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Socio-cultural Context and Sexual Health Risks of Men who have Sex with Men (MSM) and their Female Partners in Gujarat, India

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Abstract- After more than two decades of programming and activism aimed at prevention and control of the sexual transmission of HIV, the HIV pandemic continues to grow worldwide. Despite giving sexuality a prominent position in responses to the epidemic, there exist limited context specific understandings of sex health risks of Men who have Sex with Men (MSM) and their female partners of socio-cultural context. This paper discuses socio-cultural determinant of risk behaviors of MSM and their female partners of Targeted Intervention in Vadodara city, India. Such an improved understanding of the sexuality and sexual health risks of MSM is crucial for creating a scientific reference base for designing effective behavior change strategies in targeted interventions (TI).

Index Terms- Sexuality and sexual health risks of men who have sex with men, female partners of MSM, targeted interventions (TI)

I. Introduction

In Indian society, having sexual relationships with people of the same-sex is considered abnormal. Homosexual behaviors are seen in society as immoral, dirty, and unnatural. As a result, these behaviors are secretly practiced without adequate knowledge about safe sexual practices; hence, Men who have sex with men (MSM) tend to be more vulnerable to sexually transmitted infections (STIs) and host of psychiatric morbidities. MSM population constitute as one of the core groups (such as injecting drug users-IDUs and female sex workers-FSWs) for HIV prevention targeted interventions in India. According to 2009-2010 Annual Report of National AIDS Control Organization[€], HIV prevalence among MSM population is 7.3 percent, which is second highest HIV prevalence among core groups as HIV prevalence among IDUs is 9.1 9 percent while FSWs is 4.94 percent [1]. Various researches on risk behaviors of MSM population have enhanced HIV prevention interventions across the country. However, there is scarcity of adequate scientific and programmatic researches on socio-cultural determinants of risk behaviors of MSM population as well as their female partners in targeted interventions (TIs).

Lack of refined understanding on invisible socio-cultural determinants that put MSM population as well as their female partners at higher risk of HIV transmission essentially precludes health professionals from receiving adequate and scientific understanding on the topic. Familiarity of invisible socio-cultural determinants may provide reference to health professionals' to design appropriate strategies and to strengthen effective implementation of TIs in the country. The objective of the present study was to understand socio-cultural determinants of risk behaviors of MSM and their female partners.

II. Methods

This study was conducted using qualitative research method in the Vadodara city, which is also known as Baroda in the Gujarat State, India. Qualitative research methodology was applied for the study. Total 38 self-identified homosexual and bisexual men were interviewed using semi-structured interviews [2]. Twenty respondents, who were open about their sexuality and availed health services of Lakshya Trust, were purposively selected for the study while eighteen respondents who were closeted and not open to others yet accept their sexuality were recruited using snowball techniques. Since there exist no institutional review board (IRB) in India for self-financed social science researches, approval for the study was taken from the community members of the organization. Further, all respondents were informed about the study objectives, procedures, possible risks, benefits and their verbal and written informed consent was taken before an interview. Respondents' participation was primarily voluntary and they were not paid any incentives. Respondents were interviewed, face-to-face, at their convenient time, at counseling centre, drop-in-centre (DIC) of the community-based organization, Lakshya Trust, and/or respondents' home. All interviews were conducted in the vernacular language Gujarati based on semi-structured interview protocol. Interviews ranged in length from one to two hours. Interview protocol was initially developed in English and was translated and back-translated into Gujarati language by authors. Respondents were asked questions from predefined themes such as experiences of being different from others, awareness about proclivity toward same-sex, development of sexual identity, same sex sexual activities and uptake of HIV prevention activities and so. As interviews progressed, new themes such as strategies to meet heterosexual norm, disclosure of sexual identity and sexual activities, motivations for disclosure and non-disclosure of sexual identity and sexual activities were emerged and added in the interview protocol. Some respondents were followed up when some information was missing or further clarification was needed on the topic. After the data collection, the interview texts were transcribed and translated into English

by authors. Data was organized into categories that were emerged from the interview texts [3]. Data was then, coded using thematic content analysis [4]. In order to maintain trustworthiness of the study, coding and analysis were shared with two external experts and incorporated their feedback.

