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Contextual influences on condom use among men who have sex with men in India: Subjectivities, practices and risks

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Abstract

Quantitative studies among men who have sex with men in India have shown high levels of unprotected anal sex. However, there is little information about the contexts in which such men may not use condoms. Relevant information on these contexts can assist in designing HIV prevention programmes to remove barriers to consistent condom use. As part of a larger study on sexual and social networks, we explored the contexts in which men who have sex with men did not use condoms, with a focus on personal, interpersonal and structural levels of experience. Data indicate the importance of understanding the different contexts that lead to unprotected sex but also reveal that the concept 'context' itself as a complex variable to consider in research of this kind, as research subjects interpret their social worlds and sexual risks in subtle and varied ways. Based on this viewpoint we make recommendations regarding HIV prevention.

Keywords: men who have sex with men; India; subjectivities; contexts; condom use; HIV

Introduction

Men who have sex with men (commonly referred to as MSM in policy and HIV-prevention discourses) are categorised as a 'core high-risk group' by India's National AIDS Control Organisation (NACO), and targeted interventions for men who have sex with men were initiated from the third phase of the National AIDS Control Programme (NACP-III: 2007 – 2012), with condom promotion and free distribution of condoms being a key component of programme development. These steps marked a significant shift from the earlier relative inattention towards men who have sex with men among policymakers in this context.

While NACO did acknowledge in the second phase of the NACP (1999 – 2006) that Indian men who have sex with men were at risk for HIV, the World Bank's evaluation report on the NACP-II programme noted that men who have sex with men were not given adequate attention (World Bank 2003). Rather, at that time the predominating focus of HIV prevention in India was on female sex workers. In part, this was because the first case of HIV in India was detected in a female sex worker from Chennai, whilst there was also a prevailing assumption that HIV transmission in India was almost exclusively due to sex between men and women. It was also a component of the very real risks faced by sex workers and the effective mobilisation of Indian sex worker's groups in the face of such circumstances. Consequently, however, up until 2007, very few government-funded projects supported condom distribution among men who have sex with men, even as other non-governmental organisations developed increasingly extensive HIV prevention in contexts of male-to-male sexual risk. It was only within the context of a wider shift in social values concerning sexuality over the course of the first decade of the HIV epidemic in India (and associated sexual rights actions and legal reforms) that men who have sex with men have now found themselves more centrally located in state-level HIV-prevention planning, both as subjects of HIV-prevention strategies and as participants in planning and implementation (although even now this can be contentious and HIV prevention for men who have with men can face funding constrictions).

The HIV epidemic in India is heterogeneous but can be described as concentrated, with apparently vastly higher infection rates among men who have sex with men and other vulnerable groups, such as injecting drug users and female sex workers. Statistical data indicate that the prevalence of HIV among men who have sex with men is 7.3% (national average), more than 20 times the general population prevalence of 0.34% (NACO 2007), with those who engage in sex work facing an even greater risk (Dandona et al. 2006; Newman et al. 2008a, 2008b). For example, one recent study reported that men who sold sex to men had a 2.4 times

higher probability of acquiring HIV than men who had sex with men without financial exchange (Dandona et al. 2006).

Even though the HIV epidemic in the general population is perceived to be stabilizing and declining in the Southern states of India, evidenced by the decreasing trend in the HIV prevalence among antenatal women (a common proxy for HIV among the general population) (Kumar et al. 2006), HIV trends among men who have sex with men from the same Southern states have shown no signs of decrease but, rather, an increasing trend. For example, HIV prevalence among men who have sex with men increased from 2003 to 2007 in the sentinel sites in Karnataka (10.8% in 2003 to 17.6% in 2007) and Tamil Nadu (4.2% in 2003 to 6.6% in 2007) (WHO-SEARO 2010). This is despite the apparent increase in the 'coverage' of men who have sex with men through targeted interventions and their aim of 'saturation' (NACO 2010).

Increasing evidence from quantitative (and mixed-methods) studies suggest that a substantial proportion of men who have sex with men may engage in high-risk sexual behaviours with both men and women (Brahmam et al. 2008; Phillips et al. 2010; Solomon et al. 2010; Newman et al. 2008a; Verma and Collumbien 2004). Thus, the risk of transmission of HIV infection is not only between men, but also between men who have sex with men and their female partners.

