

A Study of Behavior of Men Who Have Sex with Men in Mumbai and Thane: Wave - 3

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**3rd Floor, Manthan Plaza,
Vakola Market, Nehru Road
Santacruz East, Mumbai
India**

Telephone: 26673800, 26650547

**www.humsafar.org
info@humsafar.org**

Chapter: 1 **Introduction**

Research studies as an integral part of an intervention were in-built into the programs of the Humsafar Trust. This report is the third in that series which looks into the crucial indicators of enhancement in knowledge and change in sexual behavior of men-having-sex-with-men (MSM) in Mumbai city and some suburbs located in Thane district.

1.1 The AIDS Challenge And the Humsafar Trust Response

In India, HIV/AIDS prevention programs have come a long way in bringing about many changes in the approach towards health intervention programs and health systems since the time this infection was detected. Moving from an approach focused on female sex workers to many groups such as intravenous drug users (IVDUs), street children, men having sex with men (MSM), have been incorporated for interventions. Although MSM as a group were incorporated at a later stage, there has been a regular emphasis of National AIDS Control Organization (NACO) through its National AIDS Control Program (NACP-I & II) to work with marginalized groups who may be engaging in such behaviors that may make them more vulnerable to HIV infection¹. Under NACP - II State and District AIDS Control Societies were formed for carrying out targeted interventions (TI). It was felt that marginalized groups may not avail of appropriate health and information services due to stigmatization and fear of reprisal hence community based organizations (CBOs) and the non-government organizations (NGOs) were considered as important partners for implementing targeted interventions.

In Mumbai, such a partnership was formed when the Mumbai District AIDS Control Society (MDACS) gave the first grant to Humsafar Trust in 1999-2000 for carrying out targeted interventions among the MSM community. The Humsafar Trust started outreach services along the North-South axis of the city right up to Borivali in the western suburbs and Thane in the eastern/central suburbs. Important MSM cruising and sex sites are covered through these out reach services which include behavior change communication (BCC) through an out reach worker, condom distribution and motivation to avail counseling and STI/HIV testing and treatment facility at the NGO. This project was further up scaled by the Family Health International (FHI) in year 2000-2001. The epidemiological data clearly indicates that the HIV positivity rate among MSM is still very high and hence interventions are a must.

¹ www.naco.net.in

1.2 Relevance Of The Research Study

Research plays an important role in informing, improving and planning intervention programs. This research study as it presents HIV risk behaviors of MSM is highly relevant for the Humsafar Trust. The findings of the study may be used to bring about further change in the intervention program. It could also be used for awareness and advocacy purposes at the state and national level.

1.3 Objectives

The objectives of the research study are as follows:

- to assess the knowledge and attitude of MSM towards HIV/AIDS,
- to assess sexual behavior and practices
- to assess the health seeking behavior of MSM

1.4 Presentation Of The Report

The report has been organized into nine chapters. Chapter 1 has an introduction to the study. The methodology, sampling and operational issues have been discussed in chapter 2. Since this study is in-built in the intervention program, a brief of the program through the last 4 years has been presented in the chapter 3. Analyzed data have been presented in chapters 4 through 7. These chapters give insights into socio-economic background of MSM, knowledge, attitude of MSM towards HIV/AIDS, sexual behavior and condom usage and treatment seeking behavior. Prior to this study, there have been two rounds; therefore a comparative data has been presented in chapter 8. The last chapter delves on some key lessons learnt.

Chapter: 2 **Study Methodology**

This study has been planned and executed in a systematic manner. This chapter presents an overview of study methodology, sampling and all other important actions that are necessary for a scientific social research.

2.1 Formation Of Technical Advisory Group

As a first step, a technical advisory group comprising the chairman of Humsafar Trust, Outreach Manager, Fieldwork Manager, Social Research Consultant, FHI Technical Research Expert, MDACS' monitoring officer was formed to take up decisions on technical, operational and ethical issues of the study. This group met and discussed number of times to finalize the methodology, sampling and instrument. An e-mail group was formed to keep every member abreast of the developments.

2.2 The Respondents And Study Area

The respondents were the self-identified homosexual men in the mapped out sites (sites for socialization, cruising and sex activities). Mapping of new sites and updating of sites is a regular activity with the Humsafar Trust. The most recent database was used for study purposes. The study area ranged from Churchgate to Dahisar on Western Railway, Chatrapati Shivaji Terminus to Ulhasnagar on Central Railway and right up to Belapur on Harbor Railway. All the mapped pockets of MSM activities were listed and categorized as high, medium and low turnover sites. The criterion of this classification was as follows:

- **High:** More than 10 MSM visiting the beat in given timing.
- **Medium:** 5 to 7 MSM visiting the beat in given timing.
- **Low:** Less than 5 MSM visiting the beat in given timing.

2.3 Indicators Of The Study

The core indicators of the study are as follows:

Awareness Related Indicators

1. Knowledge of HIV prevention.
2. No incorrect beliefs about HIV transmission

Sexual Behavior Related Indicators

3. Number of sex partners in the last one month
4. Condom use at last peno-oral sex (with a male partner).
5. Consistent condom use during peno-oral sex (with a male partner) in last one month
6. Condom use at last insertive anal sex (with a male partner).
7. Consistent condom use during insertive anal sex in last one month
8. Condom use at last receptive anal sex (with a male partner).
9. Consistent condom use during receptive anal sex in last one month
10. Condom use at last vaginal sex (with a female partner)
11. Consistent condom use during vaginal sex during last one month

The study is designed to assess the above core indicators. Besides these core indicators, there are number of additional indicators that provide important insights, but have a very narrow sample base. Those indicators are as follows

12. Self reported sexually transmitted infections
13. Treatment seeking behavior on sexually transmitted infections
14. Men who have sex with men seeking voluntary HIV tests
15. Men receiving/paying in cash or kind for sex
16. Condom use during paid sex

2.4 Modalities Of Informed Consent

For a sensitive study such as this, informed consent was considered to be a necessary step prior to administering the questionnaire. The technical advisory group discussed the informed consent used during previous studies. A few minor modifications were made in the informed consent and it is up to the standards and norms suggested by the international best practices in research.

2.5 Research Instrument

The semi structured research questionnaire that was used for the first study in 2000 was used this time also, albeit with a few additional questions. A few questions to study mobility pattern was added in Part I (Demographic Profile). A question on drug injecting habits was incorporated in part III (Substance Abuse). In Part IV (Sexuality), a new question on type of partners (spouse, regular partner, and non-regular partner) in last one month was asked. One of the major changes in the instrument is that of segregation of

condom usage during last time sex and in last one month and also condom usage with different types of partners in section V. A question on the type of sexual activities with commercial sex partner was added in section VI (Partner Seeking). The Technical Advisory Group discussed and incorporated these changes in the questionnaire.

2.6 Pre-testing

Pre-testing of the modified questionnaire was done by those investigators who had participated in the previous studies and were given refresher training in the new questionnaire. Around twenty questionnaires were pretested at the field level. This group was headed by the fieldwork manager. There were no changes in the questionnaire after the pre-testing.

2.7 Sample Size Calculation

The sample size for the MSM has been calculated assuming that the objective of this survey is to measure change in behavioral indicators over time, with this round serving as the third wave. This would have an implication on the sample size as the sample size required for measuring change in indicators over time will be larger than that required for measuring an indicator at one point in time. This will be taken into account for ensuring sufficient statistical power to measure the change. The formula used for calculating the sample size to be used for each round of the survey is given below.

$$n = D \frac{\left[Z_{1-\alpha} \sqrt{2P(1-P)} + Z_{1-\beta} \sqrt{P_1(1-P_1) + P_2(1-P_2)} \right]^2}{(P_2 - P_1)^2}$$

P_1 = Proportion at time 1

P_2 = Proportion at time 2

$P = (P_1 + P_2) / 2$

$Z_{1-\alpha} = 1.65$ is the value used for 95% confidence level (one tailed Z – score value for α of 0.05)

$Z_{1-\beta} = 0.84$ is the value used for 80% power

D = Design effect

n = Sample size after accounting for design effect

Based on the above formula, the sample size for MSM to be included in the survey is 267. (Details of the sample size calculation have been shown below). The sample size has

been calculated using $\alpha = 0.05$ (i.e. there is only a 5% chance that the observed change in the indicator occurred by chance alone ($Z_{1-\alpha} = 1.65$ for a one-sided test)) and power ($1-\beta$) of 80% (i.e. there is an 80% chance that if a change did indeed occur in the indicator, then it will be observed) ($Z_{1-\beta} = 0.84$).

Table: 2.7 Required Sample size

Target Group	Specific Definition	Key indicator to be measured	Estimated percent of target group in denominator	Estimated baseline value of indicator	Amount of change to detect	Sample size (N)
1. Men who have Sex with Men	Thos men who had sex with any other man in last one month	Consistent use of condom with all the non-regular partners during last one months	100%	50%	15%	267

2.8 Procedure Of Sampling

Men who have sex with men (MSM) are difficult to enumerate in sample surveys. However, in many settings, MSM tend to congregate in certain type of establishments or locations in sufficient numbers that such locations may be used as primary sampling units for cluster sampling. In many settings, this may be the only feasible means of gathering behavioral data on MSM². Time location cluster sampling results in a self weighted sample. A two-stage time-location cluster sampling approach was adopted for the study. In the first stage the required number of Time-Location clusters was selected through systematic random sampling from an exhaustive list of time-location clusters arranged geographically. In the second stage the required numbers of eligible respondents were randomly selected at each selected time-location cluster. The process of cluster selection was followed as:

Stage I: Cluster selection

1. A detailed list of various times location clusters across Mumbai was prepared. The sites were active on all days/ specific days/specific time for MSM activities. If a site was active on all days of the week, four times a day then different days a week with different time locations were considered for listing them. An exhaustive list contained around 400 time locations across Mumbai was prepared;
2. The sampling interval (SI) was calculated by dividing the total number of clusters in the target group (M) by the number of clusters to be selected (a)
SI=M/a;

² `A Handbook For Program Managers And Decision Makers'- Edited By Thomas Rehle, Tobi Saidel And Robert Magnani

3. A list of random numbers between 1 and (SI) was generated in Microsoft Excel. The cluster on the numbered list corresponding to this number was the first sample cluster;
4. Successive clusters were selected by adding the sampling interval (SI) to the number identified in step (3) that is $RS+SI$, $RS+2SI$, $RS+3SI$ etc.
5. This procedure was followed till all the required clusters were selected.

Stage II: Selection Of Respondents

Investigators were deputed on assigned time-location sufficiently in advance prior to the activating of the site. If it was a high turnover time location cluster, having more than 10 MSM, then the investigator was required to select every fourth respondent, every second if medium. Some of the selection criteria were as follows:

- Every third (or whichever as per the site size) person wearing black trousers, blue trousers or white shirt etc.
- Persons carrying umbrella
- Persons carrying black or brown office bag

2.9 Training And Fieldwork Management

A four-day training program was organized at the Humsafar Center. The Social Research Consultant conducted the training. The team was sent for mock calls and a follow up training session was conducted. The training was focused on following topics:

- Meaning and importance of research on the MSM.
- Ethics of research and field workers' responsibility.
- Posture and body language during the interview.
- Importance of informed consent.
- Importance of background information.
- How to ask a question.
- Ways of recording responses.
- How to ask sensitive information.
- How to validate information.
- Training of study questionnaire.
- Mock interviews.
- Meaning of time-location cluster.
- Selection of respondent from the time-location cluster.

Besides this, the supervisors were given a special training session on coding and scrutiny.

Fieldwork was executed from June 25th to July 25th by a group of eight investigators. Two senior supervisors were responsible for the monitoring of the fieldwork. These supervisors were also responsible for assigning clusters to investigators. As the study investigators were also the outreach workers, care was taken to assign clusters different from their usual places of outreach. All the events that interrupted the work were reported and recorded. In spite of heavy rains and other interruptions, the team completed fieldwork as per the schedule. The two supervisors were also responsible for the scrutiny of the questionnaire and coding.

2.10 Achieved Sample Size

Following table presents finally achieved sample size of the study.

Table: 2.10 Achieved Sample Size

Required Sample Size	Coverage	Terminated Interviews (after filter of 'Whether had sex with any man in last one month)	Final Sample Size
267	283	43	240

2.11 Data Analysis

An experienced analysis team of the Indian Market Research Bureau (IMRB) analyzed scrutinized data. The analysis is mainly frequencies and cross tabulations of key and additional indicators. As a good research practice, rounded percentages have been presented which may have a difference of 1% to 2% more or less.

2.12 Limitation Of The Study

Almost every nook and corner of Mumbai's MSM activities were mapped and considered for time-location cluster sampling. However, MSM who do not visit, cruise these sites and indulge in sex activities in private venues, remain beyond the scope of the study.

Chapter: 3

The Humsafar Trust Project

A project such as this has undergone several changes over the years. The project has constantly tried to learn about practical strategies along with addressing the pressing needs of the MSM. The purpose of this chapter is to review various changes in the program that have taken place after the wave 1 and 2. Although any observed change cannot be directly linked with the intervention as change always takes place in a multi program environment. However, the Humsafar Trust is exclusively working on the MSM sector; hence it may have contributed in major ways towards the observed change.

3.1 First Year, March 1999-2000

The first phase of the project was a pilot, which was supported by the MDACS after a project proposal capacity building workshop. The project was titled as '*Raising Awareness and Motivating Condom Use among MSM in Mumbai Metro*'. First six months of the project were dedicated towards raising a team, training the team and identifying sites of intervention and other modalities. There were nine sites at the beginning where condoms were distributed along with extensive rapport building. The outreach workers distributed information leaflets along with the message of safer sex practices. Health providers at the collaborating agencies such as Sion, KEM and Coopers were sensitized towards the issues of MSM. An in-house STI clinic and Voluntary Counseling and Testing Center (VCTC) were started to support the outreach services. Towards the end of the first year, a base line study on the knowledge, attitude and perception on HIV/AIDS, sexual behavior and practices was conducted. These indicators served as a baseline as well as the needs assessment for the next year. Convenient sampling was done during this study.

Needs assessed through the first baseline review were in the area of intervention as well as the program management. There was a need to increase the levels of knowledge, dispel myths surrounding transmission. Number of sex partners was found to be very high and condom usage was quite low which determined the crucial target indicators for intervention.

At the program management level, a need was felt to increase the number of outreach workers and also expand the sites.

3.2 Second Year, March 2000-2001

The Humsafar Trust extended the outreach service along the north-south axis of the city right up to Borivali in the western suburbs and Thane in the eastern/central suburbs. Number of outreach workers to work on these sites was increased. They were trained in communication skills, rapport development, community service delivery, basic knowledge of sexually transmitted infections (STIs) and the services provided by the Humsafar Trust. In February 2001, the Humsafar Trust was given a further grant by the FHI for up scaling its outreach program. The outreach program was further expanded to cover the east-west sex sites perpendicular to the north-south axis following the railway lines.

In this phase, another round of review was planned which included new sites also. This evaluation served the dual purpose; it measured change on the indicators for the first MDACS pilot project and also established indicators for the FHI project. Both the projects were actually not very divergent as MSM move from site to site and were a mobile population. However, the up scaling helped it immensely by covering a larger segment of the target population to reflect actual change and adding the care and support dimension.

At the time of this study, a listing of time and locations were made, from where the respondents were selected randomly. *This study finding revealed that the number of partners had reduced and there was an improvement in the condom usage.* By this phase, the Humsafar model was fairly established and the clients had started freely interacting with the outreach workers and also seek services at the center.

