HHS Public Access

Author manuscript

Arch Sex Behav. Author manuscript; available in PMC 2019 January 01.

Published in final edited form as:

Arch Sex Behav. 2018 January ; 47(1): 235–244. doi:10.1007/s10508-016-0775-6.

Perspectives on Sexual Identity Formation, Identity Practices, and Identity Transitions among Men who have Sex with Men (MSM) in India

Cecilia Tomori, MA, PhD[1,5], **Aylur K. Srikrishnan, BS**[2], **Kathleen Ridgeway, MSPH**[3], **Sunil S. Solomon, MBBS, MPH, PHD**[4], **Shruti H. Mehta, MPH, PHD**[1], **Suniti Solomon, MD**[2], and **David D. Celentano, MPH, ScD**[1]

[1]Johns Hopkins Bloomberg School of Public Health, Department of Epidemiology, Baltimore, Maryland, USA

[2]YR Gaitonde Centre for AIDS Research and Education, Chennai, India

[3]Johns Hopkins Bloomberg School of Public Health, Department of International Health, Baltimore, Maryland, USA

[4]Johns Hopkins School of Medicine, Department of Medicine, Baltimore, Maryland, USA

Abstract

Men who have sex with men (MSM) remain at high risk for HIV infection. Culturally-specific sexual identities, encompassing sexual roles, behavior and appearance, may shape MSM's experiences of stigmatization and discrimination, and affect their vulnerability to HIV. This multi-site qualitative study (n=363) encompassing 31 focus group discussions (FGDs) and 121 in-depth interviews (IDIs) across 15 sites in India investigates sexual identity formation, identity practices, and transitions, and their implications for HIV-prevention. IDIs and FGDs were transcribed, translated, and underwent thematic analysis. Our findings document heterogeneous sexual identity formation, with MSM who have more gender non-conforming behaviors or appearance reporting greater family- and community-level disapproval, harassment, violence, and exclusion. Concealing feminine aspects of sexual identities was important in daily life, especially for married MSM. Some participants negotiated their identity practices in accordance with socioeconomic and cultural pressures, including taking on identity characteristics to suit consumer demand in sex work and on extended periods of joining communities of *hijras* (sometimes called TG or transgender women). Participants also reported that some MSM transition toward more feminine and *hijra* or transgender women identities, motivated by intersecting desires for feminine gender expression and by social exclusion and economic marginalization. Future studies should collect information on gender nonconformity stigma, and any changes in sexual identity practices or plans for transitions to other identities over time, in relation to HIV risk behaviors and outcomes.

[5]To whom correspondence should be addressed at Johns Hopkins Bloomberg School of Public Health, Department of Epidemiology, 615 N. Wolfe Street, E6648, Baltimore, Maryland, 21205, USA, ctomori1@jhu.edu.

Keywords

Men who have sex with men; sexual identities; stigma; gender nonconformity; HIV-prevention; India

INTRODUCTION

Epidemiological studies have documented the disproportionately high incidence of HIV among men who have sex with men (MSM) (Beyrer et al., 2012; Beyrer et al., 2013). Pervasive stigmatization, discrimination, and the criminalization of homosexuality in many settings constitute key barriers to MSM's access to HIV prevention and treatment services (Altman et al., 2012; Baral, Logie, Grosso, Wirtz, & Beyrer, 2013). In India, MSM face an estimated 14–25 times higher prevalence of HIV compared to the general population (National Institute of Medical Statistics and National Aids Control Organisation (India), 2010, 2012). Homosexuality is criminalized and stigmatized, and cultural expectations demand marriage and the production of children, leading many MSM to marry and conceal their behavior (Boyce, Chakrapani, & Dhanikachalam, 2011; Closson et al., 2014; Mimiaga et al., 2014; Phillips et al., 2010; Setia, Sivasubramanian, Anand, Row-Kavi, & Jerajani, 2010; S.S. Solomon, Mehta, Latimore, Srikrishnan, & Celentano, 2010). MSM frequently experience stigmatization, harassment, and violence and have poor psychosocial health, which is associated with greater vulnerability to HIV (Chakrapani, Newman, Shunmugam, McLuckie, & Melwin, 2007; Logie, Newman, Chakrapani, & Shunmugam, 2012; Mimiaga et al., 2013; Mimiaga et al., 2014; Mimiaga et al., 2011; Safren et al., 2009; Sivasubramanian et al., 2011; B Thomas, Mimiaga, Mayer, Perry, et al., 2012; B. Thomas et al., 2009).

Diverse sexualities and sexual identities among MSM that may not map onto Euro-American categories and MSM who may not identify with any sexual identities are well-documented in India (Asthana & Oostvogels, 2001; Boyce et al., 2011; Closson et al., 2014; Khan, 2001; Kumta et al., 2010; Patel, Mayer, & Makado, 2012; Phillips et al., 2009; Setia et al., 2008; Verma & Collumbien, 2004). Indeed, we use the terminology of MSM in this paper with awareness that that this category is itself a North American cultural construction that refers to sexual behavior, not to any identities (or lack thereof) and includes diverse groups of men who may or may not form communities (Tomori et al., 2016).

Early qualitative studies have indicated that there are multiple paths into same-sex sexual relationships, including sexual encounters during childhood, ranging from casual partnerships at cruising sites to sustained relationships, both as a substitution for and in addition to relationships with women (Asthana & Oostvogels, 2001; Khan, 2001). For instance, in 2001 Khan argued that same-sex encounters may simply be considered *maasti*, or playful behavior, and need not be linked to a sexual identity per se. Moreover, Khan suggested that sexual behaviors are not necessarily the most important part of a man's identity; being a married man and a father might be far more important (Khan, 2001, p. 106). Men, who had free movement outside the domestic sphere, could also separate their

behaviors in a specific context (e.g., cruising site) and take on their heteronormative identities when they returned home to their wives and children.

In contrast, Asthana and Oostvogel's ethnographic study in Chennai (formerly Madras) found that some engaged in same-sex relationships did take on specific identities, which were gendered, and linked to patterns of sexual behavior, but some labels were only applied by other groups rather than to oneself. The label of *panthi* to refer to men with masculine appearance who primarily engage in penetrative sex, for instance, was only applied by *dangas* (more feminine men, who desired mostly penetrative partners) and *alis* (transgender women). The authors also noted that men who engaged in transactional and commercial sex could take on various sexual roles without that necessarily being linked to their identities.

