males to enable HIV prevention and treatment services to be accessed by MSM without fear of punitive actions.
- Enhance the delivery of health services and IEC by outreach workers to encourage behaviour change.
- Mobilize more resources and gain the support of international donors to address the resource gaps in HIV prevention programmes for MSM and TG.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

The first case of HIV in Nepal was reported in 1988. The National Centre for AIDS and STD Control (NCASC) estimates that the overall national HIV prevalence among adults was 0.49% in 2007, with a total of 69 790 people living with HIV (PLHIV).¹ As of October 2009, a cumulative total of 14 787 HIV infections, including 2384 cases of AIDS, have been reported in the country.² The HIV epidemic in Nepal is driven by injecting drug use, sex work and migration. In 2007, an estimated 6557 people who inject drugs (PWID) were living with HIV or AIDS: PWID accounted for 10% of the total HIV cases.³ Almost 50% of all HIV infections were in the Terai highway districts and 16% were in the Far Western hills. A steep rise in HIV prevalence was identified among PWID from the mid to the late 1990s. In Kathmandu, HIV prevalence among PWID increased from 2% in 1991⁴ to 50% in 1999.⁵ By 2009, the HIV prevalence among PWID in Kathmandu was down to 21%.⁶ In 2007, the estimated HIV prevalence among other risk groups was as follows: sex workers (1.8%); clients of sex workers (15.5%); seasonal labour migrants (41%) and men who have sex with men (MSM) (3.9%).² MSM have been identified as a core risk group because of their high-risk sexual behaviour coupled with low levels of condom use, and a high turnover of both male and female partners.

1.2 Size of the MSM and transgender (TG) populations

The population size of MSM has been estimated at 135 000 (68 000–202 000).⁷ However, a major MSM nongovernment organization (NGO), Blue Diamond Society, considers that number to be an underestimation.⁸ Information on the TG population is not known to be available.

1.3 Typologies of MSM and TG populations

Like other developing countries in South Asia, Nepal has indigenous same-sex sexual identities: *meti*, *dohori* and *ta*. The term *meti* refers to feminine same-sex attracted males who are primarily receptive partners in sexual encounters with other males. A proportion of *metis* may occasionally cross-dress. An ethnographic

study commented that the word *meti* derives from a term meaning “a person who quenches a thirst”, in reference to the idea that the role of the *meti* is to satiate men’s desires.⁹ The term *meta* has the same meaning but implies “a male who quenches someone’s thirst”.

Metis refer to their masculine (apparently “heterosexual”) male sexual partners as *ta*. Thus, *ta* is usually a label applied by *metis* and not a self-ascribed identity. Other recent terms that are synonymously used with *ta* include *panthi* and *giriya* – similar to the terms used in India.¹⁰ An ethnographic study suggests that though *metis* are not supposed to have sex with one another (since they are “feminine” and supposedly “receptive” partners), they may have sex with each other but it remains a taboo to openly admit it. *Metis* may also get married to women and continue to have sex with males after marriage.⁹

Those MSM who engage in both receptive and insertive anal sex are referred to by *metis* as *dohori*, which means “both ways” in Nepali (*dohori* is effectively the Nepali equivalent of *duplis* or “double-decker” in India). The English term “gay” is adopted as an identity among some educated middle and upper class males, and is also used as a label by some *metis*.¹¹ The Round 2 integrated biological and behavioural surveillance (IBBS), 2007 report cites that Blue Diamond Society (an agency working with MSM) uses the term *hijara* for TG as a subgroup of MSM,¹¹ presumably referring to the Nepali equivalent of TG women.

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence of sexually transmitted infections (STIs) among MSM and TG populations

The prevalence of STIs was assessed by IBBS studies where MSM were divided into two groups: male sex workers (MSWs), and “non-MSWs”. The available data reported upon were from Kathmandu only. Males who received money for having sex with another male in the past 12 months were classified as MSWs and those males who had sex with another male in the past 12 months but who did not receive money were classified as non-MSWs. The IBBS includes laboratory tests to assess the prevalence of common STIs among MSM: active syphilis, evidence of having had syphilis (termed “syphilis history” in the IBBS), rectal *Chlamydia trachomatis* infection (rectal-CT), rectal *Neisseria gonorrhoeae* infection (rectal-NG), urethral-CT and urethral-NG.

In all the three rounds, rectal-CT was higher among MSWs (range 11.1–20.5%) than among non-MSWs (range 1.5–2.6%). Among MSWs, there has been a reported decline over the years in those with a history of syphilis (14.5% in 2004 to 4.5% in 2009). The overall higher rates of STIs among MSWs compared with non-MSWs appear to suggest higher rates of unprotected anal sex (Table 1).^{11,12,13} Specific information about STIs among the TG population is not known to be available.

2.2 Prevalence and trends of HIV among MSM and TG populations

Reported HIV prevalence among MSM has remained largely stable since the IBBS commenced: Round 1 (2004): 3.9%; Round 2 (2007) 3.3%; and Round 3 (2009) 3.8%.^{11,12,13} However, some differences were observed in HIV prevalence among MSWs and non-MSWs. In 2009, HIV prevalence among MSWs was 5.2% compared with 3% among non-MSWs (Table 1). Specific information about HIV prevalence among the TG population is not known to be available.

2.3 HIV-related risk behaviours among MSM and TG populations

Many MSM in Nepal reported being sexually active at a relatively young age. More than 50% of MSM (58.4% in Round 1; 51.5% in Round 2 and 61.3% in Round 3) reported having had their first sexual experience before the age of 17 years. The first sexual partner was not always male. Half (50%; $N=358$) in Round 1, about 63.9% ($N=400$) in Round 2, and 40.8% ($N=400$) in Round 3 reported that their first sexual partner was a female. Anal sex was widely practised in the three rounds: 71.1%, 82.4% and 71.4%, respectively, reported having had anal sex with a paying male partner in the past month.

2.3.1 Consistent condom use with various types of male partners

From 2007 to 2009, a decline in the consistency of condom use was observed during anal sex with non-paying male partners (from 70.1% in Round 2 to 65.2% in Round 3). Among MSWs, consistency of condom use during anal sex decreased with both casual male paying partners and regular male paying partners. With paid male sex partners, condom use decreased among non-MSWs (82.9% in Round 2 to 73.8% in Round 3) when compared with MSWs (100% condom use was reported in Rounds 2 and 3).

Table 1. HIV and STI prevalence among MSM in Nepal

Item	(IBBS Round 1) 2004			(IBBS Round 2) 2007			(IBBS Round 3) 2009		
	MSM (N=358)	MSWs (N=83)	Non- MSWs (N=275)	MSM (N=400)	MSWs (N=135)	Non- MSWs (N=265)	MSM (N=400)	MSWs (N=135)	Non- MSWs (N=265)
	%			%			%		
HIV	3.9	4.8	3.6	3.3	2.9	3.4	3.8	5.2	3.0
STIs									
Active syphilis	1.7	2.4	1.5	2.4	1.5	2.3	1.5	3.0	0.8
Syphilis history	8.9	14.5	7.3	2.8	3.0	2.6	2.5	4.4	1.5
Rectal-CT	5.9	20.5	1.5	3.6	11.6	2.6	5.0	11.1	1.9
Rectal-NG	5.6	12.0	3.6	8.1	8.3	8.1	12.5	18.5	9.4
Urethral-CT	2.0	1.2	2.2	0.5	0.7	1.1	2.5	0.7	3.4
Urethral-NG	2.0	1.2	2.2	0.3	0.0	0.8	0.8	0.7	0.8

