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INDIA 'MSM SITUATION PAPER' SERIES
TECHNICAL BRIEF 2

Women Partners of Men who have Sex with Men in India

SEPTEMBER 2011

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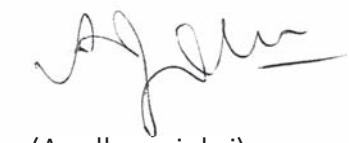
सत्यमेव जयते

PREFACE

India has largely a concentrated epidemic, thus an important focus area of the National AIDS Control Programme is reaching out to high risk groups. In this context, there has been a rapid scale up of targeted interventions in the third phase of the National AIDS Control Programme (NACP-III).

National AIDS Control Organisation (NACO) has recognised that Men who have Sex with Men (MSM) and *Hijras*/Transgenders are an important group. There is considerable evidence related to MSM but there is a need to collect more evidence in regard to Hijras/Transgenders so that their vulnerabilities can be appropriately understood and addressed.

Three key studies have been done by Technical Assistance Support Team (TAST), Futures Group International funded by Ukaid from the Department for International Development (DFID). These studies pertain to hard-to-reach MSM, women partners of MSM and the overall vulnerabilities of MSM to sexual violence. The studies have thrown up certain insights, which I am sure will be extremely useful in reaching out to these communities.



(Aradhana johri)
Additional Secretary, NACO

सत्यमेव जयते

FOREWORD

National AIDS Control Organization (NACO), in collaboration with its civil society partners, has been taking lead in controlling the spread of HIV infections and to provide treatment, care and support for people living with HIV.

NACO has made significant progress in bringing the HIV prevalence among marginalised communities such as sex workers, injecting drug users and migrant workers. However, the outcomes of the HIV interventions among Men who have Sex with Men (MSM) have been mixed in spite of the rapid scale-up of TIs among MSM across the country. In some areas of the country, HIV prevalence among MSM is still not satisfactorily coming down and there has even been an increasing trend (such as in Andhra Pradesh) in the recent years.

While the available data with NACO suggest that most MSM coming to the cruising sites (hot spots) have been covered, there seems to be an elusive group of MSM who are hard-to-reach, and who may not be accessing or using NACO-supported services. Similarly, while significant efforts have been taken to reach to MSM coming to cruising sites, the women partners of MSM, especially HIV-positive MSM, have so far not been given due attention, which means those women partners and their unborn children are at higher risk of HIV. While NACO has introduced crisis intervention systems in the targeted intervention projects to deal with police interference and ruffian harassment, an explicit focus on prevention of sexual violence and providing or linking victims of male-to-male sexual violence to necessary services have been limited – until now. Thus, NACO wanted evidence based recommendations of what needs to be done in these three areas: Hard-to-Reach MSM; Women Partners of MSM; and Sexual Violence against MSM, which lead to the commissioning of the studies on these three topics. The study findings of this 'MSM Situation Paper' series are thus very timely and useful to NACO especially when country-wide consultations have been held to design the fourth phase of the National AIDS Control Programme (NACP-IV).

We hope that we are able to effectively address the unmet needs of MSM communities and thus improve the health status of men who have sex with men.

Mr. Sayan Chatterjee
Secretary & DG, NACO

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The India 'MSM Situation Paper' series includes the following technical briefs:

1. Hard-to-Reach Men who have Sex with Men (MSM) in India: Recommendations for HIV Prevention
2. Women Partners of Men who have Sex with Men (MSM) in India.
3. Sexual Violence against Men who have Sex with Men (MSM) in India: Intersections with HIV

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
FGD	Focus Group Discussion
HIV	Human Immuno Deficiency Virus
ICTC	Integrated Counselling and [HIV] Testing Centre
IEC	Information, Education and Communication
MSM	Men who have Sex with Men
MSMW	Men who have Sex with Men and Women
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NCHI	National Coalition for Health Initiatives
NGO	Non Governmental Organisation
ORW	Outreach Workers
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
SACS	State AIDS Control Society
S-PEP	Sexual Post-Exposure (antiretroviral) Prophylaxis
STI	Sexually Transmitted Infection
TI	Targeted Intervention

Contents

A. INTRODUCTION

'Men who have sex with men' (MSM) refers to any men who have sex with other men, regardless of their sexual orientation or sexual identity. MSM may also have women sexual partners; hence, sometimes the term 'men who have sex with men and women' or MSMW is used. In this report, the term MSM includes those MSM who also have sex with women.

In India, many MSM either are married or expect to marry, and/or do not necessarily acquire a sense of sexuality that is specifically oriented only towards other men. Given this premise, women partners of MSM are especially important but, to date, they are often a neglected, vulnerable population for HIV prevention because the possibilities of HIV infection that they face intersect with both heterosexual and homosexual sexual risks.

The purpose of this report is to review the current evidence regarding HIV risk to women partners of MSM in India and to present data from a qualitative study of the sexual risk and social vulnerabilities of MSM and their female sexual partners in 11 sites in urban and suburban India. Based on this data, this report proposes strategies to reduce HIV risk and to promote early diagnosis and treatment of HIV among women partners, especially wives, of MSM with a particular emphasis on strategies to be proposed and taken forward in the fourth phase of the National AIDS Control Programme (NACP–IV).

The key recommendations in summary are:

1. The development of ***interventions aimed at single MSM*** that specifically integrate sexual health promotion that raises awareness of the risks faced by women partners; and to promote men's self–efficacy in adopting safer sexual practices with both men and women. These interventions include HIV testing and counselling strategies for MSM that more explicitly address the vulnerabilities of their women partners.

2. The implementation of ***interventions that explicitly target married MSM and their wives***, to particularly include counselling and HIV testing approaches that address the complexities of safer sex practices with both male and female sexual partners, especially in the context of marital life. These include a strong and sustained investment in the development of counselling approaches that support men in negotiating the complexities of consistent condom use coupled with the awareness that condom use is often incompatible with expectations and aspirations to conceive children in marriage and where condom use within marriage is seen as a possible indicator of extramarital sex.

3. Investment in the ***creation of an enabling environment that will help to better address the women partners of MSM*** is especially important. Many non-self-identified men who have sex with both women and men do not, and perhaps never will, attend drop-in or other community oriented services aimed at MSM.[i] Given this, messages on HIV risk and protection in the context of unprotected sex with partners of any gender ought to be explicitly integrated into National AIDS Control Organisation's (NACO) mass media campaigns and generic HIV prevention messages and materials.

These summative recommendations are elaborated on in detail in this report's last section.

B. METHODOLOGY

The main focus of this report is to identify strategies to promote the health of women partners of MSM both in terms of preventing HIV transmission and to promote early diagnosis and treatment of HIV.