While some of this early work pointed to indigenous and local sexual identities, historians and anthropologists have called into question the historical origins and continuity of these categories (Boyce, 2007; Cohen, 2005; Dutta, 2012). Boyce (2007), for instance, has suggested that while HIV prevention efforts were aiming to capture local identity categories, they have contributed to spreading and/or reifying certain kinds of identity categories. The category of *kothi* serves as an example, since it previously may have only been used in specific contexts and settings, but has become widely used to refer to men with feminine appearance who predominately engage in receptive intercourse.

Recent research points towards widespread use of specific identity categories across multiple settings, including *kothi* and *panthi* or *girya* (labeled as such by their *kothi* partners and/or by themselves) discussed above; *double decker* (*DD*), who may present as masculine in some contexts and feminine in others and practice both insertive and receptive anal intercourse; and *bisexual* and *gay* identities, which are often associated with higher social classes (Boyce et al., 2011; Chakrapani, Newman, & Shunmugam, 2008; Chakrapani et al., 2007). These identities correlate with patterns of sexual behavior but may be situationally fluid (Boyce et al., 2011; Kumta et al., 2010; Phillips et al., 2009; Setia et al., 2008). Regardless of their sexual identities, many of these men have sexual relationships with women, due to cultural pressures to marry or their own preferences (Chakrapani, Boyce, & Dhanikachalam, 2011; Closson et al., 2014; S.S. Solomon et al., 2010). Some who are born as males also identify as *hijra* (sometimes spelled *hijara*) or *aravani*, or *TG* (transgender women), and may or may not undergo castration and penectomy as part of this process (Chakrapani, Newman, Shunmugam, & Dubrow, 2011; Reddy, 2005).

Although there is a growing body of research on MSM in India, the majority of recent peer-reviewed qualitative research that addresses aspects of sexual identity originates from a limited number of settings, and tends to emphasize *kothis*' experiences (Chakrapani et al., 2008; Chakrapani, Newman, et al., 2011; Chakrapani et al., 2007; Mimiaga et al., 2014; B Thomas, Mimiaga, Mayer, Perry, et al., 2012; Thompson et al., 2013). This research indicates that many *kothis* strongly identify with feminine characteristics from a younger age, and often experience particularly high levels of stigmatization, harassment, and violence as adults. There is comparatively less information about the negotiation of other sexual identities, or about identity practices across a larger number of sites. Moreover, concern has been raised about the effectiveness of HIV prevention efforts to reach a more

diverse range of MSM and whether the complexity of identities in the Indian setting may make targeted intervention efforts for specific identity groups problematic (Mimiaga et al., 2014; B Thomas, Mimiaga, Mayer, Closson, et al., 2012). The current study's objective was to gather information about how men participating in same-sex relationships across diverse geographic locations among different groups of MSM in India describe their own sexual identities, if any, how they negotiate these identities in daily life, and how they perceive other sexual identities among MSM with whom they interact through their own social and sexual relationships. The study also aimed to gain insight into how patterns of social experiences among sexual identity groups may contribute to psychosocial vulnerabilities that contribute to HIV-risk among MSM in India. These issues were investigated, along with other topics, in preparation for a large, multi-site HIV-prevention study.

METHODS

The data for this investigation are drawn from formative research for a cluster randomized trial evaluating the impact of MSM-friendly HIV services in 5 states and one Union Territory (S. S. Solomon, Lucas, Celentano, Sifakis, & Mehta, 2013; S.S. Solomon et al., 2015). The study was approved by the Institutional Review Boards of the Johns Hopkins University School of Medicine and the YRG Centre for AIDS Research and Education. The goals of the formative research were to gain insight into the social experiences, HIV-related vulnerabilities, and experiences with HIV-related services of MSM across diverse geographic regions and settings in India. A combination of focus group discussions (FGDs) and in-depth interviews (IDIs) was selected as the research design in accordance with formative research conventions for mixed methods studies in order to acquire a broad set of insights about MSM in India, including social norms, primarily derived from FGDs, and individual experiences, primarily derived from IDIs (Bernard, 2011; Creswell, 2011; Krueger & Casey, 2014; Morgan, 1997). FGDs were not stratified by sexual identities or other criteria in order to capture the broadest possible array of different MSM in each local context, including diverse sexual identities and those without a specific identity without conveying any prior assumptions about pre-existing categories.

As part of the formative research, 31 focus group discussions (FGDs) (n=242) and 121 in-depth interviews (IDIs) were conducted by trained interviewers with 363 MSM from 15 sites in the preferred local languages (Table 1). FGDs comprised groups of 5–10 participants (median=8). Participants were identified by local NGOs who provide services for MSM and by other MSM based on their knowledge about MSM in their area and/or their involvement in outreach work and peer education among MSM. Individuals were eligible if they identified as a man, were 18 or older, and had oral or anal sex with a man in the past 12 months. For the purposes of this study, those assigned male sex at birth who identified as transgender women, TG, or *hijra* were not eligible to participate. Interviewers and FGD facilitators were trained by YRGCARE, and were highly experienced in working with hard-to-reach and stigmatized populations, including diverse MSM. They were particularly attentive to establishing a confidential, safe, and comfortable non-judgmental environment for participants. FGD facilitators had extensive experience with facilitating similar FGDs, establishing good rapport with participants, and soliciting an array of perspectives from each group (Morgan, 1997).

FGDs and IDIs addressed a wide-range of topics related to the social experiences and key concerns of MSM in everyday life; the context of HIV-risk behaviors; and the availability, accessibility, and engagement with HIV-related services in their areas. Among these topics, FGDs included questions about participants' interactions with and perceptions of the appearance, sexual behaviors, and social treatment of different sexual identities among MSM in their communities. IDIs primarily addressed participants' own experiences of same-sex relationships, and their perceptions of their sexual identity (if any) and sexual behaviors, interactions with other MSM, negotiation of their sexual practices and identities in relation to families and communities, perceptions of HIV, and engagement with HIV-related services (Bernard, 2011). FGDs and IDIs were carried out in a sensitive and confidential manner at NGO offices to facilitate to allow participants to speak freely using open-ended questions whenever possible. Participants were compensated for their time.

