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Secondary HIV prevention among *Kothi*-identified MSM in Chennai, India

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This study explored experiences and contexts of HIV risk and prevention among HIV-positive *kothi*-identified men in Chennai, India. In-depth, semi-structured interviews were conducted with 10 HIV-positive men and three service providers, recruited using purposive sampling. Interviews were audio-taped, transcribed in Tamil and translated into English. Data were analysed using a narrative thematic approach and constant comparative method. Misconceptions about HIV transmission; cultural taboos around discussing sexual behaviour and HIV; stigma related to same-sex behaviour; harassment; and the criminalization of consensual sex between men present formidable challenges to HIV prevention. Frank and open discussion about male-to-male sexual behaviour and living with HIV, which may support health and HIV prevention, may be dangerous in the context of pervasive risks due to stigmatization, violence and criminalization. Instead, culturally appropriate, multi-level interventions developed in collaboration with community stakeholders are needed to support HIV prevention among *kothi*-identified men in South India.

Keywords: India; HIV/AIDS; MSM; prevention; *kothi*; qualitative research

Introduction

Two to three million people are estimated to be living with HIV in India (Cohen 2007), the majority (~45%) in Tamil Nadu (Cohen 2007). Although the Indian HIV epidemic is officially characterised as predominantly heterosexual (National AIDS Control Organization [NACO] 2005a), men who have sex with men (MSM) may be at particular risk. Sex between men is a criminal offence under Section 377 of the Indian Penal Code. Indian and international organizations have documented extensive human rights violations in India against sexual minorities (People's Union for Civil Liberties-Karnataka 2001) and HIV/AIDS peer outreach workers (Human Rights Watch 2002).

Criminalization, stigma and discrimination make it difficult to estimate HIV seroprevalence among MSM in India. In 2004, only 2.3% ($n=15$) of 659 HIV-serosurveillance sites operated by the National AIDS Control Organization (NACO) collected data from among this population (NACO 2005a). However, local HIV seroprevalence rates of 6.8% and 9.6% have been documented among MSM in Chennai and Mumbai, respectively (NACO 2005b). The same social context of criminalization and stigma that poses obstacles to the collection of epidemiological data also creates challenges for HIV prevention among MSM.

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The kothi context

In India, as in other countries, 'MSM' is an umbrella term that may be applied to various and differently self-identified subpopulations. In Chennai, *kothis* are one of the relatively well-organised and visible subgroups of MSM. *Kothis* are generally of lower socioeconomic status and some engage in sex work. Nevertheless, *kothis* are a heterogeneous group that includes same-sex-attracted men of all ages whose gender expression is primarily female; male sex workers who may adopt feminine mannerisms to attract male clients; and transgender or transsexual women. The meanings attached to *kothi* identity may vary by region across India as well as among *kothi*-identified individuals within the same locale. It is important to acknowledge the fluidity and socially constructed nature of *kothi* as a category, which has historical, political and social underpinnings (Cohen 2005, Boyce 2006, 2007, Row Kavi 2007). In this paper, we refer to men who identify as *kothis* who are not from *aravani* or transgender communities. *Aravanis* face distinct issues that merit more focused attention.

Studies in Chennai (Asthana and Oostvogels 2001, Chakrapani *et al.* 2007), Calcutta (Boyce 2006) and Mumbai (Row Kavi 2007) reveal the fluidity and range of behaviours among men who may self-identify as *kothi*. *Kothis* in Chennai largely engage in receptive anal or oral sex. However they also may engage in insertive anal sex. *Kothis* refer to their male, predominately insertive partners as *panthis* (real men). The term *panthi* however, is not adopted by those so named. It may also denote different types of male partners depending upon the context in which it is used: casual or paying partners or a male lover with whom a *kothi* may or may not cohabit. Some *kothis* label men who engage in both insertive and receptive anal sex *double-deckers*. *Kothis* themselves acknowledge that men identified as *kothi* and *panthi* sometimes behave like *double-deckers*.

A significant proportion of MSM in India, including *kothis*, are married (Verma and Collumbien 2004) and engage in sex with both men and women. Thus, *kothis* may be at high risk for HIV infection and may pose risks to both their male and female partners. They may face particular challenges in implementing HIV-preventive behaviours.

Secondary HIV prevention

Secondary HIV prevention refers to the prevention of HIV transmission from people living with HIV to their uninfected partners and prevention of new infections (new HIV strains/subtypes or sexually transmitted infections) from others to people living with HIV (Marks *et al.* 1999). Safer sex may entail particular challenges for people living with HIV, including negotiation of self-disclosure of HIV serostatus, which should be addressed in HIV post-test counselling.

Secondary HIV prevention has not received much attention in India. National HIV testing statistics among MSM in India are unavailable; preliminary data suggests that two-thirds of MSM attending public sex environments in Chennai have been tested at least once (Newman *et al.* unpublished manuscript). Nevertheless, MSM who know they are HIV-seropositive may face particular challenges in negotiating safer sex practices.