Source: FHI, IBBS among MSM, Kathmandu Valley: Rounds 1, 2 and 3^{11,12,13}

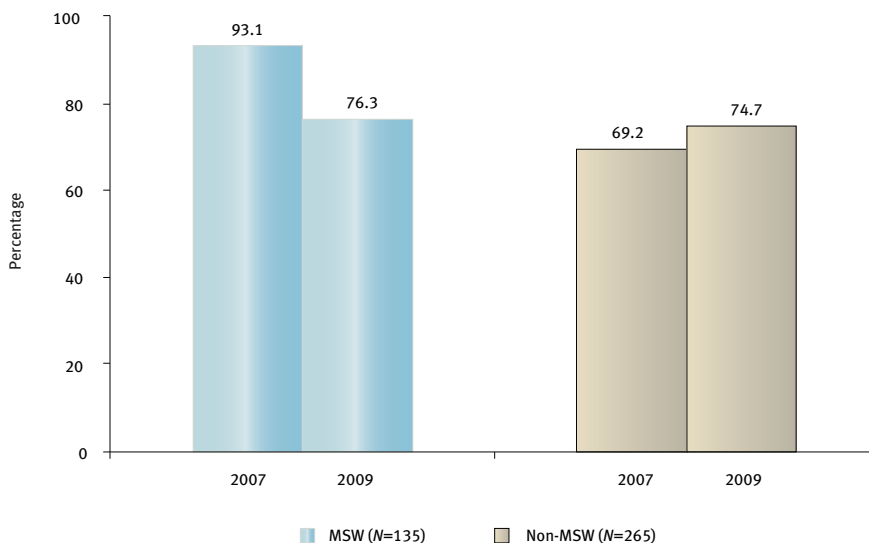
2.3.2 Condom use during last anal sex with various types of male partners

In Rounds 2 and 3, condom use during last anal sex remained almost the same (71.6% in Round 2 and 75.3% in Round 3). However, within the subgroups, condom use during last anal sex decreased among MSWs (from 93.1% in Round 2 to 76.3% in Round 3), while among non-MSWs, condom use increased from 69.2% in Round 2 to 74.7% in Round 3. Similarly, with paid male sex partners, among MSM condom use decreased from 91.1% in Round 2 to 82.4% in Round 3. An increase in unprotected anal sex was noted among both MSWs and non-MSWs, more so among the former (Figure 1).

2.3.3 Bisexual behaviour

The IBBS Rounds 2 and 3 found that a considerable proportion MSM reported being married to women (Round 2: 33.7%; Round 3: 22.5%). Differences were found in marriage status between non-MSWs (Round 2: 37.8%; Round 3: 25.6%) compared with MSWs (Round 2: 15.6%; Round 3: 16.2%). Several studies concluded that there was a lack of information about sexual behaviour and sexual networks in Nepal,^{14,15} particularly on MSM.

Figure 1: Condom use at last anal sex



Source: FHI. IBBS among MSM, Kathmandu Valley: Rounds 2 and 3^{11,13}

2.4 Potential for rapid transmission

Although the HIV prevalence among MSWs and non-MSWs remained relatively stable between the three studies (2004–2009), the IBBS does show an increase in unprotected anal sex. A rise in rectal STIs – particularly among MSM – shows that there could be an increase in HIV prevalence among both MSWs and MSM. A significant proportion of MSM and non-MSWs were married to women or could potentially get married. As a consequence, the increased risk of HIV and STI transmission to their female partners is a reality. Unless interventions among MSWs and MSM are intensified by promoting condom use, and screening and treatment for STIs, an increase in HIV prevalence may occur among MSWs and non-MSWs. The risk of acquiring HIV infection faced by Nepali migrants (especially Mumbai returnees) is well established,^{16,17,18} as is the case with female sex workers (FSWs) returning from India.¹⁵ Little is known about the crossover and linkages between seasonal labour migrants, FSWs, and MSWs and non-MSWs but, if possible networks are established, rates of HIV infection would be likely to rise.

3. NATIONAL RESPONSES

3.1 Policy and legal environment

The Nepalese Government states that it has embraced the principle of universal access (with a target of 80%) for provision of HIV/AIDS prevention, treatment, care and support services to vulnerable and infected people. The second National HIV/AIDS Strategy (2006–2011) provides details of specific components of HIV intervention programmes among MSM.¹⁹ The Strategy also provides “impact/outcome targets” in relation to MSM that include:

- Reduction in HIV prevalence among MSM from 3.6% (2004) to 2.0% and among MSWs from 4.8% (2004) to 3.0% by the end of 2011 and;
- Increase in condom use during last anal sex with a male from 55.9% (MSM) and 66.7% (MSWs) (2004) to 80% by the end of 2011.

The Government of Nepal estimated that the financial need for national HIV/AIDS programmes was approximately US\$ 32 055 143 in 2007, increasing to US\$ 40 000 000 by 2012. Budget allocation for most-at-risk populations (MARPs), including MSM, in the 2006–2008 workplan was US\$ 28 717 895, 44.8% of the total HIV/AIDS budget. The 2008 country progress report states that expenditures on programmes for MSM was US\$ 562 304 (no time frame mentioned), amounting to 6.1% of the total budget spent on HIV/AIDS programmes.⁷ However, no information is available on separate budget allocations for HIV/AIDS prevention, treatment, care and support services for MSM and the TG community for the period 2009–2011.

A portion of the funds allocated for interventions among MSM have been earmarked for the creation of “enabling environments” by the Government of Nepal.²⁰ Recently, the Supreme Court of Nepal issued directive orders to the Government of Nepal to end discrimination against sexual minorities and ensure rights equal to those of heterosexual men and women in Nepal.²¹ This is likely to be a major step towards creating an enabling environment for MSM to enhance access to and use of HIV-related services. However, currently, the law criminalizes consensual sex between same-sex adults.²¹

3.2 Interventions available

The second National HIV/AIDS Strategic Plan claims that civil society has been actively

involved in the design and implementation of HIV/AIDS programmes in Nepal. For example, the Strategic Plan states that in the 2005/06 annual plan, almost 70% of the total resources were budgeted to be executed through NGOs; however, the details of such implementation are not available.

Two key NGOs advocate for and provide services to MSM in Nepal: Blue Diamond Society founded in 2001; and White Feather founded in 2006. During the development of the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) Round 7 proposal, the “Federation for Sexual and Gender Minorities” was established, bringing together nine organizations working on HIV/AIDS, human rights, and law reform for sexual minorities in Nepal. Currently, Blue Diamond Society remains the major HIV service provider for MSM in Nepal. Before funding from Round 7 of the Global Fund, Blue Diamond Society was providing services at drop-in centres (DICs) in seven sites (Itahari, Bhairahava, Pokhara, Nepaljung, Kathmandu, Lalitpur, Janakpur) and more sites were added after the successful Global Fund Round 7 funding. As of September 2009, Blue Diamond Society’s MSM programme covers 26 districts and 31 cities. Blue Diamond Society reports that it has distributed 256 518 condoms and 25 760 water-based lubricant sachets to 5492 individuals (cumulatively).⁸ Information is not available on outreach and information, education and communication (IEC) with regard to the extent of services for sexual health, referrals to address STIs, and voluntary counselling and testing (VCT). As of 2009, the number of people ever enrolled in HIV care is 13 005 and, among them, 3423 are on antiretroviral therapy (ART).² The number of HIV-infected MSM and TG receiving ART is not known.

3.3 Coverage of interventions

The Nepalese government has set a target of reaching out to 102 880 MSM (including MSWs) by the end of 2011. In 2007, among MSWs and non-MSWs, the percentage of those who had received an HIV test in the past 12 months and who knew their results was 51.85% and 30%, respectively. The coverage of prevention programmes for MSM and non-MSWs was 55.56% and 46.75, respectively, nationwide.⁷ However, in the same report, figures from routine reporting show that national coverage for MSM ranged widely from 12.0% to 35.9%. In the capital city, Kathmandu, coverage of MSM increased substantially from 10% in 2004 to 45.75% in 2007.

3.4 Current gaps in responses

Currently, less than half the MSM (combined MSWs and non-MSWs) are covered with HIV prevention programmes. Thus, high-risk sexual behaviour continues among many MSM. Condom use is modest to high but there has been a recent decline in consistent condom use. Among MSWs, 40.7% and among non-MSWs 44.5% both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission,⁷ suggesting that greater efforts are needed to increase IEC on such issues. The prevalence of STIs among MSWs has been consistently high, suggesting that the response to this unresolved health problem requires greater focus. Substantial numbers of MSM are married or have sex with females but the efforts of HIV prevention programmes to respond to the needs of wives or female sexual partners of MSM appear to be meagre. Too many MSM who had an HIV test did not know their results and consequently a greater response will need to be implemented by the NGO (linked to MSM issues) and health sector to lessen this gap.