Most of the above-cited studies have used quantitative methods for exploring HIV-related sexual-risk behaviours and have focused primarily on factors at the individual level that influence risk behaviour. Such studies have also tended to conceive of 'risk populations' in relatively discrete terms, reiterating perceptions that men who have sex with men (and others) count as separate populations, with separate HIV epidemiologies. Such conclusions may occlude attention to ways in which men who have sex with men are a part of the general population, who (especially in a country such as India) regularly have female sexual partners or are married. Against this background, relatively little research has addressed the contexts in which men who have sex with men may not use condoms and how factors at interpersonal and structural levels may influence sexual-risk practices (as relevant to both the male and female sexual partners of men who have sex with men). Qualitative methods are particularly appropriate for exploring the meanings and contexts that underlie use and non-use of condoms. Yet only a few qualitative studies from India have demonstrated the role of social-structural influences on condom use among men who have sex with men in general (Chakrapani et al. 2007), and HIV-positive men who have sex with men in particular (Chakrapani, Newman, and Shunmugam 2008). Several authors (Blankenship et al. 2006; Chakrapani et al. 2007; Parker, Easton, and Klein, 2000; Sumartojo 2000) have suggested that sexual-risk behaviours and risk-

reduction strategies should be seen as being influenced and shaped by factors at the individual, inter-personal and social-structural levels. The present qualitative study explored the influence of contexts at all these levels on condom use among men who have sex with men in India.

Methodology

A multi-sited qualitative study was conducted in 5 Indian states that explored the sexual and social networks of men who have sex with men in the last quarter of 2006 and first quarter of 2007. This study was implemented by the Humsafar Trust, a community-based organisation (CBO) in Mumbai that has been working with men who have sex with men for over a decade, in collaboration with six community organizations that are part of the Integrated Network for Sexual Minorities (INFOSEM), a national network of more than 20 community organisations working with sexual minorities in various parts of India.

To take into account regional variations in both the extent of participation in diverse sexual networks and potential differences in the social and regional contexts of sexualities and sexual practices, five states were selected: Maharashtra, Gujarat, West Bengal, Orissa and Delhi. The selection of the states and organisations that participated in the study was also dependent on the capacity of partner agencies to implement the study. Member organisations of the INFOSEM network in the respective sites were involved in the data collection. A total of 93 in-depth interviews (IDIs) and 12 focus-group discussions (FGDs) were conducted among men who have sex with men, along with 16 key-informant interviews, from relevant social-support and HIV-prevention organisations.

Conversant with prevailing systems for monitoring and evaluation in targeted interventions for men who have sex with men, the present study organised some aspects of its findings according to whether respondents self-identified in respect of terms such as kothi, panthi and other rubrics used both popularly and in HIV-prevention research paradigms. Kothi-identified men generally perform as femininely gendered (in some if not all contexts) and are archetypically the receptive partners in anal sex with male partners. Kothis label their masculine insertive partners or any apparently heterosexual man as panthi or giriya, and label those men who have sex with men who engage in both insertive and receptive sex as 'double-deckers', duplis or do-parathas. These days, in metropolitan cities like Mumbai and Chennai and even in several small towns, some significant proportion of men who have sex with men have started to self-identify as panthi and double-deckers (Chakrapani, Newman, and Shunmugam 2008; Safren et al. 2009).

In the context of these stereotypings, it is important to note that in as much as the above characterisation of sexual roles and gendered identities may be based in a prevalent cultural framing of sexuality, it may also be interpreted as a gendered sexual archetype, or 'script', that has been especially propounded within HIV-prevention work, as a de facto culturally-grounded explanation of male-to-male sexualities and sexual risk. This version of sexual culture has been critiqued as being not only overly general but also based in derivative versions of anthropological and sociological knowledge concerning gender and sexuality (in India). This tends to propound a culturally deterministic view of male-to-male sexualities as if culturally prescribed by essential gender roles and practices, which in turn are typically reiterated in mainstream HIV prevention work as salient discursive framings via which sexual bodies and subjectivities may be read and their associated sexual risks (e.g. active or passive in anal sex) predicted and intervened into (via targeted interventions and so on).