The purpose of this study therefore was to explore the experiences and contexts of HIV risk and prevention among *kothi*-identified men living with HIV in Chennai

in order to support the development of culturally appropriate secondary HIV-prevention actions and programmes.

Methods

In-depth, semi-structured, one- to two-hour interviews were conducted with 10 HIV-positive *kothi*-identified men (hereafter *kothis*) and three key informants in Chennai. Because of the widespread stigma against people living with HIV/AIDS, many HIV-positive *kothis* are hesitant to speak openly, which accounts for the relatively small sample size. Participants were recruited in mid-2004 using purposive and snowball sampling through three community agencies providing services. Research staff informed HIV-positive *kothis* who belonged to their peer network about the study. Additionally, HIV-positive *kothis* attending these agencies informed their peers about the study. Purposive sampling was used to ensure the inclusion of *kothis* who were married and those engaged in sex work. Three key informant interviews were conducted with leaders of community-based organizations in Chennai to explore their perspectives on secondary HIV prevention.

All participants provided informed consent. The study was approved by the Research Ethics Board of the University of Toronto and the Community Advisory Board (CAB) of Social Welfare Association for Men, a Chennai-based community agency serving *kothis*. Each participant was given an honorarium of 200 Indian rupees (approximately \$4 US) as recommended by the CAB. Key informants were not paid. Interview questions elicited experiences with HIV diagnosis and post-test counselling, sexual behaviours, relationships, healthcare experiences and interactions with the larger community.

Data analysis

Interview data were explored using narrative thematic analysis, with techniques developed from grounded theory (Charmaz 2006). Initial themes were identified using line-by-line and *in vivo* coding and analyzed using a constant comparative method (Glaser 1978, Strauss and Corbin 1998, Charmaz 2006). Theoretical coding was undertaken to identify higher-level codes and relationships among categories and to ensure the saturation of categories (Glaser 1978, Charmaz 2006). Peer debriefing was conducted with community experts on *kothis* to discuss interpretations of the data (Lincoln and Guba 1985). Member checking was implemented by re-engaging key informants to discuss and clarify their interview data and reflect on emerging findings (Lincoln and Guba 1985). Researcher triangulation between investigators in India and Canada, who independently reviewed and analysed the data, and data source triangulation between participants and key informant service providers increase the trustworthiness of the findings (Lincoln and Guba 1985).

Results

Participants ($n=10$) ranged in age from 21 to 52 years, with a mean age of 29.8 years. All were HIV-positive. Two were married and three were unemployed at the time of the research. Eight participants reported occasionally engaging in sex work. All participants came of lower socioeconomic status, with an average monthly income of 1500 rupees (\$34 USD). Key informants ranged in age from 29 to 40 years. In the

quotations that follow, respondents are identified by numbers to preserve anonymity. Table 1 outlines the main themes to emerge from the data.

Avoidance of unprotected sex: 'I should not give this to others'

This theme describes reductions in risk behaviour reported by some *kothis* and the stated motivations for these behavioural changes. Some participants reported decreasing their number of sexual partners; others said that they no longer engaged in anal sex or had reduced their engagement in anal sex: 'I have greatly decreased *giving my back*' (participant 3, 30 years old, occasional sex work).

Table 1. Overview of main themes.

Theme	Overview
(1) Avoidance of unprotected sex	Motivations for reducing sexual risk behaviours after HIV diagnosis include protecting others and preserving one's own health.
(2) General reasons for inconsistent condom use	Lack of consistent condom use across partner types attributed to decreased sexual pleasure, loss of sexual performance, misconceptions about HIV transmission, perceived seroconcordant HIV-positive status and inaccessibility of condoms.
(3) Partner-specific reasons for inconsistent condom use	Specific obstacles to condom use reported by partner type: <i>panthis</i> (casual male partners), paying partners, wives, police and ruffians.
(4) Successful condom negotiations	Implementation of condom use supported by invoking cleanliness, avoidance of disease and supported by clients knowledgeable about HIV/STI.
(5) Alcohol use during sex	Alcohol use attributed to supporting disinhibition to enable <i>panthis</i> to have sex with <i>kothis</i> and to allow <i>kothis</i> to cope with violent sex.
(6) Non-disclosure of HIV status	Reasons for non-disclosure of HIV-positive status to sexual partners based on fears of violence, loss of partner, loss of income, taboos around sexual communication and avoidance of risk behaviours.
(7) Inadequate and inappropriate HIV post-test counselling	Counsellor and physician unwillingness and incompetence in discussing same-sex behaviour and newly diagnosed positive clients' inability to absorb information.
(8) Gaps in safer sex counselling and stigmatization by healthcare providers	Stigma, insensitivity, lack of competence and inconsistency of information in addressing sexual behaviour and sexuality among <i>kothis</i> and people living with HIV/AIDS leaves HIV-positive <i>kothis</i> confused and on their own in addressing secondary HIV prevention challenges.
(9) Institutional and structural barriers	Lack of services tailored for <i>kothis</i> , police harassment of <i>kothis</i> and HIV/AIDS outreach workers, criminalization of 'homosexual behaviour' and government neglect of MSM in HIV prevention.

