

Size estimations in South Asia

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MSM in South Asia

Whilst the role of male-to-male sex in the pandemic has not been greatly recognised in the region, if not ignored, there is significant anecdotal information to indicate that there are very low testing levels of MSM, that identifying as a “homosexual” is very problematic at a testing site, and that the level of knowledge of MSM behaviours, identities and contexts is also very limited.

South Asian populations tend to be very male dominated societies, where social and public spaces are primarily male “owned”. As homosocial¹ and homoaffectionalist societies, sexual boundaries between males can often be easily crossed in appropriate spaces and become sexualised. Further, significant numbers of males perform gendered roles as feminised males and can be accessed by those deemed as “real men”. Experience indicates that male-to-male sexual behaviours do exist in South Asia countries at substantial levels.

Most of these male-to-male sexual behaviours do not exist within a socio-sexual context of a heterosexual/homosexual oppositional binary and as exclusive categories. Rather, there appears to be an inclusive behaviour which involves a substantial level of males operating within a wide variety of categories and/or networks. These involve at times, gendered self-identities, a perceived ‘body heat’ leading to a perceived urgent need for semen discharge, ready and easy accessibility to male sexual partners, and the social contexts of gender segregation, social policing of females, delayed marriage, and concepts of masculinity and femininity.

The frameworks of male-to-male sex, often substantially divergent, usually involve males who self-identify primarily as *kothis*² who are generally penetrated, and males who take on the penetrating role in male-to-male sex (known as *giryas* and *panthis*³ by *kothis*). Males who are penetrated are usually perceived by *giryas* and *panthis* to be “not-men”, which enables a *giryas* or *panthi* to maintain his sense of manliness and be seen as a part of the normative male society.

This gendered framework of male-to-male sex is primarily among low-income populations, where poverty, low levels of literacy, and economic disempowerment act as drivers to the HIV/AIDS epidemic.

¹ In South Asian countries, gender segregation of social spaces is a strong form of social policing of gender relationships. Primary relations are between the same gender (homosocial). Homoaffectionalism in the sense that the term is used in this text means social acceptance of the public display of male-to-male or female-to-female affection. For example, it is common in Bangladesh to see two males holding hands or arms wrapped around each other as they walk. Often male friends will also share beds when sleeping, wrapping themselves around each other. (See Hardman: 1993; Also Khan: 1996, where he points out that the boundary between homoaffectionalism and homosexual behaviours is very “thin” particularly in shared spaces and “under the blanket.”)

² A self-identifying label, for those males who feminise their behaviours (either to attract “manly” male sexual partners and, or, as part of their own gender construction, and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and, or, orally. *Kothi* behaviours have a highly performative quality in social spaces. Self-identified *kothis* use this term for males who are sexually penetrated, even when their behaviour is not feminised. This is the primary and most visible framework of male to male sexual behaviours. *Kothis* state that they do not have sex with other *kothis*; however, this is not always true. They may also be married to women. *Kothis* are also called *metis* in Nepal, *zenanas* in Pakistan and *maigha* in Bangladesh.

³ *Giryas* and *Panthi* are *kothi* labels for any “manly male.” A *panthi* or *giryas* is by definition a man who penetrates, whether it is with a female or male. *Panthis* or *Giryas* are most likely to be married to women, and, or have sexual access to females. Their occupations vary across the social class spectrum, from rickshaw drivers to businessmen.

Other dynamics include males who access other males for discharge and/or desire to be penetrated, males who desire male to male sex and do not gender themselves and usually indulge in mutual sexual activity - 'giving and taking', friends having sex with friends for mutual pleasure, and males in all male institutions. Along side these indigenous forms of labelling, gay-identified males, primarily among English speaking, middle and upper classes also exist with their own networks, mainly in urban areas.

These networks of differing MSM contexts may at times overlap, where individuals may shift between different networks, but usually they are mutually exclusive. In other words there are complex dynamics and diffusion in relation to male-to-male sex.