3.3 Third Year March 2001-2002

This year the team was expanded further and the outreach team was restructured. Outreach workers were selected after rigorous tests (written as well as oral) on important parameters. A team of researcher, counselor and illustrator scientifically designed the information, education and communication (IEC) material. The material was pre tested amongst various target groups and then finalized for usage and distribution. The Humsafar Trust was able to come up with an innovative, reader friendly IEC material. The research study that was conducted towards the end of year (/) 2001 was disseminated in the beginning of year (/) 2002.

In this year, identification of hot spots (new sub groups) was taken up. Peer leaders were identified from among these to work with the MSMs. By now this project was covering following groups;

1. *Identity by sexuality*
Self identified homosexual men
2. *Identity as per role playing feminine gender*
Khotis
3. *Sexuality in certain occupational situation masking populace vulnerable*
Masseurs
Gym attendants
Junior cine artists
Truckers
Vegetable vendors/rickshaw drivers/ street hawkers
Migrant laborers
4. *Sexuality inspired cult groups*
Eunuchs
5. *Cult group accommodating sexuality*
Jogtas

The nutritive supplementary program for HIV +ve MSM was started at ASHA project, Kamathipura. Referrals and medical advice for opportunistic infection (OI) and anti retroviral (ARVs) were also offered at the Humsafar Center.

Data of two rounds of studies revealed that almost thirty percent of the MSM were married. Quite a few of those who were tested to be HIV+ve were also married, thus a need was felt to extend the services to their wives. In order to encourage spouse notification and treatment, counseling facilities were offered at R.N.Cooper municipal hospital to encourage spouse notification. However, this program was not successful due to non-cooperation of the married MSM. While the MSMs accessed facilities at Cooper hospital for treatment of STIs and OIs, their wives were never brought for the counseling and treatment. This was considered as a major challenge for the intervention program.

3.4 Fourth Year March 2002-2003

In this year, besides continuation of the previous year's activities, legal issues such as police persecution and discrimination of HIV+ve individuals by their employers etc. were handled at the Humsafar Trust. Services of an advocate were made available.

Project data helped the senior level project personnel in advocacy programs. Advocacy with the police, health providers, and corporate organization was taken up within and outside Mumbai. At the national level, the Humsafar Trust senior professionals played an important role in sensitizing NACO about the issues of MSMs.

By this year, the project was very well established and sustained efforts around awareness, condom usage STI treatment services and care and support etc. continued. However, the Trust did not succeed in securing partner notification from STI/HIV infected MSM.

3.5 Fifth Year March 2003-2004

A core group of senior professionals worked on the research study. Besides providing a regular outreach and in-house services the team was engaged in training and fieldwork for the research study. In the last two years, the Humsafar Trust has been pondering over the gender roles and sexuality. A section of MSM claims to adhere to feminine gender identity and feminine role. However, this identity does not ensure that such a section gives up on common societal role i.e. of men in a patriarchal society. These sections, MSM and those who adhere to feminine gender identity marry women. Socially determined gender roles and male dominating mindset also pose a serious challenge to the partner notification for STIs/HIV. Thus the MSM are not only a high-risk behavior group, but also acting as a bridge group. It is a big challenge for the project to deal with MSM as a high-risk behavior group and as bridge group.

Chapter: 4

Socio-Economic Profile Of Respondents

In a research study like this, the questions proceed from demographic information to sensitive questions. Demographic information also provides important insights about the target group.

4.1 Nativity And Current Residence

Mumbai, like any other major cities of India has its share of migrants. In the study, a little more than one fourth of the respondents were migrants (Table: 4.1a). This report does not study the relationship between migration and sexual behavior. However, anecdotal data suggests that migration provides the opportunity to exercise sexual orientation in the absence of familial and social pressures.

Table: 4.1a Status Of Being In Mumbai

Status	% of Respondents
Born and Brought up in Mumbai	70
Migrant to Mumbai	30
Total	100

Base: all respondents (N=283)

Close to two fifth MSM migrants were from districts in Maharashtra, followed by Uttar Pradesh (Table: 4.1b). One fourth of the respondent did not mention their native district and states due to maintaining their anonymity.

Table: 4.1b: Native States And District Of Respondents

Native State	Native District	% of Respondents
Maharashtra	Ratnagiri	8
	Raigad	7
	Pune	5
	Nasik	2
	Thane	2
	Amravati	1
	Aurangabad	1
	Satara	2
	Jalgaon	2
	Beed	1
	Uttar Pradesh	Azamgad
Allahabad		4
Gorakhpur		1
Sitamadi		1
Basti		1
Lucknow		1
Barabarki		1
Siddharthnagar		1
Balrampur	1	
Uttaranchal	Nainital	2
Bihar	Bhagalpur	1
	Madhubani	1
	Katiyaar	1
Union Territory	Chandigarh	1
Punjab	Gurudaspur	1
	Jalandar	2
Orissa	Ganjam	1
Karnataka	Mangalore	1
	Bangalore	1
Chattisgarh	Bastar	1
Gujarat	Saurashtra	1
	Surat	1
	Samkheda	1
	Rajkot	1
	Kutch	1
Tamil Nadu	Triichur	1
Rajasthan	Sawai Madhopur	1
Goa	Madgaon	1
Madhya Pradesh	Indore	4
	Not Available	25
	Total	100

Base: N=85

The respondents were asked the place of residence by identifying a nearby station. Respondents lived all over the study area. (Table: 4.1 c).

Table: 4.1 C Place Of Residence

Place of Residence	% of Respondents
Churchgate to Dadar	7
Mahim to Andheri	11
Jogeshwari to Borivali	12
Dahisar to Virar	4
C.S.T. to Matunga (excluding Dadar)	3
Kurla To Vikhroli	18
Kanjur Marg to Diva	8
Dombivali to Ulhasnagar	10
Ambivali, Sahad, Vangani, Badlapur	2
Wadala to Chunabhatti	6
Chembur to Mankhurd	11
Vashi to Belapur	6
Pune	0
Bardoli	0
Total	100

Base: N=283

4.2 Age and Education

The average age of the respondent was 27 years and the data in different age range revealed that the younger age groups were probably visiting the public sites.

Table: 4.2a Age

Age range	% of Respondents
18-21	21
22-25	34
26-29	16
30-33	14
34-37	6
38-41	5
42-45	1
46-49	0
50-53	1
58-61	0
62+	0
Total	100

Base: all respondents (N=283)

It was fairly educated groups with very small percentage of respondents in the category of illiterate/can read and write or can just sign.

Table: 4.2b Education

Education level	% of Respondents
Illiterate	2
Can read and write	0
Can just sign	0
Primary (completed 4th Std.)	8
Middle (completed 8th Std.)	22
Secondary (completed 10th Std.)	27
Higher secondary (completed 12th Std.)	27
Graduate	10
Post graduate	2
Diploma	0
Total	100

Base: all respondents (N=283)

4.3

Marital Status And Arrangement Of Stay

In this round of the study, it was decided to shift the question on marital status from main demographic section to the questions on sexual behavior with female partners. The outreach workers gave a feedback that being married to a female led to stigmatization of MSM at particular sites, hence most of them hid their marital status and also did not answer questions on sexual behavior properly. Therefore a decision was made to shift the question in order to get a realistic answer. This shifting also meant that marital status of respondents in terminated interviews was missed out. However, some extent of proxy information is available through the question on arrangement of stay (Table: 4.3a).

Table: 4.3a Arrangement Of Stay

Arrangement of Stay	% of Respondents
Own family (wife and children)	18
Parents	57
Friends	9
With Male Spouse	0
Others (distant relative, mess)	17
Total	100

Base: all respondents (N=283)

Almost one fifth of respondents were married as they were living with their wife and children. Around three fourths were living with their parents. Due to the above mentioned

reasons, discrepancy in responses such as sex with wife, marital status in section 6.5 of Chapter: 6 are expected.

4.4 Occupation, Place of Work And Income

Almost three fourths of the respondents were in services such as government and private office job and nearly one fifth had petty as well as medium size businesses and shops. A minority (3%) of respondents said that they were working as commercial sex workers.

Table: 4.4a Occupation Of Respondents

Types of Occupation	% of Respondents
Service	60
Business	17
Student	8
Unemployed	8
Commercial Sex Worker	3
Freelance work (on wages or one time payment)	4
Total	100

Base: all respondents (N=283)

Although the work places were spread across all over Mumbai, the main hub was mostly the town side areas and suburbs, where mainly offices and industrial estates were located (Table: 4.4b).

Table: 4.4b Place Of Work

Place of Work/Study	% of Respondents
Churchgate to Dadar	16
Mahim to Andheri	17
Jogeshwari to Borivali	5
Dahisar to Virar	1
C.S.T. to Matunga (excluding Dadar)	10
Sion To Vikhroli	12
Mulund to Kalwa	8
Dombivali to Ulhasnagar	6
Vithalwadi, Karjat	1
Sewri to G.T.B.	4
Chembur to Govandi	5
Vashi to Belapur	7
Surat	0
Not Available	8
Total	100

Base: all respondents (N=283)

The respondents were asked to give information about their family income (Table: 4.4c). The average family income has gone up by a thousand rupees as compared to the second wave. There were a segment of respondents (16%) who belonged to economically well to do families with their family incomes more than 18,000 rupees.

Table: 4.4c Monthly Family Income

Income range	% of Respondents
No income	1
< Rs. 3,000	12
Rs 3,001 - Rs. 6,000	24
Rs. 6,001 - Rs. 9,000	14
Rs. 9,001 - Rs. 12,000	18
Rs. 12,001 - Rs. 15,000	12
Rs. 15,001 - Rs. 18,000	2
Rs. 18,000+	16
Total	100
Avg. Income	Rs. 9,345

Base: all respondents (N=283)

Data on average individual income (Table: 4.4d) suggested that the respondents were almost contributing half the family income.

Table: 4.4d Monthly Individual Income

Income range	% of Respondents
No income	16
< Rs. 3,000	29
Rs 3,001 - Rs. 6,000	32
Rs. 6,001 - Rs. 9,000	8
Rs. 9,001 - Rs. 12,000	9
Rs. 12,001 - Rs. 15,000	2
Rs. 18,000+	2
Total	100
Avg. Income	Rs. 4,235

Base: all respondents (N=283)

4.5

Mobility Pattern

As has been said that mobility provides an opportunity to exercise sexual preferences of people, hence it was deemed necessary to understand what this mobility pattern entails.

Three fourth of respondents traveled outside Mumbai (Table: 4.5a).

Table: 4.5a Travel Outside Mumbai

Travel outside Mumbai	% of Respondents
Yes	76
No	24
Total	100

Base: all respondents (N=283)

What may be considered as a fairly regular traveling was done by one fourth of respondents (Table: 4.5c). Others (64%) were in the category of once a year, once in three months, twice a years etc. hence it was combined together.

Table: 4.5c Frequency Of Travel Outside Mumbai

Frequency of Travel outside Mumbai	% of Respondents
Daily	1
Once/ Twice a Week	2
Once a Fortnight	7
Once a month	25
Other	64
Total	100

Base: Those who travel outside Mumbai (N=213)

There were multiple reasons of traveling; the most common were work, entertainment and family commitment and the major reason being family commitments such as mandatory visits to relatives, marriages and visit to fulfill religious obligations. Only a minority of respondents (5%) admitted that they traveled in search of sex partners (Table: 4.5d).

Table: 4.5d Reasons Of Travel Outside Mumbai

Reasons of Travel outside Mumbai	% of Respondents
Work Related	29
Entertainment	38
Family Commitment	40
In search of sex partner	5
Total	100

Base: Those who travel outside Mumbai (N=213)

Barring Bangalore and Chennai, rest of the respondents traveled to destinations reachable in seven hours with extremely good connectivity by road and train. Several Indian towns and villages were mentioned by the respondents which were combined together and this segment was little over two fifth (Table: 4.5e)

Table: 4.5e Cities Of Travel

City traveled to from Mumbai	% of Respondents
Pune	19
Nasik	9
Lonavala	7
Daman	4
Chennai	4
Bangalore	8
Baroda	3
Other cities	46
Total	100

Base: Those who travel outside Mumbai (N=213)

Chapter: 5

Knowledge, Attitude Of MSM Towards HIV/AIDS

Awareness building about the disease is the first step of intervention. Throughout the various national, state and district level program, awareness about the disease, its prevention and transmission has been spread among the common people. Increase in awareness may have an impact on the behavior of people towards sex as well help in reducing the stigma surrounding HIV +ve people.

5.1 Knowledge About HIV

Only around three fourths of respondents are aware about HIV as a micro-organism that causes AIDS (Table: 5.1a). Two fifth of respondents knew of AIDS as a fatal disease. What is noticeable that one fourth of the respondents still consider HIV as an insect or a foreign germ.

Table 5.1a Knowledge About HIV

What is HIV?	% of respondents
An insect	19
A foreign germ	6
A fatal disease	42
A micro-organism that causes AIDS	24
Others	2
DK/CS	6
Total	100

Base: All respondents (N=283)

Along with the correct knowledge, the myths also prevail in the mindsets of people. These myths lead to misinformation about the HIV/AIDS and cause stigmatization of the HIV+ve people. These myths are, HIV could be transmitted by mosquito bite, by residing with a HIV positive person or sharing meals or utensils with such a person. Table 5.1b indicates that the respondents had fairly higher-level correct information about the HIV transmission. However, it was noticeable that slightly more than one fourth of the respondents believed that eating in the utensils of the infected person could transmit HIV.

Table 5.1b: Knowledge Of Modes Of Transmission

Modes of Transmission of HIV	Yes (%)	No (%)	DK/CS (%)	Total (%)
By mosquito bite	12	82	6	100
Through sex without condoms	97	2	0	100
By kissing on cheeks	10	87	3	100
From infected mother to unborn child	85	6	9	100
By using the same toilet as used by HIV +ve person	7	91	2	100
Via infected blood and blood products	95	4	1	100
By eating in the utensils of the infected person	30	59	11	100
By residing with an HIV+ve person	11	84	5	100
By hugging infected person	8	88	3	100
Through usage of infected needle	93	5	2	100

Base: N=260 respondents who know what is HIV

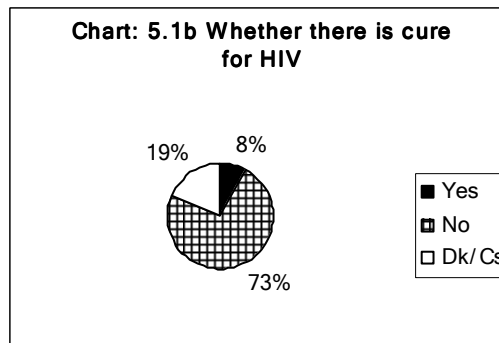
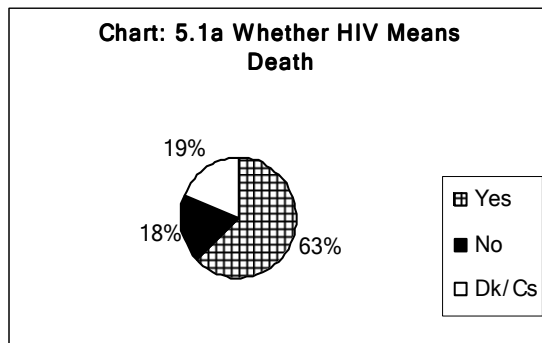
It is heartening to note that a majority of respondents were aware of correct method of prevention of HIV. The knowledge was highest on condom usage during the penetrative sex (97%) and usage of sterilized needles, syringes and skin piercing instruments (93%).