Two overarching motivations for reducing sexual risk behaviours were protecting others and preserving one's own health. As one participant stated: 'I have got this disease; I should not give it to others' (participant 7, 33 years old, daily wage labourer). Participants reported different reasons by partner type for avoiding HIV transmission. One man, who was an occasional sex worker, reported not wanting to risk infecting his educated and 'well-behaved' clients, who treated him fairly and paid on demand. A married participant (participant 5, 28 years old, private sector employee) explained: 'I do not want my [unborn] child to suffer from this', as a motivation for condom use with his wife—although this begs the question of how they might conceive a child. One participant (participant 9, 22 years old, private sector employee/occasional sex work) with a primary male partner stated: 'He should not get this [HIV]...but he might already have it', suggesting a desire to protect his partner but also uncertainty regarding his partner's serostatus.

Participants also described motivations for engaging in safer sex as a function of preserving their own health: 'Even with another positive person, one has to use condoms. Otherwise, more HIV will come from him and will lay more eggs in our body' (participant 3, 30 years old, occasional sex work). Another participant reported: '...otherwise my health will be spoiled' (participant 10, 28 years old, private sector employee/occasional sex work).

Nevertheless, not all participants reported changes in their sexual risk behaviours after discovering they were HIV-positive. As a participant noted: '...there is no change at all; the same thing continues' (participant 8, 28 years old, occasional sex work).

Reasons for inconsistent condom use

A variety of challenges to consistent condom use arose across partner types. Respondents attributed not using condoms to wanting to increase their own sexual pleasure and that of their partners. One participant gave the need to bring pleasure to his *panthi* partner as a reason for not using a condom during anal sex and described his *panthi*'s demands: 'My semen should touch your flesh; there is pleasure in that'. Another participant explained: 'How can I always use that rubber? I do want to enjoy...sometimes when I am in the mood I do not use condoms' (participant 3, 30 years old, occasional sex work).

Misconceptions about the risks of HIV transmission also supported inconsistent condom use for anal sex: 'My friend told me that he always uses condoms for oral sex. He said, "how could one put it in the mouth which one uses to eat?" But he also said he didn't use condoms for anal sex since the semen will come out in the motion' (participant 1, 21 years old, private sector employee/occasional sex work). Another participant explained: 'I cannot tolerate the smell that comes out of [the penis]...hence I always use condoms for oral sex. Anal sex, no worries about that...they do that in the back and you are not disturbed' (participant 8, 28 years old, occasional sex work). Thus, some participants insisted on condom use for oral sex, but described rationales for foregoing condom use for anal sex.

Inconsistent condom use was attributed to lack of condom accessibility and also to the risks of carrying condoms:

How can I always carry condoms? Once I went to the market. I met with a *panthi*...we had sex but without condoms. I did not go there to have sex...it happened. Even if I

keep condoms in my pocket, the old lady [mother] who washes my clothes will ask me why I have them. (participant 4, 30 years old, occasional sex work)

Although condoms reduce the risk of HIV transmission, they may increase the risk of disclosure that one is engaging in sex. Another participant recounted an incident in which he did not have a condom although he wanted to use one, similarly invoking the risks of carrying condoms:

It became very late in the night. I had one condom with me. I cannot go back with condoms to my home. I threw the one I had away and was about to go back home. Then I saw him...we had sex. I was feeling bad why I threw away that condom. (participant 9, 22 years old, private sector employee/occasional sex work)

Kothis, generally receptive partners, may at times engage in insertive anal sex with male partners. A participant described his fear of not being able to perform sexually with a condom: 'If the person who has sex with us is a *DD* ('double-decker') we may try to [insert]. If I wear a condom I may not have adequate stiffness. Hence sometimes I do not use one' (participant 2, 26 years old, private sector employee).

Kothis described difficulties in sexual performance on the part of *panthis* as another reason for not using condoms: 'Sometimes when *panthis* have drunk *TT* [any type of alcoholic beverage] the penis may not become hard. With him then we wouldn't insist on condoms; he wouldn't like to wear it either' (participant 4, 30 years old, occasional sex work).

Occasionally, lack of condom use was described as linked to the assumption that a partner was seroconcordant HIV-positive: 'I have seen him having sex with three other positive *kothis*. He might have already got HIV...so I did not use condoms with him. He also didn't ask me [about my HIV status]' (participant 8, 28 years old, occasional sex work). Bringing up condom use could also entail risking rejection by a potential sexual partner, as it may raise suspicion that the individual is HIV-positive.

