

CHAPTER : 1

INTRODUCTION

1.0 The health intervention programs in HIV/AIDS prevention have undergone several significant changes since the detection of AIDS in India. The initial intervention programs were mainly focused on the female sex workers (FSWs) and their clients. Gradually groups like the truckers; youths, which were considered to be vulnerable due to their high-risk behavior, were incorporated. However, behaviorally homosexual men (also known as the MSM) were incorporated into any kind of intervention program at a very late stage. This was partly due to the fact that there was no documented information available on the MSM behavior hence the assessment of the risk could not be made. Gradually due to organization of scattered pieces of information on MSM, magazine surveys and through NGO sensitization from anecdotal evidence, MSM behavior became a cause of concern to the health planners. It is now widely accepted in India that the MSM sector is one of the most vulnerable communities, as sex between men is not considered as sex at all but a form of fun ('masti'). The number of casual partner was also reported to be very high.

1.1 The Issue

In the Indian cultural setting where there is tremendous social pressure on every man and woman to get married, the risk of sexually transmitted infections (STIs) and HIV is limited not only to the MSMs but must also taken into consideration their female spouses and children. In the western countries, the HIV rates among the MSM have stabilized, or even decreased, due to the specific interventions and adherence to safer sex practices.

In India also there is a need to stabilize the HIV rate among the MSMs. The metropolis of Mumbai, which is at the centre of AIDS epidemic, is estimated to have a very large percentage of MSM who are engaged in high-risk behavior. According to the Humsafar Trust, which has made an approximation on the basis of Kinsey Survey estimates, a little more than half a million men were at risk due to their MSM behavior. These men were at risk mainly due to unprotected penetrative and anal sex.

1.2 Need for the Study

Ever since the government health programs have recognized the MSM segment as a risk group, efforts are being made to propagate the importance of safe sex behavior among the MSM. Prior to implementing any program, it is necessary that basic facts and figures should be known about the target group for whom the intervention is being carried out. In this baseline, the knowledge, attitude,

behavior and practices of MSM are being studied. This study is a part of a larger project titled '**Raising Awareness And Motivating Safer Sex Behavior Among MSM At Selected Sites In Mumbai Metro**' which is being implemented by the Humsafar Trust and funded by MDACS. The study is an attempt to create baseline indicators of MSM sexual behavior in selected sites of Mumbai. This baseline will facilitate a strategy towards motivating the MSM for safe sex.

1.3 Objectives

The objectives of the larger project, which will continue for two more years, are as follows:

- Street outreach and further integration with existing public and private health facilities.
- Syndromic approach to detection and treatment of STIs.
- Promotion of condom use with specific emphasis on anal sex.
- Promote partner reduction.

These activities have been carried out throughout the year 1999-2000 (March).

The objectives of research study are as follows:

- To study the socio-economic background of MSM.
- To gauge the knowledge and attitude of MSM towards HIV/AIDS.
- To gauge sexual behavior and practices with respect to:
 - Sexual self-identity
 - Partner seeking
 - Substance use prior to sex
 - Availability of condom and usage knowledge
 - Non-penetrative forms of sex and condom usage with the male partner
 - Penetrative forms of sex and condom usage with the male partner
 - Penetrative and non-penetrative sex with the female partner
- To gauge the treatment seeking behavior of the MSM

1.4 Methodology

1.4.1 Study Area

Prior to selecting the sites for intervention a mapping of sex sites was carried out before the on-set of the project. Various sites were observed for MSM socialization, cruising and sex activities. Based on the volume and intensity of these, the sites were categorized as:

a. Star sites: are the sites for socializing, cruising and pick-up sites and are marked by heavy movement of MSM on these sites. Please note that little or no sex takes place here.

b. Beats: are the apex areas where pickup and cruising happens.

c. New Beats: are the areas, which are recently added on as MSM sites.

Generally the activities were observed to be in or around the public toilets of the local railway station, parks. Specific areas were selected for distribution of condom, health intervention and for seeking respondents for the research study. The areas were as follows:

A. South Mumbai

Gateway of India on Saturday nights.

B. Western Railway

Churchgate, Dadar, Mahim, Bandra, Santa Cruz, Vile Parle, Andheri, Jogeshwari, Goregaon, Malad, Borivali

C. Central Railway

Chattrapati Shivaji Terminus, Sion King Circle, Kurla, Ghatkopar, Mulund

D. Harbor Line

Cotton Green, Wadala, and Chembur

1.4.2 Sample Size

The sample size was determined in consultation with the Family Health International (FHI). The sample size was determined to be 174 MSM.

1.4.3 Tools of Data Collection

The outreach workers were given an observation sheet for their rapport building phase. They recorded their observations of individuals whom they observed in the sex sites.

The data for the research study were collected through a structured questionnaire. However, any response, which did not fit into any of the structured categories, was recorded in 'any other' category. At the end of the interview, the respondents were requested to give their suggestions in order to capture the qualitative information.

The doctors checked all the MSM visiting the health clinic and collected smears, blood samples. The laboratory tests were carried out at the Sion Hospital. The tests confirmed the health status of the people.

1.4.4 Sampling

Convenient sampling was utilized for sampling the 174 MSM. Any MSM who was sexually active in last one month and consented to participate in the study was sampled for the study. Eight outreach workers also doubled up as investigators for the study. Approximately 25 MSM were covered for each outreach worker per area (containing 2-3 site).

1.4.5 Approach To The Study

The entire project was aimed to be humane in nature so that a large number of MSM should be able to access correct knowledge and also bring about a change in their risk behavior. The research project strictly adhered to this approach for seeking respondents. From April 99 to July 99, the outreach workers were engaged in building rapport with the MSM by way of providing him with free condoms and information regarding safe sex. They discussed with them sexual health problems in general and encouraged them for seeking treatment from the centre. These MSM were also informed of the research study. Those who agreed to participate were informed about the consent. The illiterate respondents signed / gave thumb impression for participating in the study. Thus at every stage, the MSM were informed about various activities of research and its purpose.

1.5 Nature of Analysis

The data collected through the questionnaire were thoroughly scrutinized, coded and entered in the computer for analysis purpose. The analysis of all the core indicators was done in order to get an insight into the MSM community. In this report the analysis consists mainly of frequency and averages of various indicators.

1.6 Manpower and Fieldwork

A team of Project Director, Administrator, Research Officer, Research Associate, two doctors and 15 outreach workers were engaged in the project and research study. The project started in April 1999. From April to July 1999, the outreach workers were engaged in building the rapport with the community. After three months of rapport building, the clients started visiting the health facility. From January 2000 onwards, eight of outreach workers were thoroughly trained in research related issues. The training was focused on following topics:

- Meaning and importance of research on the MSM.
- Importance of safe sex behavior.
- Ethics of research and field workers' responsibility.
- Posture and body language during the interview.

- Importance of informed consent.
- Meaning of a knowledge, attitude, behavior and practice study.
- Importance of background information.
- How to ask a question.
- Ways of recording responses.
- How to ask sensitive information.
- How to validate information.
- How to cope up with an emotionally aggrieved respondent.
- Training of study schedule.
- Mock interviews.

The field workers were trained for eight man-days after which they were sent off to conduct the pre-testing of research questionnaire. After the pre-testing, questionnaires were discussed individually and necessary changes were incorporated. The fieldwork was carried out between February third week to March first week. While most of the interviews were conducted on the site, a few of them were conducted at Humsafar Centre.

1.7 Limitations of the Study

So far the information on the MSM were available either in the form of magazine surveys or in the form of experiences of MSM published in magazines like '**Bombay Dost**'. This study is the first quantitative attempt to understand the MSM scenario in Mumbai. It is an attempt to create some baseline indicators of MSM risk behavior for the intervention program that is in its first year.