Table 5.1c: Knowledge Of Prevention Of HIV

Ways of prevention	Yes (%)	No (%)	DK/CS (%)	Total
By avoiding penetrative sex	73	21	5	100
By using condoms during penetrative sex	97	3	1	100
By using sterilized needles, syringes and skin piercing instruments	93	7	0	100
By avoiding pregnancy if a woman is discovered to be HIV+ve	81	10	9	100

Base: N=260 respondents who know what is HIV

The respondents were asked whether HIV meant death, to which three fifth of the respondents replied in affirmative (Chart: 5.1a). Only 18% of respondents were optimistic that HIV did not mean death and very smaller percentage (8%) replied in affirmative that there was any cure of HIV (Chart: 5.1b).



5.2 Knowledge About AIDS

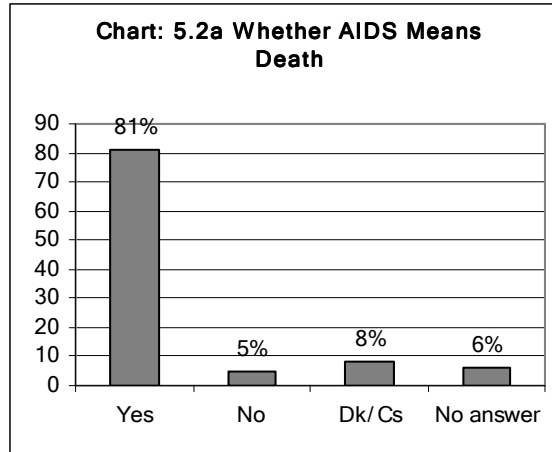
Only one fourth of the respondents knew AIDS as a condition where the body’s immune system breaks down (Table: 5.2a). Three fifth of the respondents perceived it as a killer disease.

Table: 5.2a Knowledge About AIDS

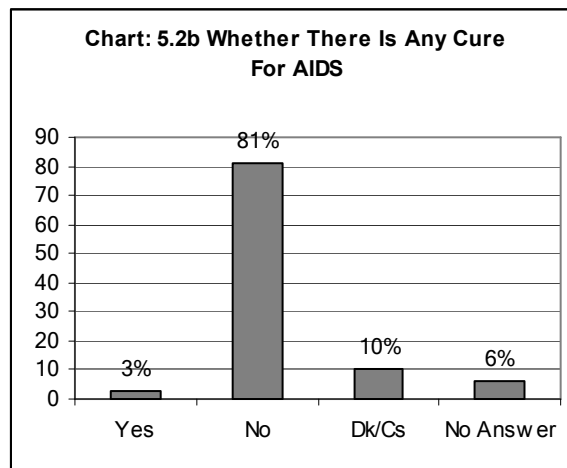
What is AIDS?	% of respondents
A condition where body's immune system breaks down	25
A killer disease	60
A deadly virus	7
DK/CS	6
Others	1
Total	100

Base: All respondents (N=283)

A predominant majority of respondents (81%) replied in affirmative when asked whether AIDS means death (Chart: 5.2a).



A majority of respondents (81%) replied that there was no cure for AIDS. One tenth of respondents were unsure whether there was any cure for AIDS (Chart: 5.2b)



5.3 Attitude Towards HIV+VE People

The awareness program on HIV/AIDS by the Humsafar project seeks to reduce the stigma against HIV+ve people. It is hoped that through the Humsafar Trust program as well as other programs, a supportive and enabling environment for the HIV+ve people will be created. It was heartening to note that only 16% of respondents said that they would break off the relationship, if their partner had HIV (Table: 5.3a). Almost half of them said that they would continue the relationship but not have sex. Another one fourth of the respondents said that they would maintain contact so as to help as and when required.

Table: 5.3a Attitude Towards The HIV+ve Partner

Response	% of Respondents
Break off the relationship	16
Continue the relationship but not have sex	49
Continue the relationship while practicing safe sex	8
Maintain contact so as to help as and when required	24
Person is dangerous for others	0
No Answer	3
Total	100

Base: N=240

Despite a supportive attitude shown earlier by the respondents, they continued to judge a HIV+ve person as immoral (33%) and being cursed by god (28%). People also perceived a HIV+ve person as someone who is punished for his mistake (Table: 5.3b).

Table: 5.3b Perception About HIV+ve Person

Perception	% of Respondents
The person has been immoral	33
He has a curse of god	28
Bad luck	6
Getting Punished for his mistake	11
Common Man, common mistake	2
He should be forgiven	5
He had sex without condom	3
He was being careless	1
No Answer	6
Miscellaneous	5
Total	100

Base: N=240

When the respondents were asked to identify what support services were needed, half of them identified hospices, three fifth identified treatment services and other important services were in the area of testing and counseling facilities (Table: 5.3c).

Table: 5.3c Support Services For HIV+ve MSM

Services	% of Respondents
HIV testing facilities	28
Counseling facilities for prevention	23
Counseling facilities for HIV+ve	30
Hospices for HIV+ve	50
STI diagnostic and treatment facilities	11
HIV Treatment	63
Give love	1
Give work	1
Special Hospital	1
Free food service	1
No answer	1

Base: N=240 (It is a multiple response question)

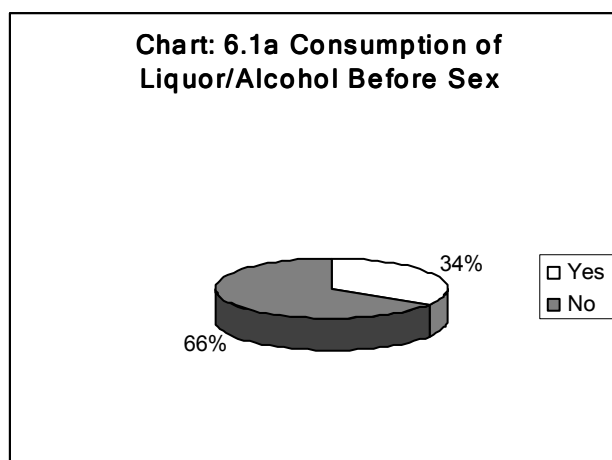
Chapter: 6

Sexual Behaviors And Condom Usage

Intervention programs catering to high-risk behavior groups work towards motivating people to adhere and sustain safer sex practices. As it is an extremely long term as well as complex procedure to ascertain decrease in prevalence of HIV/AIDS, change in behavior gives an indication about some aspects of the program that may have worked. Hence an in-depth study of the sexual behavior of MSM in project area has been made in this chapter. The chapter proceeds from general to specific questions. Even the substance abuse prior to sex has been studied. Various sexual practices and condom usages etc. have also been studied in great details.

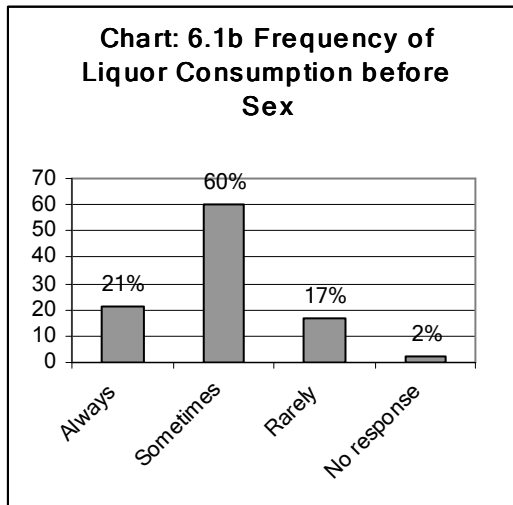
6.1 Substance Use Prior To Sex

Level of intoxication before having sex may have an impact on a person's ability to think and act rationally towards safer sex. It may also result into loss of power to negotiate condom usage during sex. In this study 34 percent respondents said that they had consumed liquor/alcohol before sex (Chart: 6.1a).

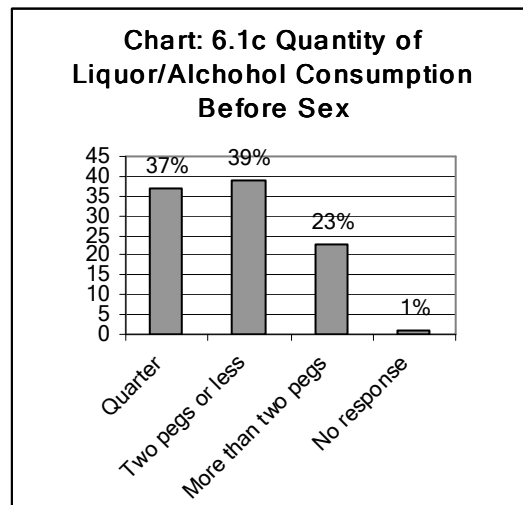


Base: N=283

Further questions were asked on how often they consumed alcohol/liquor, to which one-fifth respondents reported consuming it always and three fifths only sometimes. (Chart: 6.1b). Close to two fifths consumed a quarter bottle or two pegs or less each (Chart: 6.1c).

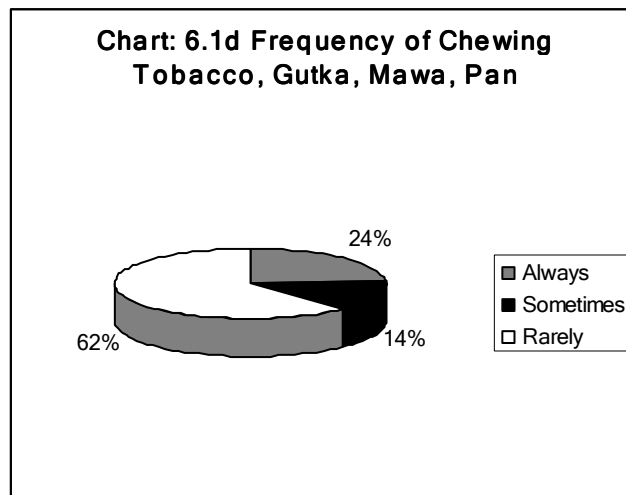


Base: N=95



Base: N=95

None of the respondents reported ever injecting drugs in the last twelve months. However some of them reported having consumed Charas (7%), Ganja (12%) and Opium (6%). Considering this fact that there is no societal stigma against consumption of solid substances, only around one fourth of the respondents reported consumption of tobacco, gutka, mawa and pan (Chart: 6.1d).



6.2 Sexuality

For the sections pertaining to sexuality and sexual behavior, the respondents were asked a question 'whether had sex (manual, oral and anal) with another man in last one month?' This was a filter question, to which 15% replied not having sex with another man in last one month. The remaining sections have data on 240 respondents.

Table: 6.2a Sex With Another Man In Last One Month

Response	% of Respondents
Yes	85
No	15
Total	100
Total number of terminated interviews	43

Different types of partners respondents had sex with were described as under:

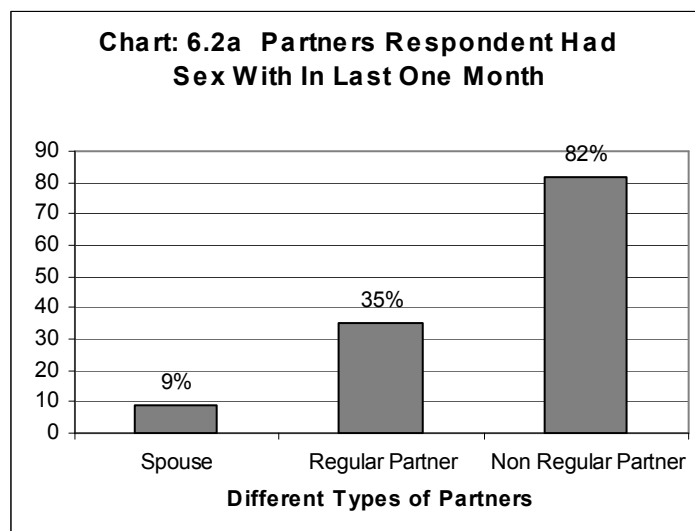
Spouse: MSM Husband/Wife

Regular: A partner with whom the respondent has sex at least once a month but not a spouse

Irregular: Casual partner meaning any pick up from these sites

Commercial sex partner: Sex in exchange of cash or kind

In the last one month, the respondents had sex with different types of partners and a predominant majority had sex with a non-regular partner, followed by regular partner (Chart: 6.2a).



Base: N=240

On an average, the respondent had sex with four male partners in last one (Table: 6.2a).

One fifth each reported having sex with one partner and 5-7 partners each.

Table: 6.2b Number Of Male Partners In Last One Month

No. of Male Partners	% of Respondents
1	19
2-4	46
5-7	21
8-10	8
11+	6
Total	100
Average Number of Partners	4
Median Number of Partners	4

Base: N=240

Considering society's pressure and centrality of marriage in familial set up, many MSM marry. Desire to beget children and conjugal obligations lead to having sex with a female partner. Close to half of the respondents reported having sex with a female partner (Table: 6.2c).

Table: 6.2c Whether Had Sex With A Female Partner

Frequency	% of Respondents
Frequently	20
Sometimes	15
Rarely	12
Never	53
Total	100

Base: N=240

Of those who had sex with female partners, half of them had sex with their wives (Table: 6.2d). Surprisingly in "other female partners" at least one and more than one were also reported. Average number of female partners other than wife was two.

Table: 6.2d Number Of Female Partner In Last Month

No. of Female Partners	% of Respondents
Wife	54
Others	
1	19
2	9
3-4	11
5-6	2
Total	100
Average No. Of Partners (other than Wife)	2
Median No. Of Partners	3

Base: N=112

6.3 Partner Seeking

Respondents picked up a partner via cruising and also through their friends. In general, people in Mumbai and Thane had to commute a lot, therefore local railway stations and public toilets served major meeting places. Surprisingly friend's house and home served as major places of having sex (Table: 6.3). It may be possible that the respondents were bringing partners home (own/friends') besides having sex in public toilets.

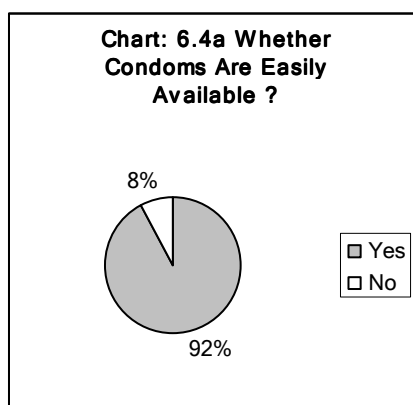
Table: 6.3 Partner Seeking

Sources	% of Respondents
Internet	20
Friends	56
Cruising	92
Places of Meeting	% of Respondents
Public Toilets	69
Parks	29
Public Transport	30
Local Railway Station	81
Sea Beaches	13
Others (home, railway track, hotel etc.)	6
Place of Sex	% of Respondents
Home	63
Public Toilet	52
Parks	8
Friend's House	70

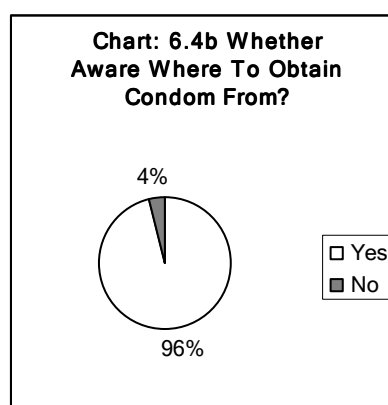
Base: N=240 *Multiple response

6.4 Condom Availability

As condom is an important means of prevention of STIs and HIV, making it available for user is of utmost importance for the implementing NGOs, NACO and even the manufacturing organizations. A predominant majority of respondents said that condoms were easily available and they were aware where to obtain it from (Chart: 6.4a and 6.4B).