The most visible of these networks are those involving *kothis* because of their highly visible flamboyant behaviour, which is a part of their self-identification. In some cities in South Asia there are also *male massage networks* and other normative masculine males working as male-to-male sex workers.

This, of course, does not tell the whole story of male-to-male sexual behaviours in these countries.

Male-to-male sex work is also significant factor in many South Asian cities and towns (and perhaps villages also). A broad range of frameworks also exists here. *Hijras*⁴, *kothis*, massage boys and men, male youth, and other males will sell sex to other males because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they will also have a regular male or female partner.

While there are substantial networks of *kothis* in urban centres, from the very feminised and cross-dressing ones, to those who have moustaches and dress in shirt and trousers, their sexual partners could well be any masculine male, who tended to go unnoticed.

MSM and HIV

The contribution of MSM to the HIV/AIDS epidemic in India was officially set at 1 percent in 2001.⁵ But these estimates seriously underestimate the significance of MSM behaviours to the epidemic in India, especially since global estimates suggest that 5 percent to 10 percent of HIV prevalence is attributable to sexual transmission between men.⁶ Truck drivers are a group known to have higher levels of male-to-male sexual behaviour than the general public.⁷ Therefore, the high rates of HIV infection among truck drivers may be an indicator of the importance of male-to-male transmission in the India epidemic because same-sex behaviour also takes place outside of this particular group.

While data on MSM and HIV is somewhat limited in terms of Nepal or Pakistan recent studies indicate a prevalence rate of 4% in Karachi, Pakistan and the same in Kathmandu, Nepal.⁸ In regard to Bangladesh, the 4th round of the national sero-surveillance reports that HIV is below 1% among MSM, while syphilis rates vary between 4% - 10%.⁹

⁴ A self-identified term used by males who define themselves as "not men/not women" but as a "third gender." *Hijras* cross-dress publicly and privately and are a part of a social, religious, and cultural community. Ritual castration may be part of the *hijra* identity, but not all *hijras* are castrated. They commonly have sex with "normal men". They also have their own language, known as *ulti*.

⁵ Government of India, Ministry of Health and Family Welfare, National AIDS Control Organisation, *Estimation of HIV Infection among Adult Population* (New Delhi, India: Ministry of Health and Family Welfare, 2001)

⁶ *AIDS and Men Who Have Sex With Men (UNAIDS Point of View)* (Geneva, Switzerland: UNAIDS, 1998)

⁷ A.D. Bryan, J.D. Fisher, and T.J. Benziger, "HIV Prevention Information, Motivation, Behavioural Skills and Behaviour among Truck Drivers in Chennai, India," *AIDS* 14, no. 6(14th April 2000):756-8

⁸ 2005, MAP report

⁹ Background document on the dissemination of the fourth round (2002) of national HIV and behavioural surveillance, National AIDS/STD Programme, Bangladesh, June 2003

It must be noted that the reliability of HIV infection data among MSM is influenced by: (i) the lack of knowledge and understanding of MSM behavioural patterns as many MSM do not have a sexual identity/orientation; (ii) many do not consider reporting on their same sex behaviours even when asked; (iii) many do not identify their sexual behaviour as MSM since their partners are not perceived as men; (iv) many gay-identified men as well as others who have developed a sexual identity, are reluctant to identify themselves and disclose their same-sex behaviours or sexual orientation to health care providers, fearing stigma, discrimination and exclusion.

As a SAATHI report¹⁰ stated, "There is no nation-wide data on the prevalence of HIV infection among MSM in India." National AIDS Control Organisation (NACO) of India says, "On HIV among MSM groups, little reliable data is available. Informal estimates suggest rapid increases may be taking place in this particularly vulnerable community" (NACO, 2000). Only a few studies from Mumbai have reported HIV seroprevalence among MSM. The prevalence of HIV infection among gay-identified men attending STD clinics in Mumbai metro was studied by the National Institute of Virology over a 6-month period in 1992 in collaboration with *Bombay Dost* (India's first gay newsletter). HIV prevalence was found to be 20.67%, which was very high given the fact that this studied cohort was of educated middle class and hence had the means and material to be adequately aware of the transmission routes of HIV. It therefore implies that HIV prevalence amongst MSM without a conscious self-identity of their sexual orientation would be higher (Ashok Row Kavi, 1999).¹¹