This is not to imply that terms such as *kothi* and *panthi* may not be popularly prevalent among men who have sex with men and others, but is to indicate a subtle and recursive relationship between HIV-prevention discourses, popular accounts of sexuality and cultural framings of sexual practice, such that reported self-identities (such as *kothi*, *panthi* and so on) among contemporary research informants cannot simply be read independently of the discursive registers of HIV-prevention research paradigms and programme implementation. Rather, such terms and actions are a component of how men who have sex with men others not only learn about sexuality and sexual risk, but also affect how sexuality and sexual risk become 'knowable' and pertinent to self-understandings (Boyce 2012). Such processes, in turn, have an intrinsic bearing on sexual subjectivities. Given this, self-reported identities such as *kothi*, *panthi*, *dupli* and so on must be interpreted reflexively, as an aspect of dynamic social, cultural and programme implementation contexts via which contemporary sexual subjectivities take shape and reproduce their own cultural authenticity (Boyce 2007, 2013; Kahnna 2009). As such, where these terms have been used in the present research (in respect of condom use, for example) they are deployed with a certain amount of reflexive equivocation, as rubrics via which social context and sexualities must be interpreted dynamically, as indicative of a fluid relationship between HIV prevention discourse, subjectivities and bodies, as opposed to static contextual framings and assumed predictive indicators for the analysis of sexual role and risk.

Participants in the present study were recruited from venues and events held at community-based organisations and also from 'cruising sites' such as public parks, public transport facilities and beaches where men meet other male partners. The research staff explained the aims and objectives of the study to participants, and eligible informants were

recruited. Some study participants referred other potential participants to this study. To identify the issues of people living within different life circumstances (for example, married persons, people living with HIV, younger men who have sex with men and those who engage in sex work), research staff were asked to specifically recruit relevant persons using stratified purposive sampling (Miles and Huberman 1994).

In all, 12 FGDs were conducted using a semi-structured open-ended interview guide. About 6 to 8 persons participated in each focus group and the duration of the discussion ranged from 45 to 120 minutes. In-depth interviews were conducted with 16 key informants using a semi-structured interview guide. These key informants included the heads of community organisations, community activists and healthcare providers. Key topics explored in the IDIs and FGDs included sexual relationships and partners, sexual practices, situations in which condoms were used or not used and reasons for using or not using condoms.

The IDIs, key informant interviews and FGDs were tape-recorded and transcribed verbatim in native languages and then translated into English. In two in-depth interviews, participants did not consent for audio-recording and, thus, active notes were taken and notes were expanded soon after the completion of interviews.

Data were explored using thematic analysis and the constant comparative method (Strauss and Corbin 1998; Charmaz 2006), a key analytic technique used in grounded theory, in which codes are systematically compared and contrasted, in order to develop a full contextual understanding of the prevailing themes and findings of the data.

Findings and discussion

Condoms and stigma

Respondents reported varying ways in which the use of condoms was stigmatised, mitigating against their use. Rohit, 39-year old kothi-identified respondent from Gujarat, who is a divorcee whose children come and stay with him a few days a month, stated that he could not carry condoms and thus could not use them: 'No. I don't use condoms [with casual partners]. I can't keep condoms in my bag or [wallet] because suppose if my children or others see them then it is not good. These days, everybody knows about condoms.' In this scenario, a concern about condoms being seen by others (including children) and the potential questions that this might invite (for an unmarried man) were a key concern, especially as a certain social status in respect of being a father was involved.

In a similar vein, Sagar, a 19-year-old gay-identified man from Sangli, Maharashtra, reported that he was too embarrassed to ask for condoms from the chemist shop: 'Sometimes if I meet someone and they give me [condoms] then it is fine. But I don't go to the medical [shop] and buy condoms, because I feel shy to do so.'

Many people reported that they knew about condoms but since they do not always carry them, they sometimes had unprotected sex. As Dashing, a 23-year-old respondent from Mumbai, said:

I don't carry condoms with me but if the other person has condoms then I won't resist using them. But I know that others also don't carry condoms with them so then most of the time we have sex without condoms.

