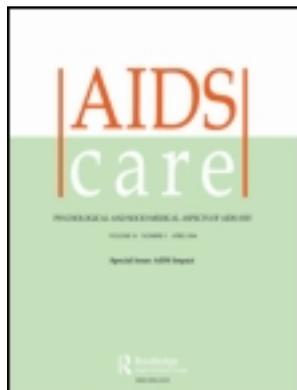


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Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India

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The Indian government provides free antiretroviral treatment (ART) for people living with HIV. To assist in developing policies and programs to advance equity in ART access, we explored barriers to ART access among kothis (men who have sex with men [MSM] whose gender expression is feminine) and aravanis (transgender women, also known as hijras) living with HIV in Chennai. In the last quarter of 2007, we conducted six focus groups and four key-informant interviews. Data were explored using framework analysis to identify categories and derive themes. We identified barriers to ART access at the family/social-level, health care system-level, and individual-level; however, we found these barriers to be highly interrelated. The primary individual-level barrier was integrally linked to the family/social and health care levels: many kothis and aravanis feared serious adverse consequences if their HIV-positive status were revealed to others. Strong motivations to keep one's HIV-positive status and same-sex attraction secret were interconnected with sexual prejudice against MSM and transgenders, and HIV stigma prevalent in families, the health care system, and the larger society. HIV stigma was present within kothi and aravani communities as well. Consequences of disclosure, including rejection by family, eviction from home, social isolation, loss of subsistence income, and maltreatment (although improving) within the health care system, presented powerful disincentives to accessing ART. Given the multi-level barriers to ART access related to stigma and discrimination, interventions to facilitate ART uptake should address multiple constituencies: the general public, health care providers, and the kothi and aravani communities. India needs a national policy and action plan to address barriers to ART access at family/social, health care system, and individual levels for aravanis, kothis, other subgroups of MSM and other marginalized groups.

Keywords: access to health care; antiretroviral treatment; men who have sex with men; transgender women; India

Introduction

In 2004, the Indian government began providing free antiretroviral treatment (ART) through government ART centers (National AIDS Control Organisation [NACO], 2006). Although scale up of ART has been considerable, in 2009 only 45% of adults with advanced HIV infection were receiving ART (NACO, 2010).

Men who have sex with men (MSM) and hijras (genetic males who identify as women and can be grouped under the international umbrella term “transgender” [male-to-female]) are designated “core high risk groups” in India (NACO, 2007a). HIV prevalence among MSM is estimated at 7.3%, more than 20 times the general population rate (NACO, 2010). Recent studies report HIV prevalence among hijras of 18% in four south Indian states (Brahman et al., 2008), 17% in Chennai (Saravanamurthy et al., 2010), and 41% among a clinical sample in Mumbai

(Shinde, Setia, Row Kavi, Anand, & Jerajani, 2009). The International Treatment Preparedness Coalition reports limited access to ART among marginalized groups, including MSM and hijras (Abraham, Chakrapani, Ram, Ramesh, & John, 2006).

MSM and hijras are diverse populations. In Chennai, kothis are a relatively visible subgroup of MSM whose gender expression is feminine. Kothis are primarily receptive partners in anal sex and a significant proportion engage in sex work (Chakrapani, Newman, & Shunmugam, 2008; Chakrapani, Newman, Shunmugam, McLuckie, & Melwin, 2007), both of which contribute to high risk for HIV infection. Some kothis also engage in sex with women and, largely due to powerful social norms and family pressure, some are married to women (Chakrapani et al., 2008). Hijras in Chennai are called aravanis and most live in aravani communities. A substantial proportion of aravanis engage in sex work for survival (Chakrapani, Babu, & Ebenezer, 2004).

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The goal of this study was to inform effective interventions to increase ART access for kothis and aravanis living with HIV in Chennai; to that end, we aimed to identify and understand barriers faced by these marginalized groups in accessing free ART at government treatment centers.