FGDs and IDIs were transcribed verbatim, translated into English and entered into Atlas.TI qualitative software (version 7.5, Scientific Software Development GmbH, Eden Prarie, MN). FGD and IDI transcripts were analyzed together in order to be able to capture a more complete set of themes derived from individual experiences (primarily drawn from IDIs) and social norms and reported experiences (primarily derived from FGDs) (Bernard, 2011; Morgan, 1997). The discussions and interviews were first read by the lead qualitative researcher (CT) (Sandelowski, 1995), and underwent preliminary thematic analysis following principles of grounded theory, using open coding to derive broader thematic categories (Bernard, 2011; Strauss & Corbin, 1990). For the purposes of this analysis, themes related to sexual identity formation, identity practices, and identity transitions were refined through an additional round of coding by two coders (CT and KR), and used to develop a final coding scheme with a codebook that was applied to the transcripts. Any discrepancies were resolved through discussion and finalized by the lead qualitative researcher (CT). Attention was devoted to the source (FGD or IDI) and specific context of the coded text for each theme during the analytical process. We examined the representation of themes across sites and participant characteristics. Quotations were selected to represent key findings, with the state, site, age, sexual identity, and data source noted below each quote.

RESULTS

Participants' median age was 30 (IQR 25–35). Systematic assessment of income and socioeconomic status was not carried out in this phase, but discussions about participants' lives in FGDs and IDIs suggest that the majority of participants were from lower socioeconomic groups. Over 40% of MSM were ever married to a woman, with *kothi* less likely to report having ever been married (24%) than *panthi/girya* (42%) or *DD* (54%). The majority identified as a *kothi* or *DD,* followed by *panthi* or *girya* and *bisexual*, and lastly, *gay*. There were no participants who did not identify with a sexual identity. Due to the distribution of participants' sexual identities in our study, our analysis primarily highlights perspectives and experiences of those identifying as *kothi*, *DD*, and *panthi*. Participants' characteristics by state are summarized in Table 1.

Sexual identity formation

The majority of *kothi*-identifying participants and many identifying as *DD*s located the origins of their present identity in childhood, and specifically identified with behaviors and appearance associated with girls and women from very early on. For instance, a *kothi* participant stated:

> I was behaving like a girl since childhood. Though I was a boy, my behavior was like a girl. All used to ask me why you behave like this. I could not answer them because it was my character.
>
> (*Kothi,* 22, Mangalore, Karnataka, IDI)

This fundamentally feminine quality of *kothis* was articulated across the research sites and discussed both in individual interviews as well as in FGDs, as another participant explained:

> I am *kothi* because all my activities are like of [a] female. I have feminine nature. Since beginning, I have feminine nature. My family, friends and teacher used to indicate my feminine nature and said that my habits are of [a] female. Family used to say that I should make effort to change my behavior.
>
> (*Kothi*, 20, Delhi, Delhi, FGD)

As in the above accounts, these participants' behavior and appearance often drew questioning and criticism from family members and others, marking them as not conforming to normative expressions of gender identity. This criticism, in turn, influenced participants' own perception and development, as a *DD*-identifying participant described:

> My behavior used to be [a] little feminine ever since my childhood. I used to do all sorts of household chores like sweeping, washing dishes, etc. People chided me for being feminine. Because of these qualities I presumed myself to be MSM. I also decided to appear and behave more girlish.
>
> (*DD*, 35, Visakhapatnam, Andhra Pradesh, FGD)

Kothi and *DD*-identifying participants frequently described how the pervasive disapproval of feminine gender expression in young boys and men often led to systematic harassment and family efforts to pursue medical treatment to "correct" participants' gender and sexuality. One *kothi* participant described the process as follows:

> I became aware of sexuality at the age of 12. […] I liked to dress like a female and apply makeup, but family members were not allowing me and asked me why you are behaving like this nowadays, and whenever I used to wash clothes my mother used to come with me and then I came to know about it, and then they started to torture me more stating that you act like a girl and there is an evil soul trouble on you, and they took me to several places [to attempt to treat him].
>
> (*Kothi*, 38, Bangalore, Karnataka, FGD)

Many *kothi* and *DD*-participants also specifically identified sexual desire for men as accompanying alternative gender expression in some, although not necessarily all cases. In these cases, such as in the example below, gender expression and sexuality were difficult to

disentangle and led to periods of confusion until the participant met others who were similar to him:

> From my childhood I am attracted towards male people that are the same gender […] At the age of 10 I did not know what was happening, because I was in a confusion about who I am. I was confused as am I a man or a woman or something else. So when I completed my 10th standard and passed, slowly I met people whose feelings are similar like me…
>
> (*Kothi*, 40, Bangalore, Karnataka, IDI)

Many participants reported that their sexual identity was also shaped by experiences of sexual violence by family members, acquaintances, persons in positions of power, such as schoolteachers and older children. For some participants, the act of sexual violence was a pivotal incident that they felt led them to have sex with men later, especially in the context of sex work.

> […] in Bombay I had gone for a dance program for 2 to 3 days. There were 5 to 6 boys with me. They mixed something in my Thumbs Up drink and they had [sex] with me. Generally we have two veins, one in the penis and one in the anal [anus], when you have anal sex the vein in front becomes weak; when they had anal sex with me my vein also became weak and after some days I started liking it. From them I started doing *dhandha* [sex work].
>
> (*Kothi*, 38, Chittoor, Andhra Pradesh, FGD)

Victims of sexual violence often reported that their feminine qualities made them more visible targets of unwanted sexual harassment and violence.

In contrast to *kothi*- and *DD*-identifying participants, those who identified as *panthi* or *girya* in this study did not necessarily report a development of their attraction to men at a young age. For instance, for several participants, the development of their sexual relationship with men was based on a specific encounter, sometimes seemingly accidental, with another man to whom they became attracted, as this *girya* participant described:

> I met one MSM in Kathgodam express and gradually become sex partners. After one year, he took me to one place of bushes and there I have seen many MSM. After 3 months I went there and made friend[s] shortly.
>
> (*Girya*, 32, Delhi, Delhi, IDI)

Another *panthi* participant described his first sexual contact with another man in his early twenties in this manner:

> I didn't feel anything. I was sitting in Tirupathi when he came and spoke to me and I was tempted and liked to hear so I had [sex with him].
>
> (*Panthi*, 36, Chittoor, Andhra Pradesh, IDI)

Panthi and *girya* participants frequently employed the phrase that they "got used to" having sex with men or "it became a habit," as this *panthi* described:

> I got used to it through a friend of mine when I was in the college. Then I started meeting them in the garden, bus stand then it became a habit.
>
> (*Panthi*, 38, Hyderabad, Andhra Pradesh, FGD)

Several participants in FGDs mentioned that these "habits" formed before men got married and then persisted afterwards, as in this example:

> [Married men] have the habit of having sex before getting married and they can't get rid of that habit and it continues even after marriage. I have so many of them who used to have sex before getting married and even now after they are married they still have sex with me. They are used to it.
>
> (*Panthi*, 27, Hyderabad, Andhra Pradesh, FGD)

