

# Challenges for Secondary HIV Prevention among Kothi- identified Men who have Sex with Men in Chennai, India

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# ***BACKGROUND***

- Criminalization of sex between men and stigmatization and discrimination against Indian men who have sex with men (MSM) makes it difficult to collect accurate HIV seroprevalance data among this population.
- Nevertheless, HIV seroprevalence rates from 4.4% to 18.0% have been documented among MSM in Chennai, Tamil Nadu.

# ***BACKGROUND (Contd.)***

- In Chennai, the predominant group of self-identified and visible MSM are *Kothis*, who are usually of lower socioeconomic status and some of whom engage in sex work.
- Community organizations working with MSM and INP+ are witnessing an increasing number of MSM living with HIV/AIDS and in order to better understand their needs this study was conducted.

# *Subgroups of MSM in India*

Lower socioeconomic class, poor literacy

- **Kothi**-identified homosexual males  
(Kothi = “*primarily feminine & generally receptive*”)
- Kothis call their masculine partners as ‘**Panthis**’  
(Panthis = “*real men who only penetrate*”).
- **Double-decker** (“who penetrate and receive”)

Middle or upper class, well educated

- **Gay**-identified and **Bisexual** identified MSM

Major subpopulation across any SocioEconomic class is likely to be MSM who don't have any specific homosexual identity


# ***OBJECTIVE***

The objective of this study was to explore the experiences and contexts of HIV risk and preventive behaviors among Kothi-identified MSM living with HIV in Chennai in order to facilitate the design and implementation of culturally relevant secondary HIV prevention interventions.

# ***METHODS***

## Qualitative research study


- In-depth, one- to two-hour interviews were conducted with 10 HIV-positive MSM (include: MSM who were married and MSM who engage in sex work) and three key informants in Chennai, using a semi-structured interview guide.
- Recruitment was conducted through three community agencies that provide services predominantly to *Kothi*-identified MSM in Chennai.
- Participants were recruited using peer-driven, snowball, and purposive sampling.

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- Approved by Ethics Review Committee of University of Toronto and Community Advisory Board, Chennai
  - Informed consent was obtained from all participants before conducting the interviews.
  - Interviews were conducted by trained research staff in private rooms at two community agencies serving MSM.
  - Open-ended questions first elicited experiences with HIV diagnosis and post-test counseling, and then explored sexual behaviors, relationships and experiences in the health care system and in related areas.

# *Data analysis*

- Interview data were explored using **narrative thematic analysis**.
- Initial themes were identified using line-by-line and in vivo coding. Themes were then listed, compared and contrasted by three independent researchers using a method of **constant comparison**, a technique from grounded theory.
- Themes were subdivided or aggregated in an inductive process according to the data that emerged, and were then applied across all interviews.



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- **Peer debriefing** was conducted with community experts to discuss interpretations of the data and to increase trustworthiness of the findings.
  - Additionally, **member checking** was conducted in several ways.


# ***FINDINGS & DISCUSSION***


The following themes emerged from the data:

- 1) motivations for avoidance of unprotected sex;
- 2) general reasons for inconsistent condom use;
- 3) partner-specific reasons for inconsistent condom use;
- 4) successful condom negotiations;
- 5) alcohol use during sex;
- 6) non-disclosure of HIV status;
- 7) inadequate and inappropriate HIV post-test counseling;
- 8) Gaps in safer sex counseling and stigmatization by health care providers; and
- 9) institutional and structural barriers.

# *1. Avoidance of unprotected sex: “I should not give this to others”*

- Some participants reported decreasing their number of sexual partners; others said that they no longer engage in anal sex at all or reduced their engagement in anal sex.
- As a participant said, “I have greatly decreased giving my back...”, meaning a decrease in receptive anal sex.

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- Motivations for avoiding sexual risk behavior were varied and differed by type of partner.
  - Two main motivations for reducing one's sexual risk behaviors after HIV diagnosis were **wanting to protect others and wanting to preserve one's own health.**
  - A participant stated, "I have got this [HIV] disease; I should not give this to others."

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- A sex worker reported not wanting to risk infecting particularly his educated and “well-behaved” clients, since these clients treated the sex workers well and paid the requested money.
  - A married participant explained, “I do not want my [unborn] child to suffer from this” as a motivation for only engaging in protected sex with his wife.

## *2. General reasons for inconsistent condom use*



Included:

- decreased sexual pleasure,
- misconceptions about HIV risk,
- lack of accessibility of condoms,
- loss of sexual performance, and
- perceived seroconcordant HIV status of one's partner.



## *Sexual pleasure*

“How can I always use that rubber? I do want to enjoy...”

Panthi partner as told to Kothi: “my semen should touch your anus; there is pleasure [in that].”



## *Misconceptions about risk*

*“I cannot tolerate the smell that comes out of [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.”*





### *Sexual performance*

“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....”

### *Presumed serostatus of partner*

“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 did not ask me [about HIV status].”