Qualitative field research

Qualitative field research used a collective case study design to collect field data from 11 sites[1] (based on maximum variation sampling) in seven states among 401 study participants through 57 focus groups (364 participants) and 37 key informant interviews (KIIs).

Purposive sampling was used to recruit participants for focus groups. Recruitment was mainly through non governmental organisations (NGOs)/community based organisations (CBOs) implementing targeted interventions (TIs), some of which are supported by NACO/ State AIDS Control Society (SACS). Focus group participants included 70 full time staff of NGOs/CBOs working with MSM, 75 peer educators, and 105 beneficiaries.

Key informants (KIs) were from different categories: officials of SACS, technical support unit of SACS, and NACO (10); NGO/CBO leaders (12); healthcare providers including doctors (10); and five others (such as police, and positive people network (PPN) leader).

Literature review

For the literature review component, multiple data sources such as peer reviewed academic articles (published in the past 10 years: 2001–2010), and data and reports from the Indian government (NACO) were used. The literature were searched and gathered primarily via electronic sources. Key academic databases searched were Medline and PsycINFO using Ovid interface. General search engines such as Google and Google scholar were also used. For the topic on women partners, key words used included combinations of: HIV, AIDS, STI, HIV prevention, female partners, women partners, spouse, wife/wives, married MSM, married *gay* men, bisexual men, disclosure of sexuality, disclosure of HIV, partner disclosure, partner notification, condom use, couples, program, interventions, Asia, and India.

Data analysis and inferences

Data from the focus groups and interviews were explored using a combination of framework analysis[ii] approach (using *a priori* codes) and grounded theory approach[iii] (inductive codes) to identify categories and derive themes. Potential interventions proposed are based on the inferences drawn by synthesising both the literature review and field research data.

[1] Delhi, Mumbai, Sindhudurg, Lucknow, Bhubaneswar, Ganjam, Kolkata, Jaipalguri, Chennai, Pudukottai, Imphal

Validity

We used peer debriefing and member checking to enhance validity of the findings. Peer debriefing was conducted by discussing interpretations of the data with community experts on MSM. Member checking (respondent validation) was implemented by re engaging select KIs to discuss and clarify their interview data and reflect on emerging findings. Data source triangulation between participants and KI service providers increase the trustworthiness of the findings. The data was also further examined and refined during a data validation consultation meeting with field researchers held in Chennai in January 2011.

Sociodemographic characteristics of focus group participants (n=364)

The age of the participants ranged from 18 to 67 years (mean and median=30 years): <30 years (57%), between 30 and 40 years (27%), and > 40 years (16%). Participants self-reported identities included *kothi* (68%), *double decker/dupli* (17%), bisexual (10%), and *parikh/panthi* (5%). About one third (33%; n=119) have studied between the sixth and tenth grades. A considerable proportion (23%; n=83) reported to have completed at least their graduation degree. Nearly half (46%; n=166) were married. Thirty participants self-reported as being HIV positive.

C. FINDINGS OF LITERATURE REVIEW AND RESEARCH

1 MSM have different types of women partners

Similar to heterosexual men, women partners of MSM can be regular or steady, including wives, casual, paid or paying partners.

Studies have consistently shown that a significant proportion of MSM are married, although the proportion varies across study sites and subgroups of MSM. In the NACO's behavioural surveillance survey (BSS) conducted in 2006 (BSS-2006[iv]), the proportion of MSM who are married ranged from 12.6 percent in Chennai to 69.6 percent in Delhi. The Avahan supported Integrated Behavioural and Biological Assessment (IBBA) study, conducted a few years later, showed that about one fourth of their MSM study participants had ever been married to women (16% to 37%). Furthermore, it reported that 11.2 percent of *kothi* identified MSM, 25 percent of *double decker* (*DD*) identified MSM, 20 percent of *panthi* identified MSM, and 61.2 percent among bisexual identified MSM reported having ever been married (*Ginnela et al.*, 2008). Thus, the proportion of MSM who are married seems to vary according to the subgroup of MSM, based on their sexual identity.

Married MSM may have extramarital women partners as well, including women sex workers. In the IBBA study (*Ginnela et al.,* 2008) conducted among MSM (n=4597) across four high HIV prevalence states, about one third (32.6% – 42.7%) had 'regular female partners' and almost an equal proportion (14% – 35.7%) had ever paid to have sex with a woman. In a study conducted in rural and semi-urban Tamil Nadu, among married MSM (n=247), about one fourth (23%) reported having had non spousal women partners in the past year and one fifth reported having paid money for having sex with women partners (*Solomon et al.,* 2010). In a population based study, about one third (36%) of married MSM (n=72) in rural India reported having casual woman sexual partners.[v] In another study among MSM attending STI clinics, 82.3 percent had ever had sex with a woman partner and 72.7 percent had ever had sex with women sex workers (*Gupta et al.*, 2006). The very high proportion of women partners, including paid women partners, in this study could be because MSM attending STI clinics are more likely to be "non identified MSM" (men from 'general' population or men who are predominantly heterosexually oriented but who engage in same sex/bisexual behaviours). Thus, the difference in the proportion of MSM with women partners especially wives and variation in the type of women partners reported in various studies are more likely to be due to differences in the subgroups of MSM, especially on the sexual orientation and/or sexual identity of MSM.

2 Women partners – especially wives – of MSM are at higher risk of HIV

Women partners of MSM, especially wives, may be at higher risk of HIV due to their male partners' high risk sexual behaviours that include having a large number of male and/or female sexual partners, combined with inconsistent condom use with both male and female partners[2]. Also, HIV high prevalence among MSM as shown in the national HIV sentinel serosurveillance (HSS) (7.3% [vi]), as well as, in several other studies (see below) indicate high HIV risk to both their male and female partners.

High HIV prevalence among married MSM coupled with lack of knowledge about their HIV positive status pose high risk of HIV transmission to their wives

Only a few studies have documented HIV prevalence among married MSM or MSM with bisexual behaviour. A clinic based study among MSM in Mumbai documented that married MSM are more than twice likely to have HIV than unmarried MSM (23.8% vs. 9.1%) (*Kumta et al.*, 2010[vii]). Similarly, another study documented a high HIV prevalence of 13.4 percent among married MSM (*Solomon et al.*, 2010[viii]), which is nearly twice that of the national average HIV prevalence among MSM.[ix] Also, a multi state study (IBBA) reported that HIV prevalence was significantly higher among bisexual identified MSM (15.9%), as compared to MSM who identified as *kothis* (13.5%), *panthis* (7.6%), and *double deckers* (10.5%) (*Ginnela et al.,* 2008).