Another participant explained that he did not use condoms with his regular partner due both to presumed HIV seroconcordance and love:

We had been having sex without condoms before I came to know that I'm positive. He might have already got this [HIV]...But I chose to tell him. Even after that [disclosure of HIV status] we used to have sex with no condoms since he said he still loved me. He has no one else besides me (participant becomes emotional)...No, he has not yet been tested for HIV. (participant 10, 28 years old, private sector employee/occasional sex work)

Partner-specific reasons for inconsistent condom use

Specific obstacles to condom use were reported by partner type. Participants described fears of displeasing and thereby losing their casual partners if they insisted on condom use: 'Some *panthis* don't like condoms. One cheese [attractive] *panthi* told me: "What is the point in using condoms...my semen should touch your anus"...what shall I say then?' (participant 4, 30 years old, occasional sex work). Another participant explained how bringing up condom use invoked disease: 'If I am going to ask him to use condoms, what will he say? He will ask me, "Do you have any disease?"...He would have walked away' (participant 3, 30 years old, occasional sex work).

Participants who engaged in sex work reported that efforts to insist on condom use might result in loss of paying partners: 'It is getting difficult for me to get *panthis* [who pay] these days. We will give a hint to use condoms; if he doesn't seem to get it, we don't ask again' (participant 4, 30 years old, occasional sex work). Participants

also reported inducements to forego condom use: 'What is the point in asking them to use condoms if they do not want to use? Some may ask how much more [money] I need if I can do it without condoms; I am tempted sometimes' (participant 3, 30 years old, occasional sex work).

Some *kothis* who engaged in sex work said that the high cost of brand name condoms, perceived to be more reliable, was an inhibiting factor: 'We get 10 or 20 rupees (25–50 US cents) from our clients; how can I spend five rupees for one condom with only this much money?' (participant 8, 28 years old, occasional sex work). Another *kothi* who engaged in sex work reported that *panthis* may not allow *kothis* to leave to buy condoms due to fear of being cheated:

A *kothi* told him [client] to wait there so that he would buy condoms from the nearby medical shop. That *panthi*, poor chap, was waiting for more than half an hour. Only later he realised that the *kothi* had cheated him. He told me he has become more careful since then. (participant 9, 22 years old, private sector employee/occasional sex work)

Respondents who engaged in sex work also described the police as barriers to condom use. When asked whether he received condoms from community organizations, one man reported: 'Yes, they do give; but how many can I carry around? If [a policeman] found me with condoms, he will book a case; why should I get caught?' (participant 4, 30 years old, occasional sex work). Another participant explained: 'I used to keep condoms in a bush in [cruising site]. Sometimes there will be policemen standing near that bush and hence I could not go and get the condoms from there; the customers can't wait' (participant 3, 30 years old, occasional sex work).

Men who were married described particular difficulties in using condoms with their wives:

How can I use that [condom]? I was just married six months ago. She would ask why should we use condoms when everyone is asking for good news [pregnancy]? (participant 5, 28 years old, private sector employee)

Another man explained that his wife had undergone sterilisation, so he could not easily justify using a condom:

We have two children. She had undergone family control operation. You tell me how can I use condoms with her? Tell me how to say to her that I have HIV. (participant 7, 33 years old, daily wage labourer)

Participants described incidents of harassment, violence and rape by police. Police harassment discouraged men from carrying condoms in general; and forced sexual encounters with police often precluded condom use. One participant described both direct and indirect effects of police harassment and rape as follows:

They took us to police station and during the night one policeman asked me to come to the bathroom. He had sex with me in the back [anal sex]. I did not have condoms at that time since I was only in my underwear; I also could not talk about condoms. Even if we show condoms they will beat us on our hands with a *lathi* [police stick]. (participant 3, 30 years old, occasional sex work)

Participants who engaged in sex work described victimization by police. An HIV-positive participant recounted being raped by police as a youth:

I was 17 years then. I was lying in the Marina beach late night. No one was around. A policeman came and asked why I was lying there. By some way he might have identified me as a *kothi*. Though I objected, he forcefully had sex in the back [anal sex]. That was my first experience [of anal sex]; it was painful. (participant 1, 21 years old, private sector employee/occasional sex work)

Another man reported being raped by police and feelings of vengeance towards policemen after he was found to be HIV-positive:

...The first thing that came to mind was that policeman. I was sure I got it [HIV] from him. I thought others [policemen] need to get it too, by some way. That was only for a short time; now I do not think about it. (participant 3, 30 years old, occasional sex work)

Participants who engaged in sex work reported robbery, violence and rape by ruffians or *beelis*:

Whenever I get out of my house or go back to my house I have to face *beelis*. What will he say? 'Show me your back [buttocks] I will give four 'punches' [penetrations] and then just walk away'. I can't refuse. He will slash me with a blade...I have to see him everyday. (participant 8, 28 years old, occasional sex work)

Participants who engaged in sex work explained their need to stand still in a particular place over time to enable clients to find them; however, this can make them more vulnerable to ruffians:

They [ruffians] have sex with us; we cannot talk about condoms with them. They will beat us, show us a knife. They have hurt me using [razor] blades; they take our money...(participant 4, 30 years old, occasional sex work)

Successful condom negotiations: 'Now we are hearing about big diseases'

Kothis generally do not talk about sex with *panthis*; they have sex instead. Nevertheless, some men described the strategies they used to encourage *panthis* to use condoms for anal sex: 'I will say, "now we are hearing about big diseases [AIDS]. You might have gone to many [sex partners], I might have gone to many; so why don't we use condoms?"' (participant 6, 52 years old, daily wage labourer/occasional sex work). Another participant reported: 'I will say, "See, this is the passage through which bowel movements come; why do you want to make yourself dirty? Instead use condoms; we can then throw it away"' (participant 8, 28 years old, occasional sex work).