III. Results

This section presents the demographic profile of the respondents and socio-cultural determinants of health risks.

3.1. Demographic Profile of Respondents

Amongst 38 men, 13 were self-identified themselves as "Koti," (feminized men, usually sexually receptive partners), 9 identified as "double-decker," 7 "bisexual," 6 respondents were those men who accepted themselves as "ghadiya," (masculine, usually active partners) and 3 were "gay." Table 1 represents demographic profile of respondents.

3.1.1. Education.

From the total sample, 15 respondents were ranged between 18-27 years of age, 11 were between 28-37, *and* 8 were ranged between 38-47, and rest 4 ranged between 48-57 years of age. Majority of respondents, 27, were educated upto 10^{th} year of schooling and then dropped out, 8 respondents had completed under-graduate studies (12 years of schooling plus 3 years of college education) and 3 respondents were illiterate.

3.1.2. Occupation.

More than a quarter, 12, respondents were engaged in daily wage labor. Almost one fourth of the total sample, 9, were working in companies; municipal corporations; and non-governmental organization while 7 respondents were doing small business such as photography, catering business, vegetable vendor, food stall and tea stall. Other 5 respondents were students. Total 5 respondents were unemployed at the time of interviews. From the total sample explained above, 4 respondents (three unemployed men and *one* daily laborer) were engaged in sex work as a source of income but did not identify themselves as sex workers.

3.1.3. Marital Status.

Total 22 respondents were heterosexually married while *2* respondents were cohabitating with their male partners and reported having estranged relations with their respective families, as their families did not accept these cohabitations. Total 14 respondents were not married at the time of the study. India has a strong traditional "joint family," (a system where multi generations of family live together), which is quite evident from the data as 33 respondents were living with their joint family, rests 5 were staying in nuclear family.

3.2. Socio-cultural Determinants for Health Risks

The study revealed socio-cultural determinants of health risks such as sexual labels and identities, disclosure of sexual identities, sexual practices and issues related to female partners of MSM.

3.2.1. Sexual labels and identities.

MSM population is diverse in labelling their sexual identities, roles with respect to their sexual behaviors. Some identify themselves with the modern 'gay,' who performs as active (sexually insertive) as well as passive (sexually receptive) partner or 'bisexual,' who are sexually active with men as well as women; interestingly some bisexually identified men closely identified themselves with women and others identified as "Koti" who are feminized men, who strongly identify themselves with women and are usually sexually receptive partner. Some homosexual men labelled themselves with "Double Deckers (DD)," those are not necessarily feminized men but shift their sexual role as active and passive partners— sexually insertive and receptive. Men who are masculine and usually sexually insertive are labeled as Ghadiya by Koti and DD. However, these men started identified themselves as Ghadiya. Many men identified them with MSM. These indigenous terms such as Ghadiya, MSM and DD, are labels, however, some men adopted them as identities based on sexual roles associated with it. There are some men indulge in homosexual activities and identify themselves with any of above sexual identities but do not disclose it to anyone and remain closeted.

3.2.2. Disclosure of sexual identities.

Based on disclosure status of respondent's sexuality, two categories were emerged: 1) Open MSM –who have disclosed their sexual identity and practices to Peer Educators (PEs) of the organization and other community members and 2) Closeted MSM – who have not yet disclosed their sexual identity and practices to anyone except few close MSM friends. Open MSM were twenty while closeted MSM were eighteen. Out of twenty open MSM, 9 were married while 13 closeted MSM were married. Open MSM attributed disclosure of their sexuality as positive aspect. Lakshya Trust was considered as catalyst to provide knowledge about sexuality, and HIV prevention.