Such "habits," however, need not have been initiated by the desire to have sex. Other participants, both in FGDs and interviews, stated that these habits could also be the consequence of sexual abuse and rape for participants across identities, as this *kothi*-identified man shared in a FGD:

> When I was 16 years old, I was friendly with a boy and used to play with him. That boy along with another man raped another person and since I was with that boy who raped the other person this man thought I too was like him and so he raped me and from that time I got used to it.
>
> (*Kothi* 40, Chittoor, Andhra Pradesh, FGD)

Concealing and recognizing sexual identities

Participants frequently emphasized the importance of hiding their sexual identities in public spaces and when at home. Like many others in the study for whom gender nonconforming behavior and/or appearance was part of sexual identity, this *bisexual* participant altered his behavior, including his speech, at home:

> When I go home in my talk and attitude I never show any change, I behave normally and I keep my nature closed. When I come out of the house along with my community I behave freely with them as I feel free but at home I am bit strict. The way I talk, I talk like a man, I don't drag my voice and talk like this, I maintain myself because of this no one can make out that I am an MSM at home.
>
> (*Bisexual*, 26, Bangalore, Karnataka, IDI)

This kind of behavioral monitoring was particularly important among married MSM. For instance, a *kothi*-identifying participant described the dangers of having feminine characteristics:

> If an MSM grows long hair, family members question why he is growing hair like a woman, they ask him to be more manly as he is a married man, sometimes misunderstandings between wife and husband, they may quarrel on this issue, which may sometimes lead to break up the marriage, or the MSM may leave home and start *dhandha* [sex work].
>
> (*Kothi*, 23, Visakhapatnam, Andhra Pradesh, IDI)

Kothis were considered particularly vulnerable to being exposed because of their difficulty with adhering to masculine gender norms, which could result in separation and eventual divorce:

> There are many ways by noticing that he is also talking like a woman or that he is having more number of male friends. Somehow she will come to know and have the fear that the people around her will taunt her saying your husband is a eunuch so she will go to her parents house.
>
> (*Bisexual*, 39, Coimbatore, Andhra Pradesh, FGD)

Married MSM used numerous strategies to reduce the potential for their sexual behavior to become known, including spatial separation of sexual activities from home:

> May be *panthis* or *kothis,* I will never take any of these people nor I introduce them to any one of my family; when I come out I talk to them, being friendly with them and have sex then we will go home, but I will never take them home; even when there is a get together, wedding and functions, I will not entertain them at home nor in my family.
>
> (*DD*, 35, Tumkur, Karnataka, FGD)

Others lied about the nature of the relationship with other men who visited. For instance, one married *DD*-identifying participant mentioned in a FGD that he regularly hosts other MSM:

> The MSM keep coming to our house and when she asks about them I manage to tell her [his wife] that we work together and go out together on business.
>
> (*DD*, 51, Coimbatore, Andhra Pradesh, FGD)

While nearly universally participants felt that wives would not accept their husband's sexual behavior, there were a few exceptions. In one case, a wife seemed to accept her husband's partner, although it was not clear whether she was fully aware of his sexual relationship with him:

> I know a *panthi* who is married. His wife knew it. He loves his wife as well as the *kothi*. He used to take him to his house, eat in their house and they go about with them.
>
> (*Kothi*, 22, Mangalore, Karnataka, IDI)

It was also unclear whether part of the acceptance was also due to the fact that the husband was a *panthi* who conformed to cultural expectations for men rather than someone who appeared more feminine.

The need to conform to cultural norms of appearance for men made recognition of MSM challenging outside of cruising areas or where sex workers congregated. Nevertheless, many participants stated that *kothis* were easier to recognize than other identities even outside cruising areas due to their more feminine behavior and appearance. Some participants also mentioned that other MSM might avoid *kothis* in these locations in order to prevent suspicion about their own behavior:

R: People don't like to speak to *kothis* in public because their body language and behavior appears to be different from normal men, anybody can immediately identify that he is MSM. We cannot identify *panthis* and *DD* as MSM.

I: You said that their behavior will be different, how different it is?

R: Their gait is a little feminine, movements of the body, posture, tilt of their head while talking all are girlish. They try to express that they want to have sex like girls through their mannerisms and body language.

(*DD*, 34, Visakhapatnam, Andhra Pradesh, IDI)

At the same time, some participants commented on the difficulties of attempting to identify any sexual identities, including *kothis*, based on their appearance, as this *bisexual* participant described:

The MSM community has *kothi*, *DD* and *bisexuals*. We cannot say who is what. A *kothi* looks like a *panthi* and a *DD* looks like a *kothi*.

(*Bisexual*, 29, Belgaum, Karnataka, FGD)

Moreover, several participants noted that outward appearance might not correspond to their sexual behavior:

I look like a *panthi*, or wearing a male costume. But I have feminine feelings. I behave like a female in bed; that is like a *kothi*. But I look like a *panthi* or *DD*. On the other hand a person look[s] like a *kothi*, but in bed he may do top or bottom.

(*DD*, 29, Belgaum, Karnataka, FGD)

This discrepancy between outward masculine appearance, and internal feminine qualities and feminine sexual behaviors, was most frequently mentioned among those identifying as *DDs* and *bisexuals*.

Negotiating Identity Practices in the Context of Sex Work

The most common reason participants described for changing their identity practices was to meet the demands of clients in the context of sex work. Such changes were most frequently employed among those currently identifying as *DD* participants and some *bisexuals*:

[…] one person will come and he will give me 100 rupees and if I am a giver to him then my sexuality will change. My role will also change and all I need is money.

(*DD*, 33, Chennai, Tamil Nadu, IDI)

Another *DD* sex worker commented on the economic benefits of flexible identity practices in the sexual marketplace:

I am a male sex worker. I had a friend by name Kumar and even if he gets a client he used to ring me up and ask me to contact him and he used to tell if you go there you should go as a *DD* and not as a *panthi*. You should act like a *DD* there. I will go and behave like a *DD* and I will collect the cash.