3.5 Recommendations – the way forward

- Increase the provision of condoms and lubricants for all types of MSM and TG populations, and promote behaviour change to ensure a higher degree of consistent use of condoms.
- Ensure quality size estimation, mapping and regular surveillance of HIV and risk behaviours among MSM as well as TG be conducted in sites other than major urban cities. An HIV serosurveillance survey and behavioural study specifically targeting the TG population should be implemented as studies among TG in other Asian countries have shown far greater risk behaviours and HIV prevalence among them compared with MSM.
- Intensify education on STIs among MSM and scale up STI diagnosis and testing services, given that STIs increase the risk of HIV transmission and acquisition; and such diagnosis and treatment provides opportunities for outreach and education.
- Focus greater attention on addressing the needs of spouses and regular female partners of MSM as condom use during sexual relations is inconsistent, which increases the risk of sexual transmission of HIV.

- Provide financial and technical resources for scaling up HIV prevention programmes among the MSM and TG communities to ensure adequate coverage.
- Continue to develop the capacity of MSM CBOs to provide advocacy, outreach and peer-based programmes to meet the needs of their communities.
- Take steps to reduce the stigma and discrimination towards MSM and TG from society, the police and health-care providers through ongoing advocacy, sensitization and education programmes, and highlight the Supreme Court of Nepal directive to the Government of Nepal to end discrimination against sexual minorities. Maintain an advocacy campaign through local activist NGOs linked to the MSM and TG communities for the decriminalization of consensual sexual relations between same-sex adults.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

Sri Lanka is one of the few countries in the South Asian region with a low-level HIV epidemic. According to Sri Lanka's National STD/AIDS Control Programme (NSACP), the mean HIV prevalence at the end of March 2009 among the general population was less than 0.1% with a cumulative total of 1099 HIV cases and 293 AIDS cases detected. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), at present, there are an estimated 4000 people living with HIV (PLHIV). The majority of those infected are in the age group of 30–39 years.¹ With an HIV prevalence of less than 1% even in high-risk groups (men who have sex with men [MSM], female sex workers [FSWs] and people who inject drugs [PWID]), there is a low probability that Sri Lanka will experience a large generalized epidemic in the near future.¹ The first few HIV cases reported in Sri Lanka were among MSM in 1987.² Cumulatively, 20% of reported AIDS cases and 11% of reported HIV infections are the result of same-sex sexual behaviour.³

1.2 Size of the MSM and transgender (TG) populations

In 2008, there was a national consensus that the estimated number of MSM in Sri Lanka was 12 000.⁴ In the recent UNGASS report (2008–2009), the estimated number of MSM was 24 000–37 000.⁵ The first round of the Sri Lankan behavioural surveillance survey (BSS) data indicated that 2500 MSM were reached through various nongovernment organizations (NGOs) and community-based organizations (CBOs) working for MSM in Colombo.⁶ Information about the number of transgender people was not available.

1.3 Typologies of MSM

The Sri Lankan BSS report mentions only the behavioural category “MSM” although organizations working with MSM and gay men were approached by the BSS team for recruiting MSM for the survey. Indigenous identities of MSM or typologies of MSM in Sri Lanka were not mentioned in the available BSS. However, in one study, local words such as *nachchi*, *jonsa* and *poppa* were used. *Jonsa* are usually considered masculine and are sexually active with both women and *nachchi*.⁷ The BSS report

notes that only a proportion of MSM may identify as “gay” or homosexual and a proportion may be married to women. The BSS was also conducted among “beach boys”. Beach boys are predominantly young men who work near or on beaches, typically tourist beaches. A proportion offers sexual services to men and women in exchange for some form of payment^{6,8} but not all engage in same-sex sexual behaviour.

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence and trends of sexually transmitted infections (STIs) among MSM

A BSS conducted in 2006–2007 indicated a relatively low prevalence of STI-related symptoms among MSM.⁶ Among 302 MSM surveyed, 8.9% ($N=27/302$) reported having ever had STI symptoms; only five persons (1.7%) reported having had genital discharge, and three persons (1%) reported a genital sore/ulcer in the previous 12 months. Notably, a higher proportion (16.4%) of the beach boys sampled ($N=553$) reported ever having had STI-related symptoms, which is twice that reported by MSM (8.9%).⁶

A conference presentation report cites a study conducted among 105 MSM in Anuradhapura in 2005, which showed that 6.4% had genital warts and 5% had evidence of past and/or current syphilis infection.⁹

2.2 Prevalence and trends of HIV among MSM

In 2008, the HIV sentinel surveillance included the population group MSM. Of the 242 MSM included in the survey, only one tested positive for HIV. In 2009, of the 411 MSM participating in the HIV sentinel surveillance, the HIV prevalence was 0.48%. It was reported that the probable mode of transmission of HIV cases detected during 2008–2009 was mostly heterosexual but MSM accounted for 15%.⁵

2.3 HIV-related risk behaviours among MSM

2.3.1 Number and types of partners

The first BSS (2006–2007)⁶ was conducted among an “MSM” group as well as other specified male groups where same-sex behaviour was reported among beach boys, male drug users and three-wheeler drivers. Among the “MSM” group ($N=302$), the mean number of non-regular male partners was 8.8 and regular partners 0.9 in the past 12 months. The majority (92.4%) reported having had anal sex with a male partner in the past 12 months. Anal sex in the past 12 months with non-regular male partners was reported by 80.9% and with regular male partners by 67.5%. Consistency of condom use in the past 12 months was higher with non-regular male partners (46%) compared with regular male partners (25.9%). A small proportion (15.8%) reported never having used a condom with their non-regular male partners, compared with their regular male partners (40.4%). Condom use at last anal sex with a non-regular male partner was 63.7% compared with 34.9% with regular partners. A small proportion of the MSM group (7.6%) were married to women and 23% reported having had sex with a female partner in the past 12 months.⁶

The BBS (2006–2007) also reported on beach boys. Among the 553 participants, it found that while not all engaged in sex work; 16% had received payment from at least one male partner and 5% had received payment from at least one female partner. Among the beach boys, 45.4% reported anal sex with a male partner in the past 12 months. Nearly half (44.5%) reported anal sex with a foreign male partner, 41.0% with a non-regular male partner, 18.9% with a local male partner and 18.7% with a regular male partner. Condom use among beach boys was inconsistent with non-regular male partners; in the past 12 months condom use was 45.9%, and at last anal sex it was 68.5%.⁶

2.3.2 Consistency of condom use

A knowledge, attitude and practice (KAP) survey conducted in five cities (Colombo – Western Province; Negombo – Western Province; Galle – Southern Province; Anuradhapura – North Central Province; and Kandy – Central Province) among the

MSM population ($N=494$) found that regular condom use was low. The survey found that for insertive anal sex, 50.1% sometimes used condoms, while for receptive anal sex, 42.4% sometimes used condoms. Many MSM participants also had sex with women (41.3%), and condom use was lower with women than with men: 18.4% rarely and 20% sometimes used a condom. Up to 18% of the participants were married to women.⁷

2.3.3 Risk behaviours among youth

A few other studies have addressed same-sex sexual behaviour among young male adults in Sri Lanka. In a sexual risk behaviour study¹⁰ conducted among young adults ($N = 3134$: males 1374; females 1760) aged 18–20 years, 20% of the males reported having had anal and/or vaginal sex (disaggregated data were not available), and 20% reported having had sex in between the thighs (a low-risk sexual practice) with a male partner. Males reported having had anal sex with both males and females. Among males who reported past anal, oral or vaginal sex, only 26.5% reported having ever used condoms. No disaggregated data are available on the type of anal sex and condom use. There is a need for continued exploration and understanding of the risky sexual behaviours of youth to promote condom use and access.

2.3.4 Prevalence of drug use among MSM

The BSS (2006–2007) included male drug users. It found that 20.4% reported ever having had anal sex with a male partner and 5.8% reported anal sex with a male partner in the past 12 months. Among the drug users who reported anal sex in the past 12 months, 90.5% had never used condoms. Over two thirds of drug users reported having had sex with a female partner in the past 12 months. Male drug users reported inconsistent condom use with female partners: in the past 12 months, 47.4% always used condoms with commercial partners and only 1.1% always used condoms with regular partners.⁶

2.4 Potential for rapid transmission

Among MSM, the large numbers of non-regular male partners coupled with the significant proportion of MSM who also have sex with female partners and inconsistent condom use with male partners indicate that if HIV is introduced into this group, it may quickly spread to both male and female partners.