Participants reported that those *panthis* who were college students may be more educated about the risks of HIV/STIs and the need to use condoms: 'They are smart; you need not tell. They come with condoms; they accept if we take out condoms' (participant 1, 21 years old, private sector employee/occasional sex work).

Alcohol use during sex: 'Panthis sometimes come with alcohol'

Panthis may use alcohol to promote disinhibition to enable themselves to have sex with other men, as well as to then attribute their engaging in sex with men to being drunk: '*Panthis* sometimes come with alcohol. They will say it is because of alcohol that they have sex with us, "otherwise I will be reminded of your moustache and will not be in the mood"' (participant 8, 28 years old, occasional sex work).

Men also explained that some *panthis* give them alcohol so that *kothis* will 'cooperate':

Once we drink alcohol we are able to tolerate whatever *panthis* do; some bite, some scratch. They know we will not allow them to do this if we have not consumed alcohol. Yes, sometimes they do not use condoms when they have anal sex. What can I do? (participant 9, 22 years old, private sector employee/occasional sex work)

Although *kothis* may be aware that they risk physical injury and that *panthis* may not use condoms when they are under the influence of alcohol, participants feared being rejected by *panthis* and loss of income if they resisted, and accepted alcohol to cope with occasional violent sex.

Non-disclosure of HIV status: 'I did not want to lose him'

Participants reported not wanting to disclose their HIV-positive status due to fear of losing their *panthi* partner and fear of violence: 'If I tell him, he will not come [to have sex]; but also beat me up' (participant 9, 22 years old, private sector employee/occasional sex work). Additionally, *panthis* do not generally engage in discussion about sex: 'Panthis come and just ask me to show my back and insert...no talk about sex' (participant 1, 21 years old, private sector employee/occasional sex work).

Men who sold sex reported not wanting to disclose their HIV-positive status to their clients at the risk of losing much needed income: 'We get 10 or 20 rupees (25–50 cents) from some clients; we do not want to lose even that' (participant 4, 30 years old, occasional sex work). This participant further questioned why he should be responsible for telling clients about his HIV status, given his own insistence on condom use: 'I ask my clients to always use condoms. If they do not want to, what can I do?'

For some *kothis*, engaging in only lower risk sexual practices was a strategy to avoid the need to disclose their HIV status while also reducing the risk of HIV transmission. As a participant reported: 'I only have oral sex' and 'I do not *give my back*' [anal sex] (participant 5, 28 years, private sector employee).

A married *kothi* (participant 5, 28 years old, private sector employee) discussed the difficulty of disclosing his HIV status to his wife: 'How can I tell her? Will she then eventually come to know I'm a *kothi* as well?' However, non-disclosure of HIV status did not necessarily result in unprotected sex. As this participant further reported: 'My wife never looks down when I have sex with her. So I can use condoms without her knowledge and take away the condom as I come out [of her]...everything happens in the dark.' In this context, non-disclosure was seen as acceptable since he was not putting his wife at risk for HIV infection and did not have to risk losing his marriage.

Inadequate and inappropriate HIV post-test counselling: 'He did not ask...'

Problematic experiences with HIV post-test counselling were described in which counsellors were either unwilling or unable to discuss same-sex behaviour and sexual orientation. A participant reported he did not discuss same-sex behaviour with an HIV post-test counsellor because 'he did not ask' and 'I was afraid to tell' (participant 2, 26 years old, private sector employee/occasional sex work). Another participant discussed telling a counsellor about his same-sex behaviour, but receiving no response: 'It is as though he did not hear what I said; maybe he wanted to avoid discussing that' (participant 9, 22 years old, private sector employee/occasional sex work).

Participants also reported an inability to understand or focus on the information given during post-test counselling. A 21-year-old participant recounted:

I was seventeen. I was very innocent at that time and could not understand what was being said by that counsellor. I was just nodding my head. I was asked to come for follow-up, but since I was doing well I did not go back. (participant 1, 21 years old, private sector employee/occasional sex work)

Another participant explained: ‘Whatever the counsellor tells you, it will not be absorbed by you since you will be in a state of shock...they need to understand that’ (participant 4, 30 years old, occasional sex work).