There were a few limitations to this study. *First*, the sample size was very small for a very large MSM population in Mumbai. *Second*, convenient sampling was used to capture the respondents. Although care was taken to capture the respondents from all the designated MSM sites, it is possible that some areas were under-represented.

It would be appropriate to utilize a time-location cluster kind of sampling for a large-scale quantitative survey. *Third*, some of the respondents had already visited the Humsafar Centre for voluntary test for HIV. Their bias in responding to the questionnaire could not be ruled out. *Fourth*, although the outreach workers covered all the designated sites, it was possible that non-cruising MSM were totally left out. This study however would serve as a guideline for formulating the strategy for second year of intervention program.

1.8 Presentation of the Report

The report has been organized into 7 chapters. Chapter 1 contains an introduction to the study, need for the study and objectives. The methodology and operationalisation of the study have been discussed in great details in this chapter. Chapter 2 focuses on the outreach services and health facility. The analyzed data have been presented in chapters 3 through 6. 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. Chapter 7 presents assessment of needs of MSM based on the findings of various issues presented in earlier chapters.

CHAPTER : 2

THE OUTREACH SERVICES AND HEALTH FACILITY

2.0 In India where half the population is illiterate and only two-thirds of the rural population is literate, the outreach services related to health assume an important role. If due to lack of knowledge, inability to read, people are not able to access benefits of scientific healthcare, then it becomes the responsibility of the government health services to reach out to people for making them a beneficiary of a modern health-care system. In the government health-care system, the outreach services have reached interior areas through the multipurpose worker (MPW) and auxiliary nurse midwife (ANM). Even in the urban areas, the grass root level functionaries or health workers have an important role to play in helping the illiterate and ignorant people to seek health care. The MSMs too require outreach services for at least recognizing the 'dos' and 'don'ts' of sexual health.

2.1 Rationale for Outreach Services

The homosexual behavior in India is considered to be a stigma and also a non-cognizable offense (Section 377 IPC), hence very few people are willing to talk about the health problems emerging out of their homosexual behavior. Due to this reason, their various needs like right knowledge pertaining to homosexual behavior and safe sex, counseling and treatment for sexually transmitted infections (STIs) are difficult to meet within the normal system of healthcare.

The Humsafar Trust recognized the specific need of the MSM community and thus a unique outreach service was chalked out for the benefit of MSM. In this system, the outreach workers were selected from the community itself, which removed any doubt regarding fear or subjective judgment. The outreach workers, who were familiar with the language, culture of MSM community and sex sites were able to reach to a large number of people in last one year.

2.2 Training of Outreach Workers

The selection of outreach workers was made on the basis of their knowledge and familiarity and communication skills in the MSM cruising and sex sites in Mumbai. They were also MSM who were familiar with the problems and issues related to their community. They were put through rigorous training programs for the project. The details of their training programs are as given:

Training	1	
Topic	:	Rapport Building and Condom Distribution
Duration	:	April 15-30, several repeat sessions
Trainer	:	Ashok Row Kavi
Contents	:	How to build gradual rapport with the community at various cruising and sex sites. How to explain to the cruising MSM about the correct usage of condom and importance of safer sex in brief.
Training	2	
Topic	:	On Spot Syndromic Checkup for Sexually Transmitted Infections (STIs).
Duration	:	June to August (twice a week)
Trainer	:	Dr. Devdutt Patnaik
Contents	:	Usually, the signs of sexually transmitted diseases are misunderstood by the people and are not taken seriously enough to consult a doctor. During this session the doctor gave detailed information on the STIs to the outreach workers. Picture chart of various STIs and their conditions was shown and explained to them. They were trained to recognize the possible STI by listening to an account of it.
Training	3	
Topic	:	Importance Of Safe Sex Behavior, Identification Of STIs, Importance Of Proper Treatment For STIs, How To Encourage A Person To Seek Treatment For His STI.
Duration	:	September to October (twice a week)
Trainers	:	Dr. Maninder, Dr. Samir
Contents	:	The trainers were also providing detection and treatment for the MSM, hence they too trained the workers. They focused on safe sex behavior, safe sex practices to be followed by the MSM. They took in-depth sessions on identification of STIs and how to encourage a person to seek treatment for his STI.

2.3 Programs Organized under the Project

The outreach services were aimed at MSMs on specific locations. However, a number of programs, which were aimed at making common people aware of the risk behavior in the wake of HIV/AIDS, were organized at different places. The details are as given:

Program : **1**
Venue : Gadkari Rangayatan, Thane
Date : 1.12.1999
Organizer : Maharashtra AIDS Control Society, Humsafar Centre
Agenda : Discussion of work towards HIV/AIDS
Coverage : 2000

Program : **2**
Venue : Andheri Station
Date : 2.12.99-5.12.99 (World AIDS Week)
Organizer : Humsafar Centre
Agenda : Distribution of condoms and IEC material
Coverage : Approximately 10,000 persons

Program : **3**
Venue : MDAC, Ackworth Complex
Date : 4.12.99
Organizer : Humsafar Centre
Agenda : NGO Mela

Program : **4**
Venue : Bandra Station
Date : 17.12.99
Organizer : Humsafar Centre
Agenda : Street Play on HIV/AIDS
Coverage : Approximately 100 persons

Program : **5**
Venue : Tutkuks Garden
Date : 2.2.00
Organizer : Humsafar Centre
Agenda : Play and fun, condom/IEC material distribution
Coverage : Approximately 500 persons

2.4 Coverage of Outreach Workers

The outreach workers started visiting their respective locations from the month of April. Initially they stood at their designated spots, observed and made notes of various activities of MSM sites. Once they became familiar faces in these sites, they started establishing rapport with the MSM. During this rapport building exercise they talked about safe sex, counseling and health facility at the Humsafar Centre. In addition to this they also distributed condoms. Once the presence of an outreach worker became known, the MSM as well as non-MSM contacted them for condoms.

At the end of February, more than three thousand persons were the beneficiary of the outreach services. The outreach worker brought a few of the MSM contacted on site to the centre for medical consultation. Table 2.4 presents the coverage of outreach workers.

Table 2.4 Coverage of Outreach Workers

Coverage Per Outreach Worker (OW)	Year 1999									Year 2000		
	April	May	June	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Total
OW 1	0	0	0	0	0	0	0	0	0	42	24	66
OW 2	0	0	0	0	0	220	65	60	24	54	15	438
OW 3	0	0	0	123	115	68	59	63	50	29	13	520
OW 4	0	0	0	121	106	110	113	60	84	30	11	635
OW 5	0	0	0	0	0	0	0	0	0	38	30	38
OW 6	0	0	0	0	0	0	0	0	0	27	25	52
OW 7	0	0	0	0	0	0	0	0	0	21	20	21
OW 8	0	0	22	102	49	3	28	0	0	51	26	255
OW 9	0	0	0	0	0	0	0	0	0	65	20	85
OW 10	0	6	10	15	31	26	7	4	18	20	13	150
OW 11	0	0	0	50	30	25	34	40	40	61	42	322
OW 12	0	0	0	92	98	81	75	77	71	59	35	588
OW13	0	0	0	45	47	48	57	55	56	34		342
Monthly Total	0	6	32	548	476	581	438	359	343	531	198	
Grand Total												3512

2.5 Health Facility

The outreach services were supported by a health facility at the Humsafar Centre. Two qualified doctors from the Sion Hospital manned the health centre. While one doctor checked patients and provided treatment, another doctor (a microbiologist) collected blood samples and prepared mounts for laboratory investigations. On the samples tests were carried out for VDRLA, TPHA and ELISA-2. The doctors provided further referrals to the patients. In most of the cases, the patients followed up with the same doctors at the Sion Hospital. As this was a small facility the patients have expressed the need for a comprehensive health facility.