In one study,[x] only four out of the 33 HIV positive married MSM were aware of their HIV status at the time of the survey; in another study, more than one fifth of married *kothis* did not indicate HIV testing uptake; and *kothis* who are married are at decreased odds of HIV testing uptake compared to unmarried *kothis* (*Woodford et al.,* 2011[xi]). This shows that the lack of HIV status knowledge among MSM especially married MSM poses the risk of HIV transmission to both wives and other women and men partners.

HIV risk of women partners of MSM may vary according to the type of women partner and type of sexual practices

Available data indicates that women partners may face differential risk according to the type of woman partner. Studies have demonstrated that condom use among wives/steady partners is lower than that with paid women partners. For example, unprotected vaginal sex with spouse varied from 72 percent (*Solomon et al.,* 2010) to 98 percent (*Phillips et al.*, 2010[11]). Similarly, in another study (*Ginnela et al.*, 2008), consistent condom use (in general) with regular women partners varied across states, ranging from 1.6 percent in Andhra Pradesh to 41.9 percent in Karnataka. The same study has documented that consistent condom

[2] In the BSS 2001, condom use at last sex with a woman sexual partner was the lowest in Kolkata (23.5%) and the highest in Bangalore (61.9%); in the BSS 2006, it was the lowest in Bangalore (11.1%) and the highest in Delhi (69.7%). Consistent condom use over the past six months (BSS 2001) was the lowest in Kolkata (10.3%) and the highest in Mumbai (25.6%); in the BSS 2006, it was the lowest in Uttar Pradesh (5.3%) and the highest in Delhi (29.8%).

use among MSM with a paid woman partner in the past month ranged from 23.3 recent in Andhra Pradesh to 78.2 percent in Maharashtra.

The proportion of MSM who reported anal sex with women partners varied from 2.2[xii] percent to 11 percent (Verma & Collumbien, 2004). Since the frequency of anal sex with women partners and associated condom use are not known, the relative contribution of unprotected anal sex to HIV risk of women partners is not clear.

Whether HIV risk of women partners of MSM vary according to their relationship type or lack of sexual identity among their husbands?

It is not clear whether the HIV risk of wives of non identified MSM is less when compared to wives of self identified MSM. Also, it is not clear whether and to what extent the HIV risk of non identified MSM could be attributed to same sex risk behaviour and opposite sex risk behaviour, given that some studies among non identified MSM or bisexual identified MSM have indicated a high number of female than male partners.[xiii]

HIV risk between MSM and their women partners may be bidirectional

Because MSM have casual, paying or paid women partners as well, HIV risk can be bi-directional that is, not only there is a risk of HIV transmission from MSM to their women partners but also risk of MSM contracting HIV from their women partners. However, the chances of HIV transmission to MSM from their wives seem less as, available studies indicate that nearly 90 percent of the married women in India are more likely to have contracted HIV from their husbands.[xiv] [xv]

Abbreviations: BW – Bhubaneswar; **CH** – Chennai; **DL** – Delhi; **IM** – Imphal; **JPG** – Jalpaiguri; **KOL** – Kolkata; **LK** – Lucknow; **MU** – Mumbai; **PKT** – Pudukottai; **SD – Sindhudurg; FGD –** Focus Group Discussion

Table 1. Women partners (especially wives) of MSM are at higher risk of HIV

Married self identified MSM have a large number of male partners
"If *kothis* have sex with their wives once in a year, they will be having sex with at least 10 men in a month." **(PKT, FGD5)**
"I would have had sex with hundreds of men so far. But I have had sex only with two women. One of them is my wife." **(Kothi identified MSM, PKT, FGD5)**
Extramarital sexual relations of wife
"Now people have become open minded. When wives [of *gay* identified MSM] get to know about their husband, they are ready to accept and as a couple both agree to have sex outside. Men go to internet chatting to find some male partners. Both [*gay*] husband and wife have sex with those partners." **(MU, FGD5)**
"I know a patchai [means obviously feminine] *kothi*. His family forced him to marry a girl. Once when he had sex with a man, he asked him to bring his wife along. He accepted this and took that guy to his home and let his wife have sex with him. Whose mistake is this? His mistake or her mistake?" **(PKT, FGD5)**
"After knowing about his same sex sexual behaviour, his wife had an affair with a neighbour. The MSM also knows that his wife is having an affair with another person. However, both have a good understanding and are living a normal life. They even have children." **(PKT, KII1)**

Barrier to condom use with wife

Difficult to use condom if wife has undergone tubectomy

"I cannot use a condom with my wife if she has undergone family planning operation (tubectomy). She will ask why condoms need to be used unnecessarily…So if I have sexual encounters with men, then I will be safe by using condoms, so that there is no risk to my wife." **(MU, FGD5)**

"Wives of MSM living with HIV question why they need to use condoms in spite of family planning [operation]. Men find it difficult to convince their wives. In situations like this, the MSM are helpless and sometimes have sex with their wives without condoms." **(CH, KII2, CBO leader)**

Cannot keep condom as it is seen as an indicator of having extramarital sex

"Married MSM cannot use condom with their wives, but they can use them with male partners. But there are many MSM who don't keep condoms based on the fear that if condoms are found by their wives while they are checking their pant pockets, then they will suspect them of having extra marital sex with women and they will face problems. " **(MU, FGD3)**

Need to answer for using condoms all of a sudden

"If a married MSM living with HIV uses a condom after he gets infected with HIV, she will question 'All these days you have not used one. What made you use one suddenly?'." **(CH, FGD6)**

Lack of simultaneous STI treatment for wives

"An MSM sought STI treatment but he did not reveal his marital status to his doctor. Even after completing the full course of treatment, he got the symptoms again because his wife had also got infected but she had not been treated. So it is a major area that needs to be addressed." **(BW, KII1)**

3 MSM enter into heterosexual marriage with willingness, under compulsion or with indifference

Some proportion of men engage in same sex (and bisexual) behaviour before marriage and may not have any specific sexual identity in relation to their same sex or both sex sexual behaviours. Eventually, most of these men get married and some unknown proportion is likely to have extramarital sex some with women and some with both women and men. Thus, for these MSM, marriage is seen as a social norm, as well as, being desirable and there seems to be no conflict with their past or current sexual behaviours and getting married to a woman.

Some self identified MSM such as *kothis*, who are considered to be primarily same sex attracted or both sex attracted (Chakrapani & Ramakrishnan, 2005[xvi]), may take a conscious decision to get married because of a variety of reasons (as that for heterosexual males), such as, seeing marriage as a societal norm and an obligation to be fulfilled to one's family and wanting to have children to sustain the lineage (*Chakrapani et al.*, 2008). However, some *kothis* report being compelled or pressurised to get married by their family members (*Chakrapani et al.*, 2008; and fieldwork data).