(*DD*, 27, Chennai, Tamil Nadu, FGD)

Several participants also described more sustained identity changes in the context of sex work, usually from more masculine to more feminine identities as this *DD*-identifying man observed:

> The transformation of pure *panthi* to *DD* and *DD* to *kothi* takes place after some days of work in sex.
>
> (*DD*, 34, Trichy, Tamil Nadu, IDI)

Participants from multiple sites mentioned that some *kothis* also changed their appearance to become indistinguishable from *hijras*, whom they joined for part of the year in large cities to participate in sex work and begging. When they returned home after several months or even some years, they resumed their previous appearance. One *kothi* participant described this process in a FGD:

> Some stay [in Mumbai] for 3 months, some 1 year and maybe 2 years; they tell their parents that they are working in that place. There they grow long hair, for wearing sarees and appearing as full-fledged *hijra*/*TG*; they cut their hair before returning to their place so that no one at home gets any suspicion. I myself did this sometime back.
>
> (*Kothi*, 27, Visakhapatnam, Andhra Pradesh, FGD)

Some of these *kothis* preferred dressing in feminine clothing and enjoyed being a part of *hijra* communities. At the same time, they reaped clear economic benefits from taking on these identities.

Transitions to other sexual identities

Many participants in both FGDs and individual interviews noted that sometimes their own sexual identity or others' sexual identities changed over the life course. Most often MSM discussed transitions from more masculine to more feminine appearance and identity, including becoming a *hijra.* However, there were a few reports of other transitions, including this one of a *kothi* transitioning to *DD* after his marriage:

> Earlier I was a *kothi* but once I got married I [have become] a *double-decker*. I have relationship[s] with men and women. I am MSM *DD*.
>
> (DD, 43, Trichy, Tamil Nadu, IDI)

The most common transition, however, was as this *kothi* described during an interview:

> Nobody will become a *hijara* in the beginning itself. First they will be MSM only. They will be either pant- and shirt-wearing *kothi* or *DD* community and first they will be brought into *Jamaat* system [a formal social hierarchy and set of relations among *hijra*]. Nobody will get operated [undergo castration] in the beginning itself and become *hijara* and enter into *Jamaat* system.
>
> (*Kothi*, 26, Chennai, Tamil Nadu, IDI)

While some MSM spent only a few months with *hijra*s in the context of sex work, and then returned to their other identities, others had sustained relationships with *hijras*. Moreover, although some MSM described sharper distinctions between *hijras* and various groups of

MSM, in many cases the boundaries between identities and communities was quite porous, especially for *kothis*. This *kothi* participant, for instance, detailed his own kinship relations that crossed the boundaries between *hijras* and other MSM in an interview:

> Some elder MSM or *hijra* take us as *chelas* [disciples], as daughters or as daughter-in-laws. We feel proud in identifying so and so is my *guru* [leader] or mother or mother-in-law, etc. Just like with the *hijra*, we too are like *hijra*, we observe a small ceremony for adopting (*reethulu*) daughters and daughters-in-law. Once adopted, we observe all the traditional duties as thus. Almost all the MSM have this kind of relations.
>
> (*Kothi*, 21, Visakhapatnam, Andhra Pradesh, IDI)

Participants reported that transitions to *hijra* or *aravani* identities among MSM were motivated by a variety of reasons. For some, the desire to become a woman originated early in life and the transition from male to female was a fulfillment of their feminine identity. Families also played a role in the decision for some MSM to become *hijras*. The preference for wearing feminine clothing (saris) in public, for instance, was a subject of many family arguments. For instance, one *kothi*-identifying participant, whose family found his preference of wearing feminine clothing unacceptable, planned to become a full *hijra*, and undergo castration in the future. The participant stated:

> I don't like to live as a male. I would like to live as a woman […] I wish for that.
>
> (*Kothi*, 21, Bangalore, Karnataka, IDI)

Family rejection and intolerance by the larger community could leave more feminine MSM without sufficient economic or social support, leading them to seek support and inclusion provided by the *hijra* community. As one *kothi* participant explained in an interview:

> Those who want to wear saris, and exhibit feminine behavior, don't get proper employment, so they come into the folds of the MSM and *hijra*, here they can have easy money, and a lot of it through *basti* [blessing shop work] or *dhandha* [sex work], they enjoy the life on one hand and on the other they earn a comfortable living.
>
> (*Kothi*, 42, Visakhapatnam, Andhra Pradesh, IDI)

The transitions to a *hijra* identity reflected these and similarly intertwined psychological, sociocultural, and economic motivations.

DISCUSSION

Our findings among a diverse group of participants across a large number of sites provide contemporary perspectives on sexual identities among MSM in India. Consistent with previous research (Boyce, 2007; Chakrapani, Newman, et al., 2011; Chakrapani et al., 2007; Reddy, 2005), gender was frequently conflated with sexual identity, so that more internal feminine qualities and more overtly recognizable feminine behaviors and appearance were considered an inherent aspect of *kothi* identity, often manifest in childhood, while masculinity was assumed among those identifying as *panthi*. Negotiating *DD* and *bisexual*

identities was more complex, however, and could combine possessing inner feminine qualities while maintaining outward masculine characteristics.

There were notable differences in identity formation between participants currently identifying with more feminine and more masculine sexual identities. While *kothis* and feminine *DDs* frequently noted their identification with feminine qualities from early childhood, this was not the case for *panthis*, who described their sexual identity formation in terms of chance encounters and attractions. Feminine appearance and behavior marked MSM as targets of sexual violence and was the basis of consistent disapproval from their families and communities, which significantly shaped *kothis'* and feminine-*DDs'* identity formation. In contrast, participants who identified as *panthis* appeared indistinguishable from other boys and men who did not have sex with other men, thereby avoiding the social consequences of gender nonconformity.

Our findings provide insight into the contextual flexibility of sexual identity practices based on socioeconomic and cultural pressures. Meeting client preferences in sex work was a main reason why participants altered their sexual identity practices and sexual behavior: this was particularly common among those identifying as *DDs* and some *bisexuals. Kothis* also reported taking on *hijra* characteristics for lengthier periods of sex work before resuming their prior identity practices. Some of these changes were motivated by these MSM's desire for femininity as well as by financial benefits. Many participants also reported that they observed such transitions and several participants themselves had plans for transitions from more masculine sexual identities towards more feminine *kothi* and *hijra* identities, in some cases accompanied by plans for surgery. Social exclusion from families and consequent limited economic opportunities could provide additional motivation to realize the desire to express feminine identification.

The findings document important distinctions in sexual identity formation and their social implications among MSM based on the degree of observable gender nonconformity, which corresponds to the level of family and community-level disapproval, harassment, violence, and social exclusion. Participants placed a high level of emphasis in concealing feminine aspects of their identity, and avoided association with others who manifested these feminine characteristics (*kothis*) in order to avoid suspicion. Keeping feminine elements of sexual identity secret was also essential for married MSM, who may face severe repercussions from their wives and families. This is consistent with previous research documenting the negative social perceptions of gender nonconformity, which leads MSM to conceal and police their own behavior (Boyce et al., 2011; Mimiaga et al., 2014), results in highly negative self-perceptions among *kothi* (Thompson et al., 2013) and is associated with higher odds of depression (Logie et al., 2012; Tomori et al., 2015). Additionally, social exclusion may also push *kothis* into sex work as a source of income, which exposes them to additional psychosocial risks, violence, and vulnerability to HIV (Chakrapani et al., 2007; Newman, Chakrapani, Cook, Shunmugam, & Kakinami, 2008). The social risks of gender nonconformity may also serve as deterrents for some MSM who may wish to take on more overtly feminine sexual identities, such as in the case of *DDs* who maintain the appearance of a *panthi* but have "feminine feelings."