In contrary to open MSM, closeted MSM did not disclose their sexuality to protect their heterosexual status in the family and community. They expressed that any kind of associationship with the Lakshya Trust or its team was threat to their secret homosexual identity and practices as the organization was very popular for working with MSM population in the Vadodara City. One respondent mentioned during an interview, *"I am staying with my wife, children and parents. They don't know about me. Lakshya Trust is very well-known organization working with MSM. If I meet any member, it is obvious that people might think I am part of MSM..."* Another said, *"...Peer Educators of Lakshya Trust behave feminine and claps on the road, which considered cheap* [by community members and society at large]. *If I talk with them, people* [neighbors and any known people] *might think I am also one of them. Therefore, it is better to keep distance with them..."* While first author asked, "What might happen if people think that you are MSM or part of the organization?" Common response was defamation of societal prestige as a real man, which is clear from following remarks of respondents.

Real man is one who is manly, strong and protects family…men acting as neither women neither considered men nor women, rather considered "hijra." There is no place for "hijra" in the society. They have their own society.

One respondent replied, *"I am not prepared to face such situation. It will defame my status in the society and I won't be able show my face to my wife and children."* The organization's popularity and fear of disclosure motivated many MSM not to avail and access HIV prevention services, which further put them at risk.

3.2.3. Sexual Practices.

Across both groups, each Koti, DD and gay had a lover or lovers with whom they are romantically committed and sexually active and at-least one regular partner that they are emotionally attached to and have regular sexual relations with them. Bisexually identified men, MSM identified men and Ghadiyas too reported to have multiple male partners primarily *Koti, DD* as well as female partners such as girlfriends, sex workers and/or wives. Average weekly same-sex relations among Koti & DDs was 9 while average weekly same-sex relations among Ghadiya, Bisexual and MSM were 5 and their average weekly heterosexual relations were 3.

Among both groups, anal sex was nearly universal; only 3 men had practiced oral-penile sex (that too without a condom!) In most cases, anal sex was followed by oral-penile sex. Oral-penile sex was always unprotected as one respondent mentioned, *"How can taste ice-cream with plastic cover on it? I do not like my partner use condom during oral sex. We both don't get taste of skin while condom is on."*

Closeted MSM were reported to irregular use of condoms. Primary reason for non-use of condom was attributed to faith in the partner, partner's insistence on non-use of condom, exchange of money or gift for unprotected sex, alcohol use before sex, unavailability of condoms, and inability to use condom in public places like park, beach, cinema, public toilets or open grounds. While open MSM reported irregular condom use with wives, (homosexual) lovers and regular partners; however, they reported regular condom use during anal sex with strangers (male partners) and female sex workers. Anal sex usually followed by oral sex and no one reported condom use during oral sex. Common reasons assigned to non-use of condom were faith in the partner, partner's insistence on non-use of condom. Both open and closeted MSM had different sexual health practices.

3.2.4. Female partners of MSM.

Bisexual relationships were also common among MSM population as most MSM were heterosexually married. Koti reported to have exclusive male partners; however, most Koti were married heterosexually and therefore, had active heterosexual life. Ghadiya, MSM and bisexually identified men had multiple male partners and had female partners such as girlfriends and/or female sex workers.

Majority respondents, *twenty nine*, confirmed to have sexual relationships with women either as a married partner or with girl-friends, or female sex workers. Only *seven Koti* and *two* gay identified men expressed to have only men as their sexual partners and never had vaginal sex in their lives. While sexual relationship with women, vaginal sex was common; however, *three* respondents reported to have oral-penile sex while *fives* reported to have anal sex with women. Further, condoms were not used while oral-penile and anal sex with women. This evidence highlighted the sexual health risks. Targeted interventions do not provide specific message to prevent sexual risks during anal sex with women and wives. Beliefs about condom use resulted into risk behaviours. Very few, *three*, married men were using condom during vaginal sex for family planning; rest were not using condom with their wives due to primarily three reasons. First reason was sterilization-f*our* wives underwent sterilization after desired child; second reason was planning of a baby and third reason was to maintain faith in wives and create safe space to hide multiple partner sexual activities with men as well as women outside marriage. These reasons challenge outcomes of previous studies [5], [6] and established that the use of protection among married MSM was minimal. In addition, the study revealed that condoms were also not used with lovers and their regular partners among both groups. It depicts changing nature of sexual practices and justifications for risky practices.