Dev, a 24-year-old gay man from Delhi, reported that he had unprotected sex since neither he nor his partners typically carried condoms. He listed the incidents in which he had unprotected anal sex:

One [incident] was in the urinal of a restaurant and a second was with a "hunk" in a hotel room. I had everything with him [meaning various sexual activities, including anal sex] but without condoms because both of us didn't have condoms. Then, it was in a disco I met one guy and he introduced me to two other guys that he knew. We didn't have a place so we had [anal] sex in his car.

In contexts such as those described, even if those involved had an awareness of safer sex and the need to use condoms, factors prevailed against their use. These were variously attributed as an aspect of desire, as implied in such a narrative of urgent passion, and a certain kind of stigma mitigating against the introduction of safer sexual practices into such a moment. This kind of stigma can be especially salient in a context such as India, for example, where discourses related to safer sex and male-to-male sexual risk have been most prevalently associated with the milieu of NGOs and community organizations, whilst potentially remaining someone dissonant from AQ1, and stigmatised within, other social contexts (especially those associated with clubbing and other commercial sexual spaces) (Boyce, Chakrapnai, and Dhanikachalam 2011).

The portrayal by some participants that men who have sex with men may be more likely to have unprotected sex in cruising sites and safer sex with friends and inside homes was

challenged by some community leaders. According to a 45-year-old gay-identified community leader from Maharashtra:

In some cruising sites you may not have time or place to have anal sex and what one can do at the most is hand job or oral sex. But within the homes of MSM one cannot tell. Within the physical safety of a home, anal sex is most likely and condoms are less likely to be used.

Some participants narrated incidents that were consistent with this opinion. Vikas, a 28-year-old gay-identified respondent from Delhi, mentioned that when there is group sex with his friends, condoms are not used:

There is a friend's place where every Saturday and Sunday, we gather and we all remove our clothes and have sex. ... No, no condoms. We [gay men] could not control sexual feelings and could not think about condoms.

Vikas proposed that persons known to his friend were less likely to be 'risky' and he was willing to take risks. Other participants also suggested that 'persons known' to their friends (but whom they have met for the first time) are likely to be safe because they are from the 'same circle' or 'same class', which led to the development of an instant trust. Such associations of risk as being commonly associated with 'others' and not with close affines is not unusual, and relates to ways in which sexual risk, and risk more widely, is commonly deferred into rationales of threat from unfamiliar persons.

Sexual violence and lack of legal protection

Many respondents, especially those involved in sex work, reported incidents of forced sex – by policemen, ruffians and in some instances from well-known clients. In some areas, it had become such a routine matter that respondents considered sexual abuse by policemen as part of their life. As Lakhan, a 34-year-old kothi-identified respondent from Gujarat said:

I remember one incident where a kothi was caught by police from [a park] ... [they] took him into a police van and forced him to have anal sex. They did not use condoms. Every kothi [in that area] came to know about this incident. How can a kothi tell police officer to use condom?

Many respondents, especially those who were kothi-identified, reported incidents of forced sex. Talking about his experience of forced sex, Ajit, a 19-year-old kothi-identified respondent from West Bengal, said: 'Once a person took me from [a train] junction on his bike under [a bridge] and two other people came. Threatening me with a knife forcefully they had sex with me, without condoms.'

Similarly, Hari, a 20-year-old kothi-identified respondent from Delhi, reported an incident of gang rape in which he was forced to have sex with a group of men and condoms were not used:

On a winter night I was looking out for one address [house]. That time I was wearing a nice outfit and had a long hair. I was lost so I enquired about the whereabouts of that place to some guys standing over there – there were about four to five [guys]. They said, "Come, we will show you" ... I refused ... but [they] took me to a garden and threatened me showing a knife. I was scared and told them I had no money but they said that they did not want money but they wanted to have sex with me ... they forcibly took me to a room and there they had sex with me one after the other ... later there was a swelling in the backside as big as a ping-pong ball. It was difficult to sit.

Hari did not report this incident to the police, for fear of further abuse, but took treatment from a private doctor, offering a fake reason for the swelling in the anal area.