CHAPTER : 3

SOCIO-ECONOMIC BACKGROUND OF MSM

3.0 An in-depth study of socio-economic background of target population is a must for any base-line study, which is being carried out with a purpose of long term intervention program. Along with behavioral factors, the socio-economic factors also provided important cues to the nature and scope of problem in question. In this chapter, a detailed analysis of socio-economic background has been presented.

3.1 Nativity and Current Residence

The metropolis of Mumbai, which is regarded as a land of opportunities, attracts people from all over India and Maharashtra. These people range from highly educated white-collar professionals to daily wage laborers. Considering this, the MSM were asked about their nativity status. Almost two-fifth respondents were migrants to Mumbai (Table: 3.1a).

Table: 3.1a Status Of Being In Mumbai

N=174	
Status	%
Born And Brought Up In Mumbai	61.49
Migrant To Mumbai	38.51
Total	100.00

The migrants to Mumbai city, belonged to different parts of India and one respondent belonged to Russia. Almost 30 percent of them were natives of Uttar Pradesh followed by 22 percent who came from other parts of Maharashtra. Andhra Pradesh ranked third with less than one fifth of MSM belonging to it. The findings are presented in Table 3.1b.

This report does not study the relationship between migration and sexual behavior in details. It is generally accepted that migration affects the emotional being which in turn affects behavior of the people. Migration provides the opportunity to exercise sexual preferences in the absence of familial and social pressures. Migratory MSM may also be a vector of spread of HIV as the disease would be transmitted from the urban areas to the interiors of the country.

Table: 3.1b Native State

N=67

State	%
Karnataka	4.48
Uttar Pradesh	29.85
West Bengal	2.99
Andhra Pradesh	16.42
Rajasthan	2.99
Maharashtra	22.39
Gujarat	8.96
Kerala	2.99
Delhi	1.49
Russia	1.49
Tamil Nadu	1.49
Bihar	1.49
Punjab	1.49
Goa	1.49
Total	100.00

While most of the respondents answered this question pertaining to place of residence, where they were required to give only the nearby station, five respondents refused to reveal the station. The details are presented in tables below.

Table: 3.2d Place Of Residence

N=170

Place Of Residence	%
Churchgate To Mumbai Central	-
Mahalaxmi To Dadar	2.35
Matunga Road To Bandra	4.71
Khar To Andheri	11.76
Jogeshwari To Malad	11.76
Kandivali To Dahisar	20.59
Meera Road To Virar	4.71
CST To Chinchpokli	2.35
Sion To Ghatkopar	12.35
Vikhroli To Bhandup	5.29
Mulund To Mumbra	11.18
Dombivali	1.18
Sandhurst Road To Wadala	3.53
Chembur To Mankhurd	3.53
Vashi	3.53
Panvel	0.59
Worli	0.59
Pune	-
Total	100.00

3.2 Age and Education

More than three-fourth of the respondents were less than thirty years of age (Table 3.2a). One-fourth of them were aged between 31 to 40 years. The outreach workers reported that most of the 45+ people displayed disinterest in talking to the outreach worker regarding their sexual behavior.

Table: 3.2a Age

N=174	
Age	%
18-20	11.49
21-1	27.59
26-30	25.86
31-35	13.79
36-40	12.07
41-45	6.32
46-60	2.30
51-60	0.57
60+	0.00
Total	100.00

Around ten percent of MSMs were illiterate and just literate. One-fifth of respondents had completed their education up to middle, secondary and higher secondary level each. Almost 15 percent each had completed their education up to primary and postgraduate level.

Table: 3.2b Education Level

N=174	
Education Level	%
Illiterate	4.60
Just literate/can just sign	5.17
Primary	13.79
Middle	19.54
Secondary	20.11
Higher Secondary	22.41
Graduate	0.57
Post Graduate	13.79
Diploma	-
Any other	-
Total	100.00

3.3 Marital Status and Arrange of Stay

A predominant majority (69%) of respondents was unmarried. More than one fourth of them were married to a woman (Table: 3.3a).

Table: 3.3a Marital Status

N=174

Marital Status	%
Unmarried	68.97
Married	28.74
Divorced	1.72
Widower	0.57
Total	100.00

Half of the respondents stayed with their parents and one-fifth of them stayed with their wife and children. In addition to friends and relatives the respondents stayed with their male spouse (4%) and guru (1%). Mostly eunuchs stayed with their leader also known as 'guru'.

Table: 3.3b Arrangement Of Stay

N=174

Stay	%
Own family(wife+children)	21.26
Parents	51.72
Friends	16.09
With Male Spouse	4.02
Guru	1.15
Owner's House	0.57
Sister's House	0.57
Alone	2.30
With In-laws	0.57
With Brother	1.72
Total	100.00

3.4 Occupation, Place of Work and Monthly Family Income

Almost three fourth of the respondents were engaged in private or government service (Table: 3.4a). The Hijras (4%) were involved in singing, begging or sexwork for their livelihood. Around three percent of respondents reported having been involved in commercial sex but they did not report being a Hijra.

Table: 3.4a Occupation

N=174

Occupation	%
Student	4.60
Service	59.20
Business/Professional/Consultant	11.49
Self Employed	5.17
Unemployed	12.07
Hijra (singing, begging, sexwork)	4.02
Household Servant	0.57
Commercial Sex	2.87
Total	100.00

The details of place of work of MSM are presented in Table: 3.4b. Most of them had their work places in stations having concentration of business and office activities.

Table: 3.4b Place of Work

N=133

Place of Residence	%
Churchgate to Mumbai Central	8.27
Mahalaxmi to Dadar	16.54
Matunga Road to Bandra	6.02
Khar to Andheri	12.03
Jogeshwari to Malad	6.02
Kandivali to Dahisar	15.04
Meera Road to Virar	1.50
CST to Chinchpokli	15.79
Sion to Ghatkopar	8.27
Vikhroli to Bhandup	5.26
Mulund to Mumbra	0.00
Dombivali	1.50
Sandhurst Road to Wadala	0.75
Chembur to Mankhurd	0.75
Vashi	1.50
Panvel	0.00
Worli	0.75
Pune	-
Total	100.00

Base: Everyone except students and unemployed persons

Almost one-fourth of the respondents reported that their monthly family income was less than three thousand rupees a month (Table: 3.4c). Another one-fourth

had family incomes between 6001-12,000. A minor percentage (3%) belonged to higher income group, which suggested that possibly these were well-off people.

Table: 3.4c Monthly Family Income

N=174

Income	%
<Rs. 3000	24.71
Rs.3001-6000	35.06
Rs.6001-12000	28.16
Rs.12001-15000	8.05
Rs.15001-18000	1.15
Rs. 18001+	2.87
Total	100.00

CHAPTER: 4

KNOWLEDGE, ATTITUDE OF MSM TOWARDS HIV/AIDS

4.0 The baseline studies pertaining to HIV/AIDS also measure the knowledge and attitude of target population. It is assumed that if a person has appropriate knowledge regarding the transmission of HIV/AIDS, his behavior would be possibly towards the low-risk side. Education, exposure to HIV/AIDS related campaigns determine to a greater extent person's attitude towards the HIV/AIDS affected people. This chapter details the knowledge, attitude of MSM towards the HIV/AIDS.

4.1 Knowledge about HIV

The respondents were asked about their knowledge of HIV, to which almost one fourth of them responded that they did not know or were unable to say what HIV was. Only one-fifth was aware that it was a microorganism that caused AIDS (Table: 4.1a).