Methods

In the last quarter of 2007, we conducted three focus groups among adult HIV-positive kothis and three among adult HIV-positive aravanis. Focus group participants were recruited using purposive sampling through four community-based organizations (CBOs) in Chennai to reflect diversity in terms of area of residence, living situation, and duration of service agency contact. We also conducted four key informant interviews with community leaders of agencies that work with kothis and aravanis.

We used semi-structured in-depth interview guides in Tamil with scripted probes that focused on barriers to ART access and how to address these barriers. Focus groups ranged from 60 to 90 minutes; key informant interviews were approximately 60 minutes. Focus group participants received an honorarium of 250 Indian rupees (~\$6 USD); key informants did not receive an honorarium. Interviews were tape-recorded, transcribed verbatim in Tamil and translated into English for data analysis. All participants provided written informed consent. The study received approval from the ethics review committee of the Indian Network for People Living with HIV/AIDS.

Data were explored using framework analysis (Ritchie & Spencer, 1994). Based on Aday and Andersen's (1974) framework of access to health services, we hypothesized barriers to ART access at family/social, health care system, and individual levels. For coding, we established a priori categories and also used open and *in vivo* coding to derive new codes that emerged, and a constant comparative method within and across cases (Charmaz, 2006; Strauss & Corbin, 1998). We used peer debriefing and member checking to enhance the validity of the findings (Lincoln & Guba, 1985).

Results

Kothi participants ($n=17$) had a mean age of 32 years. Over half ($n=10$) completed high school; two-fifths ($n=7$) were married; one-third ($n=5$) were on ART; and half ($n=8$) engaged in sex work. Aravani participants ($n=17$) had a mean age of 34 years. Over half ($n=10$) completed high school; one-fourth ($n=4$) were on ART; and two-thirds

($n=11$) engaged in sex work. Two key informants represented kothis and two represented aravanis.

We identified barriers to ART at family/social (see Table 1 for additional illustrative quotations by subtheme), health care system (see Table 2), and individual levels (see Table 3).

Family/social-level barriers

Lack of family support

Participants reported that many aravanis and some kothis are estranged from their family, and often evicted from their home. Kothis and the relatively few aravanis who lived with their families usually did not disclose their HIV status or their sexuality, fearing familial rejection and bringing shame to their family and themselves. Such estrangement or lack of disclosure precludes family support to initiate ART. For example, an aravani participant reported:

I have already made my mother suffer a lot. This [revealing HIV status] will be too much for her and she cannot face others. I will postpone [taking ART] as long as I can. I am still okay.

In contrast, some kothis who lived with their family and had disclosed their HIV status were motivated to take ART in order to support their families. A kothi key informant explained, "Kothis think that we have to live for the sake of our family. We have to save some money for them before we die, hence they want ART." Nevertheless, given the costs of ART in potentially revealing kothis' HIV-positive status, this presents a double-bind: taking ART may enable one to live longer to support one's family, however, it also risks exposing one's HIV status and thereby losing sex work clients and income (see *Unmet basic needs* below).

Discrimination and lack of support within aravani and kothi communities

HIV-positive aravanis, who mostly lived with their aravani peers, feared labeling, social rejection, and loss of emotional and psychosocial support from their own community if they were seen taking medications (ART) on a regular basis, revealing their HIV-positive status. Kothis also feared social rejection by peers. According to a kothi participant:

Some [kothis] hesitate to take these [ART] tablets. We can take these tablets in the hand and go. Surely among the friends circle, they will ask why he is continually taking tablets.

Table 1. Additional illustrative quotations for family/social-level barriers to ART access.