[A significant proportion of the information in this report focuses on married self identified MSM especially kothis, because there is limited qualitative information about other subgroups of married MSM in literature and even the field data for this study is primarily with kothi identified MSM with women partners.]

Table 2. MSM enter into heterosexual marriage with willingness, under compulsion or with indifference

Marriage with willingness ***Out of love and attraction towards women*** "When I was young I looked better. We fell in love with each other and finally got married. I met her only two months before the day we eloped to get married." **(IM, FGD2)** "Some MSM – some *kothis* too – like to get married to women as they are attracted to women. Some of them have had sex with women before marriage." **(CH, KII1)** ***Companionship and security*** "Some [MSM] get married because they believe that otherwise no one will be there to take care of them in their old age." **(MU, FGD5)**
Marriage under compulsion ***Societal expectations*** "..If I am born as a male in this society, then I have to get married., Most [MSM] get married because of pressure of this kind." **(MU, FGD3)** "In this society, if a young person does not get married, then people look at him differently." **(MU, FGD5)**
Family expectations "There is a self identified MSM near my home who does not want to get married because he likes men. He did not want to spoil the life of a girl. But his family members forced him to get married." **(BW, FGD2)** "There was another person who was forced into a marriage. It, however, did not work out and ended in a divorce. Soon he was detected with HIV but his family does not know his HIV positive status. Now there is pressure mounting on him to get married once again." **(JLPG, KII2)** "My mother emotionally blackmailed me. She insisted that if I don't get married she will commit suicide. I had no say in my marriage. She selected a girl for me. I was just made to marry her." **(LK, FGD5)**
Marriage with indifference "Some *kothis* just get married without thinking too much about it. For some, it is just part of life." **(CH, KII2)** "Marriage is a good thing and MSM should get married. We have come into this world and we should do something ... Sometimes people [MSM] think that they cannot have sex with women. But it is not like that. Any man can have sex with a woman." **(A *kothi* identified married MSM, PKT, FGD5)** "I know an MSM who got married after knowing his HIV positive status for the sake of getting part of his family property. Now the wife and his children are left alone after his death due to AIDS." **(CH, KII1)**

4 Sexual life of married self identified MSM – with wife and male partners

After getting married, some *kothis* see, having sex with their wives as a 'duty' and may be mainly concerned about their ability to sexually 'satisfy' their wives, as they do not want the wife to suspect that they are 'not men'. However, some do not have adequate sexual encounters with their wives because they are not sexually and/or emotionally interested or because they want to distance themselves from their wives to avoid passing on infections to them. Getting married and having sex with their wives was also seen by some *kothis* as moving towards the goal of having a child to avoid being labelled as impotent by others. A study noted that *kothis* expressed the thought that having children proves to others that they are not 'lesser than a man' (*Chakrapani et al.,* 2008[xvii]). In such contexts, extramarital sex with men partners continues after marriage.

Field data and other qualitative studies (*Chakrapani et al.*, 2008) indicate that married *kothi* identified MSM report no change in their sexual desire towards men even after they get married to women. However, in an effort to decrease the chances of contracting sexually transmitted infection (STI)/HIV and passing it on to their wife and children who are yet to be born, married *kothis* reported that they 'always' use condoms during anal sex; otherwise, they either avoid anal sex or continue to have oral sex with men, in addition to decreasing the number of male partners. Some *kothis* have reported that having to raise money to take care of their family and day to day family related work prevents them from actively seeking male sexual partners.

Table 3. Sex with male partners after heterosexual marriage of self identified MSM

Extramarital sex with male partners continue after marriage "I cannot agree that desire for sex with men reduce after marrying a woman. Married self identified MSM might control having sex with men for a month or two. But this cannot be controlled permanently. So far, I have not seen even a single man who left this field [same sex sexual behaviour] after marriage." **(MU, FGD5)**
Frequency of sex with men after marriage "Seventy percent of married MSM try to control their [same sex sexual] behaviour after seeing their wives and grown-up children." **(MU, FGD5)** "Even after marriage I have sex [with men].... Before marriage I had sex with guys more frequently but now the frequency has come down." **(LK, FGD6)**
Less time to find men partners due to family commitments "Going out everyday is not possible because now I have responsibilities. I have to teach my kids; my parents didn't do this [teaching kids] but now I have to do it for my kids. I have little time to go out to meet potential male partners." **(CH, FGD6)**

5 Disclosure of sexuality or same sex sexual behaviour to wife

Only a negligible proportion of married MSM tell their wives that they have sex with men also. For example, a recent study documented that only two percent of the married MSM study sample (n=247) had disclosed their sexuality to their spouses (*Solomon et al.*, 2010). In a cultural environment of secrecy surrounding sexual matters including heterosexual extramarital sex, self identified MSM may not feel the need to disclose their sexuality to their wives or other family members. Thus, extramarital sex whether with women or men is not discussed with the wife. Nevertheless, sometimes the wife becomes aware of the sexuality of her husband either by witnessing her husband's behaviour or by being told by others (*kothi* friends of husbands or those who blackmail *kothis*).

After finding out their husband's same sex/bisexual behaviour, some women continue to remain with their husbands due to several reasons (such as economic dependency and 'for the sake of children'), though some may leave. The fear of marital discord and the wife leaving the family and subsequent disgrace to oneself and one's family are some of the reasons mentioned by *kothis* why they do not want to reveal their sexuality (or HIV status) to their wives.

From the available data it is not clear whether disclosure of sexuality per se leads to any decrease in HIV risk to self or spouses of MSM, and whether the disclosure of sexuality is necessary for prevention of HIV transmission to the wife.

Table 4. Disclosure of sexuality or same sex sexual behaviour to wife

Involuntary disclosure of sexuality to wife

By witnessing husband's behaviour

"Sometimes [married] *kothis* bring their *panthis* home when their wives leave town. if the wife comes back unexpectedly, then she might come to know about her husband." **(CH, FGD5)**

"A married MSM has two children. When his wife returned back home from her home town, she saw her husband having sex with a man. She decided to break-up the relationship and it was done in front of the local area leader. Finally, she got an equal portion of the property. Now the guy is in the city." **(PKT, FGD5)**

"An MSM started having sex with guys frequently at his home itself. His wife would be in one room while he would have sex with guys in the other room. She insulted him badly and left him." **(SD, IDI3)**

"One such incident happened to me. I was with my [male] partner who is much younger than me. We were drunk and we were sexually close. My wife saw that. I feel my wife became suspicious of me from that day." **(BW, FGD2)**

By being told by others

"Our neighbours may have known about our same sex sexual behaviour before our marriage. So they would inform our wives." **(CH, FGD5)**