Table: 4.1a Knowledge Regarding HIV

N=174

What is HIV	%
An insect	15.52
A foreign germ	1.15
A fatal disease	39.08
A micro-organism that causes AIDS	19.54
DK/CS	24.71
Total	100.00

Those who gave some response to knowledge related question on HIV, were further asked to give response on various modes of transmission of HIV virus (Table: 4.1b). The response pattern showed that the respondents did not have appropriate knowledge towards HIV/AIDS. A predominant majority responded negative that it was spread by mosquito bite. They also responded in affirmative that it was transmitted through sex without condoms. However, a predominant majority responded in affirmative that using the same toilet as used by HIV+ve person and by hugging infected person transmitted HIV.

Table: 4.1b Transmission Of HIV

N=131

Modes of HIV Transmission	Yes(%)	No(%)	Total
By mosquito bite	9.16	90.84	100.00
Through sex without condoms	95.42	4.58	100.00
By kissing on cheeks	7.63	92.37	100.00
From infected mother to child	10.69	89.31	100.00
By using the same toilet as used by HIV +ve person	93.89	6.11	100.00
Via infected blood and blood products	20.61	79.39	100.00
By eating in the utensils of the infected person	20.00	80.00	100.00
By residing with an HIV+ve person	20.00	80.00	100.00
By hugging infected person	100.00	-	100.00

The respondents were asked to suggest ways of preventing HIV transmission (Table 4.1c). A predominant majority had correct knowledge that using condoms during penetrative sex could prevent HIV transmission. Half the respondents said that using sterilised needles, syringes and skin piercing instruments could prevent it. Around two fifths said that avoiding pregnancy in a HIV+ve woman could prevent it. This will avert transmission of HIV to a newborn child.

A minority of people said that masturbation, safe sex etc. could prevent the transmission of HIV.

Table: 4.1c Prevention Of HIV

N=131

Ways of Prevention	%
By avoiding penetrative sex	21.37
By using condoms during penetrative sex	86.26
By using sterilised needles, syringes and skin piercing instruments	51.15
By avoiding pregnancy if a woman is discovered to be HIV+ve	41.98
Can't Say	0.76
Masturbation	0.76
By Avoiding infusion of contaminated Blood	2.29
By practicing safe sex	0.76
By testing blood	0.76
By having sex with female	0.76

Multiple response

A question was asked to gauge what HIV meant to them. Almost three-fourth of respondents said that HIV means death (Table: 4.1d). They were asked to if there was any cure for HIV to which three-fifths responded in the negative (Table: 4.1e)

Table: 4.1d Whether HIV Means Death

N=131

Response	%
Yes	73.28
No	17.56
DK/CS	9.16
Total	100.00

Table: 4.1e Awareness Regarding Cure Of HIV

N=131

Response	%
Yes	18.32
No	61.07
DK/CS	20.61
Total	100.00

4.2 Knowledge about AIDS

All the respondents were asked knowledge-related questions on AIDS. Prior to preparing a questionnaire, the outreach workers had informed that 'AIDS' was more commonly known and understood by the people, hence the sections of HIV and AIDS were separated. Table: 4.2a showed that only 6 percent of respondents did not know what was AIDS. However, more than three-fourth of respondents (merged together) was aware of exact nature of AIDS as they responded in first two categories. A very small percentage (1%) called it 'Maharog' which is a popular term for leprosy in Marathi.

Table: 4.2a Knowledge Regarding AIDS

N=174

What is AIDS	%
A condition where body's immune system breaks down	19.55
A killer disease	68.39
A deadly virus	4.02
Maharog	1.14
DK/CS	5.75
AIDS means life is over	1.15
Total	100.00

A predominant majority of respondents replied in affirmative that AIDS meant sure death (4.2b).

Table: 4.2b Whether AIDS Means Death

N=164

Response	%
Yes	89.02
No	4.88
DK/CS	6.10
Total	100.00

Only 12 percent of respondents said that there was a cure for AIDS (Table: 4.2c). The outreach workers who had an informal discussion with the respondents on this issue said that the respondents were referring to possibly some quacks who had advertised that they could cure AIDS.

Table: 4.2c Whether There Is Any Cure For AIDS

N=164

Response	%
Yes	11.59
No	76.83
DK/CS	11.59
Total	100.00

4.3 Attitude towards HIV+ve People

In order to gauge attitude of the respondents, a hypothetical situation was given to them. They were asked if their friend had HIV, what would they do. More than one-fourth of them said that they would break off relationship with such a partner/friend (Table: 4.3a). Almost two-fifth of them said they would continue the relationship but not have sex with that person.

Table: 4.3a Attitude Towards The HIV+ve Partner

N=174

Response	%
Break off the relationship	31.61
Continue the relationship but not have sex	37.93
Continue the relationship while practicing safe sex	8.05
Maintain contact so as to help as and when required	21.84
DK/CS	0.57
Total	100.00

The respondents were also asked to give their perception about a HIV+ve person (Table: 4.3b). The responses were judgmental as well as fatalistic in nature. Responses like 'the person has been immoral' (36%), 'bad person' (9%), 'curse of god' (21%), 'bad luck' (5%) appear as typical attitude of people towards the HIV+ve persons.

Table: 4.3b Perception About HIV+ve Person

N=174

Perception	%
The person has been immoral	36.21
He has a curse of god	21.26
He is a bad person	8.62
It is his bad luck	4.60
He will die	1.15
Must have indulged in unsafe behavior	5.17
Should take him to the doctor	0.57
He is a normal person	0.57
He is a good person	0.57
He must have been immature	0.57
He must have been careless	0.57
He is an unfortunate	2.32
Can not say	17.82
Total	100.00

In order to assess the needs of this community, the respondents were asked to identify the support services (Table: 4.3c). A majority of them identified counseling facilities for prevention and hospices for positive people as support services. Counseling facilities for HIV, HIV testing, STD diagnostic facilities etc. was also identified.

Table: 4.3c Support Services for HIV+ve MSM

N=174

Support Services	%
HIV testing facilities	22.99
Counseling facilities for prevention	62.07
Counseling facilities for HIV+ve	37.36
Hospices for HIV+ve	64.94
STD diagnostic and treatment facilities	33.91
Provide medicines	2.30
Provide him a place to stay	1.72
Give him sufficient rest	0.57
Give him money	1.15
Can not say	2.30
Should practice meditation	0.57
Government accommodation	0.57
Make an organization which can help them in getting some work	1.15
Provide support and love	0.57

Multiple Response

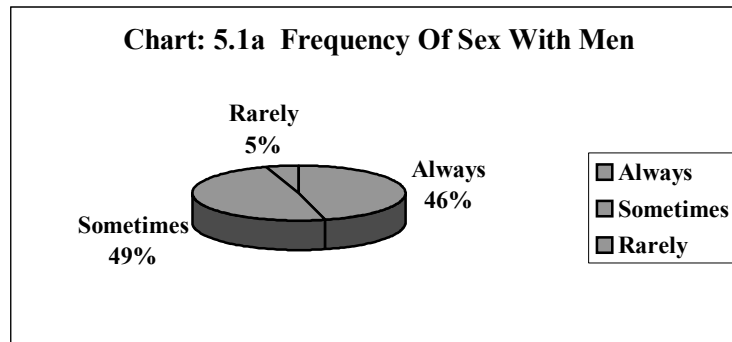
CHAPTER : 5

SEXUAL BEHAVIOR AND CONDOM USAGE

5.0 In this chapter the issues of sexual behavior and practices have been studied in-depth. The chapter progress from general issues like sexuality to specific issues of types of sex.