Beach boys, similar to the MSM group, are at high risk for contracting HIV and transmitting it to their male and female partners. It is not clear whether male drug users are at increased risk of getting HIV and STIs from their male partners. However, given the high level of unprotected sex with both male and female partners, male drug users are putting themselves and their female partners at risk for HIV. Among those who inject drugs, the sharing of needles is common: 42.3% of PWID shared a needle used by someone else and 51.1% shared their used needle with someone else.⁶ As a result of this risk behaviour, the potential to become HIV infected is significant and transmission of HIV infection to sexual partners is possible.

3. NATIONAL RESPONSES

3.1 Policy and legal environment

Sex between males is illegal in Sri Lanka. Under Section 365A of Sri Lanka's Penal Code, sex between same-sex persons is punishable by a jail term of up to ten years. The United Nations High Commissioner for Refugees (UNHCR) reports that though this law is not "routinely" enforced, gay rights and human rights groups have argued that this law has led to the stigmatization of same-sex attracted people and the Sri Lankan authorities have used this law "to exact bribes or to threaten gays".¹¹ Companions on a Journey, an organization established to support those with alternative sexualities (gay, bisexual, lesbian and transgender) in Sri Lanka, has reported harassment of their members by the police and even frequent raids of their office.¹² Incidents of violence against MSM by the general public and suicides among MSM, presumably due to family and societal non-acceptance of same-sex relations, have been reported.¹²

Prevention of HIV among most-at-risk populations (MARPs) is stated as the focus of the Sri Lanka's National Strategic Plan (NSP) 2007–2011.¹³ The Sri Lankan government has consented to reach the universal access coverage target of 80% by 2010 with special emphasis on scaling up prevention interventions among MARPs. However, no specific targets for MSM have been delineated.

Sri Lanka's 2008 UNGASS country progress report lists several recent progressive initiatives of the Sri Lankan government in relation to HIV. These include: revised National AIDS Policy that emphasizes respect for the rights of people at risk and

PLHIV; “special policy statement” on preventing discrimination and protecting the rights of MSM and sex workers; and a policy statement emphasizing the need to target high-risk groups for HIV prevention. The report also notes that a review of the national policy and laws is proposed to support the implementation of National AIDS Policy on HIV prevention. However, none of the government documents mention any proposal to decriminalize adult consensual same-sex sexual relations in Sri Lanka.¹

The National Strategic Plan will be funded by the NSACP of the Ministry of Health under the Director General of Health Services. According to the National Strategic Plan, the total resource allocation is estimated to range from US\$ 44.8 to 48.4 million and nearly 82% of the total resources are allocated for scaling up HIV prevention interventions. Ten per cent (US\$ 1 236 008) of the total resources under HIV prevention is allocated for scaling up HIV interventions among MSM in Sri Lanka.¹³

3.2 Interventions available

Traditionally, very few NGOs have shown an interest in working with MARPs, especially MSM. The National HIV/AIDS Prevention Programme (NHAPP) invited applications from NGOs in 2004–2005. Although over 100 applications were received, only 47 applications were selected, with only one application funded for HIV prevention among MSM by the NGO Companions on a Journey.

A 2006 review of the national response report to STIs and HIV/AIDS by WHO and UNAIDS states that, over the past few years, there have been scattered “awareness” programmes for MSM, mainly in three cities: Colombo, Kandy and Anuradhapura.¹⁴ In earlier years, most of these programmes were conducted by three NGOs that worked with MSM. In 2005, the government STD clinic also conducted an awareness programme for MSM in one city.

Two key service delivery and advocacy agencies working with MSM in Sri Lanka are Companions on a Journey and Equal Ground.¹² Companions on a Journey was established in 1995 and its activities comprise conducting support group meetings for MSM including those living with HIV, running a drop-in centre (DIC), distributing educational materials, conducting awareness campaigns on alternate sexualities, organizing media campaigns, and conducting research into the needs of HIV-positive men and women. It also advocates for decriminalizing homosexuality in Sri Lanka.

Companions on a Journey has received funding from the Humanist Institute for Development Cooperation (HIVOS) and the Sri Lankan government. Equal Ground is an NGO that seeks human and political rights for the lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ) community of Sri Lanka. Established in 2004, its activities include organizing sensitization workshops on LGBTIQ issues, coordinating Sri Lanka's annual pride celebrations, running a community centre for LGBTIQ in Colombo, publishing quarterly newsletters and offering hotline counselling. Funds are received from a number of foreign donor agencies including HIVOS.

3.3 Coverage of interventions

As of late 2007, the coverage of HIV prevention interventions for MARPs (FSWs, MSM and PWID) was not reported. The United Nations General Assembly Special Session (UNGASS) report (2008) showed the following findings: 13.5% of MSM had received an HIV test in the past 12 months and knew their results; 19.8% of MSM could correctly identify ways of preventing the sexual transmission of HIV and could reject major misconceptions about HIV transmission; and 61.9% MSM reported the use of a condom the last time they had anal sex with a male partner.¹ In 2006, out of the estimated number of 250 MSM in Anuradhapura district, 150 were reached by an NGO working with the STD clinic.¹⁴

The UNGASS report also found that within prisons, HIV prevention education and training of prisoners as peer leaders is being carried out. The importance of condoms is reportedly promoted among prison inmates. Condoms are not distributed within prisons but are available with the prison Welfare Officer.

Currently, eight targeted HIV prevention interventions are being implemented among MSM and TG women through various NGOs in four cities in Sri Lanka – Colombo, Dankotuwa, Kandy and Anuradhapura. All these interventions are being funded either by NGOs or by UN agencies. In 2008, a total of 13 104 condoms were distributed through NGOs carrying out HIV prevention interventions among MSM and TG women in Sri Lanka (personal communication, UNAIDS Sri Lanka).

3.4 Current gaps in responses

There is a lack of national funding for NGOs and CBOs to implement targeted HIV

prevention interventions for the most vulnerable populations, including high-risk MSM and beach boys. Negative societal attitudes and criminalization of consensual same-sex adult relations mean that reaching out to MSM presents various challenges that need to be addressed. The findings of the behavioural and services access indicators from the first BSS among MSM in Sri Lanka indicates the need to focus on improving knowledge of HIV and access to HIV voluntary counselling and testing (VCT), and promoting condom and lubricant use among MSM in Sri Lanka.⁶

3.5 Recommendations – the way forward

- Conduct extensive mapping of MARPs in each district, with the objective of identifying the size and location of MSM and other high-risk populations.
- Ensure that targeted HIV prevention interventions support behaviour change (such as use of condoms and lubricants, recognition of STI symptoms, and early health care-seeking behaviour) beyond simple awareness about HIV.
- Develop peer-support activities together with NGOs, CBOs and the target populations.
- Ensure that education and awareness programmes for the general population focus more on reducing stigma and discrimination against PLHIV and members of highly vulnerable groups. In this regard, conduct specified programmes with the police and other groups to produce an enabling environment for conducting targeted interventions among FSWs, MSM and drug users including PWID.
- Provide technical assistance to the NSACP to build its capacity for providing the required care, treatment and support to MSM. The NSACP should in turn assist existing NGOs that focus on MSM and build their capacity to provide community-based care and advocacy, and respond to MSM issues. Encourage assistance from the NSACP towards the formation of CBOs interested in working with MSM communities.
- Encourage existing NGOs to work with high-risk populations, including MSM, in collaboration with gay groups and public health staff. Build the

capacity of NGOs to implement targeted interventions among MSM and other high-risk populations.