Consequences of disclosure of sexuality to wife

Not wanting to live together

"The wife of an MSM somehow came to know about her husband and decided not to live with him. Even the in-laws of that guy said that they would not let their daughter live with him. They took their daughter and child back to their home." **(DL, FGD6)**

"Most [MSM] do not tell their wives [about their sexuality]. If at all the wife starts suspecting or finds out, the matter usually leads to separation or divorce." **(KOL, FGD2)**

"One girl left her husband on the very next day of her marriage after getting to know about his same sex sexuality." **(SD, IDI3)**

Continue to live together due to economic dependency and other reasons

"Some wives [of MSM] do not want to leave the relationship even after knowing about their husbands' behaviour. They think, 'Where will I go? How can my poor father afford to arrange for my remarriage? Will I get a bad name in society?'" **(DL, FGD6)**

"In my case, I think she accepted me just for the sake of social security and family respect. Also, it is almost four years after marriage and we have two children. So now it may not be possible to break the relationship." **(LK, FGD5, A participant who had disclosed his sexuality to wife)**

Acceptance but with conditions

"Once she enquired about my feminine mannerisms. So I thought of disclosing my sexuality to prevent any problem in our relationship. Fortunately, she accepted and did not find any fault in my life style. She told me, 'You are giving me sexual satisfaction so I have no problem'. She added, 'My pregnancy is proof enough that you are a man'." **(BW, FGD2)**

Reasons for non-disclosure of sexuality

Fear of disgracing family

"If we tell our wives that we are MSM, then our whole family will be affected. All our relatives will hate us. Even our children will avoid us. These days even a child studying in the sixth or seventh grade knows about same sex sexual behaviour." **(CH, FGD5)**

Fear of separation

"Married MSM are afraid that if they reveal their sexuality, their wives will hate them, and then how would they deal with their wives and run the family. They are also afraid that their wives might just leave them." **(SD, IDI3)**

6 Disclosure of HIV status to wife

HIV positive status disclosure behaviour of *kothi* identified MSM seems to be similar to that of HIV positive heterosexual married men (*Chakrapani et al.,* 2010[xviii]; *Sri Krishnan et al.*, 2007[xix]). Like heterosexuals, HIV positive *kothis* too, may or may not disclose their HIV status immediately after they come to know their HIV positive status. For example, in a qualitative study among 60 HIV positive MSM, of the 14 MSM who have had sex with regular women partners in the past 3 months, nine did not disclose their HIV status (*Chakrapani et al.*, 2007[xx]). Eventually, some, if not all, HIV positive MSM, tell their HIV serostatus to their wives.

Sometimes, certain circumstances lead to the disclosure of HIV status or getting the wife tested for HIV. Social risk of disclosure (losing wife, loss of one's own reputation and that of the family, fear of shame and discrimination) seems to take precedence over the risk of transmission of HIV to their wives. However,

non disclosure of HIV status does not necessarily result in unprotected sex, as some *kothis* may use certain risk reduction strategies that prevent or decrease transmission of HIV to wife. These strategies include avoiding sex or using condoms by citing various reasons and decreasing the frequency of sexual acts (*Chakrapani et al.*, 2008).

Table 5. Disclosure of HIV status to wife

Voluntary disclosure of HIV status (without revealing sexuality)

"A married MSM living with HIV did not disclose to his wife that he had got infected by having sex with men. He made up some other reason. Now there is no problem as his wife supports him." **(MU, FGD5)**

Disclosure at the time of pregnancy

"There are three such cases. During the time of the delivery, doctors identified HIV positive status of wives of MSM and disclosed the status to both of them in couple counselling. In these three deliveries that took place, two children were negative and one was positive." **(CH, KII2)**

"Since HIV testing is done for all pregnant mothers from the third month onwards, the wife of an MSM was told about her HIV positive status by the counsellor, although she did not hear it from her husband [who is an MSM living with HIV]." **(PKT, KII1)**

Consequences of disclosure

Separation

"Since HIV testing is done for all pregnant mothers from the third month onwards, the wife of an MSM was told about her HIV positive status by the counsellor, although she did not hear it from her husband [who is an MSM living with HIV]." **(DL, FGD3)**

"A wife] came to know about the positive [HIV] status of her husband. She was found to be HIV negative. She left her husband saying, 'You are going to many places for sex. I don't want to live with you'." **(SD, IDI5)**

Acceptance [with lack of knowledge about possible modes of HIV transmission]

"I remember a case where the wife accepted her HIV positive husband. She thought that her husband had got infected by HIV unknowingly. She lacked knowledge about HIV transmission, so she extended her support." **(BW, KII1)**

"The CD4 level of an HIV positive married MSM was too low and he had to be started on antiretroviral therapy (ART) immediately. Only at that stage he told his wife about his HIV positive status. She asked him how he had got infected. He told her the truth that he had got infected by having sex with men. By this time his wife was already HIV positive. They still live together with a better understanding." **(IM, FGD2)**

Reasons for non-disclosure

Not wanting one's sexuality to be known to one's wife

"If I tell her that I have [HIV] infection but do not know how I got it, then she will question, 'How is it possible to get infection without your knowledge? Have you gone to someone else?' We can live with the label of a womaniser, but it is not easy to live with the label of a man who is after other men." **(PKT, FGD5)**

"Even if I was in a position to disclose my HIV positive status, I would say that I had [unsafe] sex with a girl before marriage and not after marriage. And, I will never say that I had sex with men. I will always say that I had sex with women." **(MU, FGD5)**

Wife's weakness as an excuse

"I am HIV positive but I cannot tell my wife because I live with my wife and son. And she takes even a minor thing very seriously. As it is she is very weak and the doctor has recommended that I should not give her any such news, otherwise something might happen to her. That is why I haven't disclosed yet." **(DL, FGD3)**

7 Perspectives and experiences of self identified MSM and MSM community leaders in relation to protecting the health of women partners of MSM

Fieldwork data has captured the range of opinions among MSM community participants and KIs on what can be done. Participants differed in their opinions on the attitude of self identified MSM towards their wives. While some thought that *kothis* are more likely to take good care of their wives and take steps to ensure that their wives have sexually and emotionally satisfying marital lives, some thought that *kothis* cannot cope with dealing with women in whom they are not sexually interested. Both apparently contradictory narratives are likely to be correct given that the differences can be explained in terms of the sexual orientation of *kothis* (whether they are same sex or both sex oriented) and other related factors. Concerns of MSM about infecting their wives and the risk reduction strategies used by them have been discussed previously and they show that at least some proportion of MSM do take active steps on their own, though a significant proportion of MSM do seem to require support to adopt safer sex behaviours with their men and women partners.