3.3. Knowledge about HIV/AIDS and Access to Sexual Health Prevention Services

All MSM who were open, 20, knew the meaning of STIs, HIV/AIDS and strategies to protect themselves from STIs; however, sexual health services such as treatment of STIs, health check-ups, free condoms, and HIV counseling offered through targeted interventions were availed regularly by only 11 MSM. Primary reasons for not availing services were service timings, fear of disclosure of their identity and attitudes by service providers.

Among closeted MSM, many misconceptions around condom use, STIs and HIV existed. For instance, one respondent, who was closeted, shared, *"I use two condoms because one condom is not safe…sometimes it break off."* One respondent (*Koti*) said, *"When I have boils on penis, I wash it with water boiled in neem leaves."* Another respondent mentioned that HIV can be spread while staying with HIV positive people. Closeted MSM had not availed sexual health services, despite some of them knowing about sexual health services, due to fear of unexpected disclosure of their sexual identity and sexual practices. In general, across both groups, MSM had reported various common misconceptions such as, alcohol consumption before sex gives more power and enhances pleasure; anal sex is not high-risk behavior; masturbation weakens sexual power and lead to impotency; homosexual men have excessive sexual drive than others; and sexual acts between men is masti or khel (fun or play).

Many respondents expressed satisfaction from a sexual act without condom use. One respondent mentioned during an in-depth interview, *"…I feel satisfied only when my partner ejaculates in my anus and feel the semen in my anus."* Another expressed, during the focus group interview, *"…condom is like a plastic cover on ice cream. You cannot eat and taste an ice cream with a plastic cover on it. Similarly, when penis covered with condom, we do not get taste or feel the penis skin during oral sex and its sensation during anal sex."* Belief that sex is only pleasurable without condom can put MSM at considerable risk of transmission of STIs including HIV and chances of transmitting STIs to their female partners.

IV. Discussion

4.1. Open Vs. Closeted MSM

Men, who were closeted, had not availed sexual health services, as they feared unexpected disclosure of their sexual identity and sexual practices. They reported that they avail condoms from peer educators of the organization and from condom outlets. It was also evident from the data that closeted MSM had high frequency of new partners and unprotected sex while the frequency of sexual activities with lover/s, regular partners and wives was higher among those MSM who were disclosed their sexual identity and availed HIV prevention services.

4.2. Sexual labeling and identity

Research has also shown that Indian men often do not evaluate their "self" in terms of sexuality. For example, number of recent studies have discussed that the context of sexual interactions between men as "Musti" (Fun) (See, [7] and [8]. This research revealed that sexual behaviors are important determinant for deciding one's homosexual behaviors. It disproves what Alderson (2003) mentioned that sexual behavior is least important in deciding up on one's sexual orientation¥ [9]. Koti, DD, Gahdiya are essentially performance based labels to their roles, later are adopted as identities in given socio-cultural context. Further, many men identified themselves with "Ghadiya," who are masculine and usually active partner. This particularly disproves the notion presented by Venkatesan and colleagues in 2002 that "Ghadiya," "Panthi," "Parikh," or "Giriya," are labels used by Koti for other men with masculine traits and not necessarily "identities" [10].

4.3. Gender and well-being

Men who were effeminate and identified as Koti, were prone to indulge in high risk sexual behaviors as well as psychiatric morbidities due to gender roles and power dynamics. Koti being a receptive partner, they are more prone to STIs including HIV as well as stigma, discrimination and domestic violence. It is largely perceived feminity of many MSM as a performance based identity often becomes determinant of stigma, discrimination and domestic violence. Further, low socioeconomic condition paves the way for sex work. Need for money triggers indulgence into high-risk behaviors despite they are aware of such behaviors, for instance, they agree not to use of condom, if clients promise to give more money.