<i>Lack of family support</i>	
<p>“Some kothis think that, ‘if we go to the hospital, we have to write the names of our parents. [Then] everyone will eventually come to know about this.’ Then [society] will look at the entire family in a different way.” (kothi key informant)</p> <p>“Those who live with their family will take ART regularly. If father and mother know about this matter [HIV status], they will say, ‘Time is 9’o clock, take medicine [ART].’ There is no one for me. I am living alone for two years. No one will tell me to take ART.” (kothi participant)</p> <p>“My parents eventually came to know that I have HIV as well as how I got it. They told me they would take care of me even if I am HIV-positive – but they had one condition – that I should not tell others how I got it . . . Even now my relations with my parents and brothers are strained . . . No dignity. But life goes on.” (kothi participant)</p>	
<i>Discrimination and lack of support within aravani and kothi communities</i>	
<p>“[Some aravanis say] ‘I live in a group. If I take ART regularly in the morning and evening, my community will come to know. Whatever measures I will take to cover up my HIV-positive status, my community people will eventually come to know that I have this disease.’” (aravani key informant)</p> <p>“I initially told them [aravani friends] that those tablets are for breasts [development]. But when they wanted me to share or asked me to write the name of the tablet . . . I know of people [aravanis] who do not want to be started on ART because of these problems.” (aravani participant)</p> <p>“Taking tablets would reveal one has HIV. You can take tablets for 5 days – 10 days. But for lifelong? Others will come to know. Even if I take ordinary tablets for a cold – my [aravani] friends are asking ‘Do you have <i>Pootchi</i> [code word for HIV]?’ – It has become a joke. But once an aravani is found to have HIV she will be isolated. Some avoid taking any tablets for this matter.” (aravani participant)</p>	
<i>Unmet basic needs</i>	
<p>“Most of us don’t have our basic needs met. We don’t have a proper place to stay. Only slum [people] supports us. In slums, there will not be adequate cleanliness. Water facilities will not be fine. Food will not be hygienic . . . mosquitoes problem . . . typhoid and malaria will come . . . [aravanis] have said in our field [visits] that due to these issues they are not taking [ART].” (aravani key informant)</p> <p>“[Some kothis would say] ‘we are struggling even for our survival; above this, what am I going to get by taking ART?’” (kothi participant)</p> <p>“While in sex work, if their [HIV-positive] status is revealed, that will reduce the number of clients and their business will be affected. So knowingly they do not take tablets.” (aravani participant)</p>	

In light of lack of support, aravani participants and key informants expressed a desire for a proactive role on the part of aravani community members as peer caregivers. An aravani key informant explained:

If we arrange food in time for them [other aravanis], there are more chances [to enroll them in an ART program] . . . if a *TG* [transgender] is on ART, other *TG* should always monitor her . . . For others, we need to ask whether they are taking ART or not . . . If we do like this, they will come to take ART.

Some aravani participants who initiated ART despite the risks acknowledged that referrals by aravani staff of CBOs helped them to initiate ART.

Unmet basic needs

The struggle of many aravanis and kothis to meet day-to-day needs for food and shelter presented obstacles to initiating even free ART. Participants and key informants reported that often when parents learn of “gender-inappropriate” (feminine)

behaviors of their son, aravanis are evicted from their homes or run away when pressured to behave in a masculine manner or to marry a woman. In cities, aravanis take shelter in low income areas where basic amenities and proper nutrition are difficult to access. Aravanis and kothis who engaged in sex work to meet basic needs worried about potential loss of subsistence income if their HIV-positive status were revealed to potential clients by sex work colleagues. Initiating ART became secondary. A kothi key informant explained: “They are living with 100 rupees per day from sex work. When things are like that, only that [money] could be their priority.”

Health care system barriers to ART access

Negative experiences with health care providers

Participants and key informants noted a trend of increasingly positive attitudes among government health care providers, but also indicated continuing

Table 2. Additional illustrative quotations for health care system barriers to ART access.