But data from NACO (2000) of 232 HIV sentinel serosurveillance sites across India, 2 of which targeted MSM, suggested HIV seroprevalence rates among MSM of 23.94% in Mumbai (in Maharashtra State) and 4% in Tamil Nadu State (in Chennai).¹² These figures can be taken as indicators of the increasing risk of HIV infection among MSM across the region as the above comments are equally valid for Bangladesh, Nepal, and Pakistan.

Who are MSM?

What do we mean by the term "males who have sex with male"? Who are these "males who have sex with males"? Does this include males who have only had sex with another males once, twice, three times? Does this include males who just masturbate with other males? Why do I use the term "males" and not "men".

The fact is that in South Asian cultures the word "man" is socially constructed and usually does not refer to the biological age of a male person. Further many feminised males involved in male-to-male sexual behaviours do not identify themselves as men. It seem sensible to use the biological term male to ensure inclusive of all biological males, irrespective of their gender identity or performance.

For many service providers and agencies the term MSM it has become synonymous with "homosexuals", of "gay" men, and at the least, of *kothi*-identified males (however their masculine partners are usually invisible and thus not recognised), while it is often signified within the context of discussions of "vulnerable groups", or "target groups", or "at risk groups". In other words MSM is often taken to mean a specific and exclusive "sexual identity" in opposition to "heterosexuality", where MSM form an exclusive and bounded group/community. Too often programmatic decisions are taken within this limited view of what is essentially a behavioural term.

¹⁰ HIV Prevention Among Men Who Have Sex With Men (MSM) In India: A Review Of Current Scenario and Recommendations – background paper prepared by SAATHI (Solidarity and Action Against The HIV Infection in India) working group on 'HIV prevention and care among Indian GLBT/Sexuality Minority communities', revised draft, April 2002

¹¹ Ibid

¹² National AIDS Control Organisation of India's website (<http://naco.nic.in/vsnaco/indianscene/overv.htm>). Accessed on 23rd September 2001)

Male-to-male sex then includes those who do, or do not identify with same-sex sexual desire, often through gendered sex roles, as well as those who do not. It involves biologically adult males, as well as adolescent males. If we only address HIV/AIDS risks for MSM based on identity/sexual orientation, then what happens to those males whose sexual behaviours with other males are outside the purview of such frameworks because they do not see themselves possessing a sexual orientation other than a normative masculinity as men?¹³

To attempt to reduce this complexity will just lead to a greater invisibility of many divergent contexts of male to male sexual behaviours, expressed in an often bewildering variety and range of personal identities, behaviours, gender identifications and practices, which defy such a simple categorisation. In this context, and from the reality of experience in South Asia, Euro-American understandings and discourses on “gay identities”, heterosexuality, homosexuality, bisexuality, or even the term “sexual minorities”, will be misleading.

Contemporary research on sexualities and genders have clearly shown that the bipolar categories, such as ‘man’ or ‘woman’ or ‘heterosexual’ or ‘homosexual’, are not useful to describe the range of identities, desires and practices¹⁴ existing in India. The terms “gay” or “homosexual” are too contextualised by a specific history, geography, language, and culture to have any significant usefulness in a different culture from their source. In this we should be talking about sexualities, genders, and at the least, homosexualities and heterosexualities, and about behavioural constructions. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the South Asian context.

Whereas some of the male to male sexual acts could perhaps be called ‘homosexual’ (within the context of a local sexuality based upon a feminised gender identification - self-labelled as *kothis*) in that a sexual sense of self is operating within a framework of gendered sex roles and desires, a significant majority of the male sexual partners of these *kothis* should be seen within a context of semen discharge rather than desire for another male. It should be recognised that within a gendered construct of male to male sex and desire, there are *giryas/panthis* who form emotional and sexual relationships with *kothis*. These *giryas/panthis* do not see themselves (nor are they perceived as such) as homosexuals, but rather as “real men”, defined by their supposedly exclusive penetrating role that they take in the sexual encounter with a *kothi*.