The results also suggest that sexual identities that incorporate visible feminine qualities along with receptive anal sex practices may be subject to a convergence of social and biological risks for HIV (Chakrapani et al., 2008; Chakrapani, Newman, et al., 2011; Chakrapani et al., 2007; Logie et al., 2012; Narayanan et al., 2012). A similar convergence has been documented in South Africa by Sandfort and colleagues (2015), who have found that MSM who identify with more feminine gender characteristics are at increased risk for HIV. While HIV-prevention efforts have usually collected data on sexual practices and self-identities, large-scale systematic investigations of gender nonconformity in relation to stigma, discrimination, violence, mental health, and HIV risk are sparse. Moreover, while more feminine MSM (especially *kothis*) may experience gender nonconformity stigma most acutely, exploring social awareness and internalized dimensions of gender nonconformity may also provide insight into the psychosocial burden on other MSM. Many of these MSM carefully avoid associating with feminine-appearing MSM near their homes and continually monitor their own behavior and appearance to avoid being perceived as feminine in order to minimize negative social consequences.

Gender nonconformity as an investigative measure may also facilitate better insight into the shared vulnerabilities and social connections between some same-sex attracted men and male-to-female transgender identities in India. Many HIV prevention studies, including this one, which only sampled MSM who identified as men, maintain separation between MSM and *hijra* or *aravani* because of differences in gender identity, and socio-historical and political differences in the treatment of the *hijra*, or "third sex," in India (Dutta, 2012). While these distinctions are important, our findings indicate substantial overlap between MSM and *hijra*/*aravani* based on various degrees of feminine gender identity, with MSM participating in communities similar to *hijras*, or taking on *hijra* identities and participating in *hijra* communities for extended periods of time. While transitioning to these identities for shorter periods or permanently may partly reflect innate preferences, our findings suggest that the economic and social vulnerabilities of social exclusion also assert considerable force in why some MSM may seek support among *hijras/aravanis*, who have tight-knit communities comprised of formal kinship relationships and social hierarchies. Taking on the *hijra/aravani* identity, however, has its own social risks, with heavy societal stigmatization of overt feminine appearance and behavior and reliance on begging and sex work for employment, as well as potential pressure to undergo castration (Chakrapani, Newman, et al., 2011; Reddy, 2005).

It is important to note that while more masculine *DD*s and *panthis* may face comparatively less overt stigmatization, all MSM across sexual identities face considerable social risks if their behavior becomes known by their families or communities, which may be particularly grave for married MSM, leading to divorce, family rejection and suicide (Chakrapani, Boyce, et al., 2011; Closson et al., 2014; Tomori et al., 2015). The stigma and secrecy that surrounds same-sex attraction and practices makes MSM (as well as their wives and female partners) vulnerable to HIV through numerous psychosocial mechanisms and social barriers to HIV-related services. Therefore, the engagement of all MSM who may be at risk, including those whose may not identity with any of the common groups and those who are more able to conform with conventional masculine appearance and behavior, is essential in HIV research. While this qualitative study could only offer limited information about more

masculine identities, other recruitment strategies, such as respondent driven sampling, have great potential in reaching these groups (S.S. Solomon et al., 2015).

Our study is limited by reliance on one-time interviews and focus group discussions, which limit our understanding of the development and negotiation of sexual identities over time. Moreover, the majority of our sample identified as *kothi* and *DD*, yielding less insight into the *panthi* and other sexual identities or those who do not have any specific sexual identities. Nevertheless, participants represented most major sexual identity groups, hailed from a large number of sites across India, and provided a wide array of accounts of MSM life experiences across India. IDIs and FGDs addressed sensitive topics, and therefore the responses might have been limited by social desirability bias. This limitation was mitigated by participants' existing comfort with local MSM-friendly NGOs where many FGDs and IDIs were held, and the efforts of our well-trained and experienced research team, which successfully established good rapport with participants. Our study did not stratify FGDs by sexual identity. This facilitated the discussion of potentially overlapping experiences, behaviors, and perceptions. At the same time, a stratified study may provide better insight into potential greater differences among the different sexual identities among MSM. There was variation in the richness of data produced across research sites based on the participants in the discussions and interviews at each site and the amount of follow-up and probing by interviewers. Future qualitative studies may explore these issues in greater depth with a purposeful stratified longitudinal sample that balances participants by sexual identities (using existing social networks to recruit *panthis*) and enables systematic comparison of these identities across regions and sites.

Conclusion

Our study provides contemporary perspectives on MSM sexual identity formation, identity practices, and some identity transitions from a wide range of settings across India in the context of sociocultural and socioeconomic pressures. Future longitudinal studies of MSM in India are needed to follow the evolution of sexual identities and associated vulnerabilities over time. This work should include measures of gender identity and expression, document flexibility in sexual identity practices and any sexual identity transitions over time, and include greater attention to masculine sexual identities and interactions between MSM and *hijra* communities.

Acknowledgments

This research has been supported by grants from the National Institutes of Mental Health R01 89266, and R21 101059, and the Johns Hopkins Center for AIDS Research (1P30AI094189). No conflicts of interest are declared. We thank the National AIDS Control Organization (NACO), India, all of our partner non-governmental organizations throughout India, and the countless participants, without whom this research would not have been possible.

References

Altman D, Aggleton P, Williams M, Kong T, Reddy V, Harrad D, … Parker R. Men who have sex with men: stigma and discrimination. Lancet. 2012; 380(9839):439–445. DOI: 10.1016/S0140-6736(12)60920-9 [PubMed: 22819652]

Asthana S, Oostvogels R. The social construction of male 'homosexuality' in India: implications for HIV transmission and prevention. Soc Sci Med. 2001; 52(5):707–721. [PubMed: 11218175]

Baral S, Logie CH, Grosso A, Wirtz AL, Beyrer C. Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. BMC public health. 2013; 13:482.doi: 10.1186/1471-2458-13-482 [PubMed: 23679953]

Bernard, HR. Research methods in anthropology: Qualitative and quantitative approaches. Rowman Altamira; 2011.