Those who engage in sex work also described incidents in which they were forced to have unprotected sex with their male clients. Often, forced sex happened with a group of men. Biju, a 27-year-old kothi-identified respondent in sex work in Orissa, explained how, a few years earlier, he was cheated by a known client and gang-raped by a group of men, leading him to contract an STI:

Once my client called me to his place and said that he was alone. But I did not know that he had also called up his office colleagues. They started drinking alcohol and after drinks they forced me to have unsafe sex in the back [anal sex] with them. I suffered from [anal] STD problems after this incident. I was scared that I would have got HIV. I came to [CBO] and regularly got myself tested and now I am sure that I am not having HIV.

Loss of faith in the law enforcement agency, lack of redress and the shame in admitting to being sexually assaulted prevented respondents from reporting assaults and from receiving proper medical and psychological care. Only in select major cities do certain CBOs provide STI testing and treatment to men who have sex with men, but many do not have professional

counsellors who can competently counsel male victims of sexual assault. It is especially salient and sobering to note the high reported incidence of violence in this present research, especially those who in one way or another presented a feminine gendered persona, either through self-identification as kothi, or through other attributes of styling and performance, or a gender subjectivity that varies from (hetero)normative values (transgender or otherwise). As India currently struggles with its social and legislative response to male sexual violence toward women, it is important to remember that non-heteronormative people are victims of sexual violence and assault on a day-to-day basis.

Trust and intimacy in steady relationships

Many respondents who had previously or currently had regular male sexual partners reported that they did not use condoms during anal sex with such partners. Some did not specify any reasons for not using condoms but most conveyed that intimacy, love, being in a 'long-term' relationship and trust lead them to have unprotected sex with their regular partners. Rahat, a 29-year-old gay-identified respondent from Gujarat, for example, noted that: 'I used to not allow him to [have anal sex] as often as he wanted and he used to fight with me. [. . .] No, we did not use condoms. We were very close.' Similar reasoning was described by Meghnad, a 32-year-old kothi-identified respondent from Maharashtra, in terms of sex with his regular partner: 'I have not used condoms. He is my man. We have body sex, oral sex and anal sex.' Similarly, Tej, a 23-year-old kothi-identified participant from West Bengal, responded to the question of whether condoms were used with regular partners with a laugh and added, 'Do husband and wife have sex with condoms? I don't use condoms with my husband [partner].'

Nilesh, a 23-year-old gay-identified respondent from Mumbai, noted that he trusted his male regular partner, who was a medical doctor, and thus did not use condoms: 'No – because he is an MBBS [Bachelor of Medicine and Bachelor of Surgery] doctor and I trust that he never goes outside [has sex] with anybody else.' This belief among some respondents, that their regular partners were monogamous, was questioned by a 36-year-old kothi community leader from Maharashtra, who did not currently have a male regular partner: 'They [male couples] say to each other that they are faithful but in reality both have multiple partners.' This informant believed that sex with multiple partners was common and both the partners in a steady relationship may have sex outside the primary relationship. Another person reported that before he found a male steady partner he used to have safer sex with a lot of casual male partners but he was currently not using condoms with his steady partner. In this and other cases, condom

use was seen as rational in casual partnerships, while non-use of condoms was perceived as rational in steady relationships.

Trust as a factor in not using condoms was not only seen with steady partners but also with regular male clients of those involved in sex work. As Jai, a 24-year-old kothi-identified sex worker from Orissa, noted:

I have two or three customers who are regulars. When I had sex with them for the first time I used condoms but later they started telling me that they have sex only with me and then I started having unsafe sex [without condoms] with them.

Familiarity and reliance on the self-reported monogamy of regular male clients led this person to discontinue condom use with them. Regular income from these clients might also be a factor not to insist on using condoms.

Some informants had taken a decision of testing themselves and their regular partners for infections (STIs and HIV) before they started to engage in unprotected sex. But this usually happened after the development of trust. It seemed that the goal was not just to have unprotected sex without condoms, but to 'take forward and strengthen' the relationship, with the abandoning of condoms as symbolically significant within such relationship trajectories. As a 29-year-old gay-identified participant from Delhi who was cohabiting with his male partner explained: 'We have tested ourselves for HIV and both of us are negative. Only because of that we do not use condoms when we have sex with each other.'