5.1 Sexuality

The respondents were contacted for the study only after months of rapport building on site therefore it was considered that all of them were the MSMs. However, for the study, they were asked as to how frequently did they have sex with another man. To which only 5 percent responded that they rarely had sex with another man (Chart: 5.1a)



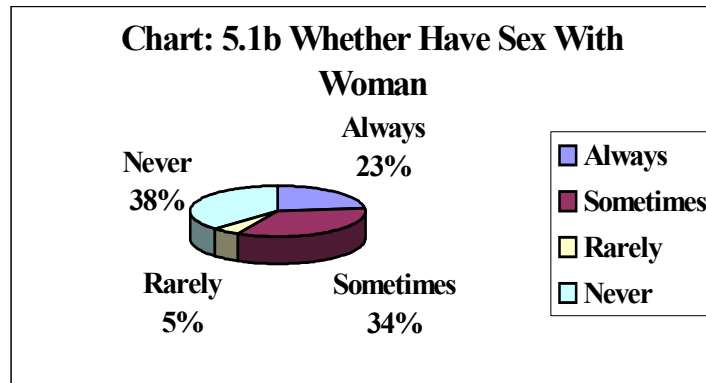
The respondents were asked about the total number of male partners in last one month (Table: 5.1a). Two-fifths of the respondent had 2 to 4 sex partners in last one-month period. Usually eunuchs who were engaged in commercial sex work reported having 40-50 partners in last one month. The average number of partners in last one month was 11.

Table: 5.1a Male Partners In Last One Month
N=174

Male Partners	%
1	13.22
2-4	40.23
5-8	18.97
9-15	14.37
16-1	4.02
26-35	2.87
36-45	2.30
46+	4.02
Total	100.00

Average = 11

The respondents were also asked about female partners, to which 38 percent replied that they never had sex with women (Chart: 5.1b). The rest were having sex with women in varying frequency.



N=174

Although a total of 109 respondents said that they had sex with female partners, but only 86 of them had been having sex with female partners in last one month (Table: 5.2c). Most of them (60%) had only one partner, probably the wife. The average number of female partner was 2.

Table: 5.1c No. Of Female Partners In Last One Month

N=86	
Female Partners	%
1	60.47
2	18.60
3	11.63
4	3.49
5	4.65
6	1.16
Total	100.00

Average = 2

5.2 Partner Seeking

As the average number of sex partners of respondents was found to be very high, it is suggested that the relationships were temporary in nature and the partners changed frequently. Although separate questions were asked for sources, places of meeting partners and sex, for many respondents only one place served all the three purposes.

Table: 5.2a Sources Of Meeting Sex Partners

N=174	
Sources	%
Internet	3.45
Newspapers/ Magazine Classifieds	1.15
Friends	64.37
Through soliciting	6.90
Through cruising in Public Toilet	24.71
Through body language	1.15
Cruising at railway station	18.97
Cruising at sea beach	0.57
Cruising inside train	2.30
S.T. Bus Depot	1.72
No need to search, have a steady partner	1.72
Park	1.72

Multiple Response

The most popular sources were friends, followed by cruising in public toilets and railway stations (Table: 5.2a).

Local railway stations, public toilets, parks and even public transport served as meeting places for the sex partners (Table: 5.2b).

Table: 5.2b Place Of Meeting Sex Partners

N=174

Meeting Place	%
Public Toilets	51.15
Parks	20.69
Public Transport	14.94
Local Rly. Station	71.26
Sea Beaches	13.22
House Terrace	0.57
Own room	1.72
Hotel	1.15
Friend's House	2.87
Film Theatre	0.57
Own Shop	0.57
Bandra Talao	0.57
Temple	0.57
Highway	0.57
Library	5.75

Multiple Response

Although stations were major meeting points, almost half the respondents said that they usually had sex at a friend's house (Table: 5.2c). Home (44%), rented room (34%) and public toilets (26%) were some of the places of sex.

Table: 5.2c Place of Sex

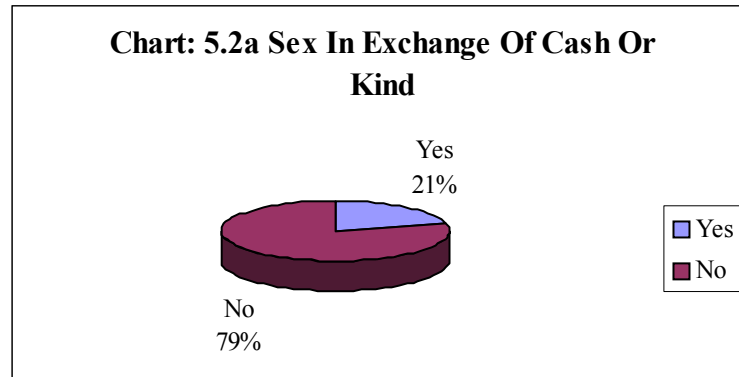
N=174

Places	%
Home	43.68
Public Toilet	26.44
Parks	1.92
Friend's House	48.28
Rent a Room	34.48
Sea beach	1.72
Railway Tracks	8.05
Behind Bushes	8.05
Inside Train	2.30
In the hotel	1.15
Terrace	3.45
Any lonely place	1.15
In the Car	0.57
Tripods at Marine Drive	0.57

Multiple Response

Prior to this project, The Humsafar Centre had come across MSM who were engaged in commercial sex. These people were consistently in sex work like female commercial sex workers. In this research study, an indirect question was

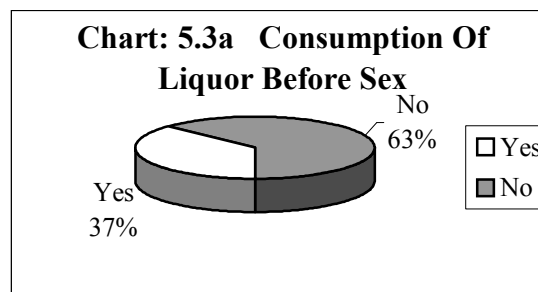
posed to the respondents whether they had sex in exchange of cash /kind. This was targeted towards the recipients as well as provider of commercial sex. It was found that less than one-fourth of the respondents had sex in exchange of cash/kind (Chart: 5.2a).



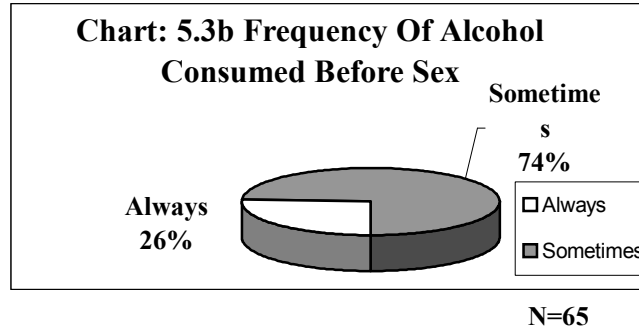
5.3 Substance Use Prior To Sex

The state of mind plays an important role in determining a person's control on self. Therefore, the contribution of intoxicating drinks and substances in inducing risk behavior has been increasingly recognized.

In this section an attempt has been made to gauge substance use prior to sex among the MSMs.



In this study it was found that 37 percent of the respondents consumed alcohol before having sex (Chart: 5.3a). Only one-fourth of them reported to have always consumed alcohol before sex (Chart: 5.3b).

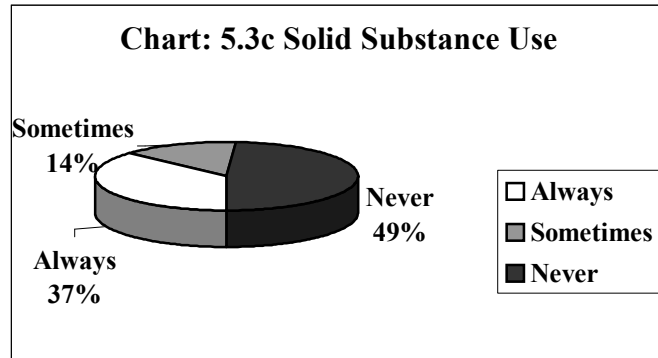


Quantity of alcohol consumed is an important factor in affecting the state of mind, hence the respondents were asked about the quantity of alcohol, which they usually consumed before sex. About half of them said that they consumed a quarter (Table: 5.3a). This was considered a situation of 'alcohol abuse' in which a person lost control over his behavior.