<i>Negative experiences with health care providers</i>
<p>“They [doctors] know that I have [HIV]. They will say ‘open and show,’ ‘turn this side,’ ‘turn that side.’ They will not touch us at all [in the genital examination]. For namesake they will wear gloves but they will not touch. They will ask us to show. ‘Ok, Ok, now close and wash your hands.’ If the doctor is sitting here we will be sitting 5–10 meters away; this is what happens in a government hospital.” (kothi participant)</p> <p>“[A doctor] asked me ... ‘Where did you go and get this disease?’ I did not want to tell him that I am a kothi. I told him, ‘I went to [a place near Chennai] once. I [had sex] with a woman there.’ Then he asked, ‘Is your wife with you?’ I said, ‘Yes.’ Immediately he said, ‘You should have done all this with your wife. Otherwise it [HIV] would not have come.’ ... Imagine what would have happened had I told him that I have sex with men?” (kothi participant)</p> <p>“Even while entering inside ... lower rung staff such as <i>Aayah</i> [women helpers] and ward boys will laugh at us. We don’t know how we appear to them. According to us, we look good.” (aravani participant)</p>
<i>Lack of transgender-friendly registration and admission procedures</i>
<p>“When [patients] go for ART, they ask for address proof ... Until now, aravanis have not been recognized as aravanis ... they are asked to bring a ration card; if they bring it in their male name, the name called out in their [biological] family ... they [service providers] say that, ‘I will give [ART] only in [your] male name.’ ... They [aravanis] get confused and do not know what to do. They will think, ‘How could we get [ART] in our male name when we have rejected it [male name]?’” (aravani key informant)</p> <p>“... hospital [authorities] are confused about whether to admit us in male or female wards.” (aravani participant)</p> <p>“Some hospitals put us in male wards and some in female wards. Until recently, in [name of hospital] we were asked to put on male dress and were admitted in the male ward even if we are <i>Nirvan</i> [post-operative] and in <i>Chatla</i> [woman’s attire]. Now there is relatively better understanding.” (aravani key informant)</p> <p>“[Some] aravanis are never attached to a place. They keep shifting places often. There are also some aravanis who will stay in Chennai away from their native places. They will be on ART here and when they go to [their] native place to stay there, getting ART is a big problem. They cannot change the record to get it in a different place. We have to get a letter from the doctor [in Chennai]. ... there are so many procedures to be followed.” (aravani participant)</p>
<i>Inadequate counseling services and lack of confidentiality</i>
<p>“In government hospitals counselors are only telling about how to take ART – but no details on how to increase CD4 count such as – ‘If you take milk, your bones will become stronger; if you take date fruits, you will get iron’ – are given. They only say that your CD4 count is low-you have to take ART ... If they [counselors] make them [kothis and aravanis] sit and give counseling only as a mere routine [without involvement], I would say that what they do is not fair.” (aravani key informant)</p> <p>“People say ‘a snake will know another snake’s leg.’ [a saying in Tamil] A kothi will know another kothi. You have seen how good kothis are when they are counselors. We need more such counselors from the kothi community.” (kothi participant)</p>
<i>Perceived lack of focus on ART in HIV/AIDS interventions</i>
<p>“Both in NGOs and CBOs, the focus is only on how to protect oneself from getting HIV. [They] distribute condoms, give <i>jelly</i> [water-based lubricants], [talk about] how to practice safe sex ... No clear information on ART is given. [NGOs and CBOs] have to train them. Will they [outreach workers] always have to talk only about STD and HIV? They can also talk about ART.” (kothi key informant)</p> <p>“The government has to start [ART] campaigns. They often give advertisements about HIV testing. Similarly, they need to give ‘advertisements’ about ART in the public media. And everyone wants to see that.” (kothi participant)</p>

incidents of discrimination in government ART centers. Both actual negative experiences and perceived and anticipated discrimination discouraged some kothis and aravanis from accessing ART and health care services. Judgmental attitudes, substandard treatment, perceived deliberate delays in services, outright verbal abuse and non-verbal cues, such as facial expressions and body language, from health care providers were reported, which

created significant obstacles to accessing ART and health care generally. For example, an aravani participant reported discrimination in accessing ART at a government hospital:

When [patients] come to get ART, “*normal*” women will be given ART and sent early. But when they [pharmacists] see people like us, there is laziness and they will say, “Wait for some time, I will give you ART. Let the crowd go first.”

Table 3. Additional illustrative quotations for individual-level barriers to ART access.