### 3. *Partner-specific reasons for inconsistent condom use*

Difficulties in enacting consistent condom use included:

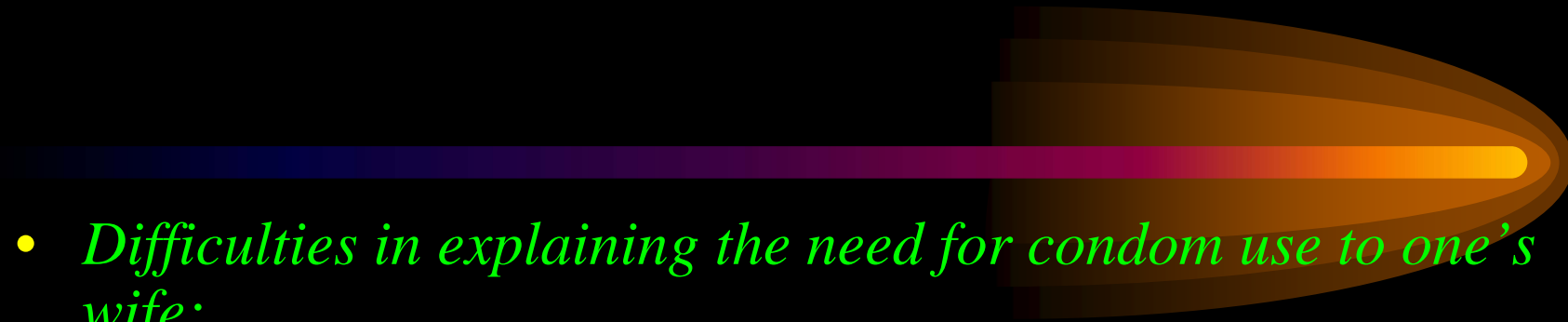
- *Fear of loss of one's Panthi partner;*

“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?”

- *Paying partners: Loss of income and police harassment;*

“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 with out condoms; I am tempted sometimes.”

“How many can I carry around?...if [police] found me with condoms he will book a case...why should I get caught?”

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- *Difficulties in explaining the need for condom use to one's wife;*

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 [*wife becoming pregnant*].

- *Forced sex by police;*

They took us to police station and during night one policeman asked me to come to the *bathroom* [toilet]. He had sex with me in the back. 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 in our hands with *lathi* [police stick].



*Ruffians: violence, theft, and rape*

They [ruffians] have sex with us; we can not talk about condoms with them. They will beat us; they also show us a knife. They have hurt me using [shaving] blades; they also take away our money....

## 4. *Successful condom negotiations*

- As one participant explained, “I will say, ‘now we are hearing about big diseases [i.e., AIDS]. You might have gone to many [sexual partners], I might have gone to many; so why don’t we use condoms?’”
- “They [college students] are smart; you need not tell. They come with condoms; they accept [to use condoms] if we take out condoms...”

## 5. *Alcohol use during sex*

- “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?”

## 6. *Non-disclosure of HIV status*

Reasons given were:

- **Fears of rejection and violence**

“If I tell him he will not come [to have sex] but also beat me up”.

- **Loss of partner**

“That Panthi was ‘*cheese*’ [very attractive] ...I did not want to lose him.”

- **Norms about sexual communication**

“*Panthis* come and just ask me to show my back and insert...no talk about sex...”



- **Loss of clients and income**

“We get Rs. 10 or Rs.20 from some clients. We do not want to lose even that.”

- **Always using condoms**

“I ask my clients to always use condoms. If they do not want to what can I do?”

“My wife never looks down when I have sex with her. So I can use condoms without her knowledge .... every thing happens in the dark....”

- **Avoidance of anal sex**

“I only have oral sex” or “I do not *give my back*” [no anal sex]




## *7. Inadequate and inappropriate HIV post-test counseling: “He did not ask...”*

- Participants reported that counselors were either unwilling or unable to discuss same-sex behavior.
- As a participant explained, he did not discuss same-sex behavior with the post-test counselor because “he did not ask” and “...was afraid to tell,” due to fear of being rejected and judged.
- Another participant discussed telling the counselor about his same-sex behavior, but receiving no response: “It is as though he [counselor] did not hear what I said...may be he wanted to avoid discussing that.”

## 8. *Gaps in safer sex counseling and stigmatization by health care providers*


A participant on how the stigmatization of PLHA and MSM on the part of doctors truncates discussions of safer sex:

“Tell me, when one has become HIV-positive, should they no longer have sexual feelings? We are also human beings. Why this is not discussed by the doctors? They say, ‘*Do not have sex*’. Many do not even talk about it.”



Another participant recounted the stigma and **unprofessional reactions** on the part of his physician to the patient's report that he had engaged in sexual behavior:

“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 [name of a public hospital].”

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

## *9. Institutional & Structural barriers*

A key informant:

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



*A key informant:*


“While NACO talks of ‘MSM’ as a target group and recognizes the need for condom distribution in cruising areas, the outreach workers face problems from policemen if they have condoms with them. Outreach workers are even afraid to carry the educational materials that show pictures of STDs. Some policemen 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].”

# *CONCLUSIONS*

- HIV-positive MSM in Chennai face multiple challenges on individual, interpersonal, community and societal levels.
- Lack of competent and tailored services for HIV-positive MSM, including a dearth of appropriate safer sex information and health care, render secondary HIV prevention a difficult endeavor.
- Vertical programs of secondary HIV prevention for HIV-positive MSM are important but not sufficient. There is a need to create an enabling environment to reach out to all subgroups of MSM.

- Creating an enabling environment includes:
  - 1) decriminalizing consensual same-sex relationships;
  - 2) combating police violence against MSM;
  - 3) Providing education and sensitivity trainings for healthcare providers to enable them to work competently with MSM and PLHA; and
  - 4) promote anti-discriminatory messages in 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 seen as the sole responsibility of HIV-positive MSM, but as a shared responsibility of the general public, at-risk persons, their sexual partners, community based organizations, public health agencies and government in India.