Gaps in safer sex counselling and stigmatization by healthcare providers: ‘They say, “Do not have sex”’

Participants reported either not receiving safer sex information or that the information they did receive was often incomplete and inconsistent across providers. Lack of discussion of sexual behaviours and safer sex on the part of healthcare providers and outreach workers was also associated with stigma against *kothis* and people living with HIV/AIDS.

One participant explained how stigmatization of people living with HIV/AIDS and *kothis* by doctors truncates discussion of safer sex:

Tell me, when one has become HIV-positive, should they no longer have sexual feelings? We are also human beings. Why is this not discussed by the doctors? They say, ‘Do not have sex’. Many do not even talk about it. (participant 1, 21 years old, private sector employee/occasional sex work)

Another participant recounted his physician’s unprofessional reactions:

I told that doctor that I had sex last month. He gave back my [outpatient case] sheet and asked me to get out. I was told later that he actually slapped one patient for having had sex. I was fortunate (giggles). He is no longer in hospital. (participant 9, 22 years old, private sector employee/occasional sex work)

Mixed messages from healthcare providers also left some participants confused:

The doctor told me not to have anal sex but [that I] can have oral sex...that too with condoms. That nurse told me I should not be having sex at all, since I should not infect others. The counsellor was telling me to reduce sex. He did not even talk about condoms. (participant 2, 26 years old, private sector employee/occasional sex work)

Information on sexual practices with women, particularly their spouses, was even less readily available. A married *kothi* explained:

...they [outreach workers] talk about male-male sex, but not much information is given on sex with women or STDs in women. And many *kothis* are married, too. How can they tell their wife that they have HIV? They can’t use condoms with their wife. (participant 5, 28 years old, private sector employee)

Participants discussed being left largely on their own in facing challenges around sexual behaviours: negotiation of safer sex, information about risks to themselves and others, management of disclosure of their HIV status and implementation of condom use with sexual partners, particularly their wives.

Institutional and structural barriers: ‘Outreach workers are even afraid’

Stigma, discrimination, criminalization and violence against *kothis* and outreach workers were articulated. A key informant explained:

Whether [HIV] positive or negative, homosexual behaviour is criminal, which makes MSM feel bad about themselves. They are blackmailed by police and rowdies. They are sexually assaulted even in police stations. Where will the self-respect of MSM be then?

NACO is the Indian government agency responsible for HIV/AIDS prevention and care policy, HIV serosurveillance and preventive interventions. One key informant

explained: 'Though NACO has mentioned MSM as one of the target groups, not much intervention programmes are happening in India. Of course, no one will think separately about HIV-positive MSM and their needs; they may think that is a very small number'. When asked about initiatives by the Tamil Nadu State AIDS Control Society, largely funded by NACO, key informants reported that they were not aware of any initiatives for HIV-positive MSM and minimal attention in general to issues faced by these men in Tamil Nadu. A key informant pointed out the inconsistencies in what is stated by NACO in its national HIV/AIDS policy and what is happening on the ground:

While NACO talks of MSM as a target group and recognises the need for condom distribution in cruising areas, outreach workers face problems from policemen if they have condoms with them. Outreach workers are even afraid to carry educational materials that show pictures of STIs. Some police don't even look at the identity cards shown by the outreach workers; they will say, 'I know who you are...don't fool me by showing this [card].'

Key informants described that Indian government laws, policies and unofficial practices contribute to lack of services for *kothis*, including primary and secondary HIV prevention, and overall denial of their existence in Tamil Nadu.

Discussion

Kothi-identified HIV-positive men in Chennai are under-served in terms of HIV post-test counselling, education about HIV/STI transmission risks, institutional supports and secondary prevention in a system that appears to promote stigma, discrimination and violence against them. As a result, they remain at high risk for STIs and other infections, including re-infection with drug-resistant HIV strains, and lack information and support to facilitate safer sex and other health-promoting behaviours. This scenario may contribute to increased risk for HIV and STI transmission among HIV-positive MSM, as well as to their male and female partners.

Some of the challenges for secondary HIV prevention among *kothis* in Chennai mirror those among MSM more generally in the developed world, including barriers to condom use, difficulties with sexual negotiation and self-disclosure of HIV status, fear of partner and societal rejection, AIDS-related stigma and sexual prejudice (Herek and Glunt 1998, Wolitski *et al.* 2004). Nevertheless, a number of formidable obstacles to HIV prevention may be particularly relevant in the South Indian context: lack of HIV-prevention and care resources tailored for *kothis*; stigma and discrimination within the healthcare system; basic misconceptions and misinformation about HIV risk; cultural norms that proscribe frank discussions about sex and stigmatize condom use; the complex relationship between sexual behaviours and self-identifications; the ubiquity of marriage among *kothis* and challenges with female spouses; police harassment and violence against *kothis* and HIV/AIDS peer outreach workers; and criminalization of male-to-male sexual behaviour.