Institution of marriage provides safe social space and an opportunity to explore secretive homosexual and bisexual relationships safely. Usually unaccepted extra marital homosexual and bisexual relationships are accepted within popular culture. The term popular culture is interpreted by here as widely accepted cultural practices of groups, which are usually prohibited in the larger society, for example, going to sex worker or having extramarital affair is prohibited in the society; however, in popular culture going to sex worker or extramarital relationship by men is considered as normal, natural and one of the characteristic of masculinity. Further, married feminized men who are submissive in their homosexual relationship often face domestic violence such as beating, cheating, emotional blackmailing etc. Similarly these married feminized men exert frustration to their wives. Such transference of domestic violence is very important human rights and social justice issue. Within this patriarchal social structure feminized men as well as women become recipient of social, sexual and mental health risks.

V. Conclusion

Present study highlighted socio-cultural determinants of health risks. The study established that not all MSM are at same risk. Sexual health risks vary among MSM population. Therefore, each MSM have varied health needs. It is clear that there are invisible socio-cultural structures that put MSM and their female partners at various health risks.

Misconceptions regarding HIV/AIDS, sexual practices among both open as well closeted MSM needs to be addressed through appropriate strategies. This study also highlighted the prevalence of bisexual behaviors among MSM, chunk of unreached MSM population and unavailability of HIV prevention services to female partners (FP) of MSM within TI framework. As a result, closeted MSM and FPs of MSM are not able to avail HIV prevention as well as care and support services.

Existing targeted interventions lack communication and counseling strategies to address unique socio-cultural issues of MSM. There is a need to make present targeted interventions responsive to the HIV prevention needs of MSM population by devising culturally sensitive strategies to reach out unreached MSM and designing appropriate policy to deliver HIV prevention services to female partners of MSM.

5.1. Implications for Targeted Interventions

As many MSM are hidden and do not want to open up, mechanism must be developed to reach out unreached hidden MSM population. One feasible mechanism as emerged from the study was anonymous peer educators. These peer educators are from the hidden population or know few MSM who do not want to disclose their identities. However, this strategy is suggested to use as a entry point because it may become challenging in long run to address issues of accountability of outreach services to them, agenda to mainstream HIV prevention services and HIV prevention intervention as a whole. Counseling services need to be enhanced to address counseling needs of MSM population. All counselors should be trained to deliver mental health counseling and appropriate referrals. Peer counseling is another strategy can be introduced to immediately address issues of open as well as closeted MSM and their female partners at community level. There is an urgent need to provide HIV prevention services to female partners of MSM through existing targeted HIV prevention intervention framework. Female peer educator can be recruited to reach out female partners of MSM. Policy framework on the same need to be developed and should be incorporated in the National AIDS Control Program-IV (NACP-IV).

Communication strategy should be developed based on understanding of health risks within socio-cultural context. Communication strategies such as MSM (open and closeted MSM) as well as female partner centric IEC materials in local language to be developed urgently with appropriate graphics, short culturally sensitive messages, documentary film, case studies especially on condom use with wives, lovers and regular

partners; condom negotiation, living healthy life with HIV, regular HIV test and medical check-up needs. Also, other IEC strategies such as group educational sessions with MSM and female partners based on the analysis of their health risks, community events, community shows (awareness show by community members within community), public awareness shows by community members. Further, culturally tailored behavior change messages should be evolved through participatory approach actively involving MSM population in designing culturally tailored communication strategies. These communication strategies should be used during individual counseling, educational group sessions, and group counseling sessions to create awareness regarding healthy sexuality, sexual health, and mental health. Large-scale mixed-method research need to be conducted to build primary data on the topic, and validate concepts evolved in the study. Similar study with transgender population is also required.