Beyrer C, Baral SD, van Griensven F, Goodreau SM, Chariyalertsak S, Wirtz AL, Brookmeyer R. Global epidemiology of HIV infection in men who have sex with men. The Lancet. 2012; 380(9839):367–377.

Beyrer C, Sullivan P, Sanchez J, Baral SD, Collins C, Wirtz AL, … Mayer K. The increase in global HIV epidemics in MSM. AIDS. 2013; 27(17):2665–2678. DOI: 10.1097/01.aids.0000432449.30239.fe [PubMed: 23842129]

Boyce P. 'Conceiving kothis': Men who have sex with men in India and the cultural subject of HIV prevention. Medical Anthropology. 2007; 26(2):175–203. [PubMed: 17469015]

Boyce, P., Chakrapani, V., Dhanikachalam, D. Hard-to-reach men who have sex with men in India, recommendations for HIV prevention. 2011. Retrieved from http://strive.lshtm.ac.uk/resources/india-%E2%80%98msm-situation-paper%E2%80%99-series-technical-briefs

Chakrapani, V., Boyce, P., Dhanikachalam, D. Women Partners of Men who have Sex with Men in India. 2011. Retrieved from http://strive.lshtm.ac.uk/resources/india-%E2%80%98msm-situation-paper%E2%80%99-series-technical-briefs

Chakrapani V, Newman PA, Shunmugam M. Secondary HIV prevention among kothi-identified MSM in Chennai, India. Culture, health & sexuality. 2008; 10(4):313–327. DOI: 10.1080/13691050701816714

Chakrapani V, Newman PA, Shunmugam M, Dubrow R. Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India. AIDS care. 2011; 23(12):1687–1694. [PubMed: 22117127]

Chakrapani V, Newman PA, Shunmugam M, McLuckie A, Melwin F. Structural violence against Kothi-identified men who have sex with men in Chennai, India: a qualitative investigation. AIDS Education and Prevention. 2007; 19(4):346–364. [PubMed: 17685847]

Closson EF, Sivasubramanian M, Mayer KH, Srivastava A, Safren SA, Anand VR, … Mimiaga MJ. The other side of the bridge: exploring the sexual relationships of men who have sex with men and their female partners in Mumbai, India. Culture, health & sexuality. 2014; 16(7):780–791. DOI: 10.1080/13691058.2014.911960

Cohen, L. The Kothi wars: AIDS cosmopolitanism and the morality of classification. In: Adams, V., Piggs, SL., editors. Sex in Development: Science, Sexuality, and Morality in Global Perspective. Durham: Duke; 2005. p. 269-304.

Creswell, JW. Designing and conducting mixed methods research. 2. Plano Clark, VL., editor. Los Angeles: SAGE Publications; 2011.

Dutta A. An epistemology of collusion: Hijras, kothis and the historical (dis) continuity of gender/sexual identities in eastern India. Gender & History. 2012; 24(3):825–849.

Khan S. Culture, sexualities, and identities: men who have sex with men in India. Journal of homosexuality. 2001; 40(3–4):99–115. DOI: 10.1300/J082v40n03_06 [PubMed: 11386341]

Krueger, RA., Casey, MA. Focus groups: A practical guide for applied research. 5. Thousand Oaks, CA: Sage publications; 2014.

Kumta S, Lurie M, Weitzen S, Jerajani H, Gogate A, Row-kavi A, … Mayer KH. Bisexuality, sexual risk taking, and HIV prevalence among men who have sex with men accessing voluntary counseling and testing services in Mumbai, India. Journal of acquired immune deficiency syndromes (1999). 2010; 53(2):227. [PubMed: 19934765]

Logie CH, Newman PA, Chakrapani V, Shunmugam M. Adapting the minority stress model: associations between gender non-conformity stigma, HIV-related stigma and depression among men who have sex with men in South India. Social Science & Medicine. 2012; 74(8):1261–1268. [PubMed: 22401646]

Mimiaga MJ, Biello KB, Sivasubramanian M, Mayer KH, Anand VR, Safren SA. Psychosocial risk factors for HIV sexual risk among Indian men who have sex with men. AIDS care. 2013; 25(9): 1109–1113. DOI: 10.1080/09540121.2012.749340 [PubMed: 23339580]

Mimiaga MJ, Closson EF, Thomas B, Mayer KH, Betancourt T, Menon S, Safren SA. Garnering an in-depth understanding of men who have sex with men in Chennai, India: a qualitative analysis of sexual minority status and psychological distress. Archives of Sexual Behavior. 2014; Epub ahead of print. doi: 10.1007/s10508-014-0369-0

Mimiaga MJ, Thomas B, Mayer KH, Reisner SL, Menon S, Swaminathan S, … Safren SA. Alcohol use and HIV sexual risk among MSM in Chennai, India. International journal of STD & AIDS. 2011; 22(3):121–125. DOI: 10.1258/ijsa.2009.009059 [PubMed: 21464447]

Morgan, DL. Focus groups as qualitative research. 2. Thousand Oaks, CA: SAGE; 1997.

Narayanan P, Das A, Prabhakar P, Gurung A, Morineau G, Rao G, … Risbud A. Self-Identity, Sexual Practices and Sexually Transmitted Infections among High-Risk Men who Have Sex with Men Attending Clinics in Urban India. J AIDS Clinic Res S. 2012:S1.

National Institute of Medical Statistics and National Aids Control Organisation (India). Technical Report: India HIV Estimates. 2010. Retrieved from http://naco.gov.in/upload/Surveillance/Reports&Publication/TechnicalReportIndiaHIVEstimates2010.pdf

National Institute of Medical Statistics and National AIDS Control Organisation (India). Technical Report: India HIV Estimates. 2012. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/data-and-analysis/tools/spectrum/India2012report.pdf

Newman P, Chakrapani V, Cook C, Shunmugam M, Kakinami L. Correlates of paid sex among men who have sex with men in Chennai, India. Sexually transmitted infections. 2008; 84(6):434–438. [PubMed: 19028942]

Patel VV, Mayer KH, Makado HJ. Men who have sex with men in India: a diverse population in need of medical attention. Indian Journal of Medical Research. 2012; 136(4):563–570. [PubMed: 23168696]

Phillips A, Boily M, Lowndes C, Garnett G, Gurav K, Ramesh B, … Alary M. Sexual identity and its contribution to MSM risk behavior in Bangaluru (Bangalore), India: the results of a two-stage cluster sampling survey. Journal of LGBT Health Research. 2009; 4(2–3):111–126.