In numerous workshops conducted by NFI held with groups of *kothi*-identified males in a number of cities in South Asia, when asked with whom they had sex, the response was a long list of occupational groups which ranged from street dwellers to businessmen, from the unemployed or low income groups to very wealthy men. These were primarily identified as *panthis*.

Thus what does exist in South Asia are a range of masculinities and genders with differing contextualisation of sexual behaviours, sex partner choices, perceived sexual needs, pleasures and desires, where male-to-male sex is seen primarily within a gendered dynamic, rather than in terms of sexual orientation or identity. This means that for many whom could be categorised as MSM would not define themselves as such because they would see themselves as normative penetrative males.

Sexually accessing masculine partners by *kothis* is not considered difficult. All urban areas appear to have sexualised spaces, such as parks, toilets, railway and bus stations, specific bazaars, streets, and other public areas where *kothis* would go to meet potential *giryas/panthis*, often marketing sexual availability through their feminised social behaviours. Many ‘real men’ also go to these sites, not only to meet such

¹³ See: The risks of categorisation, Shivananda Khan, Pukaar, Issue 21 April 1998; Varieties of homosexuality in Bangladesh, paper presented by Dr. Carol Jenkins at the 12th World AIDS Conference, Geneva, June 28-July 3, 1998, Pukaar, Issue 24, January 1999; Men and HIV: sociocultural constructions of male sexual behaviours in South Asia, Shivananda Khan, Pukaar, Issue 28, January 2000; Males who have sex with males in South Asia – a *kothi* framework, Pukaar, Issue 31, October 2000. Pukaar is the quarterly journal of Naz Foundation International and available on its website www.nfi.net

¹⁴ Personal discussion with Dr. Carol Jenkins, Care Bangladesh, 1999

accessible males, but often for quite legitimate purposes, where they can get caught up “in the heat of the moment” and access *kothis* there at the time.

Size estimation of the numbers of MSM

As discussed above MSM as a category is highly complex, diverse, and for many significantly gendered which makes it extremely difficult to make any effective size estimation. Simplifying this complex scenario, it is composed of two or more fairly distinct populations, those that are relatively visible, i.e. *public kothis*, and those invisibilised because they are a part of the normative male population, as well as non-public *kothis*, males in all male institutions, neighbourhood encounters, and so on.

At the same time, the issue of who is being defined as MSM is extremely pertinent. Do two males who only mutually masturbate each other defined as MSM? Does a single male-to-male sexual encounter define the participants as MSM? Indeed, how frequently does a male have to sex with another male to be defined as MSM? Should risk to HIV infection be taken into account?

Behavioural surveillance studies are often problematic, inadequate and badly designed. Many procedural and ethical issues are problematic where inappropriate questioning is the norm, poor formatting of studies, lack of confidentiality, stigmatisation by researchers, or even no mention of same-sex relations. This poverty in information and knowledge is further enhanced through a lack of understanding of the dynamics and frameworks of same-sex behaviours in an Indian context.

This leads to a lack of sensitivity to the realities of male-to-male sex and thus inadequate programming, which can often further socially exclude many MSM from service provision, treatment and care, as well as significantly underestimate the number of at-risk MSM in any given population along with a lack of resources to support HIV intervention programmes.

The qualitative and quantifying studies regarding MSM in any given population depends very much on the sensitivity of the methodology used, who conducts such studies, how they are conducted, and the groups of males being accessed.

Sexual behavioural studies in India have classified homosexual as anything from 1% of the sexually active male population to nearly 28% of the ‘occasionally homosexually behavioural males’.