Table: 5.3a Quantity Of Alcohol Consumed Before Sex

N=65	
Quantity	%
Quarter	49.23
Two pegs or less	36.92
More than two pegs	13.85
Total	100.00

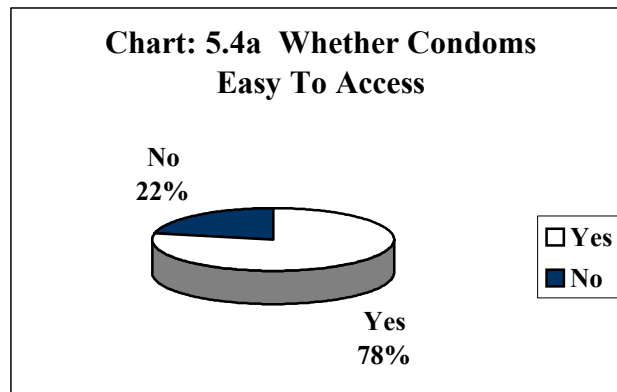
The section on substance use also focused on consumption of tobacco/gutka/mawa/khaini. Most of these contain intoxicating substances, which affect the state of mind to some extent. These are packaged in a pouch and are easily available everywhere. These are commonly used by the people hence carry almost no social restrictions. Those who consume these substances have tendency to keep it in their mouth for long duration. This usually causes gum infections, mouth ulcers and cancers. In HIV transmission the role of these substances is recognized for the potential of transmission through oral root. In this study it was found that almost half the respondents never consumed any of these substances. However, 37% of them reported to always consume these substances (Chart: 5.3c).



N=174

5.4 Availability of Condoms and Usage related knowledge

If used correctly, a condom is the only means of prevention of STIs and HIV. Condom usage depends on easy accessibility and attitude of the people. This section focuses on the issues related to condom usage. A predominant majority of respondents (78%) said that they find it easy to access condoms (Chart: 5.4a).



N=174

Non-availability of condoms near the place of sex (42%), difficulty in storing/keeping condoms (34%) and cost (8%) were given as some of the reasons for respondents facing difficulty in accessing condoms (Table: 5.4a). There was also a section of MSM (16%) who strongly denied having using condoms. Instead of answering whether they find it easy to access condoms, they said that they did not like condoms, did not use or were embarrassed to use condoms.

Table: 5.4a Reasons For Condom Not Being Accessible
N=38

Reasons	%
Condoms are not available near the place where I have sex	42.11
Condoms are too costly	7.89
Condoms are difficult to store/ to keep with me	34.21
I do not like condoms	2.63
I do not use condoms	10.53
I feel embarrassed to use condoms	2.63
Total	100.00

Mere availability of condom does not have any meaning if people do not know the correct method of wearing it. There are ten correct steps of wearing condoms. The respondents were given a jumbled show card to refer. They were asked to give the correct sequence of wearing condoms. The supervisor then assessed this sequence at the centre. Many respondents instead of giving correct steps said that the method of wearing a condom was '**fada, khola aur lagaya**' (meaning **tear the packet, open the condom and put it**). According to the assessment of the supervisor, only one person was able to give the correct steps of wearing a condom (Table: 5.4c).

Table: 5.4c Correct Steps of Wearing Condom

N=174

Assessment of Respondent	%
Aware	0.57
Unaware	99.43
Any other	100.00

5.5 Non-penetrative Forms of Sexual Activities

Non-penetrative forms of sexual activities are considered to be safer forms of activities. This section highlight on how much non-penetrative sexual activity is happening among the MSM.

5.5.1 Wet Kiss and Mutual Masturbation

Wet kiss is one of the starting steps of sexual act in which about 41 percent of the respondents reported to be never involved in last one month (Table: 5.5.1a).

Table: 5.5.1a Frequency Of Wet Kiss In Last One Month

N=174	
Frequency	%
Frequently(5 times or more in a month)	14.37
Sometimes(2-4 times a month)	31.04
Rarely(once a month or less)	13.79
Never	40.80
Total	100.00

One fourth of the respondents reported to be never involved in mutual masturbation in last one month (Table: 5.5.1b).

Table: 5.5.1b Mutual Masturbation In Last One-Month

N=174	
Frequency	%
Frequently(5 times or more in a month)	14.37
Sometimes(2-4 times a month)	45.98
Rarely(once a month or less)	13.79
Never	25.86
Total	100.00

5.5.2 Peno-oral Sex and Condom Usage

Although peno-oral sex is non-penetrative and relatively safer it still requires usage of condoms to prevent any kind of oral transmission of STIs/HIV. Almost 64 percent of respondents had peno-oral sex in last one month (Table: 5.5.2a). The respondents who were engaged in sucking/licking penis of another person stood at risk as in a majority of cases (70%), the sex partner did not use condoms.

Table: 5.5.2a Peno-Oral Sex And Providing Oral Sex

Whether Had Peno-Oral Sex	N=174
Response	%
Yes	63.79
No	36.21
Total	100.00
Frequency Of Suck/Licking Penis Of Another Person In Last One Month	N=111
Frequency	%
Frequently(5 times or more in a month)	22.52
Sometimes(2-4 times a month)	33.33
Rarely(once a month or less)	17.12
Never	27.03
Total	100.00
Whether Sex Partner Used Condoms	N=81
Response	%
Yes	29.63
No	70.37
Total	100.00
Frequency Of Condom Usage By Sex Partner	N=24
Frequency	N
Always	11
Sometimes	10
Rarely	3
Total	24

The respondents were asked about the oral sex, which they received from some one else (Table: 5.2.2b). This trend too was similar to providing oral sex to someone else. The condom usage, which was alarming in this case, was found to be very low.

Table: 5.2.2b Receiving Of Oral Sex

Frequency Of Getting Penis Sucked / Licked By Another Person In Last One Month	N=111
Frequency	%
Frequently(5 times or more in a month)	9.91
Sometimes(2-4 times a month)	42.34
Rarely(once a month or less)	21.62
Never	26.13
Total	100.00
Whether Used Condoms (Self)	N=82
Response	%
Yes	17.07
No	82.93
Total	100.00
Frequency Of Condom Usage (Self)	N=14
Frequency	N
Always	7
Sometimes	6
Rarely	1
Total	14

5.5.3 Oral-Anal Sex And Condom Usage

Most of the outreach workers reported that many of the respondents seemed perturbed when they were asked about oral-anal sex (Table: 5.5.3a). A few of them said that since it was a very dirty form of sex no one would report about it. Only ten respondents said that they did have anal-oral sex in last one month. All the respondents who received or gave oral anal sex did it without any protection.

Table: 5.5.3a Oral-Anal Sex Scenario

Whether Had Oral-Anal Sex	N=174
Response	%
Yes	5.75
No	94.25
Total	100.00
Frequency Of Licking Anus Of Another Person In Last One Month	N=10
Frequency	N
Frequently(5 times or more in a month)	1
Sometimes(2-4 times a month)	5
Rarely(once a month or less)	3
Never	1
Total	10
Whether Sex Partner Used Condoms	N=10
Response	
Yes	0
No	9
Total	10
Frequency Of Getting Anus Licked By Another Person In Last One Month	N=10
Frequency	N
Frequently(5 times or more in a month)	1
Sometimes(2-4 times a month)	3
Rarely(once a month or less)	2
Never	4
Total	10
Whether Used Condoms (Self)	N=10
Response	N
Yes	-
No	6
Total	6

5.5.4 Anal Sex and Condom Usage

In Mumbai, quite a few MSM identify themselves as receptive MSM and insertive MSM. However, there may be an overlap between these two as roles of insertive as well as receptive partners might change according to the relationship and attitude of the MSM. The scenario of insertive anal sex has been presented in table below (Table: 5.5.4a). Only 33 percent of the respondents said that they did not insert penis in another person's anus. Around 58 percent of

respondents reported having used condoms, but more than half of them used it only sometimes.