Base: N=240



Base: N=240

Medical stores were the most popular place to obtain condoms followed by Humsafar Trust and friends. Respondents fairly knew multiple sources of obtaining condoms (Table: 6.4).

Table: 6.4 Places And Persons To Obtain Condoms

Places and Person from Where Condoms Could Be Obtained	Yes (%)	No (%)	Total
Pan Shop	55	45	100
Medical Shops	76	24	100
General Shop	14	86	100
Clinic	35	65	100
Hospital	44	56	100
Family Planning Center	51	49	100
Bar/ Guest House/Hotel	42	58	100
Peer Educator	39	61	100
Friend	70	30	100
NGO Humsafar Trust	71	29	100

Base: N=240

6.5 Non-penetrative Forms Of Sexual Activities

Considered to be safer, non-penetrative sexual activities are studied in this section.

6.5.1 Wet Kiss and Mutual Masturbation

Table below indicates that barring 29%, the respondents were engaging in wet kiss in varying degrees. Also what is alarming is, almost two fifth of respondents were not engaging in safer sex such as masturbation. They may be inclined towards engaging in riskier penetrative activities.

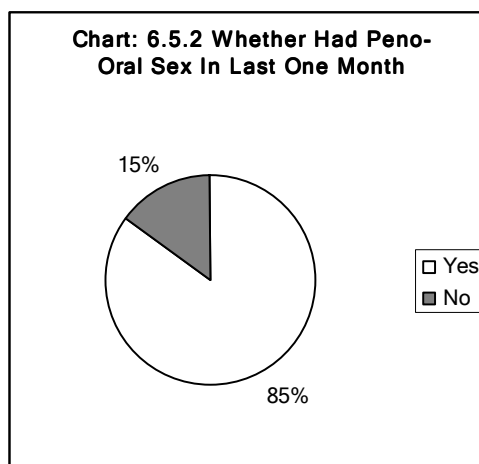
Table: 6.5.1 Safer Sex Practices

Frequency	Wet Kiss In Last One Month	Mutual Masturbation In Last One Month
	% of Respondents	% of Respondents
Frequently(5 times or more in a month)	29	5
Sometimes(2-5 times a month)	28	20
Rarely(once a month or less)	14	17
Never	29	58
Total	100	100

Base: N=240

6.5.2 Peno-oral Sex And Condom Usage

Peno-oral sex in MSM is receiving as well as giving activity and during such a transaction both or one activity could take place. Therefore a filter question was asked if the respondent was involved in peno-oral sex in last one month, to which a predominant majority (85%) replied in affirmative (Chart: 6.5.2).



Base: N=240

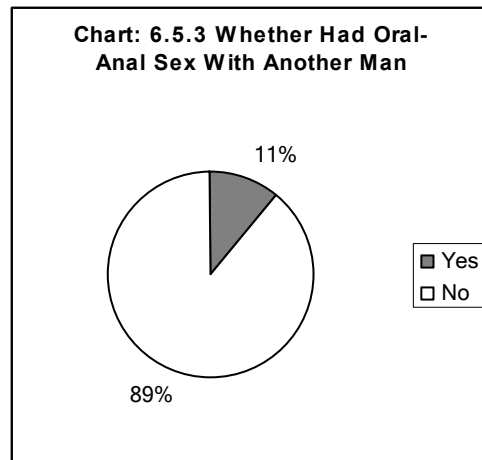
As the table below indicates, peno-oral sex is happening at varying degrees and the condom usage by the respondents as well as their partners at any point of time, i.e. last time or in last one month remains extremely poor thus making them vulnerable to oral STIs.

Table: 6.5.2 Peno-Oral Sex And Condom Usage

FREQUENCY OF SUCKING/LICKING ANOTHER PERSON'S PENIS	BASE: N=205
Response	% Of Respondents
Frequently(5 times or more in a month)	25
Sometimes(2-5 times a month)	29
Rarely(once a month or less)	11
Never	35
Total	100
Usage of Condom by Partner When Respondent gave Oral Sex Last Time	Base: N=133
Response	% Of Respondents
Yes	20
No	80
Total	100
Usage of Condom by Partner When Respondent gave Oral Sex in Last One Month	Base: N=133
Response	% Of Respondents
Always	16
Sometimes	5
Rarely	1
Never	79
Total	100
Frequency Of Another Person Giving Oral Sex To Respondent	Base: N=205
Response	% Of Respondents
Frequently(5 times or more in a month)	23
Sometimes(2-5 times a month)	36
Rarely(once a month or less)	12
Never	29
Total	100
Usage of Condom by Respondent When He Received Oral Sex Last Time	Base: N=145
Response	% Of Respondents
Yes	13
No	87
Total	100
Usage of Condom by Respondent When He Received Oral Sex in Last One Month	Base: N=145
Response	% Of Respondents
Always	12
Sometimes	1
Rarely	-
Never	88
Total	100

6.5.3 Oral-Anal Sex And Condom Usage

Despite the fact that there is a wide scale denial of oral-anal sex and it is considered to be unhygienic, one tenth of the respondents have reported involving in oral-anal sex (Chart: 6.5.3).



Base: N=240

As Table: 6.5.3 indicates that oral-anal sex happens only sometimes and no protection is used.

Table: 6.5.3 Oral-Anal Sex And Condom Usage

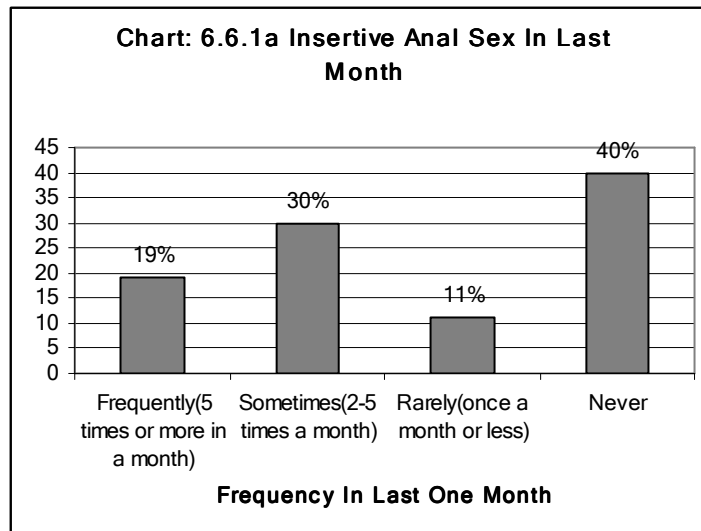
FREQUENCY OF GIVING ORAL-ANAL SEX TO ANOTHER PERSON IN LAST ONE MONTH	BASE: N=26
Response	No. Of Respondents
Frequently(5 times or more in a month)	5
Sometimes(2-5 times a month)	16
Rarely(once a month or less)	4
Never	1
Total	26
Usage of Condom dam/ Protection by Partner When Respondent gave Oral-Anal Sex Last Time	Base: N=25
Response	No. Of Respondents
Yes	-
No	25
Total	25
Frequency of Usage of Condom dam/Protection by Partner When Respondent gave Oral Sex in Last One Month	Base: N=25
Response	No. Of Respondents
Never	25
Total	25
Frequency Of Another Person Giving Oral –anal Sex To Respondent	Base: N=26
Response	No. Of Respondents
Frequently(5 times or more in a month)	3
Sometimes(2-5 times a month)	8
Rarely(once a month or less)	1
Never	14
Total	26
Usage of Condom dam/ Protection by Respondent When He Received Oral –anal Sex Last Time	Base: N=12
Response	No. Of Respondents
Yes	-
No	12
Total	12
Usage of Condom dam/ Protection by Respondent When He Received Oral –Anal Sex in Last One Month	Base: N=12
Never	12
Total	12

6.6 Anal Sex With Male Partner And Condom Usage

In the context of MSM, change in sexual behavior pertaining to anal sex remains a major concern as well as a program priority. Some sections of MSM continue to identify themselves as people who only receive insertive anal sex. However as has been maintained in the first study, there may be role overlap of insertive as well as receptive partners. Condom usage during anal sex may vary as per the type of partners. All these key questions have been dealt with in this section.

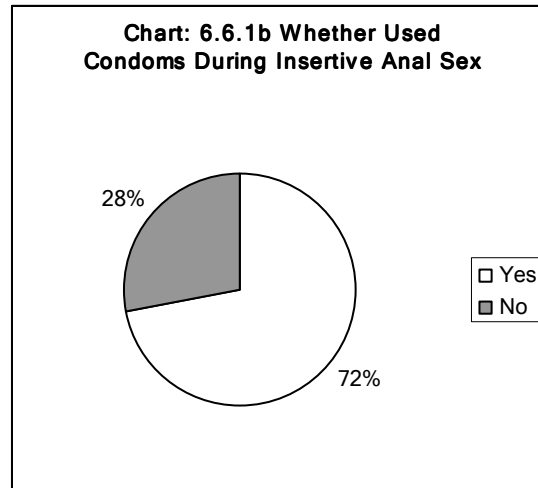
6.6.1 Insertive Anal Sex

A total of 60 percent of the respondents indulged in insertive anal sex (inserting in another partner) in varying frequency (Chart: 6.6.1a).



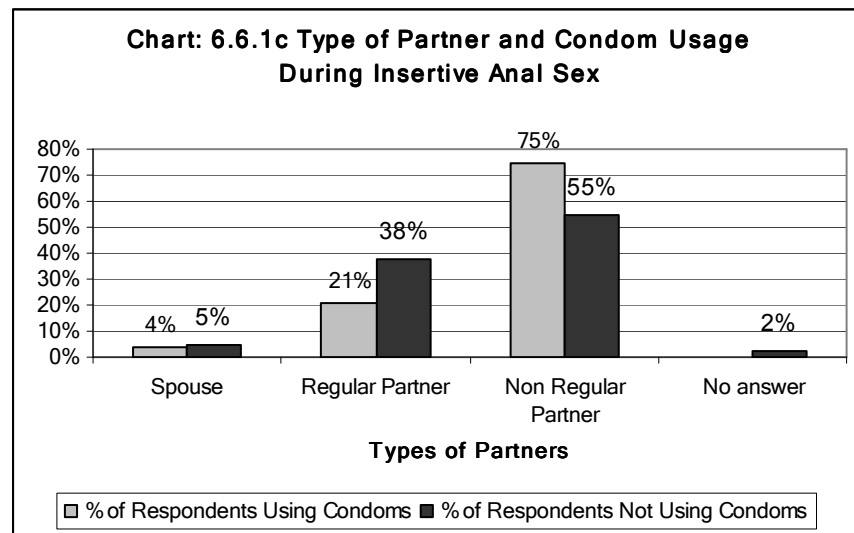
Base: N=240

Almost close to three fourth of the respondents said they did use a condom last time when they indulged in insertive anal sex (Chart: 6.6.1b). Asking questions on the type of partner with whom the condoms were used and not used were further probed.



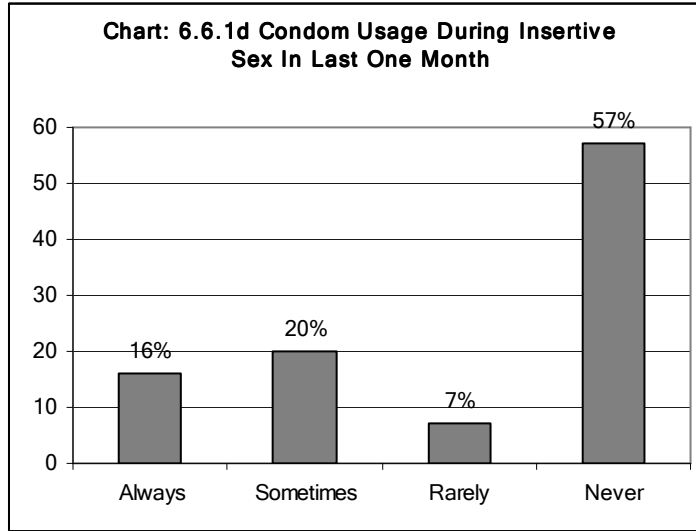
Base: N=145

Of those who indulged in insertive anal sex and used condoms last time, mostly did so for a non-regular partner the most and the least with a spouse (Chart: 6.6.1c). Usage of condom may be associated with relationship issues like bond, loyalty and mutual; therefore usage is least with a spouse. Those who did not use condoms mostly did not use it with a non-regular partner.



Base: N= 105 Respondents Using Condoms, 40 Respondents Not Using Condoms

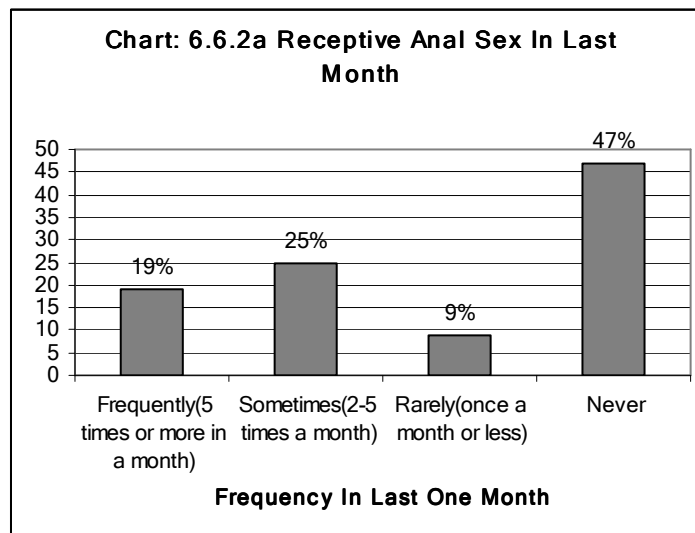
A minor percentage (16%) reported having always used condoms in the last one month (Chart: 6.6.1d). The remaining respondents including those who never used condoms in the last one month and in varying degrees stood at the risk of getting STIs and HIV.



Base: N=145

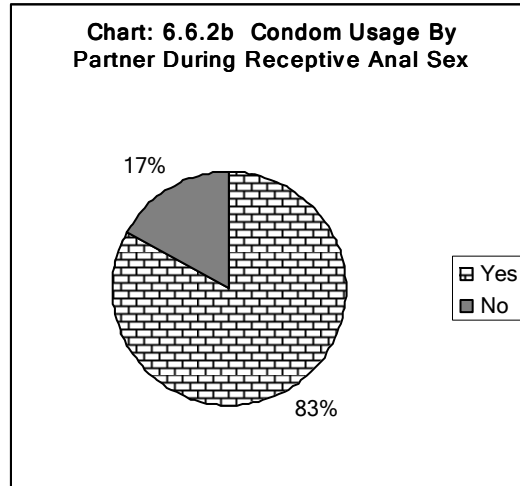
6.6.2 Receptive Anal Sex

Almost close to half the respondents reported not indulging in receptive anal sex (insertion by another person) in last one month (Chart: 6.6.2a).



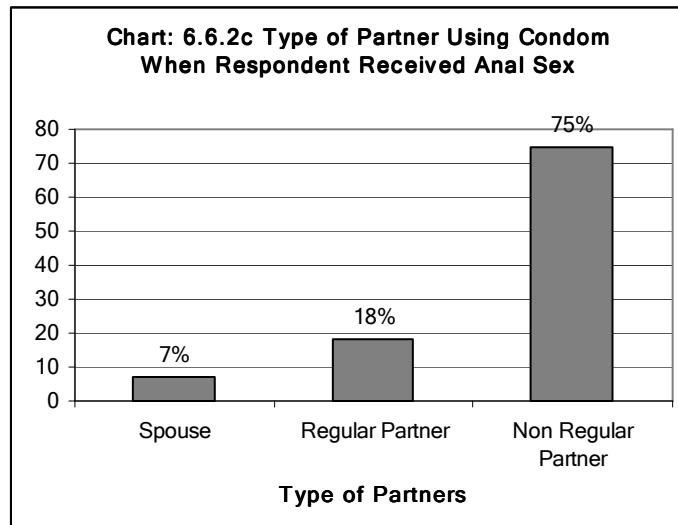
Base: N=240

An overwhelming majority (83%) reported condom usage by the partner (Chart: 6.2.2b) when they had sex last time.