Quantitative studies conducted in India include:

- A survey at Patna medical college in India in 1992 revealing that 25% of male medical students and doctors had had same-sex relationships (H.V. Wyatt, 1993)
- A postal survey of the readership of ‘Debonair’, an English men’s magazine from Mumbai revealing that of 1500 men who replied, 29.5% had sex with another man, before the age of 20 years in 80% of the cases (Roy Chan, et al, 1998)
- A survey of 527 truck drivers in northeast India revealing that 15% had sex with men (S.I. Ahmed, 1993)
- A major study conducted in Pune cities, where only 1.2% of men interviewed said they had homosexual relations although the authors did add, “we do feel it is extremely difficult to get an accurate estimation of homosexual experience in a general survey like we did”. The researchers agree that a completely different kind of questionnaire has to be designed to get more information on the prevalence of homosexual behaviour (Roy Chan et al, 1998)
- A postal survey of rural and semi-rural men in Tamil Nadu to which 1200 men replied found that 8% had sex with other men (Shreehar Jaya, 1994)
- According to a report on MSM in developing countries, the prevalence of MSM behaviours in the Indian male population range from 8 to over 50% (Neil McKenna, 1996)

- In a study of sexual behaviour among 1600 college students in Chennai, (Hausner D, 2000) it was found that approximately 20% of male students reported having had sex at least once in their lifetime and among these, 35% had their first experience with another male.

In Bangladesh, in a study conducted by the International Centre for Diarrhoea Diseases Research, Bangladesh (ICDDR,B) in 2002 indicated that over 22% rickshaw pullers had sex with other males¹⁵.

In Pakistan, AIDS Analysis Asia, reported in July 1996¹⁶ that:

- 20% of men in one rural area have male-to-male sex
- 40% of men living in a Karachi squatter settlement had male-to-male sex
- 72% of truck drivers in central Karachi had sex with other males, while 76% had sex with female sex workers

NFI has conducted a number of surveys among MSM in a range of cities across Asia, where in each site 200 *kothi*-identified males were interviewed. From these situational assessment reports (which can be accessed on NFI's website, www.nfi.net) the number of "real" men partners accessed in one month were:

Sylhet, Bangladesh	8800
Hyderabad, India	8100

Similar levels were reported in other cities, where most of these sexual partners are so-called normative males. While these figures may well be to some extent exaggerated by respondents in the studies, there is a clear indication of considerable male-male sexual activity.

It appears then that in the socio-sexual cultural framework in South Asian countries, it is almost impossible to get an accurate size estimation of the numbers of MSM in any given locality nor the levels of those who are most risk.

This is because of the prevalent concepts of masculinity and gendered dynamics of so much of male-to-male sex, the act of penetration itself is seen as an act of masculinity and manliness, not of homosexuality. Gender segregation, lack of access to females, along with socio-cultural dynamics of homoaffectionalism, homosocial behaviours, and male bonding, along with the range of all-male institutions such as prisons, hostels, and armed forces increases the difficulty.

Class, economic deprivation, mobility, gendered identities, and a range of other factors need all to be taken into account, and this has not been done. This means that in these countries what estimates do exist are grossly under-reported.

It has been estimated that between 3% to 20% of all men are estimated to have sex with other men at least once in their lives in parts of Asia (*Caceres CF et al. 2005: Estimating the number of men who have sex with men in low and middle countries. Sexual Transmission Infection Journal 82 -Suppl III*). In a study conducted by Dr Ravi Verma of Population Council (*AIDS 2004: 18. 1845-1856*), findings indicated that 10% of single men, and 3% of married men had unprotected anal sex with another male in the past year, while in the same study it was reported that MSM often had more female partners than other men, and they practice anal sex in 11% of their heterosexual contacts.

National or other representative samples of males throughout the world usually find between 5 and 20 percent have had sex with another male some time in their lives, although in certain countries proportions were higher. However, the proportion of males who report recent male-to-male sex within the past year or past 6 months is always considerably lower, ranging from 2 to 10 percent, or approximately half.