Table: 5.5.4a Insertive Anal Sex

Frequency Of Insertion Into Another Person's Anus In Last One Month	N=174
Frequency	%
Frequently(5 times or more in a month)	17.82
Sometimes(2-4 times a month)	33.91
Rarely(once a month or less)	14.94
Never	33.33
Total	100.00
Whether You used Condoms	N=116
Response	%
Yes	57.76
No	42.24
Total	100.00
Condom Usage (Self)	N=67
Always	34.33
Sometimes	55.22
Rarely	10.45
Total	100.00

The respondents were also asked questions about the receptive anal sex (Table: 5.5.4b). Almost 53 percent of respondents had receptive anal sex of varied frequency. Some interesting pattern of condom usage was found in this category. Exactly half of the respondents said that their insertive partner did use condoms during such encounters. Also, the frequency of using condoms always and sometimes was found to be equal.

Table: 5.5.4b Receptive Anal Sex

Frequency Of Someone Inserting Penis Into Anus In Last One Month	N=174
Frequency	%
Frequently(5 times or more in a month)	18.97
Sometimes(2-4 times a month)	22.99
Rarely(once a month or less)	10.92
Never	47.13
Total	100.00
Whether Sex Partner Used Condoms	N=92
Response	%
Yes	50.00
No	50.00
Total	100.00
Frequency Of Condom Usage	N=46
Always	41.30
Sometimes	41.31
Rarely	17.39
Total	100.00

5.5.5 Sex with Female Partners and Condom Usage

The MSM might be having sex with a female partner on account of their being married or practicing bi-sexuality. Only eight respondents said that they had vaginal oral sex with a female in last one month (Table: 5.5.5a). None of their female sex partners used condoms during these encounters.

Table: 5.5.5a Vaginal Oral Sex In Last One Month

Frequency	%
Frequently(5 times or more in a month)	0.00
Sometimes(2-4 times a month)	5.81
Rarely(once a month or less)	3.49
Never	90.70
Total	100.00

In marriage situation if the male female sexual encounters are unprotected in nature, then the risk extends to the wife and children to be born. The female sex partner outside marriage also stands at the same risk, but it goes unnoticed, as there is a strong possibility of the female partner to be a casual partner. About half of the respondents reported having sex with a female partner in last one-month.

Of these, half of them were frequently having with their female sex partners (Table: 5.5.5b). However, only 34 percent were using condoms during these encounters. Of those who were using condoms, 55 percent reported to have always used a condom.

Table: 5.5.5b Peno-Vaginal Sex

Frequency Of Peno-Vaginal Sex In Last One Month	N=86
Frequency	%
Frequently(5 times or more in a month)	51.16
Sometimes(2-4 times a month)	29.07
Rarely(once a month or less)	18.60
Never	1.16
Total	100.00
Whether You Used Condoms	N=85
Response	%
Yes	34.12
No	65.88
Total	100.00
Frequency Of Condom Usage	N=29
Always	55.17
Sometimes	37.93
Rarely	6.90
Total	100.00

CHAPTER: 6

TREATMENT SEEKING BEHAVIOR

6.0 Treatment seeking behavior is an indicator of a person's perception of seriousness of his/ her health problems. For small infections and illnesses, people in India usually seek treatment in the form of homemade remedies, self-medication or they consult quacks. However, this behavior becomes alarming when it is extended to treating sexual health problems, many of which might arise due to sexually transmitted diseases. There is a stigma, taboo attached to sex and sexual health problems hence both men and women continue to suffer due to embarrassment in seeking a proper medical treatment. The situation among the MSM is precarious due to societal, legal sanctions against their sexuality. This chapter is an attempt to capture the treatment-seeking behavior of the MSM.

6.1 Medical Diagnosis

The MDAC funded health facility at Humsafar Centre provided check up and treatment to the MSM brought by the outreach workers. A counselor provided pre and post-test counseling to all the clients who volunteered to undergo medical test for confirming the status of STIs and HIV.

The Department of Dermatology, STI and Leprosy and the Department of Microbiology of Lokmanya Tilak Municipal General Hospital, Sion carried tests on the blood samples collected at the voluntary test centre of The Humsafar Centre. From June 1999 to February 2000, total of 232 blood samples were tested for HIV. Of these 32 (13.89%) were found to be positive by the ELISA method for HIV. Out of 200 blood samples tested for VDRL 35 (17%) were found to be positive. Out of 73 blood samples tested for TPFA 25(34.25%) were found to be positive.

According to the doctors this was an alarming figure and there was a need to follow up with the HIV+ve people for self-care and safe sexual behavior.

6.2 Self Reported Health Problems and Treatment Seeking

At the end of the interview, the respondents were asked about STDs, which they might have suffered in last six months. According to the outreach workers, there could be an underreporting in this question as the MSMs in general were embarrassed to talk about STIs. Out of 174 respondents; five refused to answer questions related to STIs. One-fifth of the respondents reported having suffered from STIs in last six months (Chart: 6.2a).



The respondents experienced most common problem like itching sensation in genitals (42%). The respondents also reported symptoms having serious health implications. These symptoms were green yellowish discharge from penis (22%), blisters and ulcers on and around penis (19%), redness and swelling in groin (19%), blisters in groin region (6%), boils and bloody discharge from anus (3%). The symptoms reported by MSM were indicative of serious STDs like gonorrhoea, syphilis, herpes etc.

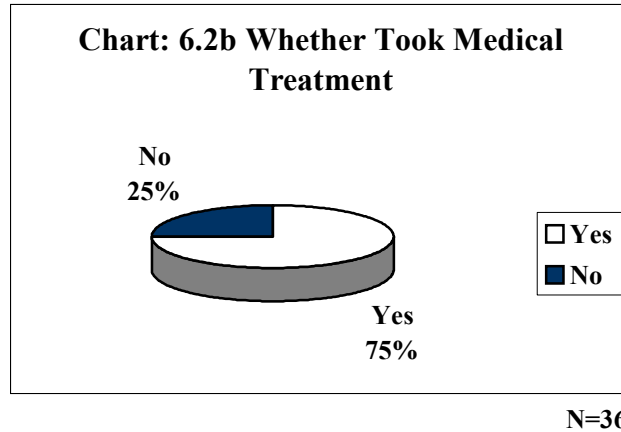
Table: 6.2a Symptoms Of Problem

Symptoms	%
Greenish-Yellowish discharge from Penis	22.22
Blisters and ulcers on and around penis	19.44
Redness and swelling of scrotum	5.56
Blisters in groin region	5.56
Redness and swelling in groin	19.44
Intense itching in genital	41.67
Burning sensation in anus	5.56
Boils and bloody discharge from anus	2.78

Multiple Response

A predominant majority of respondents did seek medical treatment for their problems (Chart: 6.2b). An informal discussion with the respondents revealed

that they consulted a doctor only when the problem became serious and unbearable.



A majority of the respondents sought treatment from an allopathic doctor (Table: 6.2b). A few tried home remedies and self-medication of warm water bag massage, washing blisters with *Dettol* and then applying *Soframycin* on it. Some even consumed painkillers like *Disprin* and *Brufen*.