In India, where people 'don't talk, but do sex', taboos about discussion of sexual practices—and even more so among HIV-positive *kothis*—pose challenges across individual, interpersonal, community and societal levels. In the present study, *kothis* cannot talk about safer sex/condom use with *panthis*; married *kothis* are unable to discuss condom use with their wives; HIV-positive *kothis* are often unable to disclose their HIV status or their sexuality; HIV post-test counsellors and doctors often do

not address same-sex or bisexual behaviour in their counselling or clinical encounters; and the government seems reticent to acknowledge the existence of MSM in India. Condom use, though apparently promoted by all sectors, is construed as a sign of infidelity, mistrust and disease, rather than a responsible health behaviour. Denial or condemnation on the part of healthcare providers and counsellors in terms of HIV-positive *kothis* engaging in sex at all seems to be more commonplace than health promotion and secondary HIV prevention.

The engagement of HIV-positive *kothis* and other MSM in the development of secondary prevention interventions is particularly important, as most HIV prevention models and theories have emerged from vastly different, western contexts. Existing HIV prevention efforts in North America may be least effective in reaching MSM who do not self-identify as gay. Lack of specific self-identification in relation to sexuality, however, appears to be the dominant reality among MSM in South India. The complex relationships (from a western perspective) between sexual behaviours and identities may not be amenable to the predominant models of HIV prevention for gay and bisexual men. For example, both *panthis*, ostensibly insertive partners, and *kothis*, ostensibly receptive partners—and each with some investment in maintaining those representations of themselves—may behave like *double-deckers*, which changes the requisites of effective prevention. Interventions that might target men who appear to occupy stereotypical gender roles or that presume men who are receptive partners are necessarily feminized or disempowered, for example, may overlook both strengths of *kothis* in negotiating safer sex as well as the vulnerability of men referred to as *panthis*.

Furthermore, the presumption that men who identify as *kothis* do not have sex with women is problematic; several *kothis* in this study reported a vacuum in terms of information on how to negotiate condom use with their wives—given fears of being revealed as HIV-positive, as having sex with men and being shamed and rejected. While engaging in sex with men is a source of stigma and shame among wives and families, being married is a source of stigma within the *kothi* community. Issues around sex with female spouses are also overlooked by many healthcare providers, HIV counsellors and outreach workers, some of whom may be *kothis* themselves. The multifaceted obstacles to *kothis* engaging in discussion about female partners present further barriers to effective secondary prevention.

To be effective, HIV prevention in India (as elsewhere) should not seek to engage with pre-determined and fixed categories of sexuality. Identities and behaviours are fluid and may be constructed in part by the very HIV-prevention policies and research that purport to study them as objective phenomena (Boyce *et al.* 2007, Row Kavi 2007). Superimposing even locally constructed HIV-prevention paradigms on what are sometimes understood to be readily available, 'indigenous' and fixed sexual identities needs to be critically examined (Boyce 2007); however, it is equally important to avoid privileging the insights and critiques of HIV prevention that emerge from the worldviews of western and expatriate Indian social scientists that construct conceptualizations of Indian sexuality on behalf, particularly, of low socioeconomic MSM.

The present study explores the worldview of self-identified *kothis* in Chennai and suggests that enduring misconceptions about the risk of HIV transmission due to anal sex and cultural taboos, both around engaging in oral sex and discussion of sexual behaviour, may render western harm-reduction (Marlatt 1998), negotiated

safety (Kippax *et al.* 1997) and sexual-communication (van Kesteren *et al.* 2005) strategies problematic for HIV-positive *kothis* in South India. Frank and open discussion about male-to-male sexual behaviour and living with HIV, which may support health and HIV prevention in the circumscribed world of AIDS, may not be perceived as health promoting when one faces pervasive and more immediate risks due to stigma, violence, rape and criminalization.

The criminalization of consensual sex between male adults in tandem with police harassment and sexual violence against *kothis*, police harassment of HIV-prevention outreach workers, assaults against *kothis* that go unreported due to police collusion and social exclusion from 'mainstream' HIV-positive networks create a context of hostility and violence against *kothis* (Newman *et al.* 2006, Chakrapani *et al.* 2007). The present study suggests that HIV-preventive interventions for *kothis* in South India—whether informed by public health or social science perspectives—that neglect to address these powerful social and structural factors are unlikely to be effective.

Despite the myriad challenges and recognition of the potency of structural obstacles to HIV prevention, it is vital to see *kothis* as active agents in shaping their own lives. Several participants demonstrated keen awareness of the fluidity of categories of sexuality and the complex relationship between sexual labels and behaviours. Their articulation of the successful and strategic implementation of risk-reduction strategies, and of motivations to avoid HIV transmission, suggest seeds for the design of effective local preventive interventions. Importantly, the sustained presence, against all odds, of three grassroots community based organizations in Chennai dedicated to HIV prevention and care among *kothis* and other MSM suggests an important foundation for effective intervention. Initiating and supporting local community organizations responsive to the needs of *kothis*, through Indian government and international funding and technical support mechanisms that include programme monitoring and evaluation, may facilitate HIV prevention among *kothis* and other MSM in Chennai.