When a self identified MSM such as a *kothi* is diagnosed with STI or HIV, screening and treatment of their wives or steady women partners become a challenge. As many *kothis* do not even want their married status to be known to the outreach workers (ORWs) of CBOs/NGOs, they (*kothis*) bring their wives/women partners to the government or private hospitals for HIV and STI screening and treatment. In one site, the MSM CBO has established collaborations with a mainstream sexual health clinic (Mumbai branch of Family Planning Association of India) and MSM and their wives visit that clinic. Here, these women are not told about the sexuality or sexual behaviour of their husbands even though disclosure of STI status may take place with prior consent of the husband.

Even in the government HIV testing centres, once the husband is diagnosed HIV positive, the counsellor asks all married men (including those MSM who may or may not have revealed their sexuality) to bring their wives for HIV testing; usually the sexuality or sexual behaviours of the husband is not revealed. MSM participants and KIs were against the idea of directly approaching the women partners of *kothis* or other self identified MSM because it would not be acceptable to the MSM and instead would damage the long term rapport that had been built by the agencies with those MSM. Instead, they emphasised that the MSM should be counselled and provided support to bring their women partners for HIV or STI screening and treatment, and to practice safer sex with their extramarital partners and wives.

Table 6. Perspectives and experiences of MSM and MSM community leaders about protecting the health of women partners of MSM

Taking care of wife

Equal importance to wife and steady male partners

"Some [married MSM] will take care of their wives in a manner which is similar to the care they give their male lovers." **(MU, FGD3)**

"She is my wife, so I will have to take care of her. I need to take her to the doctor and do all the things which she requires me to do. I need to be helpful towards her." **(A participant articulating the responsibilities of married MSM, PKT, FGD2)**

"Some are very particular about their wives. They do not consume alcohol or stay out of home at weekends in addition to returning to their rooms strictly by 9:30 at night. They do all this to keep their wives happy." **(KOL, FGD2)**

Suggestions of participants to prevent HIV transmission to wife

HIV testing for MSM before marriage

"I suggest HIV testing should be done [for MSM] before marriage to prevent transmission." **(MU, FGD3)**

"At the time of marriage, instead of matching horoscopes or going to the priest, it is more important to get the man and woman tested for HIV." **(MU, FGD5)**

Repeated HIV testing and condom use with men partners

"Whenever MSM engage in sex with male partners, they should use condoms. If they think that they have had unsafe sex then it is better for them to take an HIV test. If the HIV test result is negative, then they should continue to have safe sex in the future." **(DL, FGD3)**

Reducing frequency of extra-marital sex with men

"If we don't want to infect our wives, then we should use condoms and have less frequency of sex with men." **(DL, FGD6)**

Disclosing HIV positive status

"MSM should disclose their behaviour to their wives. He should at least inform her that he is HIV positive and can give the excuse of either used needles or blood as being the way by which he got this virus, so that he can keep his wife safe." **(MU, FGD5)**

"I feel that it is noble to disclose one's HIV positive status, even if one cannot spend one's life together. The first thing is that the wife should not get [HIV] infection." **(LK, FGD6)**

Need to ensure women's health is addressed in HIV interventions among MSM

"We must emphasise that partner screening is of utmost importance for keeping both of them safe. We must make it a point to convey this whenever we meet a married MSM in the TI." **(JPG, FGD)**

"We might think about bringing wives of married MSM into the clinical services as well. We should also create awareness among these women about the issues of MSM and their associated health risks. Of course there will be inevitable problems in doing that as they will never be able to accept their husbands after that. However, this will greatly help in HIV prevention." **(JLPG, KII1)**

Concerns about directly reaching out to wives of MSM

"Reaching-out directly to wives is not possible. The wife will question the NGO staff where they have come from and whether her husband is an MSM or HIV positive." (**CH, FGD6)**

"It is possible to reach-out to the female partners only through the MSM. If we go directly, then it can be a problem both for the MSM and their female partners." **(DL, FGD3)**

D. RECOMMENDATIONS

(Note: The following recommendations need to be read keeping in mind that MSM is a label that denotes any man who has sex with other men and is not restricted to self identified same sex or both sex attracted men. Diversity among MSM means some of the following recommendations need to be tailored according to the characteristics of the diverse subgroups of MSM.)

Guiding principles

The following recommendations are evidence based (based on available literature and field data); they are based on public health approaches that balance the rights of individuals and society at large while at the same time, they balance the right to confidentiality of individuals with the right to the health/life of their partners.

The HIV risk to women partners/wives of MSM cannot be attributed solely to the individual risk behaviours of MSM as those behaviours are, in turn, influenced by societal norms (on sexuality in general and the stigma associated with HIV, same sex behaviours, extramarital sex, and condom use in marital relationships); social risks (damage to reputation and bringing disgrace to the family); legal issues (criminalisation of transmission of HIV and lack of protective laws for people living with HIV); and gender inequalities especially, the economic dependency of women on their husbands and the stigma attached to being a divorcee that may prevent women from questioning the fidelity of their husbands or to ask their husbands to use condoms. Thus, both short term and long term interventions are needed to prevent HIV transmission to women partners/wives of MSM and to facilitate early HIV diagnosis and treatment.

I. Individual or couple level Interventions

The following recommendations are grouped into those interventions that can be introduced among single MSM and married MSM.

1. Potential interventions among single MSM *(to prevent HIV transmission to their current and future women partners) that can be incorporated into the existing TIs and Integrated Counselling and Testing Centres (ICTCs).*

1.1 Providing information/counselling to MSM about HIV risk, to and from, both male and female partners and promoting condom use with partners of any gender
Based on the logic of preventing HIV among MSM which, in turn, will prevent HIV transmission to their male and women partners (including their wives), there is a need to discuss about HIV risk to both women and men partners if condoms are not used consistently in the existing interventions among MSM (which are primarily focused on self identified MSM such as *kothis* and *DDs* from lower socioeconomic status).

Also, there is a need to initiate prevention interventions among other MSM who are not currently outreached (including *gay*/bisexual identified MSM) and to promote condom use with both men and women partners.

1.2 Promoting (regular) HIV testing among self identified MSM (irrespective of marital status)

Another possible strategy is to promote voluntary HIV testing among men including self identified MSM (or any men) if they have had engaged in unprotected vaginal and/or anal sex in the recent past, especially for those who are planning to get married in the near future. The assumption is that if they are HIV positive, then they may reconsider or avoid getting married to a woman, and if they are HIV negative, they will be motivated and supported to stay negative[3] by adapting and sustaining safer sex practices.