'Heat' and unprotected sex in casual relationships

In general, respondents across the research sites blamed their male partners for not allowing condoms to be used: 'panthis do not want condoms. Even if you use condoms they will throw them away when you turn your back'; '[panthis] tear the tip of the condom because they want the "heat" to be released during sex'; and '[panthis] will say "Do I look like one [who practices high-risk sex]?"' However, some respondents blamed kothis for not allowing panthis to use condoms: 'They [kothis] will say it is okay [not to use condoms] as I know you and I am using condoms with others.' A community leader felt that both of these versions of failure in condom use were likely to be true. Also, as seen in the above-mentioned quotes, the concept of 'releasing the heat' during sex seems to be present in different parts of India and has been reported in research among married heterosexual couples also (Bhattacharya 2004). The need to release the semen into the vagina or anus is seen as necessary by some men to complete

the sexual activity and also to get their 'money's worth' if they were clients of male or female sex workers. Some respondents also talked about the need to have sex in which there is skin-to-skin contact. For instance, Raj, a 25-year-old panthi-identified respondent from Orissa, said: 'At least with some [persons] you need to have "real sex". Our skin should touch their skin.'

'Good-looking' and 'clean' partners

For some respondents, a good-looking partner was perceived to be more likely not to have any infections and hence safer to have unprotected sex with. Naveen, a 36-year-old married respondent from Gujarat, noted that he would not mind having sex without condoms if the partner was 'good'. When asked what he meant by a 'good' partner, he replied: '[Good] means decent, one who looks handsome and one who behaves well to me too. One who's penis is clean; has no boils or lesions on his penis, then I don't mind having unsafe sex also.' This reflects the way in which some respondents took external appearance (not only lack of obvious STI-related symptoms, but other perceptions related to a good or attractive appearance) in a potential partner as a proxy for lack of infections and a rationalisation for their unprotected sex.

Also, if a good-looking potential sexual partner was seen, not wanting to lose that opportunity for sex with that partner prevented many respondents from even raising the topic of condoms. As a 30-year-old kothi-identified community leader key informant from Orissa said, 'If someone is a "cheese" [good-looking] panthi, then you would not want to leave him. You will not talk about condoms because he might suspect that you are promiscuous. Also, panthis don't sleep much with men as they only like women. So we can take our chances.'

The concept of clean partner was evoked by another participant, Pranav, although in a different sense. This respondent, 23 years old and kothi-identified from Mumbai, and a Hindu himself, did not feel the need to use condoms with his Muslim partners as he felt that their organs were clean. Traditionally, male children born into Muslim families undergo circumcision in their childhood. This removal of penile foreskin tends to keep the organ clean without any deposits such as smegma. According to this particular respondent, a clean organ was less likely to have any infections and hence it was safer to have unprotected sex: 'If the partner is Muslim then I don't use condoms because his [penis] is clean; with others' it is not clean and it smells.' It was also felt by one participant that 'kothis like Muslim panthis' because they are of the opinion that for Muslims ejaculation will be delayed because of the supposedly decreased sensitivity of their glans penis – which was another reason given for why sometimes either the Muslim partners or their partners would not want to use condoms. Even though circumcision may perhaps offer some limited protection to the insertive partner in same-sex relationships

(Wiysonge et al. 2011), none of the participants explicitly reported that as a reason for not using condoms with a circumcised male partner.

Personal dislike and discomfort

Sometimes a personal dislike for condoms lead to unsafe sex. As Inder, a 21-year-old kothi-identified respondent from West Bengal, said: 'If I wear a condom and have sex then I don't feel like I have had sex. If sex is without it [condoms] then I feel good. Till the sex is not over that feeling [pleasure] should remain.' According to another man, when someone else wears condoms and anally penetrates him he does not feel that penis enter entirely, which diminishes his pleasure. As he explained: 'Yes, there are some who prefer condoms and don't do anything without condoms. But I don't like condoms personally because I feel that the man's penis is not going completely inside.'

Another participant, Hari, 27-years old from Sangli, was concerned about allergic reactions to lubricated condoms. As he expressed: 'I didn't know much about condoms and I was also scared to use condoms, I was scared that the sticky substance that they had put in the condoms would give some allergy to me.' Hearing from someone that [pre-lubricated] condoms can produce allergy justified his non-use of condoms.