Notwithstanding our findings, this study has limitations. The purpose of this investigation of a small purposive sample of *kothis* in Chennai was to explore in depth their experiences in relation to HIV risk and prevention; caution should be exercised in generalising the findings to others. We were successful, however, in including diverse *kothis* and community leaders providing HIV-prevention services. Further investigation of other groups of MSM in Chennai and other locales in India, including systematic comparisons by age, employment status and other demographic variables, will help to determine the transferability of our findings and specific needs for secondary HIV prevention.

Further research should focus on voluntary counselling and testing services and the government healthcare system, and evaluate interventions to improve services for HIV-positive *kothis*. Providers in each of these systems represent important resources to promote secondary HIV prevention. Actions to encourage HIV testing among MSM in India are also vital; however, the latter should be launched in tandem with structural changes in counselling and testing to better accommodate (rather than alienate) this population. Additionally, research focused on the development of support networks for HIV-positive *kothis* and facilitating their inclusion in general HIV-positive support networks may expand an important resource for promoting secondary prevention.

Overall, the multiple levels of challenges to the health and safety of *kothis* suggest that programmes that tend to operate in isolation and focus on individual deficits (e.g. in knowledge, attitudes, sexual negotiation skills) as the foundation of HIV risk are unlikely to be effective in addressing the powerful social, cultural and structural factors that create an ongoing context of vulnerability. Tailored secondary prevention intervention programmes that reach out to diverse populations of MSM are needed, in conjunction with interventions that aim to: (1) decriminalize consensual sex between same-sex adults; (2) stop police violence against *kothis*; (3) provide education and sensitivity training for healthcare providers and HIV post-test counsellors to enable them to work competently with MSM and people living with HIV/AIDS; (4) promote HIV-positive support networks that are inclusive of *kothis*; and (5) disseminate anti-discriminatory messages in educational and public health institutions and the mass media to combat the stigma associated with 'homosexuality' and condom use. Prevention of HIV transmission thus should not be addressed as the sole responsibility of HIV-positive *kothis*, but as a shared responsibility of the general public, vulnerable persons including others living with HIV and their sexual partners, community-based organizations, public health agencies and the government of India.

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Résumé

Cette étude a exploré les expériences et les contextes du risque lié au VIH et de la prévention parmi des hommes identifiés comme *kothi* à Chennai, en Inde. Des entretiens en profondeur et semi structurés ont été menés avec 10 hommes séropositifs au VIH et trois responsables d'organisations à assise communautaire dispensant des services, recrutés au moyen d'un échantillonnage dirigé. Les entretiens ont été enregistrés, transcrits en tamoul et traduits en anglais. Les données ont été analysées à partir d'une approche de récit thématique et par comparaison constante. Les idées fausses sur la transmission du VIH, les tabous culturels concernant les échanges sur les comportements sexuels et le VIH, la stigmatisation relative aux rapports sexuels entre personnes de même sexe, le harcèlement, et la pénalisation des rapports

sexuels consentis entre hommes, représentent des défis considérables pour la prévention du VIH. Les échanges ouverts et francs sur les rapports sexuels entre hommes et sur ce que signifie vivre avec le VIH, sur lesquels les efforts de prévention du VIH peuvent s'appuyer, pourraient s'avérer dangereux dans le contexte des risques omniprésents dûs à la stigmatisation, la violence et la pénalisation. En revanche, il est nécessaire d'élaborer, en partenariat avec les parties prenantes communautaires, des interventions culturellement appropriées et à mener sur plusieurs niveaux, afin d'apporter un appui à la prévention du VIH parmi les hommes identifiés comme *kothi* dans le sud de l'Inde.

Resumen

En este estudio hemos analizado las experiencias y los contextos del riesgo y la prevención del virus del sida entre hombres seropositivos identificados como *kothi*, en Chennai, la India. Para esta muestra se realizaron entrevistas exhaustivas y semiestructuradas con 10 hombres seropositivos y tres proveedores de servicios. Las entrevistas fueron grabadas y transcritas en Tamil y luego fueron traducidas al inglés. Los datos fueron analizados mediante un enfoque de temática narrativa y un método comparativo constante. Para la prevención del VIH, los retos más importantes fueron los conocimientos erróneos sobre la transmisión del virus del sida, los tabúes culturales en torno a la discusión de la conducta sexual y el VIH, el estigma relacionado con los contactos entre personas del mismo sexo, el acoso y la criminalización del sexo consentido entre hombres. Las charlas francas y abiertas sobre cuál es la conducta sexual entre hombres y cómo se vive con el VIH, que podrían ayudar en la salud y la prevención del virus del sida, podrían ser peligrosas para los riesgos dominantes debido al estigma, la violencia y la criminalización. Sin embargo, lo que sí son necesarias son las intervenciones culturalmente apropiadas y a todos los niveles desarrolladas en colaboración con las partes interesadas en la comunidad para apoyar la prevención del VIH entre los hombres identificados como *kothi* en el sur de la India.