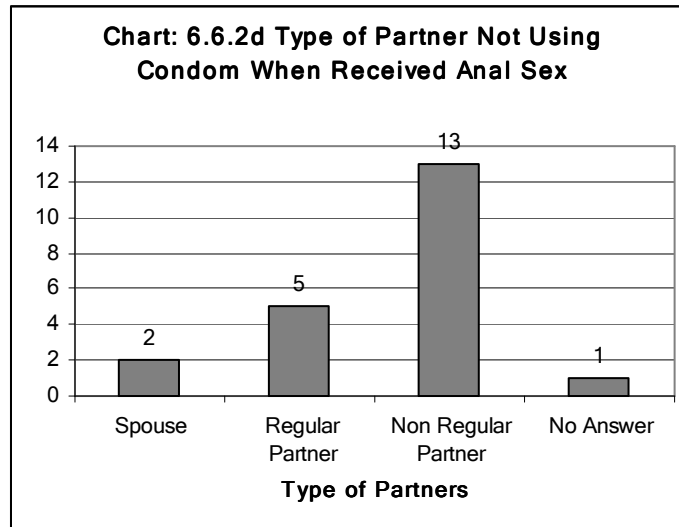
Base: N=127

Three fourth of the respondents reported that condom was used by a non-regular partner (penetrating partner). Least usage was again reported from a spouse (Chart: 6.6.2c)



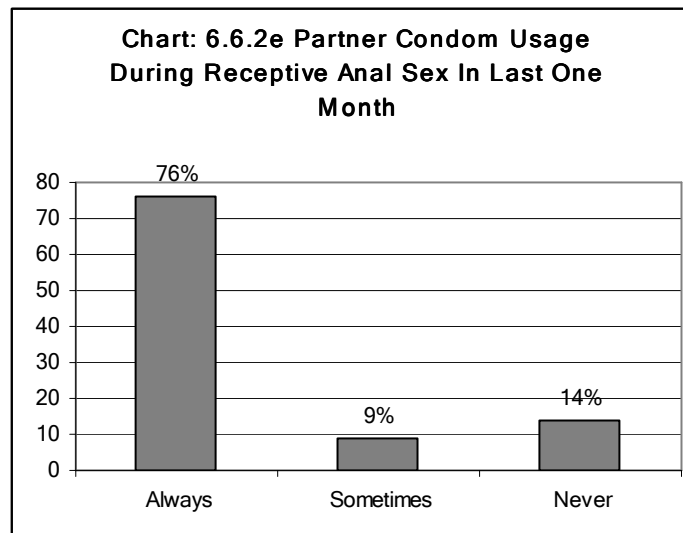
Base: N=106

It was again non-regular partner(s) (Chart: 6.6.2d) who had not used condom when the respondents got penetrated.



Base: N=21

As against the condom usage by partner last time, three fourth of the respondents reported that in last one month, their partner always used condoms (Chart: 6.6.2e).



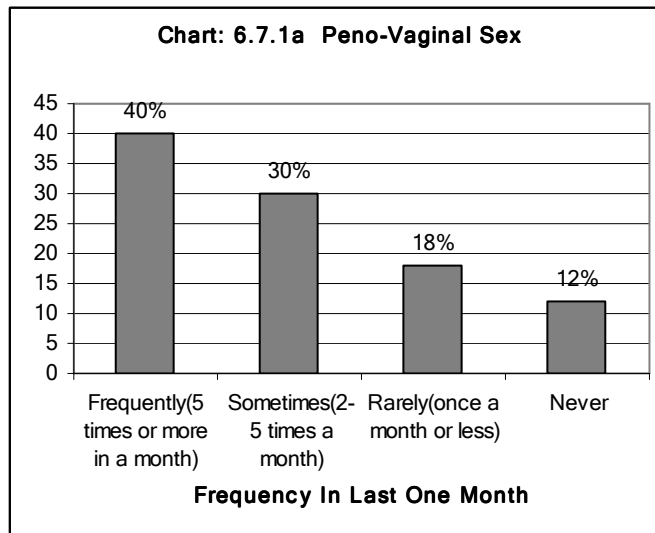
Base: N=127

6.7 Sex With Female Partners And Condom Usage

Despite having an average of four partners, respondent had sex with female partners. In case of married MSM, sex with wife may be mandatory. However, what was unexplainable was; why there was an average of two female partners throughout the three studies? In this section, various sexual practices with female partners have been covered.

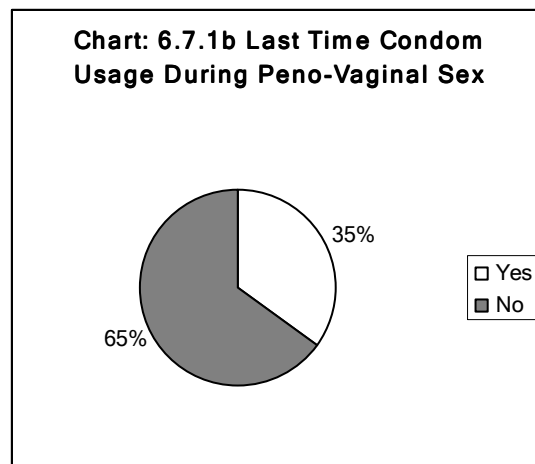
6.7.1 Peno-Vaginal Sex And Condom Usage

Barring a very small percentage of respondents (12%), rest of them had peno-vaginal sex in varying degrees (Chart: 6.7.1a).



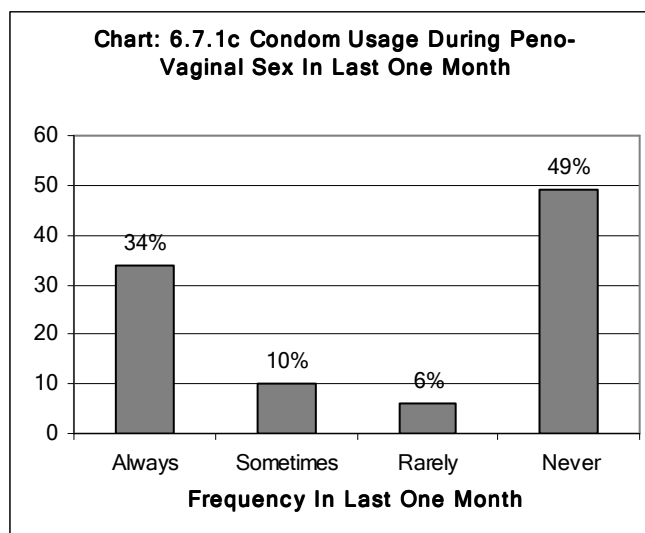
Base: N=112

It was alarming to note that during peno-vaginal sex, 65% of respondent did not report condom usage when they had sex last time (6.7.1b).



Base: N=99

During last one month also only half of the respondents reported having used condoms at varied frequencies and their partners may stand at risk (Chart: 6.7.1c).



Base: N=99

6.7.2 Oral Sex And Condom Usage

Only 30% of respondents reported engaging in oral-vaginal sex with a female partner. None of them (N=34) reported using any protection.

Table: 6.7.2 Oral-Vaginal Sex With Female Partner

Response	% Of Respondents
Frequently(5 times or more in a month)	13
Sometimes(2-5 times a month)	11
Rarely(once a month or less)	6
Never	70
Total	100

Base: N=112

6.7.3 Peno-Anal Sex With A Female Partner And Condom Usage

A minor percentage (15%) of respondents reported having anal sex with a female partner.

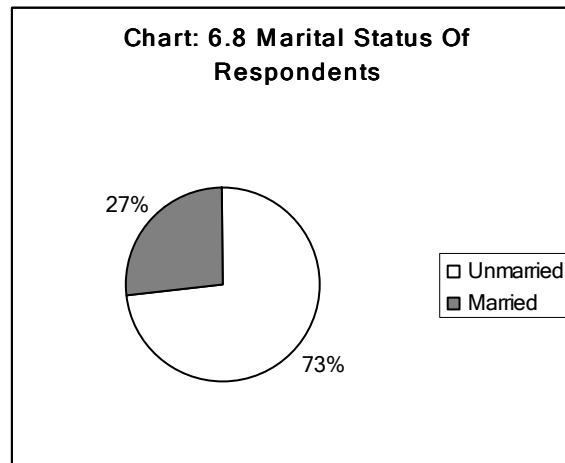
A majority of them replied in negative to question of last time as well as condom usage in last one month (Table: 6.7.3).

Table: 6.7.3 Peno-Anal Sex With A Female Partner

FREQUENCY OF PENO-ANAL SEX WITH A WOMAN IN LAST ONE MONTH	BASE: n=112
Response	% Of Respondents
Frequently(5 times or more in a month)	5
Sometimes(2-5 times a month)	6
Rarely(once a month or less)	4
Never	85
Total	100
Last Time Condom Usage During Peno-Anal Sex With A Woman	Base: N=17
Response	No. Of Respondents
Yes	6
No	11
Total	17
Frequency Of Condom Usage During Peno-Anal Sex With A Woman In Last One Month	Base: N=17
Response	No. Of Respondents
Always	6
Sometimes	1
Never	10
Total	17

6.8 Marital Status

In order to secure a realistic answer, after the key questions on sexual behavior, the respondents were asked about their marital status (Chart: 6.8). Three fourth of respondents reported being unmarried and the percentage of married respondents was high as compared to the proxy question of arrangement of stay in Chapter 4. There were single cases of being a divorcee and widower, each which have been excluded due to rounding of figures.



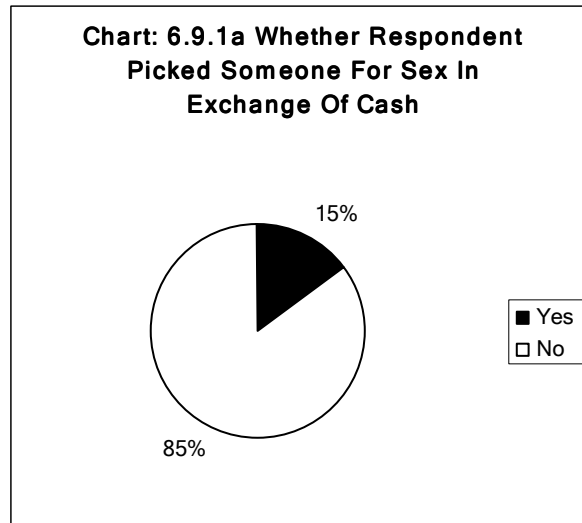
Base: N=240

6.9 Commercial Sex And Condom Usage

Commercial sex is defined as sex in exchange of cash or kind. The Humsafar Trust has mapped out the sites where MSM cruise for sex in exchange of cash. However, in the study area, many MSM engage in it unwittingly when after sex, the person who had sex with them gives gifts and articles or taxi fare. In such cases there may not be a pre determined monetary transaction, but gifts and articles amount to kind and the taxi fare to cash. This kind of transaction may have an impact on the condom usage; therefore it is an important area of study. The entire gamut of sex in exchange of cash or kind has been covered in this section. The first aspect of this is, when the respondent picked up someone (a commercial sex worker) and the second aspect is, when someone picked up a respondent and gave him something after the sex act.

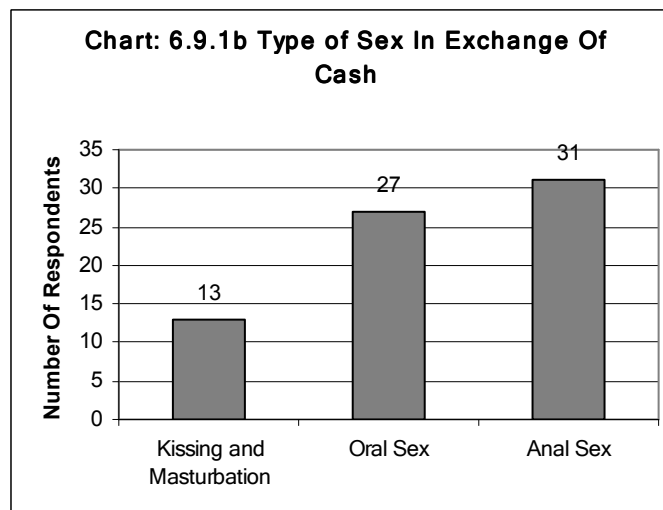
6.9.1 Sex In Exchange Of Cash

At least 15% of respondents said that they had picked up someone for sex in exchange of cash in last one month (Chart: 6.9.1a).



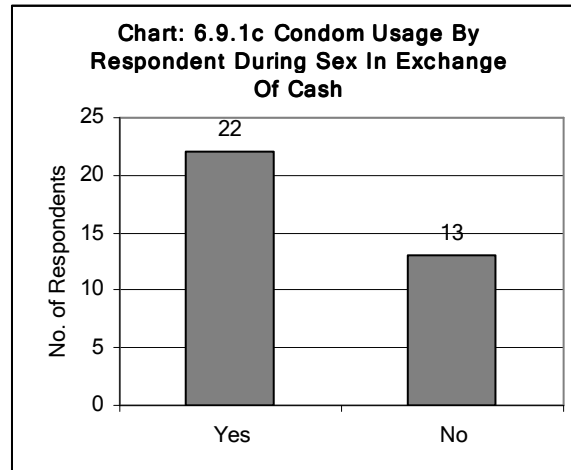
Base: N=240

Those who picked up someone for sex engaged in primarily oral as well anal sex (Chart: 6.9.1b).



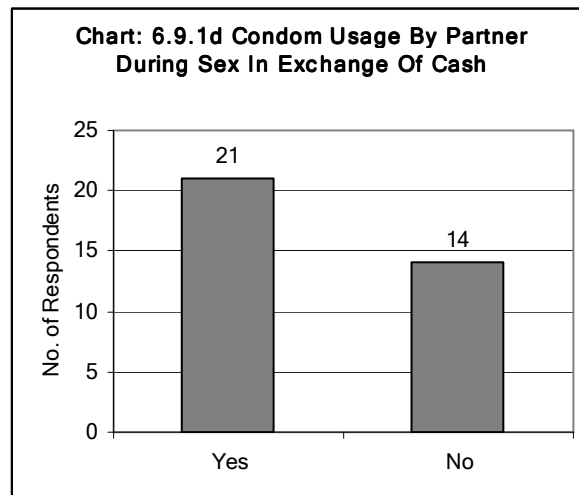
Base: N=35 (*Multiple answer)

Respondents reported self condom usage and an equal proportion usage by their commercial partner (Chart: 6.9.1c and Chart 6.9.2d).