Difficulty in maintaining an erection

Nilesh, a 24-year-old kothi-identified respondent from Maharashtra, explained that it can be difficult to get or maintain erection when wearing condoms. Nilesh had a male steady partner but sometimes had sex with 'unknown persons', often without condoms, and reported:

Just imagine that you are about to [insert] someone and your dick becomes stiff. At that time would you really get the packet and then open it and put on the condom? By that time, the [erection] would have gone. Then after putting on the condom you would have to rub your penis to harden it again. ... [Hence] it is better to get infected by any disease rather than using condom.

For some kothi-identified respondents, who are archetypically assumed to be mainly receptive partners in sexual encounters with men, when they take on the 'penetrator' role, putting on a condom could be problematic. As a 22-year-old kothi-identified sex worker from West Bengal, said: 'Being a kothi, you would not be interested in penetrating, but if the client demands you need to do it. In such cases, not using condoms would be good. You can maintain the stiffness.' On the other hand, as previously seen, some thought that an erection will last longer for panthis if condoms are on (because of diminished sensitivity in the glans penis). But

for others, especially those in sex work, the effect of the condom in delaying ejaculation was seen as a bane rather than a boon because of the time taken by their partners to achieve orgasm. For sex workers, time may be money, whilst in many instances they may also be required to have sex with men who they do not desire (and hence prolonging that experience may be especially unwelcome).

Conclusion

Multiple and diverse social, cultural and personal factors influence condom use among men who have sex with men and others in different life circumstances. The first author has often heard people involved in policy and programme development raise the query that 'if MSM know about condoms and have access to them, then why they do not use condoms every time'. Such a thought indicates an assumption that knowledge and access to condoms alone are sufficient for a person to use condoms every time. Such thinking and approaches, however, do not sufficiently take account of the complexities of the real world, where factors at different levels interact in a nuanced manner to prevent something that is so desired by HIV-prevention policymakers and health educators alike – consistent condom use.

While the present data do seem to suggest that there are individual-level factors at play, such as perceptions that condoms decrease pleasure and a 'chubby-looking [healthy, fit, attractive etc.] person is unlikely to be HIV-positive', data from this and other studies (Blankenship et al. 2006; Chakrapani et al. 2007; Parker, Easton, and Klein, 2000; Sumartojo 2000) strongly suggest that social-structural factors influence the sexual-risk behaviours of individuals. For example, a reluctance to carry condoms may be linked to wider social stigma associated with condoms and this, in turn, may be associated with stigma associated with non-marital sexual activity – whether with same-sex or opposite-sex persons – and possible harassment by police if caught with condoms. Given the criminal nature of adult consensual same-sex sexual practices in India at the time of data collection, and the negative and often-times sexually violent consequences of inadvertent disclosure of same-sex sexuality, it can be easily understood why men who have sex with men may try their best to avoid any indication of being sexually active beyond the boundaries of marital orthodoxy, let alone any indication that they are sexually active with men.

Male-to-male sex is still be heavily stigmatised in India, despite the recent 'reading-down' of 'anti-sodomy laws' (section 377 of the Indian penal code) and albeit given significant social and cultural complexity regarding ways in which people of same-sex sexual orientation might

often be socially ignored or culturally marginalised as much as being explicitly prejudiced against (Boyce and khanna 2011; Misra 2009). Given this, issues pertaining to reluctant condom use among men who have sex with men remain especially pertinent and complex. It is not simply that such men may not use a condom because of a stigmatising social context, but also that many may not strongly self-identify as men who have sex with men or MSM, given a socio-cultural context within which identities based on such a sexual orientation remain nebulous for many. For others, a sense of gender variance, or a transgender identity, may be more salient (and, for example, the rubric kothi may be more personally meaningful in terms of gendered subjectivity and difference as opposed to any association with a male-to-male sexuality and sexual risk per se). In these circumstances, the explicit integration of condom use within safer-sex practices may not occur as for many people same-sex sexual practices may not be integrated into a sense of (sexual) subjectivity. Given a potential dissociation between sexual practice and sexual subjectivity in these terms, rational condom-promotion messages aimed at men who have sex with men are likely to fall short of the mark, as is an overly simplistic focus on either personal or contextual determinants of sexual risk (as, for example, prescribed by stereotyped kothi and panthi roles). The present research has illustrated a far more complex array of variant contextually-specific interpretive practices related to condom use and safer sex, none of which can be uniformly predicted in respect of putative cultural archetypes of same-sex sexual subjectivity or role.