5.2. Implications for advancement of counseling

Counseling is an important aspect in TI. However, programmatically counseling component is not viewed as strategic. Counseling, in targeted intervention merely reduced to activities of information sharing (about potential risks involved in risks activities, risk reduction alternatives, and available services). This study revealed that counseling does not address micro issues such as sexuality issues, for example, one's disclosure of sexual identities; non-use of condoms, power dynamics within homosexual relationships, mental health issues. These micro level issues need to be addressed carefully in TI. Counselors should gain deeper understanding of MSM population and their female partners, and their mental health needs and risk practices. Further, identifying potential community members to become community counselors and train them in counseling will be helpful strategy to reach out un-reached MSM population.

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NOTES

National AIDS Control Organization (NACO) is an autonomous body established by the government of India, working on HIV prevention, control, and care and support.

Sexual orientation embraces physical, interpersonal, and intra-psychic factors. A person's sexual orientation can be assessed based on the sexual attraction, sexual behavior, sexual fantasies, and self-identification.

REFERENCES

[1] NACO (2011). 2009-10Annual report of National AIDS Control Programme (NACP)-III. New Delhi.

[2] Morgan, D. L., and Spanish, M. T., 1984, Focus groups: a new tool for qualitative research, Qualitative Sociology, 7(3), 253-270.

[3] Bogdan, R. C., and Biklen, S. K., 1992, Qualitative research for education: An introduction to theory and methods, Allyn and Bacon, Boston.

[4] Miles, M. B., and Huberman, A. M., 1984, Qualitative data analysis: A source book of new methods, Sage, Beverly Hills, CA.

[5] Pandya, A., 2011, Psychosociocultural issues of MSM in Gujarat, India, International Journal of Psychology and Behavioural Sciences, 1(1): 18-23.

[6] Larmarange, J., A. S. and Wade, et al., 2010, Men Who Have Sex with Men (MSM) and factors associated with not using a condom at last sexual intercourse with a man and with a woman in Senegal, PLoS ONE, 5(10), e13189.

[7] Khan, S. (2004). MSM and HIV/AIDS in India. Retrieved [10/11/2012] from http://www.nfi.net/NFI%20Publications/Essays/2004/MSM,%20HIV%20and%20India.pdf

[8] Asthana, S., and Oostvogels, R., 2001, The social construction of male 'homosexuality' in India: implications for HIV transmission and prevention, Social Science & Medicine, Volume 52(5), 707–721.

[9] Alderson, K., 2003, The ecological model of gay male identity, The Canadian Journal of Human Sexuality, 12(2), 75-85.

[10] Venkatesan, Chakrapani, Ashok Row Kavi, L Ramki Ramakrishnan, Rajan Gupta, Claire, Rappoport, and Sai Subhasree Raghavan, HIV Prevention among Men who have Sex with Men (MSM) in India: Review of Current Scenario and Recommendations, April 2002. Retrieved [1211/2012] from http://www.indianglbthealth.info/Authors/Downloads/MSM_HIV_IndiaFin.pdf

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Table 1: Respondents profile

Sub-groups of Respondents	Age Range					Marital Status				Education				Occupation					
	18 to27	28 to 37	38 to 42	43 to 47	**Total**	Married	Unmarried	Cohabitation with same-sex partner	**Total**	Illiterate	Upto 10th	Graduation	**Total**	Daily labor	Service	Student	Small business	Unemployed	**Total**
Koti	3	5	3	2	**13**	9	2	2	**13**	2	10	1	**13**	8	1	2	0	2	**13**
Double Decker	4	3	2	0	**9**	5	4	0	**9**	1	8	0	**9**	1	1	3	2	2	**9**
Bisexual	2	1	2	2	**7**	6	1	0	**7**	0	6	1	**7**	2	4	0	1	0	**7**
Ghadiya	4	1	1	0	**6**	1	5	0	**6**	0	2	4	**6**	1	1	2	1	1	**6**
Gay	2	1	0	0	**3**	1	2	0	**3**	0	1	2	**3**	0	2	0	1	0	**3**
Total	**15**	**11**	**8**	**4**	**38**	**22**	**14**	**2**	**38**	**3**	**27**	**8**	**38**	**12**	**9**	**7**	**5**	**5**	**38**