- Sensitize law enforcement agencies to not interfere in HIV prevention activities in the field or offices of CBOs and NGOs working with MSM.
- Encourage the Sri Lankan government to repeal laws impeding HIV prevention activities.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

The first case of HIV infection in Thailand was detected in a Thai homosexual student returning from the United States to Bangkok in 1984.^{1,2} The first case of AIDS was identified in 1984; though it was not related to the epidemic, it served as an effective warning of the arrival of HIV infection. A large number of HIV infections and AIDS cases resulted from various transmission routes: drug injecting, heterosexual and homosexual sex, and from mother to child. In the late 1980s, rapidly developing HIV epidemics were identified, primarily among people who inject drugs (PWID). For example, among PWID in Bangkok, HIV prevalence rose from 0% to 49% within one year (1987–88).^{3,4} HIV prevalence among military conscripts and pregnant women reached a peak at 3.40% and 2.29% in 1992 and 1995, respectively, and then came down in 2006 to 0.40% and 0.87%, respectively.⁵ The HIV epidemic among men who have sex with men (MSM) started in 2003 and increased rapidly in 2005.⁶ It is estimated that over a million people have been infected with HIV since the epidemic started; 585 800 people have died of AIDS since the mid-1980s; 532 500 people live with HIV and 12 800 new HIV infections would have occurred in 2008.⁷ The Joint United Nations Programme on HIV/AIDS (UNAIDS) has estimated that, currently, the number of people living with HIV (PLHIV) is 610 000 (410 000–880 000) and the prevalence in adults aged 15–49 years is 1.4% (0.9–2.1%).⁸ According to the latest Asian epidemic model (AEM) for Thailand (2008), MSM will contribute to 30% and 33% of new infections in 2009 and 2010, respectively.⁷

1.2 Size of the MSM and transgender (TG) populations

The proportion of Thai men with same-sex experience is estimated to be between 3.3% and 16%.^{9,10,11} According to the latest AEM for Thailand, there are an estimated 560 000 MSM and 10 000 male sex workers (MSWs).⁷ With an adult male population in Thailand of about 22.5 million,¹² the number of males with same-sex behaviour is likely to be substantial.¹³ That MSM are involved in the sex trade has been shown by one study, which found that the number of MSM involved in the sex trade increased from 59 in 1997 to 1156 in 2002 in the Patong district of Thailand.¹⁴ The estimated

number of TG, commonly known as *kathoeys*, is around 17 000 in Bangkok and 180 000 in Thailand as a whole.^{15,16}

1.3 Typologies of the MSM and TG populations

In Thailand, the most visible same-sex attracted males are those with feminine behavioural traits and known to “cross-dress” either temporarily or permanently. They are commonly called *kathoeys*, which is an umbrella term that includes effeminate same-sex attracted males, TG/trans-sexual women and “hermaphrodites” (inter-sex people).^{17,18,19} Class differences among *kathoeys* have been noted in a study. *Kathoeys* from a lower socioeconomic background may engage in sex work while *kathoeys* from the middle or upper socioeconomic classes may work in hotels, bars and beauty parlours.¹⁸ The conclusion from this study should not be generalized or applied to all settings in Thailand. It is possible that many of those from a lower socioeconomic background may engage in street sex work. However, those who work in bars, for example, also engage in sex work. In addition, differences in socioeconomic status may not hinder a crossover in work settings from the street to establishments if they are good-looking and have connections.

Among same-sex attracted males, current terms include “gay king”, “king gay man”, “king”, “gay queen”, “queen gay man” or “queen”. “Kings” are supposed to be heterosexual and masculine-looking, and presumed and expected to play an active role in sex encounters. On the other hand, “queens” are feminine in nature and reported to play a receptive role in sexual encounters as they are “true homosexuals”.¹⁸ However, a qualitative study documented that a division between the sexual category of “king” and “queen” related to the sexual practice of being the insertive or receptive partner is not always so rigid.²⁰ Many men who have sex with other men including with gay- or *kathoeys*-identified males, do not have any specific labels. Gay men and *kathoeys* may simply see these males as masculine men who once in a while engage in sex with effeminate males like them. These masculine-looking, apparently heterosexual males are called “complete men” (*phuu-chaai tem tua*) or “100 per cent male” (*phuu-chaai roi poe-sen*).¹⁸

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence and trends of sexually transmitted infections (STIs) among MSM and TG populations

The available data indicate a relatively high prevalence of STI-related symptoms and STI prevalence among MSM in Thailand. A study conducted among 2049 Thai men in Bangkok, Chiang Mai and Phuket found a 43.5% ($N=489/1125$) prevalence of STI symptoms (urethral pain or discharge) in the past six months among MSM, while among bisexual men it was 38.2% ($N=172/450$). However, the same study found that self-reported STI-related symptoms were associated with HIV infection among bisexual men. Among HIV-positive bisexual men, the prevalence of STI symptoms was 62.2% ($N=23/37$) compared with 49.4% among HIV-positive MSM ($N=118/239$).¹³

A 2006 study in Bangkok found a high prevalence of hepatitis B virus (HBV) and herpes simplex virus (HSV)-1 and -2 among HIV-positive MSM (73.4%, 69.0% and 39.8%, respectively) when compared with HIV-negative MSM (44.8%, 48.6% and 12.1%, respectively). The prevalence of urethral chlamydial infection was 8.1%; urethral gonorrhoea 4.7% and pharyngeal chlamydial infection 5.8% among HIV-positive MSM.²¹

2.2 Prevalence and trends of HIV among MSM and TG populations

Thailand has a well-established national HIV surveillance system. However, there are gaps as MSM were not included as part of the eight sentinel groups identified by the Ministry of Public Health (MOPH). MSWs, on the other hand, were included but this limits the scope of capturing the MSM population as a whole.²²

From the available data of the special surveys in the three large cities of Bangkok, Chiang Mai and Phuket, a rise in HIV prevalence among MSM is observed. HIV prevalence among MSM in Bangkok increased from 17.3% in 2003²³ to 28.3% in 2005²⁴ to 30.7% in 2007.²⁵ In 2009, the HIV prevalence among MSM in Bangkok had declined to 24.7%.⁶ Among MSWs and TG women recruited for a study in Bangkok and Chiang Mai, the HIV prevalence was 15.6% and 13.5%, respectively,

while among MSM it was 19.2%.²⁴ The study found that among TG women recruited from Chiang Mai, the HIV prevalence was 17.6%. HIV prevalence among drug-using MSM in northern Thailand was 31.8% ($N=21/66$). In the 2007 annual surveillance survey, the Thai MOPH estimated that the HIV prevalence among MSM was 16.9% in Chiang Mai.²⁵ By 2009, a decline in HIV prevalence among MSM in Chiang Mai was observed and reported as 8.3%.²⁶

Data on the HIV incidence among MSM remains limited in South-East Asia. However, data have been collected from Thailand. In Thailand, HIV incidence density was 5.7 per 100 person-years in a cohort of MSM in Bangkok, and 2.7 per 100 person-years among MSM attending an HIV testing clinic (2006–2007) to detect acute infection.^{27,28}

2.3 HIV-related risk behaviours among MSM and TG populations

2.3.1 Number and types of partners

A study in Chiang Mai from the mid-1990s found that, among MSM, the average number of sexual partners in the past two weeks was five.²⁹ Another study conducted around ten years later in the same city found the number of sexual partners to be two per week.³⁰ In Bangkok, studies among MSM reported in 2003 showed a range of 1–4 clients per week.³¹ The three biennial cross-sectional assessments among MSM in 2003, 2005 and 2007 in Bangkok demonstrated that the high percentage of MSM who reported having one or more casual sex partners significantly decreased over the years (65.3% in 2003, 51.1% in 2005 and 38.5% in 2007). About 37% of MSM reported ever having had sex with a woman and there was no change in trend across the three biennial surveys. A significant increase was observed in sex in exchange for receipt of money, favours or valuables (2.0% in 2003, 17.0% in 2005 and 17.3% in 2007).³²

2.3.2 Condom use by partner type

Between 2003 and 2007, results from the three biennial surveys in Bangkok revealed that the proportion of sexually active MSM reporting anal sex in the past three months significantly decreased (97.9% in 2003 to 87.5% in 2007), and having casual or steady male sex partners also significantly decreased (65.3% and 45.9% in

2003, to 38.5% and 27.8% in 2007, respectively). However, there was no significant change in consistent condom use with all male steady or casual partners (63.2% in 2003, 95.7% in 2005 and 65.6% in 2007).³²

A 2006 study among MSM in Bangkok reported that 37% had had unprotected sex with a male partner in the past three months. Unprotected sex was reported by 45% of those who had steady partners compared with 21% of those with casual partners.³³