¹⁵ Presentation by ICDDR,B at the 2nd National Male Sexual and Reproductive Health Consultation Meeting organised by Bandhu Social Welfare Society, Bangladesh, August 2003

¹⁶ Reported in AIDS Analysis, Asia, July 1996, Focus on Pakistan, page 6

Certainly, the manner in which these surveys are conducted and the degree of stigma associated with male-to-male sex varies region by region and can be expected to influence survey results, most likely towards under-reporting. Men who report being exclusively interested in male-to-male sex rarely exceed 5 percent in any population. A recent review attempting to examine surveys from around the world suggested that lifetime prevalence of male-to-male sex was 3-5 percent for East Asia and 6-12 percent for South and Southeast Asia (Cáceres, C., Konda, K., Pecheny, M. Chatterjee, A. and Lyerla, R. *Estimating the number of men who have sex with men in low and middle income countries. Sexually Transmitted Infections* 82(Suppl. III): iii3-iii9, 2006. doi.10.1136/sti.2005.019489). This same study also estimated that the prevalence of male-to-male sex during the past year was approximately half of the lifetime figures but that the prevalence of unprotected sex was around 40-60 percent in East and Southeast Asia but 70 to 90 percent in South Asia (Dr Carol Jenkins: *Male sexuality and HIV – the case of male-to-male sex; paper developed for UNAIDS and Risks and Responsibilities: Male sexual health and HIV in Asia and the Pacific, an international consultation meeting; 23rd-26th September, 2006, New Delhi, India*).

Current studies and formulae that are being used to develop size estimations in regard to MSM at risk in various states in India are also problematic, and the experience of NFI and its local partner projects have found that they their level of reach to at-risk MSM populations, often have a higher number than the prevalent questimates being offered by so-called experts. While it is understandable that funding agencies and programme designers need some framework to understand the size of the issue and problem, often these MSM “estimates” are framed within implicit homophobia and denial. Socio-cultural dynamics of sexual practices are not taken into account, how MSM are defined and how risk is defined provide convenient barriers to fully understand what is actually going. All we can really say with any honesty is that there are significant levels of high risk male-to-male sex going on involving a significant level of the sexually active male population, and that this is usually higher than most people believe. The individual state reports below try to calculate actual numbers as indicated by these differing formulae, but NFI disclaims and responsibility for their accuracy.

Based on the calculations of Cáceres (see above paragraph) of 6%-12% range, this gives an approximate number of MSM in the South Asian countries where almost half of this would have experienced male-to-male sex in the previous 6 months, we are suggesting a figure of some 6% of sexually active males have been involved in at risk male-male sex in the previous month.

Country	Total population	Total males 15+	6%	10%
Bangladesh ¹⁷	141,822,000 (2006 estimate)	45,369,092	2,722,145	4,536,910
India ¹⁸	1,065,070,607 (2004 estimate)	375,671,529	22,540,0292	37,567,153
Nepal ¹⁹	28,287,429 (2006 estimate)	9,193,414	551,605	919,341
Pakistan ²⁰	165,803,560 (2006 estimate)	51,470,363	3,088,222	5,147,036

¹⁷ Bangladesh: www.discoverybangladesh.com (accessed 16/5/07)

¹⁸ India: www.iloveindia.com/population-of-india (accessed 16/5/07)

¹⁹ Nepal: www.google.co.in/search?hl=en&q=Nepal+population (accessed 16/5/07)

²⁰ Pakistan: www.en.wikipedia.org/wiki/Pakistan (accessed 16/5/07)

There are of course many other estimates, some much lower, some much higher. Ashok Row Kavi of The Humsafar Trust in Mumbai, India, a leading expert on MSM and HIV issues, had at one time estimated that there are perhaps some 50 million MSM in the country based on the Kinsey framework, while the Indian government estimate of MSM at risk hovers around 2.5 million.