Poverty as a structural context plays a key role in condom use (Chakrapani et al. 2007, 2008; Dandona et al. 2006; Newman et al. 2008a, 2008b). Those who sell sex often do not have an option of using condoms during physically forced sex or when the purchase of sex is bound up with significant coercion not to use condoms – again due to the impact of structural contexts such as presence of criminal law, lack of protection (or indeed violence) from police and extortion by ruffians – which often happens to same-sex oriented men, and perhaps especially those with a feminine subjectivity. This may be especially so among those who may not have support from family, police or society and who may want to conceal their sexuality from their families and community.

Men who have sex with men who do not have an identity related to their same-sex sexual practices (even though some proportion may be labelled by others as panthis) are an especially important population to consider in respect of HIV prevention and condom promotion. Given a social construction of same-sex sexualities in which insertive partners especially are most often seen as 'men' (meaning heterosexual) as contrasted to a common use of the term MSM by project staff in HIV-prevention programmes to refer to self-identified (often visibly feminine) men

who have sex with men, many men can be inadvertently excluded from the mainstream focus of 'MSM interventions'. This dynamic has consequences in terms of access to information about risk behaviours involved in sex between men and access to condoms.

Such challenges suggest that interventions are needed at multiple levels – individual, couple, community and societal. These interventions need to be tailored according to the presence or absence of particular sexuality-related identities, age group, marital status, HIV status and type of partners. Moreover, the kinds of discursive exclusions that are affected through the unreflexive iteration of terms such as MSM, kothi, panthi and so on in HIV prevention work require renewed attention, for potentially negative effects on safer-sex promotion (including condom use).

Often, the focus of HIV-prevention intervention remains at the individual level as individuals are seen as solely responsible for their behaviour – in this case, use or non-use of condoms. As such, prevailing intervention strategies (focused on men who have sex with men in India) are predominantly oriented toward changing an individual's personal attitude towards condoms (for example, overcoming dislike) or imparting skills in using condoms, through ubiquitous condom use demonstrations in community-based interventions and so on. However, these individual-level approaches seem to largely overlook contextual factors, including interpersonal (for example, power differentials and force between male sex workers and their male clients or police or ruffians) and structural factors (such as law and social control of sexuality and gender conformity). For example, how can we help a person to use condoms who is concerned that talking about condoms will affect the relationship with his male or female steady partner? And what can be done to address situations where men who have sex with men know about using condoms and always carry condoms, but are forced by policemen or ruffians to have unprotected sex with them?

There is a need to assess these contextual factors (and the interpersonal and structural dynamics) and to devise appropriate interventions. For instance, improving sexual-communication skills and condom-negotiation skills can be one of the many possible ways to break the silence around talking about condoms within steady or casual relationships. Addressing structural factors, such as legal barriers (upholding the Delhi high court's judgment that consensual adult same-sex relationships are not criminal) and laws related to sex work, which lead to police abuse of power against male and transgender sex workers, are vital to reduce vulnerability to HIV. In addition, there is also a need to effect meaningful means of support and legal redress in contexts of adult non-consensual same-sex sexual acts, because those men who force sex with other men, transgender people and kothis are typically

unprosecuted and typically face no consequences as there is little or no well-established route to civil or legal action for the 'victims' of such actions.

The purpose of this investigation was to understand the contexts of inconsistent condom use in relation to HIV prevention in contexts of same-sex sexual practices. Caution should be exercised in generalising the findings, even though the sample was from both urban and rural sites, different age groups and from different regions of India. Further investigation in other locales in India, including systematic comparisons by age, employment status and other demographic variables, will help to determine the transferability of our findings. Nonetheless, the data presented here contribute to a fuller and improved understanding of the interpersonal and contextual factors that mitigate against sexual safety and consistent condom use among men who have sex with men in India. We advocate for improved understanding of these issues in health promotion at all levels of practice, be it national and international policy making environment or the everyday actions of fieldworkers undertaking condom promotion.

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