Phillips A, Lowndes CM, Boily MC, Garnett GP, Gurav K, Ramesh B, … Alary M. Men who have sex with men and women in Bangalore, South India, and potential impact on the HIV epidemic. Sexually transmitted infections. 2010; 86(3):187–192. [PubMed: 20522632]

Reddy G. Geographies of contagion: Hijras, Kothis, and the politics of sexual marginality in Hyderabad. Anthropology & Medicine. 2005; 12(3):255–270. [PubMed: 26873670]

Safren SA, Thomas BE, Mimiaga MJ, Chandrasekaran V, Menon S, Swaminathan S, Mayer KH. Depressive symptoms and human immunodeficiency virus risk behavior among men who have sex with men in Chennai, India. Psychology, Health & Medicine. 2009; 14(6):705–715. DOI: 10.1080/13548500903334754

Sandelowski M. Qualitative analysis: what it is and how to begin. Res Nurs Health. 1995; 18(4):371–375. [PubMed: 7624531]

Sandfort TG, Lane T, Dolezal C, Reddy V. Gender Expression and Risk of HIV Infection Among Black South African Men Who Have Sex with Men. AIDS and behavior. 2015; doi: 10.1007/s10461-015-1067-1

Setia M, Brassard P, Jerajani H, Bharat S, Gogate A, Kumta S, … Boivin J. Men who have sex with men in india: a systematic review of the literature. Journal of LGBT Health Research. 2008; 4(2–3):51–70. DOI: 10.1080/15574090902913727 [PubMed: 19856739]

Setia M, Sivasubramanian M, Anand V, Row-Kavi A, Jerajani H. Married men who have sex with men: the bridge to HIV prevention in Mumbai, India. International journal of public health. 2010; 55(6):687–691. [PubMed: 20680656]

Sivasubramanian M, Mimiaga MJ, Mayer KH, Anand VR, Johnson CV, Prabhugate P, Safren SA. Suicidality, clinical depression, and anxiety disorders are highly prevalent in men who have sex with men in Mumbai, India: findings from a community-recruited sample. Psychology, Health & Medicine. 2011; 16(4):450–462. DOI: 10.1080/13548506.2011.554645

Solomon SS, Lucas GM, Celentano DD, Sifakis F, Mehta SH. Beyond surveillance: a role for respondent-driven sampling in implementation science. American Journal of Epidemiology. 2013; 178(2):260–267. DOI: 10.1093/aje/kws432 [PubMed: 23801014]

Solomon SS, Mehta SH, Latimore A, Srikrishnan AK, Celentano DD. The impact of HIV and high-risk behaviours on the wives of married men who have sex with men and injection drug users: implications for HIV prevention. Journal of the International AIDS Society. 2010; 13(Suppl 2):S7. [PubMed: 20573289]

Solomon SS, Mehta SH, Srikrishnan AK, Vasudevan CK, Mcfall AM, Balakrishnan P, … Laeyendecker O. High HIV prevalence and incidence among MSM across 12 cities in India. AIDS. 2015; 29(6):723–731. [PubMed: 25849835]

Strauss, A., Corbin, J. Basics of qualitative research. Newbury Park, CA: Sage; 1990.

Thomas B, Mimiaga M, Mayer K, Closson E, Johnson C, Menon S, … Safren S. Ensuring it works: a community-based approach to HIV prevention intervention development for men who have sex with men in Chennai, India. AIDS education and prevention : official publication of the International Society for AIDS Education. 2012; 24(6):483–499. DOI: 10.1521/aeap.2012.24.6.483 [PubMed: 23206199]

Thomas B, Mimiaga M, Mayer K, Perry N, Swaminathan S, Safren S. The influence of stigma on HIV risk behavior among men who have sex with men in Chennai, India. AIDS care. 2012; 24(11): 1401–1406. [PubMed: 22519945]

Thomas B, Mimiaga MJ, Menon S, Chandrasekaran V, Murugesan P, Swaminathan S, … Safren SA. Unseen and unheard: predictors of sexual risk behavior and HIV infection among men who have sex with men in Chennai, India. AIDS Education and Prevention. 2009; 21(4):372–383. DOI: 10.1521/aeap.2009.21.4.372 [PubMed: 19670971]

Thompson LH, Khan S, du Plessis E, Lazarus L, Reza-Paul S, Hafeez Ur Rahman S, … Lorway R. Beyond internalised stigma: daily moralities and subjectivity among self-identified kothis in Karnataka, South India. Culture, health & sexuality. 2013; 15(10):1237–1251. DOI: 10.1080/13691058.2013.818714

Tomori C, McFall AM, Srikrishnan AK, Mehta SH, Solomon SS, Anand S, … Celentano DD. Diverse Rates of Depression Among Men Who Have Sex with Men (MSM) Across India: Insights from a Multi-site Mixed Method Study. AIDS and behavior. 2015; doi: 10.1007/s10461-015-1201-0

Tomori C, Srikrishnan A, Ridgeway K, Solomon S, Mehta S, Solomon S, Celentano D. Sisters, wives, and friends: social support and social risks in peer relationships among men who have sex with men (MSM) in India. AIDS Educ Prev. 2016; 28(2):153–164. [PubMed: 27459166]

Verma RK, Collumbien M. Homosexual activity among rural Indian men: implications for HIV interventions. AIDS. 2004; 18(13):1845–1847. [PubMed: 15316346]

Table 1

Participant characteristics

State	N	IDI (n)	FGD	Median age (IQR)	Marital Status (n)		Sexual Identity (n)				
			Number of Groups/Total people		Single	Ever Married	Kothi	Panthi/Girya	Double Decker	Bisexual	Gay
Madhya Pradesh	24	8	2/16	25 (21, 31)	15	9	4	6	3	2	9
Uttar Pradesh	23	8	2/15	28 (26, 32)	18	5	9	3	8	3	0
Delhi	20	8	2/12	28 (24, 32)	12	8	8	6	5	1	0
Andhra Pradesh	96	32	8/64	27 (22, 35)	55	41	46	19	26	5	0
Karnataka	107	33	9/74	29 (25, 35)	62	45	41	6	35	23	2
Tamil Nadu	93	32	8/61	32 (27, 37)	52	41	40	15	37	0	1
Total (%)	363	121 (33.3)	31/242 (66.6)	30 (25, 35)	214 (59)	149 (41)	148 (40.8)	55 (15.2)	114 (31.4)	34 (9.4)	12 (3.3)

IDI In-depth interview

FGD Focus group discussion

IQR Interquartile range