A study comparing risk behaviours among Thai bisexual men with those among MSM found that consistent condom use with male partners was higher among bisexual men (77.6%) than among MSM-only (62.9%). The prevalence of condom use during sex with a female partner was 44.4% among bisexual men. The number of sexual partners was higher among bisexual men compared with MSM. Sixty-seven per cent ($N=300/450$) of bisexual men had more than six sexual partners in the past three months compared with 27.4% among MSM ($N=308/1125$). HIV prevalence among bisexually active men was 8.1% while among MSM-only it was 21.2%. This may be attributed to higher levels of consistent condom use with male partners, and lower levels of receptive anal sex among bisexual men.¹³

2.3.3 Sex between men in prisons

Documentation by an NGO providing HIV prevention and treatment services in two prisons in Bangkok, Thailand³⁴ highlighted that a major risk factor for HIV transmission within Thai prisons was unprotected sex between men. Consensual sex (both commercial and non-commercial), non-consensual sex such as rape, coerced sex as repayment of debt, and sex in exchange for protection can be common among inmates. However, data on condom use are not available. One study (2001–2002) highlighted that among more than a quarter of the participants ($N=699$) who reported same-sex behaviour, up to 80% continued this behaviour while incarcerated.³⁵

2.4 Potential for rapid transmission

Overall, the MSM and TG populations are neglected in terms of HIV prevention efforts in Thailand; they have high STI rates and HIV prevalence is rapidly increasing

among them. However, MSM have started to be recognized as one of target populations for HIV prevention in the current National AIDS Strategic Plan, covering the years 2007–2011.³⁶ The current evidence shows that HIV infections will not remain contained within this specific male subpopulation, and may spread through regular and casual sexual partners, sexual contact with female and male sex workers, and wives of married MSM. It has been suggested that a consequence of the lack of good HIV prevention efforts targeted towards MSM will result in almost 3500 MSM becoming HIV infected every year in the foreseeable future.⁷

3. NATIONAL RESPONSES

3.1 Policy and legal environment

Sex between men is not illegal in Thailand. Buddhist teachings do not condemn same-sex relations. A study indicated that homophobic violence against masculine MSM has not been reported, but cross-dressing *kathoey* are often subjected to sexual harassment and even sexual violence by men.¹⁸ However, this is not the norm in society. Negative and stigmatizing attitudes of some service providers toward MSM, due in part to a lack of training and skills, remain a barrier to access of MSM-friendly and appropriate STI and HIV prevention and treatment services.⁵ The lack of user-friendly services for HIV and STIs is not unique to MSM; there are similar gaps in services for sex workers and young people. Laws against prostitution, and lack of cooperation from entertainment establishments and saunas due to fear of law enforcement by the police, are cited by the MOPH as obstacles to HIV prevention programmes for MSWs.⁵

Given the recent evidence indicating a high prevalence of HIV infection among MSM in Thailand, the MOPH started consultations in 2005 on HIV prevention programmes for MSM, in collaboration with Purple Sky Network, an association of groups advocating for HIV prevention and care for MSM in the Greater Mekong subregion.¹ At the same time, organizations and groups of MSM, through a series of meetings, have formed an MSM Consortium, facilitated by the Policy Research and Development Foundation Institution and supported by UNAIDS, United Nations Population Fund (UNFPA) and Family Health International (FHI), in an attempt to

work together as a national network and be able to push for a national agenda on HIV prevention among MSM. This consortium was active in working with the MOPH in developing the MSM prevention section of the national strategic plan. MSM are currently included in the National HIV Strategic Plan of Thailand. The current National Integration Strategic Plan for HIV/AIDS Prevention and Alleviation addresses the MSM population.³⁶ The National Plan has been implemented at the local level in some areas. For example, through the 4th HIV/AIDS Prevention and Alleviation Plan in Bangkok Metropolitan Area (2007–2011), HIV prevention interventions among MSM have been re-introduced after a decade of slowdown in prevention efforts. The Thai government states that services in the government system are being developed to be client-friendly and that linkages have been made with the network's services. During the past five years, it is very clear that HIV prevention among MSM was a high-priority policy of the government. Yet, implementation remains limited due to a combination of factors: limited implementing capacity of MSM organizations, limited experience in running consolidated projects by different partners, and limited long-term sustainable funding for partners at the national and local levels.

While the national prevention policy may have acknowledged MSM as an important group to work with, the budget for HIV prevention among this group is still limited. Out of the total HIV/AIDS expenditure for the year 2007, expenditure on the HIV prevention component was 14.1% (Thai Baht 949 855 219), which has been criticized as being insufficient.⁵ Notably, within the prevention component, only 1% (Thai Baht 8 149 570) was spent on HIV prevention programmes for MSM, who in 2005 were estimated to account for 22.6% of new HIV infections. It is suggested that unless effective and expansive prevention efforts are made for MSM, new HIV infections contributed to by MSM will increase to 43% by 2015.⁷

3.2 Interventions available

Some MSM groups are formally established as organizations, while others have formed networks. Most of their work includes peer education and outreach programmes focusing on HIV prevention interventions among MSM. Originally, these initiatives were primarily limited to urban areas such as metropolitan Bangkok and Chiang Mai. Recently, intervention programmes have covered many

other provinces, in both urban and rural areas, in all four regions of Thailand. Drop-in centres (DICs), condom promotion and distribution, and outreach education are some of the activities of these local community-based organizations (CBOs). Information about the approximate numbers of condoms and lubricants distributed to MSM, bisexual men and the TG population are not known to be available. DICs for MSWs and TG sex workers are operational but still in the trial period in Bangkok and Pattaya. A few innovative interventions have been developed and are operational: for example, establishment of MSM-friendly clinics in the Silom area of Bangkok and training of health personnel and MSM volunteers to provide MSM-friendly services in government STI and HIV clinics in Bangkok and Pattaya.

Some key service delivery and advocacy agencies working with MSM in Thailand include the Rainbow Sky Association of Thailand (RSAT), Bangkok Rainbow Organization (BRO), Service Workers in Group (SWING) and M Plus+.³⁷ RSAT was established in 2001 and focuses on HIV prevention among MSM and improving their sexual health. It provides outreach education, and distributes condoms and water-based lubricants to MSM and TG. It works in many provinces in Thailand including Bangkok and Phuket. (RSAT started working in Phuket through a CBO under the Global Fund to fight AIDS, Tuberculosis and Malaria [Global Fund] Round 8; prior to that it was a CBO together with Patong hospital, with support from the Thailand MOPH–US Centers for Disease Control and Prevention [CDC].)

BRO focuses on increasing the acceptance of same-sex attracted people in Thai society and also connects with MSM in saunas to introduce HIV prevention in their businesses. SWING, established in 2004, serves MSWs and has DICs in Bangkok and Pattaya. M Plus+, in Chiang Mai, started in 2004 and focuses on HIV prevention among MSM and TG through outreach and Internet education, and STI treatment services.

The first and largest MSM prevention project in recent years was the MSM Consortium Prevention Project in 2009 led by RSAT with 19 other MSM organizations from Bangkok and other provinces. It has a funding of 23 million baht by the National Health Security Office through the Health System Research Institute and its Center for Development of Prevention Models and Mechanisms under the guidance of the Sub-Committee on Mobilization of Prevention Action of the National AIDS

Committee. The main activity of this Project includes recruitment, training of MSM, peer education and use of outreach workers to provide information, education and training to MSM in city centres and district communities in nine provinces. The MSM Consortium was established through a series of consultations among MSM networks facilitated by the Policy Research and Development Institute and supported by UNFPA, UNAIDS and FHI. Based on the experience of this project, the MSM Consortium has developed a scaled-up project funded by the Global Fund with technical support from the MOPH.

In 2009, with the initiative and joint effort of the Office of the Public Sector Development Commission and MOPH under the directive of the National AIDS Committee, the country now has a National AIDS Action Plan for 2010–2012 that describes joint key performance indicators (KPIs) that are in concert with the United Nations General Assembly Special Session (UNGASS) indicators, and the responsibilities of each ministry as well as civil society organizations in order to reduce new HIV infections by half by 2011. This 2010–2011 Plan is accompanied by a detailed budget plan as instructed by the Prime Minister, who is Chair of the National AIDS Committee. MSM prevention is a key component of this Plan. The budget plan is yet to be submitted for approval.