1.3 Adding pre-marital counselling for self identified MSM (in NGOs/CBOs working with MSM)

For those self identified MSM (such as *kothis*, *DDs* and *gay* men), who are in a dilemma of whether or not to get married, non-directive and non judgemental counselling can be provided through NGOs/CBOs to support them in making informed decisions about getting married. Counselling is also needed for those MSM who do not wish to get married to a woman but who require support and guidance on how to deal with their families and society which expects him to get married.

Note: Training

Sub modules that address the above issues need to be developed and incorporated into the existing training modules/programmes of NACO in order to train counsellors and peers in TIs, counsellors in ICTCs and ART centres and other health care providers. In addition, other submodules on violence, hard-to-reach MSM, and well being and mental health of MSM need to be developed and incorporated into NACP-IV programme for MSM.

2. Potential interventions for married MSM and their wives

2. 1 Re-testing as a safer sex strategy

After marriage, self identified MSM or non identified MSM may continue having sex with men and women other than their wives. Hence, during counselling (post test and follow up counselling sessions) of married men or married self identified MSM, a variant of 'negotiated safety[4]' arrangement (described below) is suggested as a harm reduction strategy.

[3] Anecdotal reports of HIV positive men getting married to women without disclosing their HIV positive status have been reported elsewhere in the literature and in the study fieldwork data.

[4] 'Negotiated safety' refers to the strategy of not using condoms within HIV-seronegative concordant regular sexual relationships under certain conditions.

If married MSM (self identified or online identified MSM) have not already tested themselves for HIV and STIs, they should be supported in doing so[5]. After testing HIV negative, ideally the MSM should negotiate condom use with all extramarital[6] partners (men, women or transgender partners), and/or condom use with their wives. However, if condom use with their wives is not feasible, consistent condom use with all extramarital partners is needed to protect them from getting HIV (and thus to protect their partners from getting HIV). If the MSM failed to consistently use condoms during sexual encounters with extramarital partners, then they would be asked to wait until the 'window period' of three to six months gets over and retest themselves. Until the test result comes, they will be counselled about the importance of having protected sex with their wives (and others). Thus, counselling should focus on imparting sexual communication and negotiation skills to MSM. Also, counselling should support MSM in understanding the reasons behind inconsistent condom use with extramarital partners and what could possibly be done to promote consistent condom use. For those MSM who consistently use condoms, supportive counselling to maintain safer sex practices is necessary. Relevant submodules that cover these issues need to be added in the existing training modules for counsellors, doctors, ORWs and peer educators.

2.2 Counselling and educational interventions for those who are found to be HIV positive after marriage (positive prevention) Ethical partner counselling If an HIV positive man wants some time to disclose his HIV positive status to his wife, then he would be strongly encouraged to use condoms (or avoid having sex) with his wife until disclosure. Once he discloses his HIV status[7], the wife is also encouraged to undergo HIV testing; if she is found to be HIV negative, then safer sex counselling and sexual communication skills education are provided to the couple. If the wife is found to be HIV positive, then she will be linked to appropriate HIV treatment related services and positive people networks. Safer sex counselling and sexual communication skills education are needed for even HIV positive seroconcordant couples.

If requested by HIV positive MSM, service providers can provide couple counselling in which the HIV status of the men is disclosed to their wives ('mediated disclosure'). There is a need to have a clear national policy on partner notification strategies[8] for people who are HIV positive or who have STIs. Given the increasing evidence for 'ART as prevention'[xxi xxii], linking HIV positive MSM with ART centres and ensuring ART adherence will also help in decreasing HIV transmission to their partners both men and women.

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[5] Ideally wife should also be tested for HIV at this stage and men can be asked to bring their wives for HIV testing

[6] For the sake of simplicity, the term 'extramarital' here denotes all sexual relationships with persons other than the wife – although some may view this term to have a negative connotation.

[7] MSM may also need to be informed about where they can refer their wives for STI/HIV screening and treatment.

[8] WHO recommends three ways of disclosure of HIV status to the (regular) partners of HIV positive people: 1) 'patient referral'; 2) 'provider referral' (on behalf of the patient); 3) 'conditional referral'– providers wait for an agreed upon time period and if the patient does not disclose the information, then the provider directly contacts the partner. (UNAIDS and WHO – Opening up the HIV/AIDS epidemic. Guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting Geneva: UNAIDS; 2000).

Appropriate counselling also needs to be provided if the HIV serodiscordant or seroconcordant couples want to have their own children: for the former, the options can be sperm washing and artificial insemination; and for the latter, interventions that prevent mother to child transmission of HIV. In the case of condom breakage, HIV serodiscordant couples (e.g., husband HIV positive, wife HIV negative) should have access to sexual post exposure antiretroviral prophylaxis (sPEP) for free. The mechanisms used to provide occupational post exposure antiretroviral prophylaxis (PEP) for healthcare providers in the public hospitals can be used to provide sPEP.

(Note: Sometimes, wives will be first diagnosed with HIV through the prevention of parent to child transmission (PPTCT) programme, after which the men will be tested. These days, couple counselling and simultaneous HIV testing are offered in PPTCT).

2.3. Counselling and educational interventions for those who want to disclose their sexuality to wives/family members [in the existing TIs for MSM, ICTCs and ART centres]

Counselling needs to be provided for self identified MSM who want to disclose their sexuality (and HIV positive status) to their wives or family members. Couple counselling and psychosocial support services for the wives and other family members are needed as well.

2.4. Counselling and educational interventions for those who have 'completed' their family (example, those who have two children) [in the existing TIs for MSM, ART centres, and Family Planning clinics]

Based on the harm reduction principle, for MSM (irrespective of their sexual identity) who may continue to have extramarital partners even after completing their families, an option that can be provided is the usage of dual methods i.e., condoms along with another contraceptive method. Thus, even if the wife has undergone tubectomy, condom use can help in preventing HIV/STI transmission within the marital relationship. Otherwise, condom use alone can be promoted as a 'dual protection' method. In case condom use with the wife is problematic or not acceptable to the MSM or his wife, then the 'retesting' strategy mentioned above can be adapted.