Base: N=35

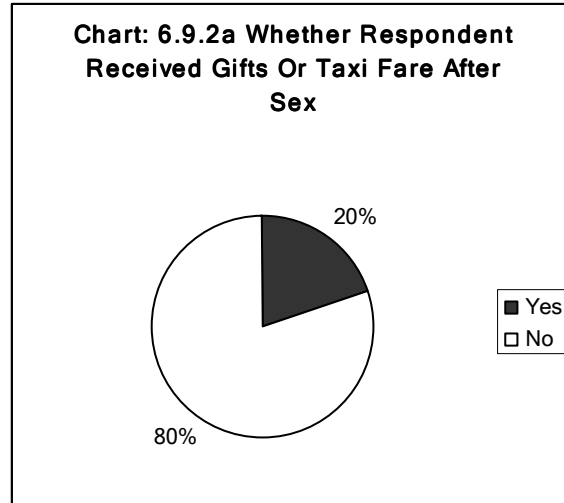
It suggested that during the commercial sex, there was equal amount of providing and receiving of sexual activity took place. People engaged in commercial sex probably knew the risk hence they used condoms.



Base: N=35

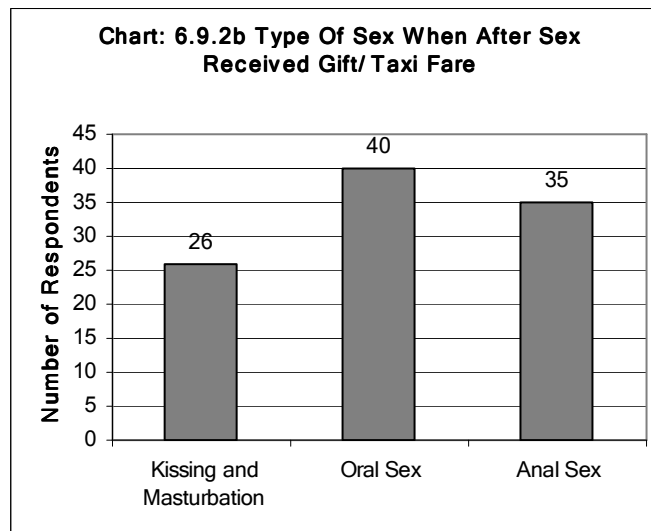
6.9.2 Sex In Exchange Of Gift, Articles, Things Or Money For Taxi

There was probably less inhibition in admitting (20%) that after sex some of the respondents were given gifts, articles or money for Taxi (Chart: 6.9.2a). Reason could be as there was no amount fixed at the beginning hence those who indulged in it did not consider it as commercial sex yet, unwittingly engaged in it.



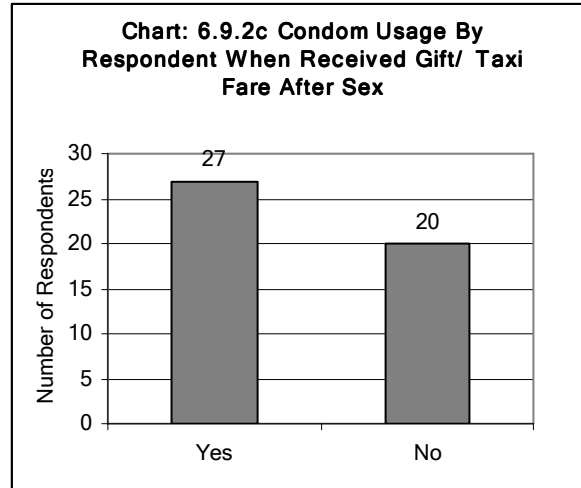
Base: N=240

A predominant majority reported having oral and anal sex during such type of sexual encounter (Chart: 6.9.2b).



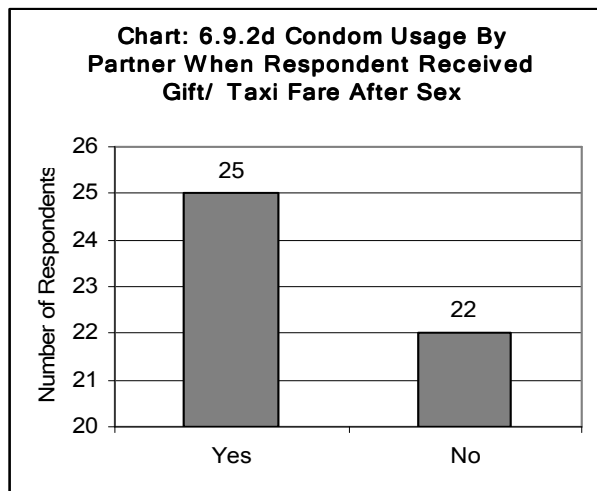
Base: N=47

For the condom usage, here also the proportion of respondents reporting self and partner condom usage was nearly equal (Chart: 6.9.2c, Chart: 6.9.2d).



Base: N=47

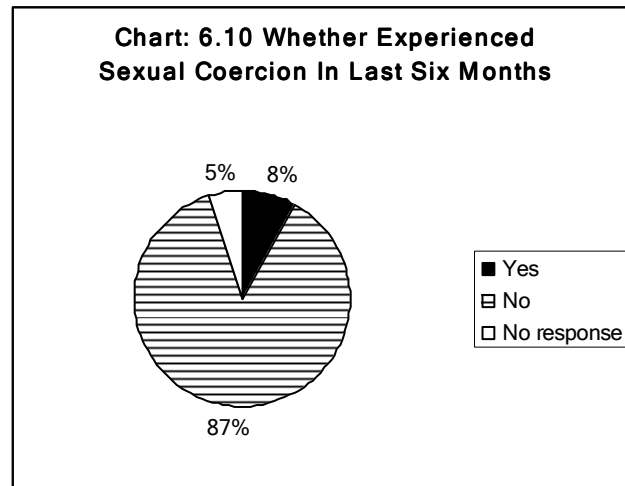
As any gift/ money or taxi fare given after sex is not a predetermined transaction, therefore a respondent may be hesitant to use condom with a partner with whom he desires to engage in sexual activity. This could be reason why usage in such transactions was lesser than usage during sex in exchange of cash (Chart: 6.9.1c)



Base: N=47

6.10 Sexual Coercion

Although only a minority (8%) reported having experienced sexual coercion in last six months, younger MSMs and those who are migrants may be more vulnerable to being sexually coerced. Sexual coercion may reduce the power to negotiate condom usage and therefore such people may be more exposed to STIs/HIV (Chart: 6.10).



Base: N=240

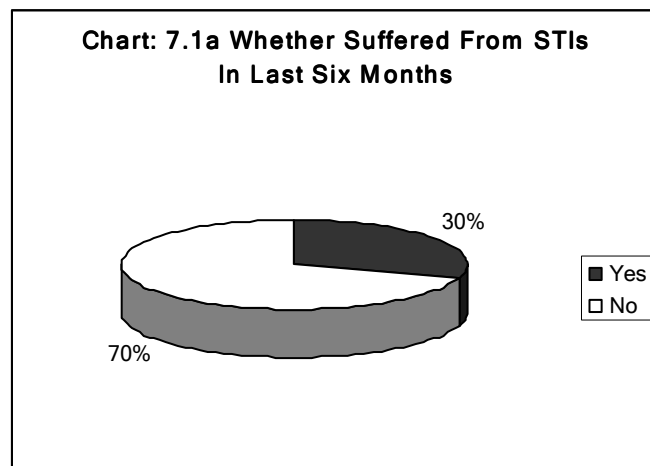
Chapter: 7

Treatment Seeking Behavior

Appropriate treatment seeking behavior is an indicator of person's perception and acceptance of seriousness of his/her health problems. Programs that seek to increase the correct knowledge about the disease also impart knowledge on what should be the correct course of action to treat such a disease. As shame and stigma is associated with sexually transmitted infections (STI), people usually try a range of self and unscientific treatments before seeking treatment from a trained medical practitioner. The Humsafar Trust through its' special clinic, alliances with Municipal hospitals and by sensitizing STIs health care providers has constantly made efforts to improve the STI care for the MSM. This chapter captures the treatment seeking behavior of the MSM in the study area.

7.1 Self Reported Health Problems And Treatment Seeking

It was assumed that sensitive and well-trained field investigators will be able to secure an honest response on questions pertaining to STIs experienced in last six months. A little above one fourth of the respondents reported suffering from STIs in last six months (Chart: 7.1a).



Base: N=240

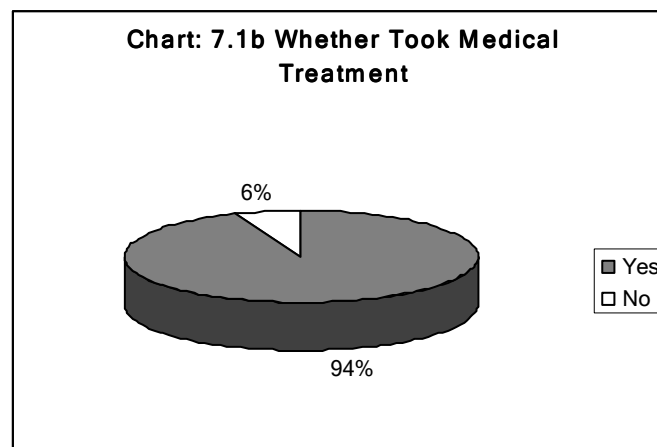
As the Table: 7.1a indicates, a large pool of health problem was clearly STI as well as hygiene related such as itching in genitals (61%).

Table: 7.1a Symptoms Of Health Problem

Symptoms	% Of Respondents
Greenish-Yellowish discharge from Penis	23
Blisters and ulcers on and around penis	8
Redness and swelling of scrotum	21
Redness in groin	14
Itching in genital	61
Other Health Problems	
Anal Infections	4
Burning during urination	1

Base: N=71 (*Multiple Response)

It was encouraging to note that a predominant majority of respondents had taken medical treatment for their STIs (Chart: 7.1b).



Base: N=71

As the Table: 7.1b indicates the respondents probably knew implications of their STI; hence they sought treatment from an allopathic doctor. However some of them may have tried home remedies, self-medication etc. before seeking an appropriate treatment.

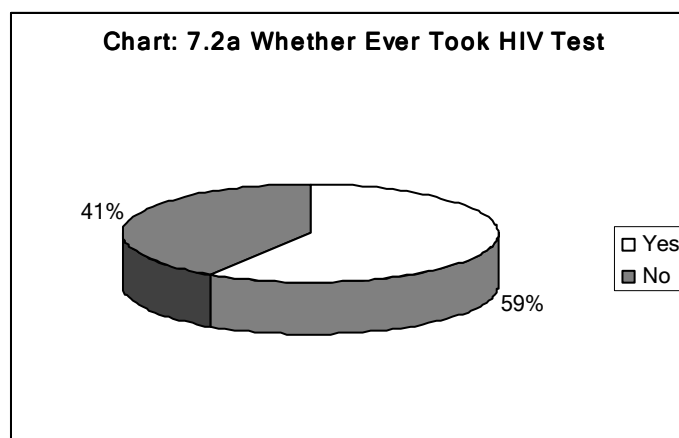
Table: 7.1b Types Of Treatment

Treatment	% Of Respondents
Home remedies	16
Self medication	19
Treatment from an allopathic doctor	88
Alternative system of medicine	9
Treatment from 'Vaidu' 'Buva'	1
Others	1

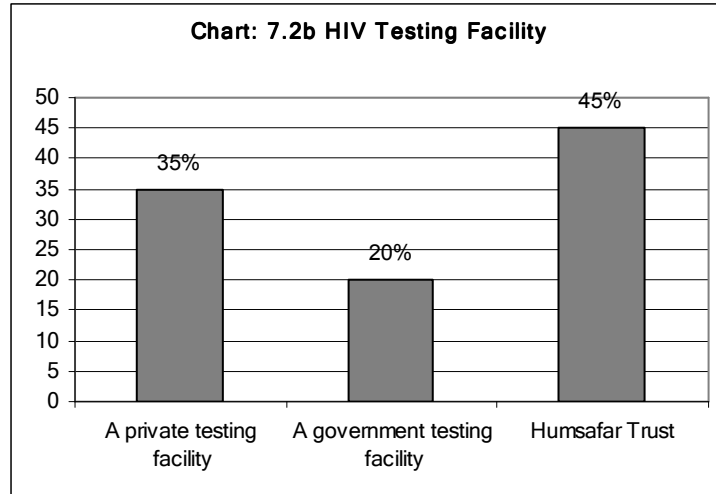
Base: N=67 (*Multiple Response)

7.2 Approach Towards HIV Testing

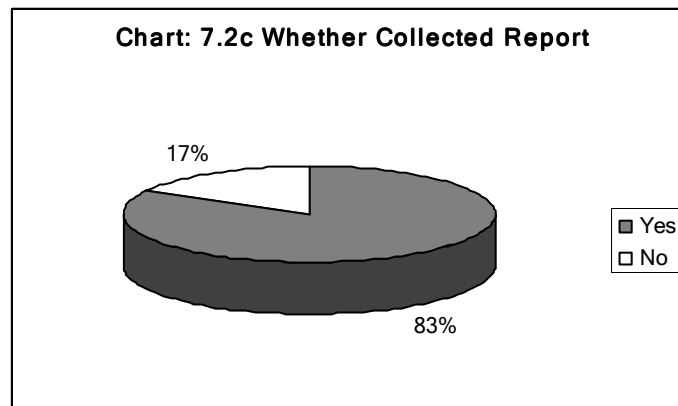
In a situation where the MSM have multiple partners and condom usage in varying degrees, it becomes utmost important that they should take HIV tests from time to time. Around three fifth of respondents reported having taken HIV tests (Chart: 7.2a)



Respondents went to different private, government or NGO facilities, top most being the Humsafar Trust (45%), followed by private facility (35%) and remaining in the government facility (Chart 7.2b).



It was encouraging to note that a predominant majority of respondents collected the results of their test (Chart: 7.2c).



Chapter: 8

Comparing Situations 2000-2003

This study has the advantage of making comparison across previous studies. With every round, the Humsafar Trust's capability to conduct research on HIV related MSM risk behaviors have positively grown. There has been approximately twenty months gap between three studies. The indicators as mentioned in Chapter 2 have been the same. The first study was conducted in February, 2000. An instrument consisting socio-economic profiles and main areas of sexual behavior was prepared and rigorously pretested. The sample size (174 MSM) was determined in consultation with the Family Health International (FHI). Convenient sampling was utilized for sampling 174 MSM. Any MSM who was sexually active in last one month and consented to participate in the study was sampled for the study. This study was disseminated in March, 2000.

The second study took place in October, 2001 in which 327 MSM were sampled. This time a list of time location clusters was prepared and every second time location was chosen from which required number of respondents was randomly selected. This study was disseminated in March, 2002.

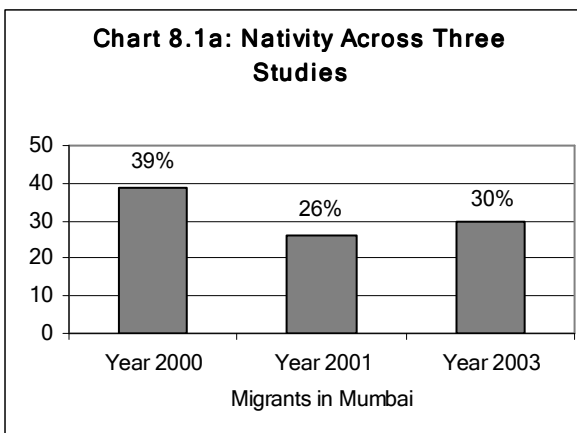
By and large the instrument remains the same with minor changes and few additional questions. In this section, a comparison will be made on select common parameters across the three studies.

8.1 Socio-economic Profiles

Change in the socio-economic profiles depends on many factors such as change in employment opportunities, social and political environment in the study area as well as in the country.