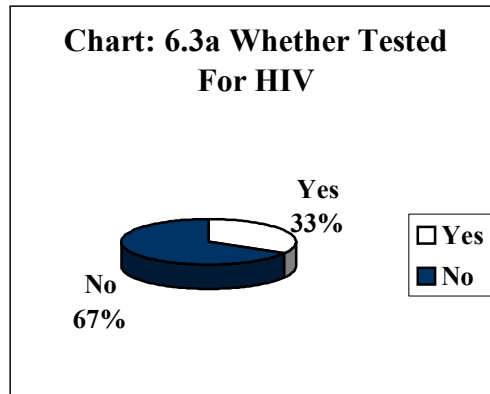
Table: 6.2b Types Of Treatment

N=27	
Treatment	N
Home remedies	4
Self medication	2
Treatment from an allopathic doctor	17
Alternative system of medicine	3
Treatment from 'Vaidu' 'Buva'	1
Total	27

6.3 Approach Towards HIV Testing

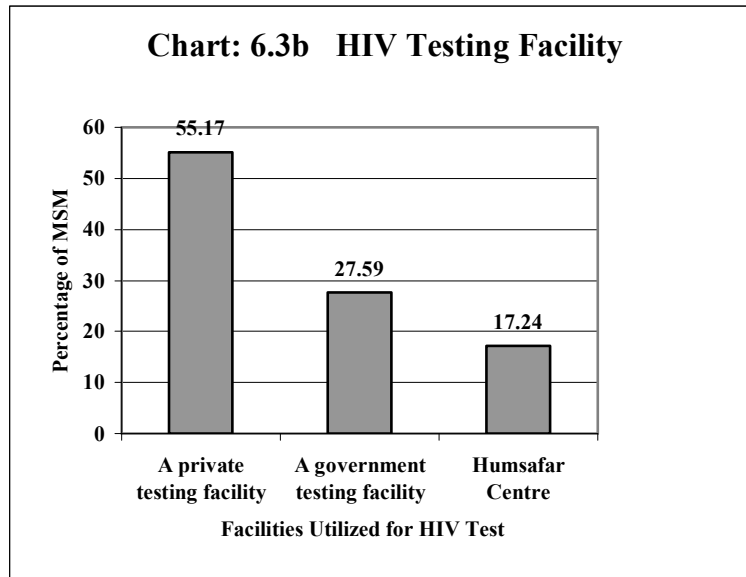
The MSMs as previous chapter shows, have a high turnover of partners with whom they engage in unprotected sex, hence they are at a vulnerable position in HIV epidemic. It is necessary that this community should be sensitized towards taking regular HIV tests. In this section their approach towards the HIV testing has been given.

Of all the respondents surveyed only 33 percent had tested for HIV (Chart: 6.3a). It is quite alarming that a large number of MSM had not yet tested for HIV.



N=174

More than half of the respondents visited a private facility to confirm their HIV status (Chart: 6.3b).



N=58

CHAPTER : 7

CONCLUSION AND NEED ASSESSMENT

7.0 This chapter is a wrap up of earlier chapters. Based on the findings of the study, a discussion of various issues pertaining to MSM behavior has been presented in the final section. Based on the inputs from the outreach workers and survey findings a cursory need assessment too has been presented.

7.1 Conclusion

The project which will enter into its second year has important lessons to learn from the previous year's activities and the findings of the study. The programs of public awareness were highly successful in terms of reaching to a large number of people. More such programs should be organized at regular intervals at various places to make people aware of the implication of unprotected sex. If these campaigns encourage people in seeking proper medical advise and counseling for the issues around homosexuality, the battle against HIV/AIDS would be half won.

According to the doctors at the Humsafar Centre, a lot of clients visited a proper doctor only when they could no longer tolerate the pain. Most of the clients said that they were embarrassed to consult a doctor, They also did not know who could treat them.

The socio-economic information shows significant presence of migrant MSM. Mumbai's awareness campaigns for MSM alone will not be sufficient. These efforts must be backed by the states like Uttar Pradesh, Andhra Pradesh and Bihar from where the migrants continue to come to Mumbai in search of livelihood.

More than one-fourth of the MSM are married and including them in HIV prevention is important and more than half of them have had sex with women. This is an alarming situation as the threat is extended to not only their multiple partners but also to wife and children to be born. It would be worthwhile to study why only a few married MSM use condoms while having sex with their wives.

Only a minority of MSM are illiterate hence there is a hope that continuous IEC will have a positive impact on those who are literate or educated fairly well. However, there is a need to open a dialogue on homosexuality as the data shows, predominantly MSM are unmarried and more than half stay with parents. Families, parents have to be involved in awareness campaigns.

According to the inputs of outreach workers, there are no monetary constraints on having sex with another man, as it is freely available. This is a dangerous

proposition as there is no check on number of partners, sexual encounters and types of sex. If sex is free than it is quite possible that both the partners might not use condoms on account of hesitation or fear of losing a sex partner. Possibility of sexual coercion can not be ruled out.

The findings on knowledge pertaining to HIV/AIDS show that the larger percentage of people is aware of AIDS. Probably they are not able to distinguish between HIV and AIDS. Also they understand HIV and AIDS in the same manner. While people understand that it is transmitted through sexual route, they also equate the virus with other contagious diseases that could spread by hugging, eating in the same utensil or using toilets as used by a HIV+ve person. This misunderstanding might be demoralizing and discriminatory towards the HIV+ve people.

It is ironic that the respondent MSM whose behavior emerged as risky had quite fatalistic and judgmental views regarding a HIV+ve person. However, only one fourth of them said that if they learnt about a partner being positive, they would break off the relationship. There is still a hope that there might be quite a few MSM who would not be averse to the idea of helping, supporting a HIV+ve MSM.

Although the study findings show that the respondents use substance before sex, a qualitative study is required to understand the details of intoxication and sexual encounters and its relation with risky sexual behavior. Similarly a qualitative study would help in understanding 'why' of unprotected receptive and insertive anal sex.

7.2 Need Assessment

The MSM must be *made aware of the dangers of easy and free sex*. The Humsafar campaign 'Sasti Masti Mahengi Hai' (meaning: free sex is dangerous) needs to be intensified.

There is a need to start *a campaign specially aimed at married MSM* for motivating them to have protected sex with their wives.

There is a need to *involve families* in the awareness campaigns for the MSM. Due to ignorance and prejudice of parents towards MSM behavior, the young generation is likely to be isolated and may perish in the epidemic even before reaching 30 years of age.

The MSM should be *encouraged to seek timely medical treatment* from proper doctors for their STIs. There is a need to make communities of Hijras, Masseurs aware of the STIs.

The outreach workers distributed ribbed and dotted condoms at the sites. The MSM who used them came back to outreach workers demanding the same type. They expressed that *the ribbed and dotted variety gave more pleasure* and the *person did not feel the need to seek another partner*. If usage of these condoms can reduce the number of partners, then *these need to be popularized and distributed*.

At the moment, only The Humsafar Centre has an exclusive voluntary testing centre for STDs and HIV. *There is a need for more such centres for MSM*.

There is a need for deputing outreach workers at more sites especially on western, harbor and central line as well as apex areas in order to cover large population of MSM.

Mumbai has submerged population of film junior artists, jogtas (male devdasi), male sex workers and malishwalas (masseurs). These are often hidden groups hence *there a need to depute outreach workers and peer leaders* for covering submerged under the project.

The Humsafar Centre provided health facility for the MSM, which was well received by the clients visiting it. Further referrals were provided to them for the treatment of STD/HIV related infections. However, the clients have continuously expressed the *need for a better-equipped health facility* where they could go for their health problems. They also expressed that such facility should provide them with the medicines. A few of them emphasized that they required constant counseling on HIV care, nutrition care to combat the virus. There is *a need to start a complete continuum of care for the MSM*.