Calculations depend on quality of research and a broad range of factors, but for example, the National AIDS Control Programme in India uses the following model:

District/Town	Number of males	Male population above 15 years (approximately 67% of the total male population – 2001 Census)	65% of these males deemed to be sexually active	5% of this population deemed having anal sex in previous year	20% of this population deemed as having more than 5 or more partners in previous month – to be reached by programme
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But we cannot assume that the assumptions and figures realistically reflect those MSM most at risk, since the derived percentages may not reflect the reality of male-male sexual behaviours and risk, as can be seen from many of the situational assessments that NFI has conducted in several cities across South Asia. What about the partners of these males? For NFI, the size estimations used to formulate policy and funding decisions appear suspiciously under-estimates.

A similar problem exists where in India, some State AIDS Control Societies believe that the size estimation of those MSM most vulnerable who need to be reached is developed through a different formula, i.e. total number of new MSM reached multiplied by 8 (an average number of different male sex partners in the previous month). But using this formula would mean that the estimated numbers of MSM that should be reached by an MSM HIV project is based on their productivity and effectiveness (i.e. how effective their outreach activity is).

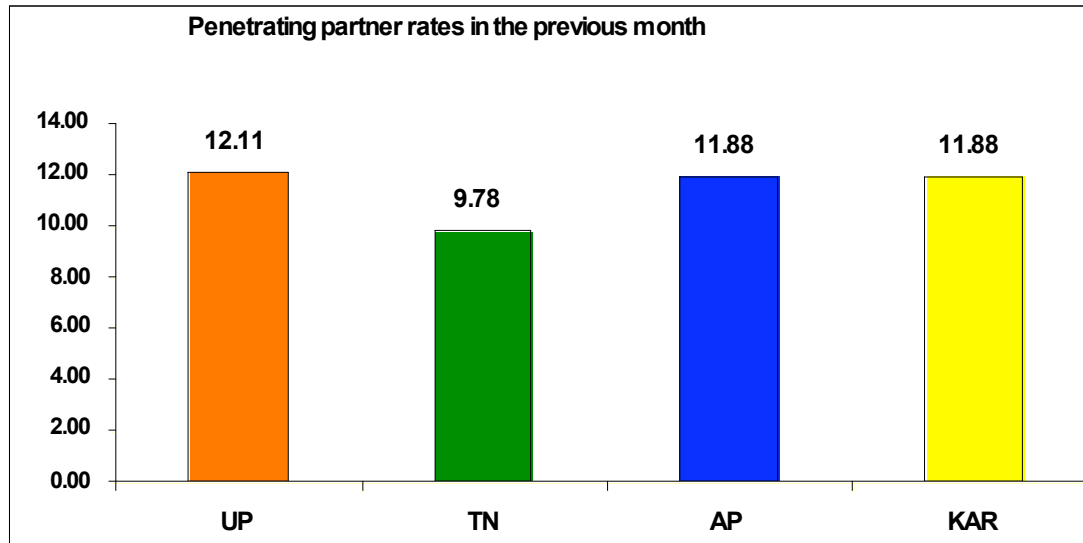
There would also be issues of concern regarding the derived numbers using this formula, primarily how many newly identified MSM are reached by the project will be dependent on a variety of factors, chief among these being:

- a. How long has the intervention being going on
- b. Number of outreach workers being employed
- c. Quality of outreach
- d. Frequency of outreach, time and location

All this has an impact on the number of newly identified MSM, which will vary from month to month. NFI believes it is somewhat dubious to try to identify the number of MSM that needs to be met by any given intervention using this particular approach.

In an NFI study in 2006 across 36 districts in 4 Indian states, some 7,200 self-identified MSM were interviewed in a situational assessment.

As can be seen from the graph below partner rates were significant higher that estimated above.



A final question needs to be raised in trying to determine size estimations of MSM at risk, and that involves a deeper understanding of male-to-male sexual dynamics and networking in South Asia. All the evidence indicates that a very high proportion of MSM are highly sexually active with multiple partners along with low condom use, irrespective of whether these MSM are involved in commercial sex or not. Further gender performance, invisibility and denial also impacts on being able to determine size estimations. All this numbering depends on who MSM are being defined. Who are MSM?