Nativity

The first ever study had a high proportion of migrants as compared to second and third. May be Mumbai may no longer be viewed as a land of opportunities hence this drop is observed. In the baseline there were more migrants from Uttar Pradesh. From second round onwards, the largest numbers of migrants were from Maharashtra.



Age And Education

In the first study, the average age of respondents was 29 years and has remained 27 in the second and recent study. Throughout the three studies, the maximum number of respondents was concentrated in the primary to secondary education bracket.

Marital Status And Arrangement Of Stay

In the first and second study, the proportion of married respondents was slightly more than the one fourth. In the recent study it was barely one fifth. As there were predominantly unmarried MSM in the study, through out the three studies, more than half the MSM lived with their parents.

Occupation, Place Of Work And Income

Across the three studies, the MSM who were occupied in service in private and public establishments dominated the study. A minor percentage (3-4%) reported involvement in sex work in the first and recent study. In all the three studies, the places of work were spread across all over Mumbai with some crucial business districts such as Fort, Churchgate and suburbs such as Andheri, Santa Cruz, Ghatkopar and Kurla often reported as the places of work. Compared to the first and second study, in the third study the average monthly income had gone up by a thousand rupees (is at Rupees 9,345) in every round. However, what was important was, a good 16% of respondents were in the income bracket of 18,000 plus. This percentage was very low (3%) in the first round and gradually rose in the second round (7%).

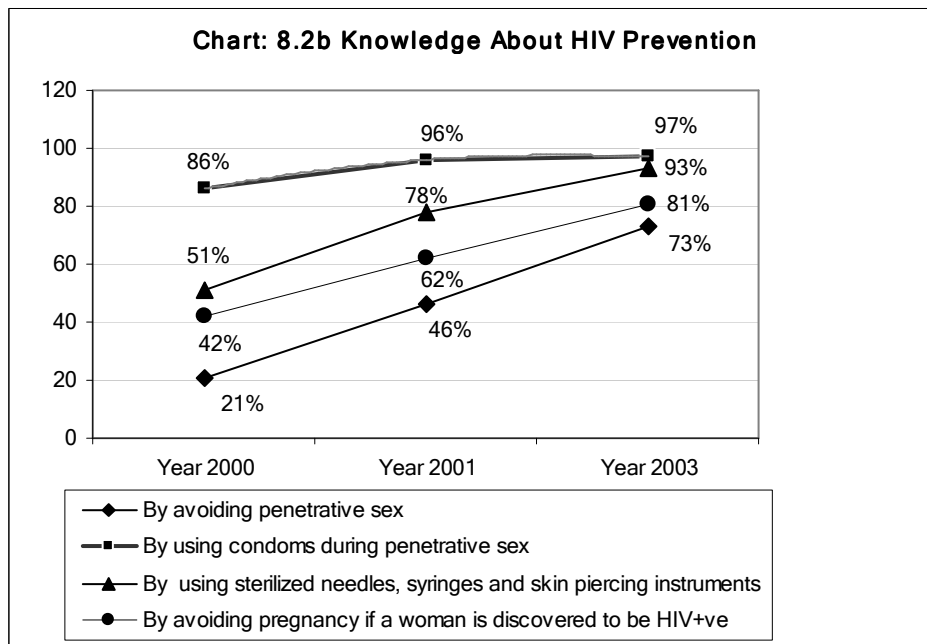
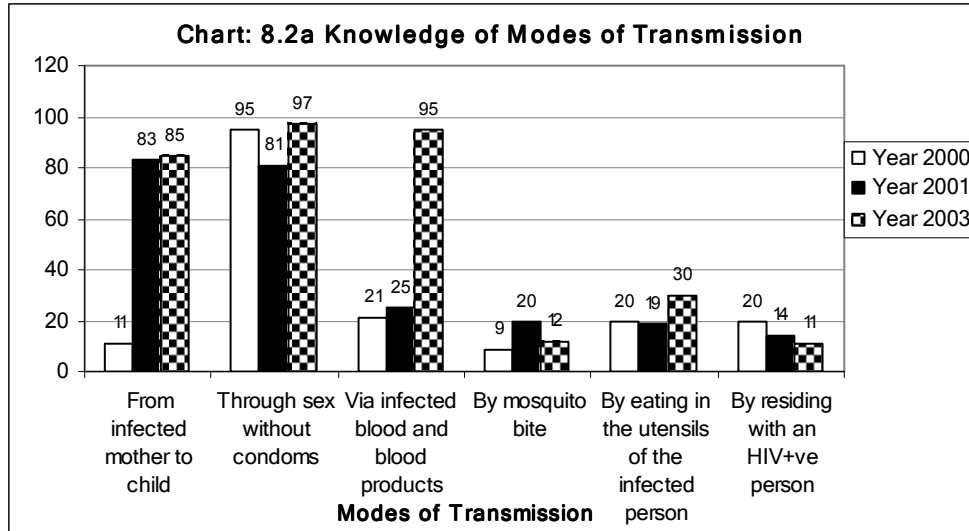
8.2 Knowledge And Attitude Of MSM Towards HIV/AIDS

Knowledge of respondents was compared across the three studies. As the Table: 8.2 a reveals, the change in knowledge about what is HIV/AIDS, was fluctuating. At the outset of the project, respondents had little knowledge about the modes of transmission. Over a period of time, knowledge on how HIV is transmitted had increased. However, myth such as HIV transmission by eating in the utensils of an affected person on the other hand had also increased.

Table: 8.2 a Knowledge About HIV/AIDS

QUESTIONS PERTAINING TO KNOWLEDGE AND ATTITUDE TOWARDS HIV/AIDS	YEAR 2000 (%)	YEAR 2001 (%)	YEAR 2003 (%)
What is HIV?			
A micro organism that causes AIDS	20	32	24
A fatal disease	39	31	42
Modes of Transmission of HIV			
From infected mother to child	11	83	85
Through sex without condoms	95	81	97
Via infected blood and blood products	21	25	95
By mosquito bite	9	20	12
By eating in the utensils of the infected person	20	19	30
By residing with an HIV+ve person	20	14	11
Prevention of HIV			
By avoiding penetrative sex	21	46	73
By using condoms during penetrative sex	86	96	97
By using sterilized needles, syringes and skin piercing instruments	51	78	93
By avoiding pregnancy if a woman is discovered to be HIV+ve	42	62	81
Yes, HIV means death	73	68	63
What is AIDS?			
A condition where body's immune system breaks down	20	33	25
A killer disease	68	43	60

It was heartening to note that, while myths might be persisting along with the correct knowledge, the respondents' knowledge on prevention of HIV had steadily increased (Chart: 8.2b) across three studies.



As it is commonly known, revelation of HIV+ve status generally results into breaking off relationship. This also results in the stigmatization of the affected person. The project IEC attempted not just to enhance knowledge but also reduce stigma through its different tools. Change in the attitudes was also observed. Over a period of time, there was less number of people who said they would break off the relationship, if they learnt their partner was HIV+ve (Table: 8.2b). Almost half of them had said that they would continue the relationship but not have sex. This was indication of change in a positive direction.

In the second wave/study, there was an overwhelming demand for support services such as counseling facility for HIV+ve, for prevention, hospices, STD diagnostic facilities and HIV testing facilities, etc. In the recent round this demand has considerably reduced, which was indicative of increased availability of these services in Mumbai and Thane area.

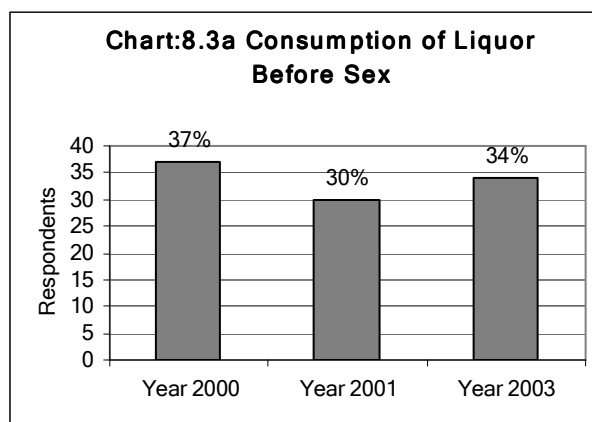
Table: 8.2 b Attitude Towards HIV/AIDS

QUESTIONS PERTAINING TO ATTITUDE TOWARDS HIV+VE PEOPLE	YEAR 2000 (%)	YEAR 2001 (%)	YEAR 2003 (%)
If the partner is HIV+ve			
Break off the relationship	32	18	16
Continue the relationship but not have sex	38	34	49
Perception about HIV+VE Person			
The person has been immoral	36	45	33
He has a curse of god	21	18	28
Required support services for HIV+ve MSM			
Counseling facility for HIV+ve	37	84	30
Counseling facilities for prevention	62	74	23
Hospices for HIV+ve	65	74	50
STD diagnostic and treatment facility	34	64	11
HIV testing facilities	23	61	28

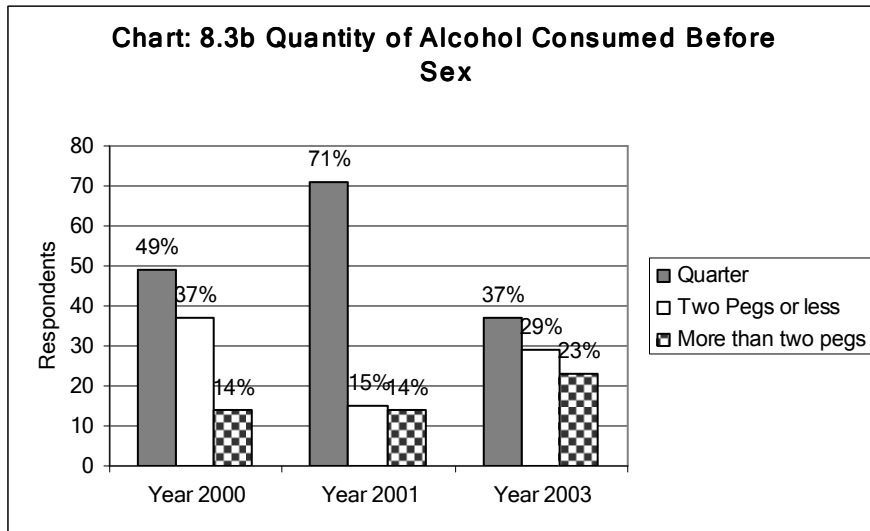
8.3

Substance Abuse Prior To Sex

There had been minor change in the respondent's pattern of consumption across three studies (Chart: 8.3a).

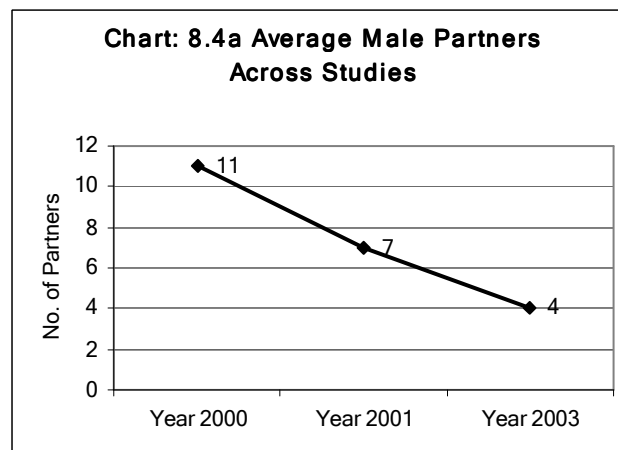


Across the three studies, reporting had always been more for the higher quantities of liquor i.e. quarter liquor consumed before sex. All time higher quantity of liquor was reported in the second study and there was a drop in the third study, but higher distribution in lesser quantities (Chart: 8.3b).

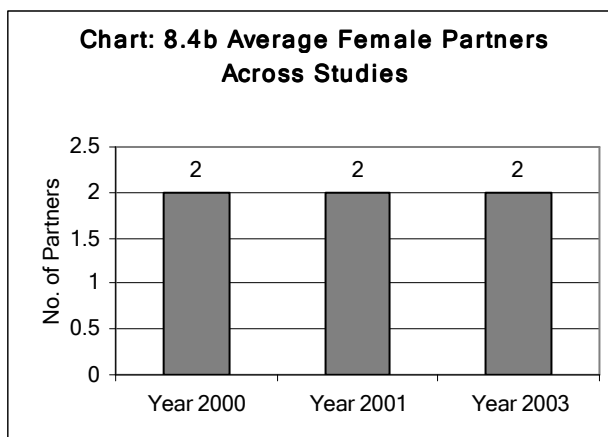


8.4.1 Number Of Sex Partners

It was encouraging to note that the average number of male partners had decreased gradually (Chart: 8.4a).



Over the years, the average number of female partners had remained the same (Chart: 8.4b). The intervention may be focusing exclusively on reducing number of male partners; therefore this was still an area where awareness was not attempted at all.



8.4.1 Partner Seeking

As the table below indicated, cruising had again assumed importance for securing partners. Across three studies, local railway stations remained popular place of meeting partners. Sex; however was taking place mostly in the safety of homes.

Table: 8.4 Partner Seeking

SOURCES OF MEETING PARTNERS	YEAR 2000 (%)	YEAR 2001 (%)	YEAR 2003 (%)
Friends	64	74	56
Internet	3	20	20
Cruising	50	0	92
Places Of Meeting			
Local Railway Station	71	85	81
Public Toilets	51	40	69
Parks	21	40	29
Places Of Sex			
Home	44	76	63
Friend's House	48	74	70
Public Toilet	26	35	52

8.5 Oral Sex And Condom Usage

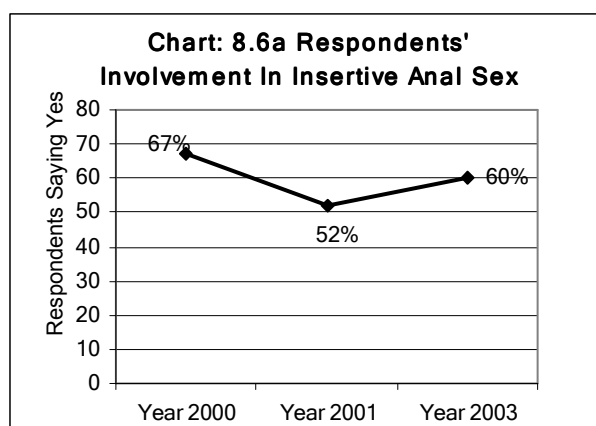
Across three studies, peno-oral sex was on rise and the condom use during oral sex by the sex partner as well as by the respondent was reported to be on decline (Table: 8.5). Probably the respondents were considering oral sex safer and hence there was a decline in condom usage.