Thailand's UNGASS report 2008 states that both the government and civil society sectors have been supported for implementing programmes in Bangkok and other cities.⁵ HIV prevention interventions addressing sexual- and drug use-related risk among prison inmates is limited. However, the Bureau of AIDS, TB and STI has been working on a peer education intervention and voluntary counselling, testing and treatment services in prisons with the Department of Correction under the Thai MOPH–US CDC Collaboration since 2007. Médecins Sans Frontières (MSF) has provided HIV prevention and treatment in two prisons (Minburi Remand Prison and Bang Kwang prison) in Thailand.³⁵ The services include providing prevention education, HIV testing and counselling, providing and linking prison inmates with antiretroviral treatment (ART), and ensuring continuity of treatment after inmates are released from prison. While condom distribution within prisons is not banned, in practice it is difficult to get permission from the prison guards to distribute condoms. ART services are available to HIV-infected MSM and TG in prisons, and

are usually linked with the hospitals in their areas. HIV-infected prisoners who are eligible for ART are provided ART under the national health-care programme.

3.3 Coverage of interventions

Thailand's UNGASS report 2008 explicitly states that no data are available on the coverage of HIV prevention programmes for MSM.⁵ The Bureau of Epidemiology of the Thai Government conducted a survey among MSM in three provinces and found that 25.3% correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission (among PWID the figure was 49.2%); 88.2% used condoms during last anal sex with male partners (though consistent condom use in the past three months was 65.8% among MSM in Bangkok); and 54.2% of MSM had been tested for HIV in the past 12 months and knew their results. The relatively high level of condom use in spite of the low level of knowledge could not be explained. However, condom use during anal sex among MSM must increase to over 90% in order to significantly reduce new HIV infections. Quality behavioural surveillance among MSM, MSWs and TG in various cities across Thailand should be encouraged.

3.4 Current gaps in responses

Thailand's response to the heterosexual HIV epidemic has been much lauded worldwide as an effective national response in the early days of the epidemic. The limited attention to MSM stands in stark contrast to the early successes among heterosexuals. A great deal more is needed to control the HIV epidemic among MSM. Although surveys among MSM in 2003 and 2005 provided some HIV prevalence and behavioural data for this population, the data were gathered from only a handful of major population centres and were not available for most of the provinces in the country. Data on rural MSM behaviours currently do not exist. Recently, the Bureau of Epidemiology has included two more provinces in their annual surveillance, Udonthani and Pattalung, which are smaller provinces compared to the other three major population centres of Bangkok, Chiang Mai and Phuket. As a sign of increasing effort for and focus on the MSM population, under the Global Fund Round 8, MSM prevention has been expanded to 14 provinces in 2010 and will increase to around

31 provinces the following year (personal communication, government peer reviewer as told to WHO Country Office Thailand).

The challenges include strengthening the implementation capacity of the MSM National Consortium and local MSM organizations, as well as government STI and HIV service outlets to scale up and increase coverage using best practices for effective and user-friendly interventions as soon as possible. How to institutionalize and sustain programme funding is another challenge.

3.5 Recommendations – the way forward

- Accelerate the implementation of HIV prevention interventions – condom and lubricant distribution, outreach, information, education, communication (IEC), counselling services on sexual health for MSM and those with drug-use problems, voluntary counselling and testing (VCT), detection and management of STIs, promotion of hepatitis B vaccinations among MSM, MSWs and TG in urban areas to start with, and scaling up interventions to other areas based on data from mapping and size estimations of these populations.
- Provide technical and financial support for establishing CBOs to implement HIV prevention interventions among MSM, MSWs and TG.
- Strengthen consortiums and networks of MSM organizations and groups for sustainable coordination, teamwork and implementation capacity, including the ability to recruit and train a large number of peer educators and outreach workers.
- Increase the amount and long-term sustainability of funding allocated to HIV prevention programmes in general, and vastly increase the limited funding for HIV prevention programmes among MSM in particular.
- Ensure that provincial governments focus on MSM when planning and budgeting for HIV prevention interventions in their respective provinces.
- Revise/repeal laws and practices of the authorities in relation to sex work, which impede HIV prevention activities among male and TG sex workers.
- Introduce and scale up HIV prevention interventions within Thai prisons, addressing both sexual- and drug use-related risks.

- Raise awareness among and mobilize support from the MSM population to advocate for and engage in prevention activities for themselves and their communities.
- Conduct advocacy through education and sensitization programmes to contribute towards a reduction in stigma and discrimination faced by MSM, MSWs and TG from the family, society and health-care settings.
- Build the capacity of health-care providers so that they are competent and sensitive in providing quality STI and HIV prevention, treatment and care services to MSM, MSWs and TG.
- Establish an improved monitoring and evaluation system for all HIV prevention interventions targeted at the MSM and TG population.

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1. THE CONTEXT

1.1 Overview of the HIV epidemic

Timor-Leste is considered to have a low-level HIV epidemic, with a national HIV prevalence of less than 0.1%.¹ The first case of HIV was detected in 2001. As of June 2009, there were 126 HIV-positive cases. Issues such as cross-border migration, high unemployment and sexual risk behaviours pose a risk for an increase in the HIV prevalence.² Despite the low prevalence of HIV in the general population, men who have sex with men (MSM) are among the subpopulations considered to be most at risk for HIV infection.¹

1.2 Size of the MSM and transgender (TG) populations

In 2009, the number of MSM in Timor-Leste was estimated at 350–2000,³ which includes what are termed the so-called “hidden” MSM population. In an earlier study in Dili, Timor-Leste’s capital city, it was estimated that the MSM population ranged from 500 to 3000, but the higher figure was likely to be an overestimate.⁴ The National HIV Strategic Plan indicates that reliable information is not available regarding the presence of visible MSM populations in other parts of Timor-Leste. Information about the population of TG is not available.

1.3 Typologies of MSM and TG populations

A situational analysis of MSM, combined with the findings of a sexually transmitted infection (STI) survey in 2004,⁵ suggests that MSM in Timor-Leste fall under three main groups: transgender people (commonly called *behu* and *pangleru*), “gay” men and “hidden” MSM among the general population. The first two groups are considered to comprise a small minority of the entire population of MSM.

A mapping exercise conducted by National Centre in HIV Social Research, University of New South Wales in six districts of Timor-Leste between May and August 2008 found that there are no designated venues where MSM congregate or socialize in Dili or other cities.¹ Nevertheless, a well-established social network reportedly exists in Dili, in which 267 MSM have been identified. These are men who identify as being gay or MSM (as they term themselves), but does not include their sexual partners who identify as being heterosexual.

The sexual partners of the sampled MSM, though they are MSM by definition, may represent an even more “hidden” group of MSM that is hard to reach. These men are known as “clients”, even though most were paid by MSM (in the sample population) for sexual services. These “clients” appear to identify as heterosexual, often have girlfriends or wives, and tend to perform only insertive anal sex. The “clients” are rewarded by MSM in the form of money or goods such as phone cards. No other studies provide information about subgroups of MSM in Timor-Leste.

2. ANALYSIS OF THE EPIDEMIC SITUATION

2.1 Prevalence of STIs among MSM and TG populations

A study conducted among MSM ($N=110$) in 2004 in the capital Dili found a high prevalence of STIs: herpes simplex virus (HSV)-2 infection 29.1%; rectal gonorrhoea 16.1%; syphilis 15.5%; and rectal chlamydial infection 14.9%.⁵ Results from the first round of the behavioural surveillance survey (BSS) conducted in 2008 among 253 MSM in Dili indicated that one fifth (21.1%) reported having ever had an STI-related symptom.¹ Information on STIs among TG is not known to be available.

2.2 Prevalence of HIV among MSM and TG populations

A study in 2004 found a low HIV prevalence (0.9%) among MSM.⁵ It was reported that 24.6% of MSM in the BSS 2008 had ever had an HIV test.¹ The high prevalence of STIs among MSM populations in Dili indicates a high risk for HIV infection. Information about HIV among TG is not known to be available.

2.3 HIV-related risk behaviours of MSM

Given the absence of other studies, assessment can rely only upon two available studies^{1,5} conducted among MSM in Dili. MSM in both the studies were relatively young: the average age was 23 years in 2004 and 19 years in 2008. Information on risk behaviours specifically about TG is not known to be available.

2.3.1 Number of partners

The BSS 2008 showed that among MSM, the mean number of male casual sexual

partners over 12 months was six, and for regular partners it was two.¹ Information on partner number among TG is not known to be available.