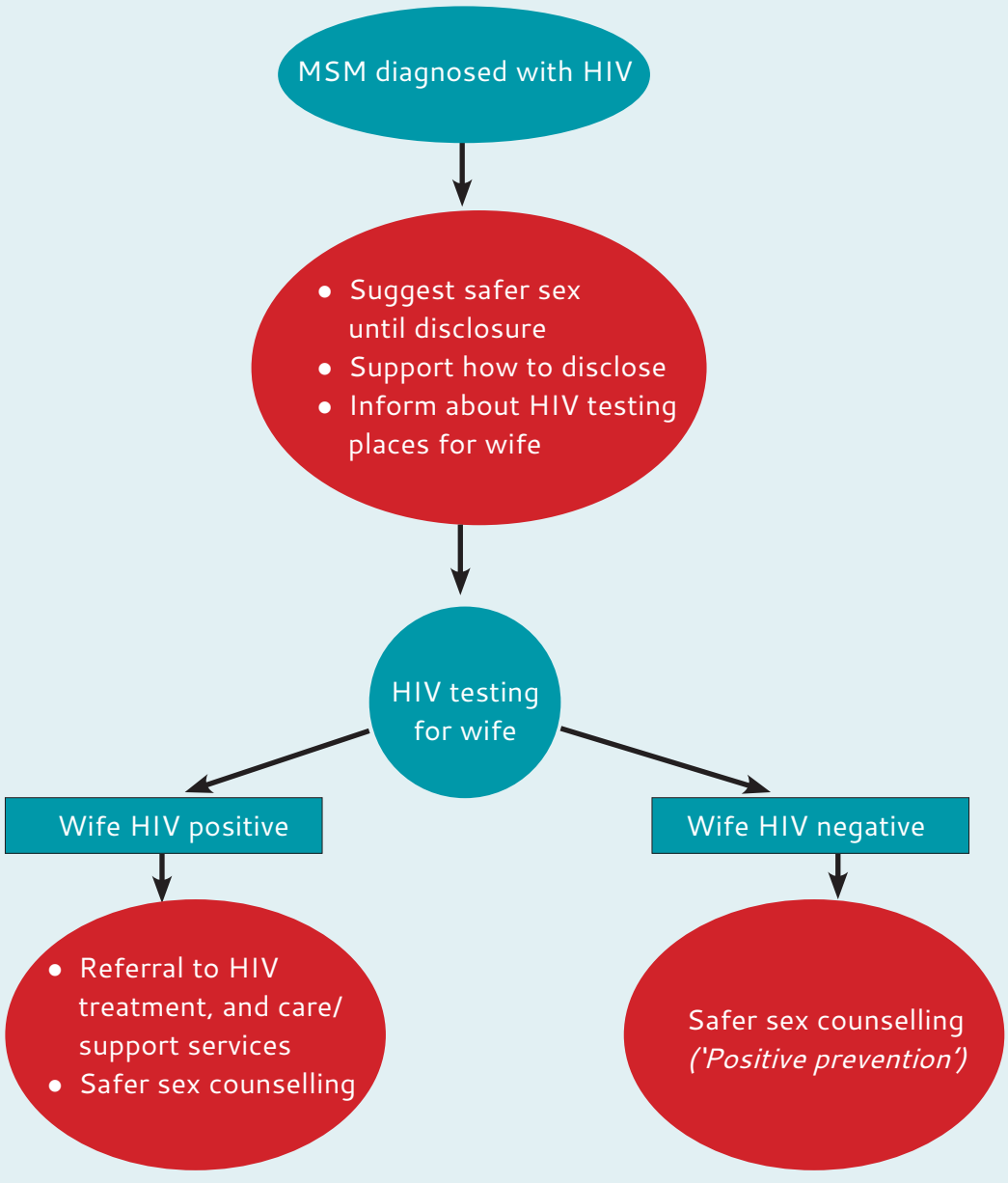
> *[Note: Even though the unofficial policy of the Indian government is a non-hierarchical and non judgemental way of offering the three options of 'ABC' [Abstinence, Be faithful and Condoms] and it strongly recommends married men/MSM to avoid extramarital sex or have sex with men, it would be an insufficient strategy perhaps even counter productive, given the complex reasons for extramarital sex even though for some married men it may be possible to decrease the number or frequency of sex partnerships with other men or women.*

Note: Training
Sub modules that address the above issues need to be developed and incorporated into the existing training modules/programmes of NACO and National Rural Health Mission (NRHM) to train counsellors and peers in TIs, and counsellors in ICTCs and ART centres and other healthcare providers.

II Community level interventions

Creating a conducive environment (in NGOs/CBOs and in the MSM communities) for married MSM or bisexually oriented MSM to discuss openly about their relationships with women

Figure 1. Potential intervention strategies among HIV positive MSM to prevent HIV transmission or to enable early diagnosis of HIV among wives



Since in certain urban or rural settings, married MSM or bisexually oriented MSM are stigmatised by other self identified MSM, NGOs and CBOs working with MSM need to discuss about the sexual diversity among MSM and create an organisational climate for MSM to openly talk about women partners as well as marriage. CBOs and NGOs working with MSM also need to ensure that they do not have any explicit or implicit policies that may hinder MSM with women partners or married MSM to be open about their relationships with women and which may be a barrier for some to access services. Agencies may also facilitate support groups for married MSM and to sensitise other MSM about the issues faced by married MSM from both MSM communities and the general public. Guidelines on this issue need to be developed by NACO in consultation with the NGOs and CBOs working with MSM, when the strategic plan for NACP-IV is prepared.

III Interventions through mass media campaigns of NACO

Mass media messages addressed to men need to focus on the HIV risk in unprotected sex with partners of any gender

Because MSM are not a discrete and separate social group, there can be HIV prevention messages in the mass media or other channels of communication that talk about HIV risk due to unprotected sex with anyone (men, women or transgender people). Irrespective of the sexual identity of MSM, HIV prevention messages (both targeted and public messages) can be framed around the responsibility to one's sexual partners (male or female); however, there could be a possible backlash of men being seen as the vectors of HIV transmission to women. One way to avoid that backlash is to show the connection between individual rights and responsibilities, and portraying caring for partners as being part of masculinity. NACO needs to develop a plan to incorporate these messages as part of its awareness campaigns in the mass media.

IV Policy-level interventions

Need for a national policy (of NACO) on ethical partner counselling (partner notification) if a person has HIV or STI

1. Currently, there is no specific policy that looks into the issues surrounding partner counselling and screening/treatment if a person has an STI or HIV. NACO, in collaboration with NRHM, needs to develop specific operational guidelines on the same to ensure ethical partner counselling of persons who have STIs and/or HIV.

Ensure bisexual behaviour is addressed in HIV interventions for men in programmes of NACO and other partners

2. Analyse the behaviour change communication (BCC) materials and modules available for counselling specific men populations (migrants, truck drivers, injecting drug users, clients of women sex workers, college youth) targeted

through NACO's programmes and ensure that those materials and counselling address MSM (including MSMW). Counsellors in these interventions for various male populations need to be trained on sexuality issues, particularly in relation to bisexuality and bisexual behaviour among men, as a means of enhancing and developing a broad range of interventions that address the sexual risks that male to male sexual practices may present for women partners of MSM. NACO needs to incorporate messages addressing bisexual behaviour in a sensitive manner in the operational guidelines and counselling guidelines for various male populations.

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