Table: 8.5 Oral Sex Across Three Studies

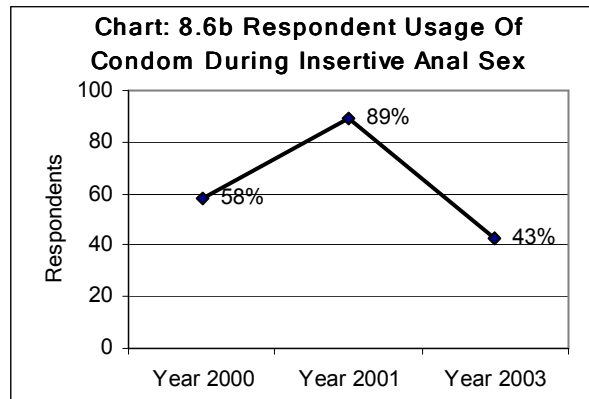
PENO-ORAL SEX	YEAR 2000 (%)	YEAR 2001 (%)	YEAR 2003 (%)
Yes, had peno-oral sex in last one month	64	79	85
Yes, Sex Partner used condoms (Oral sex given by respondent)	30	36	21
Yes, Respondent used condoms (Oral sex received by respondent)	17	33	12
Oral-Anal Sex			
Yes, had oral-anal sex in last one month	6	15	11
Yes, Sex Partner used condoms(Oral sex given by respondent)	0	11	0
Yes, Respondent used condoms (Oral sex received by respondent)	0	3	0

8.6 Anal Sex And Condom Usage

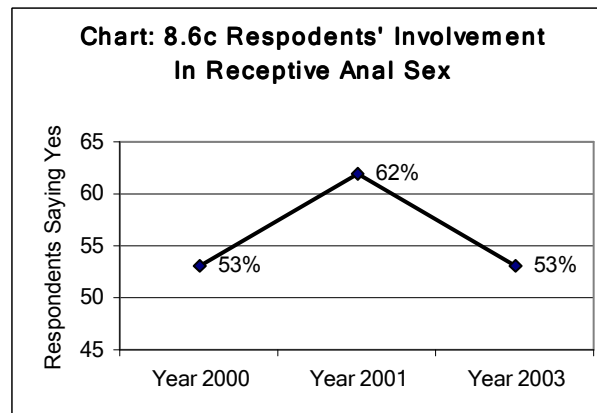
After the baseline, 15% fall in insertive anal sex was experienced in the second study, which had increased again by 8% (Chart: 8.6a).



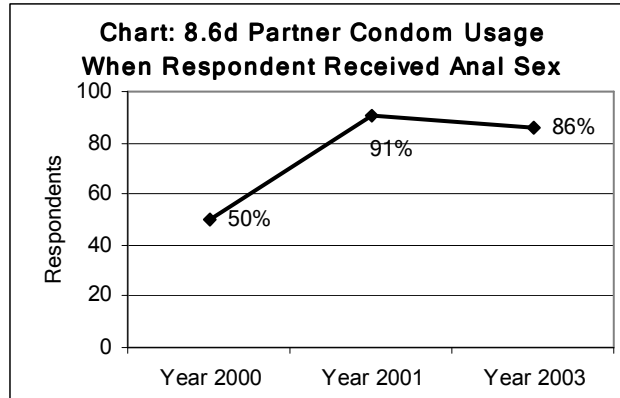
Condom usage during anal sex had increased significantly in the second study and a fall again was experienced. This could be due to the fact while the respondents had reduced partner, they may feel themselves to be not at risk therefore were not using condoms (Chart: 8.6b).



It was encouraging to note that after experiencing an increase in receptive anal sex, in the third study, it went back to the level of first study (Chart: 8.6c).



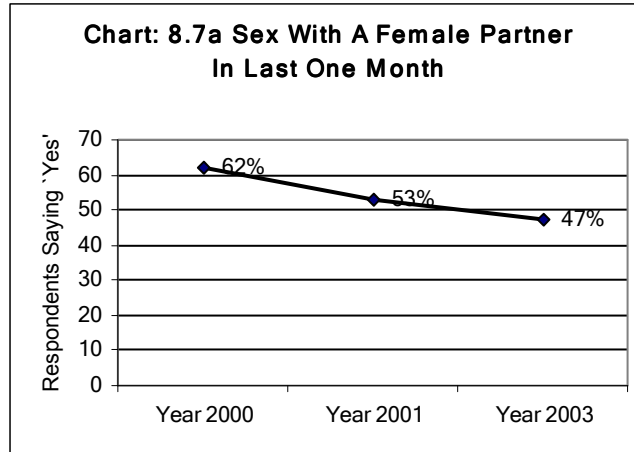
When the respondent received insertive anal sex, condom usage by the partner was not reported to be as high as what was reported during the second study, yet it was reasonably high (Chart: 8.6d).



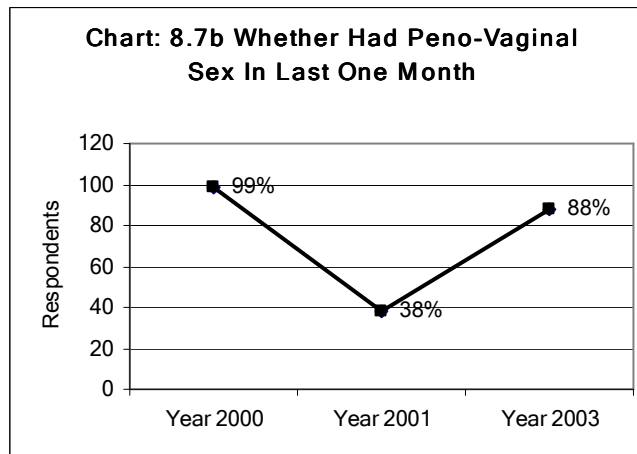
It is important to note that condom usage per se would not make difference unless it was used consistently, every time during insertive and receptive sex. However, due to modification in questions of condom usage, frequency in condom usage comparatively could not be captured. Nevertheless in the third study, last time condom usage had been close to three fourth and above in insertive as well as receptive anal sex. Also, 'always' condom usage in last one month had been reported by three fourth of the respondents. The only weak area was when the respondent indulged in insertive anal sex, 'always' condom usage was extremely low. Therefore it could be assumed, that if compared, condom usage consistency during insertive anal sex might have fallen from the second round and remained high as ever for receptive anal sex (refer to section 6.6.1 and 6.6.2 of Chapter: 6)

8.7 Sex With Female Partners

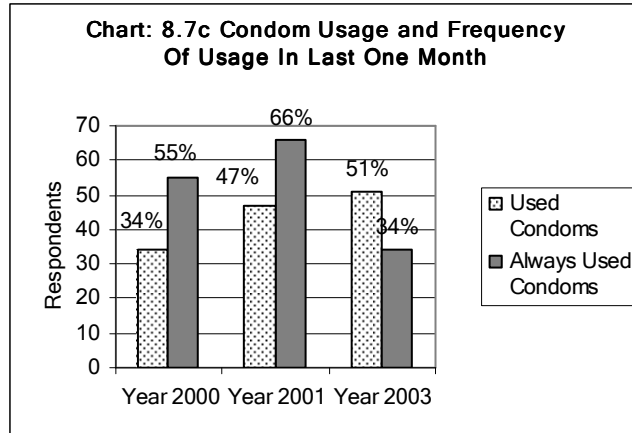
There was a drop in respondents who reportedly had sex with a female partner in last one month (Chart: 8.7a) this could be due to the fact there were less number of married MSM in the recent study.



After registering a drop in the second study, peno-vaginal sex had increased again in the third study (Chart: 8.7b).

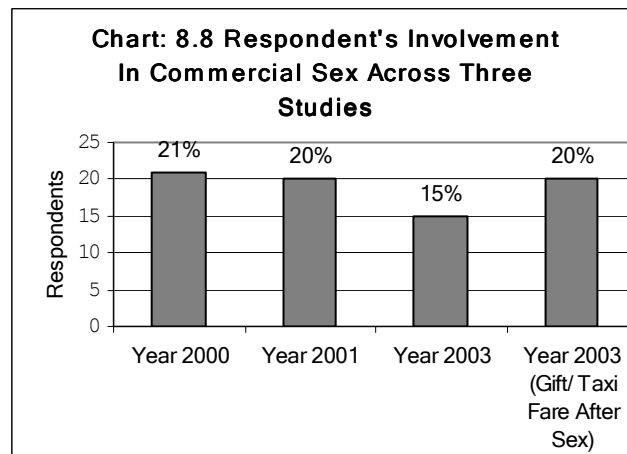


Condom usage as well as frequency of usage (Chart: 8.7c) in last month during peno-vaginal across three studies showed fluctuating trends. In the second study condom usage as well as 'always' usage frequency was reasonable.



8.8 Commercial Sex

In the first and second study, commercial sex question was asked by single question on whether had sex in exchange of cash or kind. In the third round, this question was segregated in sex in exchange and whether the respondent received gift, article or taxi fare after sex. A comparison across three studies (Chart: 8.8) showed that there was no change beyond 20% and it was even less in case of sex in exchange of cash.



8.9 STIs And Treatment Seeking Behavior

In the first round of the study, the field team reported that there could be underreporting of STIs. In the second study, the reporting increased, which could be due to the fact that the Humsafar intervention was known to respondents and therefore they were less hesitant to admit if they suffered from a STI in last six months. In the third round actually a drop in reporting was observed in STI reporting. Maximum reporting was more hygiene related (itching in genitals). However, what was alarming was an increase in Gonorrhoea

(greenish yellowish discharge), redness and swelling of scrotum was reported after decrease in second study (Table: 8.9). It was encouraging to note that other highly infectious symptoms such as blisters and ulcers on and around penis had come down. Also those who took treatment and from an allopathic doctor had steadily increased over three studies.

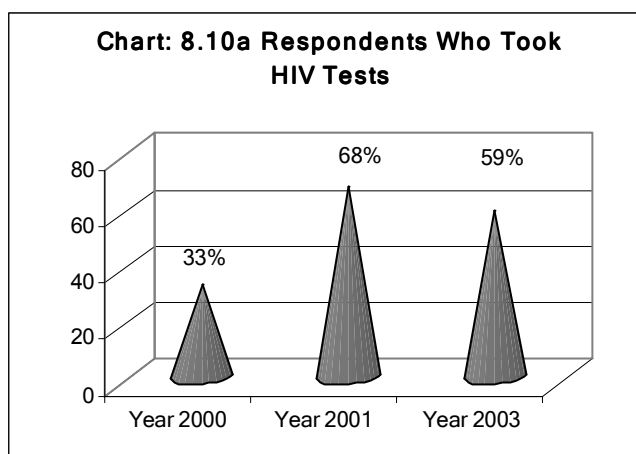
Table: 8.9 STIs And Treatment Seeking Behavior

STI AND TREATMENT SEEKING BEHAVIOR	YEAR 2000 (%)	YEAR 2001 (%)	YEAR 2003 (%)
Yes, suffered from STIS in last six months	21	35	30
Symptoms of health problem			
Greenish-Yellowish discharge from Penis	22	9	23
Blisters and ulcers on and around penis	19	22	8
Redness and swelling of scrotum	6	13	21
Redness in groin	19	42	14
Itching in genital	42	8	61
Yes, took treatment	75	86	94
Took treatment from an allopathic doctor	63*	89	88

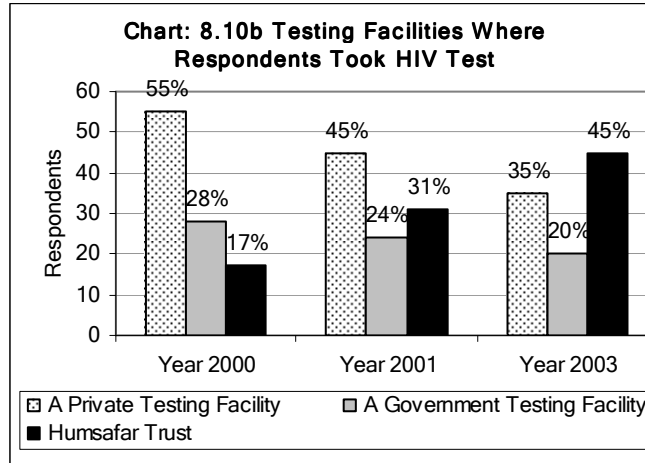
* 17 out of 27 Respondents

8.10 Voluntary HIV Tests

After registering a hundred percent increase in those who took HIV Tests, again a drop was reported in the third study. It could also be due to the fact that having reduced number of partners, MSM no longer considered themselves at risk of HIV; therefore they were less inclined to go for HIV tests (Chart: 8.10a).



At the time of first study, most of the respondents got themselves tested at a private testing facility. This had decreased over a period of four years and Humsafar Trust became a known facility for HIV test (Chart: 8.10b).



Chapter: 9

Listening To The Data

The current study as well as comparative data has made revelations about what may have worked and what has not. Despite the fact that the change is occurring in a multi-program environment, these findings are relevant for the intervening NGO to strengthen weaker areas and also to reformulate its strategies. The last chapter is an attempt to understand what may have worked and what more needs to be done.

9.1 What May Have Worked

- The Humsafar Trust's IEC tool kit which was scientifically designed and field tested and the effective communication by ORWs along with several campaigns by MDACS, and social marketing agencies like DKT and Population Services International (PSI) etc. may have contributed towards increasing the awareness about HIV/AIDS among the MSM of study area. Although some stigmatizing attitude still persists, much more supportive atmosphere for HIV+ve MSM seems to have been created.
- There had been regular communication and other support such as counseling, VCTC, STI test and further treatments as well as referrals provided by the Humsafar Trust. This may have motivated the MSM to reduce their number of partners. This may have also been responsible for improved treatment seeking behavior.
- It was also encouraging to note that the respondents had fully understood the risk of having sex with a commercial partner; therefore there was a better condom usage. However, during an unwitting commercial sex encounter in which a person received gift or taxi fare afterwards, only a little over half the respondents reported self and partner condom usage. The Humsafar Trust needs to work on those MSM who engage in these unwitting episodes of commercial sex in which condom usage is not negotiated.
- It was also encouraging to note that more than three fourth of respondents reported condom usage by their partners when they received anal sex. It reflects better condom negotiating abilities among the MSM.
- The NGO may have generated confidence among the MSM therefore, nearly half the people who tested themselves for HIV, went to the Humsafar Trust to perform tests.

- Throughout the first and second study, there were major demands for support services for MSM. By the third study, there was a considerable drop that could be due to the support and referrals provided by the Humsafar Trust. There may have been an overall increase in the awareness about the services and public health care system has made services for by the Municipal and Government health services.

9.2 Areas Of Improvement

- Cruising has again emerged as an important source to meet partners. Along with this, sex in public toilets has also increased. It indicates that there may be lesser police and public crackdown on MSM activities. It is easier to reach out to known public places. The efforts in the gap area should be intensely taken up in the MSM cruising sites and public toilets.
- It needs to be investigated further on how to intervene differently. Almost three fourths were living with their parents and the same percentage of respondents was having sex at home and at friend's house. In a city like Mumbai where a separate room is a costly proposition, it is unlikely that it may be happening in the presence of parents or other family members in the house. Mostly the sex may be happening during the daytime when the parents and other family members may have gone away to work.
- Over the four years of intervention, the average number of female partners has remained 2, which is alarming in the generalized epidemic set up. The project has been emphasizing on reducing the number of male partners, therefore reduction in number of female partners (other than wives) may have remained at the periphery. The project needs to devise a strategy to also motivate MSM to reduce number of female partners as also improve condom usage.
- There is a need to highlight the importance of consistent condom use during oral sex to prevent oral STIs.
- The condom usage must be hundred percent, but the MSM might be exhausted of routine messages of importance of using condoms. Therefore there is a need to shift the perception from condom as a tool to prevent STIs and HIV to condom that not only protects but also enhances sexual pleasure.

- Married status of MSM continues to pose challenges for the project. Due to social and familial pressure, MSM are marrying women and also leading double lives, which pose risk of STIs and HIV. The project may have to strategize to bring married MSM in the fold of responsible sexual behavior.
- MSM in the study area should be motivated to go for voluntary HIV tests. Awareness about the HIV/AIDS should also be placed along with the importance of going for voluntary HIV tests.
- After the Humsafar Trust, the second most popular test facility was a private facility. As the anecdotal evidence suggests, in most of the private facilities, HIV tests are conducted without pre and post-test counseling. There is therefore a need to motivate the respondents to also utilize the Municipal and Government hospitals based facilities that are equipped with counseling and further referrals for treatment.