2.3.2 Consistency of condom use

The BSS 2008 conducted among MSM in Dili showed that condom use during anal sex with male partners in the past 12 months was inconsistent. Less than one fifth of MSM reported consistent condom use with their regular partners (14.8%; $N=21/141$). Among casual male partners, 18.0% ($N=41/228$) reported consistent condom use. Of those who reported having had anal sex ($N=252$), a majority (89.3%) engaged in insertive anal sex and 22.9% had both insertive and receptive anal sex. The mean number of male sexual partners among those who had receptive anal intercourse was 13 in the past 12 months, while among those who had insertive anal sex it was 4.¹ The risk of acquiring HIV infection is higher among MSM who are receptive partners.

The 2004 study showed that 58% of MSM had multiple sex partners in the past month; 46% reported unprotected anal sex with more than one male partner. About 80% had unprotected anal sex with Timorese, and 70% with foreign partners.⁵

2.3.3 Condom use during last anal sex with different types of male partners

The BBS 2008 found that condom use at last anal sex with regular male partners was low (37.5%; $N=54/144$) compared with casual male partners (43%; $N=99/230$).¹ Information on condom use among TG is not known to be available.

2.3.4 Bisexual behaviour

Bisexual behaviour was commonly reported by MSM in Dili. Forty-six per cent of MSM in the 2004 study⁵ and 93.8% of MSM in the BSS 2008 reported sex with women in the past 12 months.¹ The BSS 2008 reported that among MSM, 93.8% reported having had sex with women in the past 12 months: 91.7% had sex with a casual partner, with an average of 4 partners. In the BSS 2008, condom use during vaginal sex with a regular partner was 9.1%, while with a casual partner it was 20.4% in the past 12 months.¹

2.3.5 Drug use

In the 2004 survey, 4% of MSM reported having ever injected drugs.⁵ The BSS 2008 showed that among MSM, 9% reported drug use in the past 12 months, and 3.3% had injected drugs in the past year. Among those who used drugs, the most commonly used drug was *hashish* (84.0%).¹

2.4 Potential for rapid transmission

Despite the limited amount of research undertaken among MSM, this group is at high risk for HIV infection. High levels of unprotected sex with both male and female partners (regular and non-regular), together with multiple sexual partners and high levels of STIs could fuel a rise in HIV infection among both MSM and their male and female partners. In addition, though the level of injecting drug use is low at present, it may have the potential to contribute to a rise in HIV infections.

3. NATIONAL RESPONSES

3.1 Policy and legal environment

It has been reported that sex between adult males is legal in Timor-Leste.⁶ However, it is important to note that “sexuality” is not included in the Constitution under Part II, Section 16 on Universality and Equality, which concerns discrimination due to race, colour and gender. As a result, the Constitution does not specify if sex between adult males is legal or not. However, as of September 2009, the government is a signatory to the Universal Declaration of Human Rights. While stigma and discrimination is likely, the National HIV Strategic Plan states that discrimination against MSM is not common.

The National HIV/AIDS/STIs Strategic Plan for 2006–2010 focuses on scaling up services for HIV prevention and education, and voluntary counselling and testing (VCT) among most-at-risk populations (MARPs).⁷ The plan outlines measures to intensify prevention and education interventions among MARPs through a range of strategies, such as peer-based education, social marketing, condom distribution, and direct provision of clinical services. Most of these interventions are to be delivered

through outreach services. The plan also prioritizes provision of comprehensive VCT to sex workers and MSM populations outside Dili. However, there is no indication in the National HIV/AIDS/STI Strategic Plan of the total resources necessary or allocated to carry out the above-mentioned activities among MARPs.⁷ Additionally, 99% of the national AIDS programme is funded by the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) Round 5 HIV grant.⁸

3.2 Interventions available

Some of the key service delivery agencies working with MSM in Timor-Leste include Fundasaun Timor Hari'I (FTH), Clinic Café Timor (CCT) and Bairo Pité Clinic. FTH's activities include behaviour change communication (BCC) services, peer outreach activities, condom distribution, a drop-in centre (DIC) and VCT/STI referrals for MSM (Dili) and other MARPs. FTH's target is to reach out to 500 MSM in Dili, an estimated 100% of the openly gay and TG population.⁸ FTH received support from Family Health International (FHI) till the end of 2005. Both CCT and Bairo Pité are clinics that have been providing VCT/STI/HIV services to MSM and FSWs in Timor-Leste. FHI supported these two clinics in providing specialized STI/HIV-related services through the end of 2005. Currently, the intervention activities of FTH and STI services at the CCT and Bairo clinics are being supported through Round 5 of the Global Fund grant.⁸ There are no interventions that distribute condoms among prison inmates. An AIDS awareness campaign as part of a "holistic approach to assist prisoners" was launched by the United Nations Population Fund (UNFPA) in May 2009 in Becora prison in Dili.⁹

3.3 Coverage of interventions

The National Strategic Plan outlines outreach activities implemented by FTH in Dili to reach most MSM (estimated 500 "openly" MSM) in 2005. However, as previously noted, there could be an estimated 3000 MSM in Dili when including the "hidden" MSM population. Reaching the visible and relatively more easy-to-reach population of MSM alone will not be sufficient to ensure widespread distribution of condoms, lubricants and other risk reduction behaviour change interventions to all those engaged in sexual risk behaviours. There is poor coverage of sexual health intervention services outside the capital for MSM and TG. Information on the

coverage of antiretroviral therapy (ART) for those MSM or TG who are HIV infected is not known to be available.

3.4 Current gaps in responses

Timor-Leste is a small country but it is important to undertake HIV sentinel sero- and behavioural surveillance of MSM and TG outside of the capital Dili. An integrated biological and behavioural surveillance (IBBS) is currently under way and will include MSM populations in Dili, Baucau and Maliana. The findings of this study will be available in 2010. Unprotected sex is common (inconsistent condom use is the norm) as is having multiple sexual partners, be they males or females. Raising the profile of behavioural change and ensuring access to information, education and counselling (IEC) on sexual health matters for self-identified MSM and those considered to be part of the “hidden” MSM population are lacking. The IEC needs of female partners of MSM have not been addressed and this will need to be given a higher priority. Information about the TG population is lacking and research among this high-risk group will be necessary to respond to their needs. Information on and better understanding of drug use, specifically injecting drug use, among MSM is required. Research is currently under way to examine this topic and will make an important contribution to developing an appropriate response.

3.5 Recommendations – the way forward

- Conduct periodic HIV serosurveillance and behaviour surveillance surveys among MSM and TG in Dili and other cities (where MSM have been mapped) to identify trends in HIV incidence and areas of new HIV epidemics.
- Strengthen strategic information such as mapping, surveillance and coverage of MARPs including MSM so that appropriate responses can be planned and implemented.
- Engage more members of the MSM and TG communities to assist in outreach to the vast majority of MSM and TG not included in current mapping, strategic plans or HIV prevention interventions.
- Intensify BCC among MSM and promote consistent condom use with both male and female partners, since levels of condom use are low with both male and female sexual partners.

- Intensify education on STIs among MSM and scale up STI diagnosis and testing services, given that STIs increase the risk of HIV transmission and acquisition; and such diagnosis and treatment provides opportunities for outreach and education.
- Increase monitoring and raise awareness of drug injecting and other drug use among MSM, as an increase in drug use, specifically injecting drug use, has the potential to escalate an HIV epidemic among MSM.
- Address the needs of spouses and regular female partners of MSM as condom use with female sexual partners is not common among MSM. This increases the risk of sexual transmission of HIV.

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Same-sex behaviour is identified in all societies. However, in the South-East Asia Region, the majority of men who have sex with men and transgender persons are highly stigmatized and discriminated against. There are an estimated 4–5 million men who have sex with men; among the transgender population, the number is less clear. Many of them are involved in high-risk sexual behaviours that put them at risk for HIV infection, resulting in a high and increasing HIV prevalence in several countries of the Region. Control of HIV infections among these populations is thus an urgent public health priority.

The countries included in this review are Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. Though most of them have some form of interventions for men who have sex with men and transgender populations, the majority of these populations do not have access to various HIV services due to widespread stigma and discrimination, and punitive laws in most countries.

This report provides information on the status of the epidemic among these populations in the South-East Asia Region. It highlights the need for improved advocacy efforts and a greater national response to save the lives of these populations who are at risk for HIV infection.