<i>Delays in HIV testing</i>	
<p>“[Aravanis might say] ‘only when I get symptoms, I will check my body. Until that, whatever counseling sessions I attend, I never go [for HIV testing].’” (aravani key informant)</p> <p>“Some will never come for HIV testing; even if they come, they say, ‘it is all right, let us spend our life like this [without treatment].’” (kothi key informant)</p>	
<i>Fatalism</i>	
<p>“... There also are people [kothi] like – ‘We don’t have a married life. Why do we have to live? Okay, we live while my beauty and youth remains. See, already I got this [HIV]. Thus living for ten to fifteen more years is enough. Then, why should I take treatment?’” (kothi key informant)</p> <p>“There are some old kothis. For them not being on ART is not a big deal. They may ask, ‘I have already enjoyed my life. What difference will it make if I live for some more years?’” (kothi participant)</p>	
<i>Alcohol use</i>	
<p>“What [kothis] think is those who drink alcohol cannot take this tablet [ART] and one who takes this tablet should not be consuming alcohol. Maybe due to this they do not want to take ART.” (kothi participant)</p> <p>“If CD4 [count] is reduced and they [aravanis] get referred to ART, they cannot stop that habit [alcohol use]. If stopped suddenly, their hands and legs will start shaking ...” (aravani key informant)</p>	
<i>Insufficient knowledge about ART and belief in alternative ‘cures’</i>	
<p>“What many think is, ‘Only when the [CD4] count becomes very low, we have to take ART.’ They don’t have in-depth knowledge about when to take ART.” (kothi key informant)</p> <p>“[Peer educators] provide enough information on HIV and condoms ... Not much about ART. They need to tell all people about where one can get [ART].” (kothi participant)</p> <p>“Apart from ART, I have heard about homeopathic medicine ... they [aravanis] said that this homeopathic medicine is better.” (aravani key informant)</p>	

Lack of transgender-sensitive registration and admission procedures

A valid identity card/proof of address is required for enrollment in government ART programs to enable follow-up. Recent Tamil Nadu government initiatives have allowed some aravanis to obtain food ration cards in their chosen name and gender; however, some aravanis who live with their biological family have their male name listed on their family ration card and are asked by ART center staff to register using that name. Although some aravanis begrudgingly comply with this requirement to get free ART, others refuse to access ART at the expense of humiliation, and denial of their gender identity and human dignity.

Additional barriers for aravanis were being admitted to a male ward where, in some government hospitals, they are forced to wear male clothing, and being mocked or taunted irrespective of whether they stand in male or female queues for admission. According to an aravani participant:

[We cannot] stand in the queue for males or females. We are bad-mouthed by people standing there as well as by hospital staff. [We] ran away from [our parents’] home being convinced that we are women.

Now our life has become worse than that of a dog. Why should we lose our respect to get this medicine? Instead I would rather die ... saying this, I walked away [from the ART center].

Inadequate counseling services and lack of confidentiality

Many participants reported that counseling services in government hospitals have substantially improved over the years; and some reported receiving adequate information about ART. However, some participants and key informants expressed dissatisfaction with the quality of counseling services, expecting more time and treatment details. Some expressed concerns about lack of aravani and kothi counselors, lack of privacy and confidentiality, and inadequate time for counseling. As an aravani key informant reported, “They are counselors from the general population. How could they have that much sensitivity or understanding?” A kothi key informant described the substandard counseling milieu, which presents threats to confidentiality:

They don’t even have a door; there is only one screen. [Others] keep coming and going ... peep in to check whether the talk is over or not. ... She [counselor] also

does not have time. Many are waiting. . . There is no privacy.

Key informants further explained that many government hospitals lack adequate space to enable them to follow national guidelines to ensure confidentiality through providing HIV counseling in private.

Perceived lack of focus on ART in HIV/AIDS interventions

Participants and key informants reported that targeted interventions among kothis and aravanis focused extensively on HIV prevention, and condom promotion and distribution, with relatively little attention to ART. Key informants reported that lack of training about ART among outreach workers and peer educators contributed to this shortcoming. An aravani participant explained:

If they become HIV-positive, counseling [in NGOs] will be given like this: "Take this food. Take healthy food. We have to increase the CD4 count," and so on. Even in NGOs, it is rare for them to talk about "there are first-line and second-line in it [ART]." Only 20% talk about that . . . they talk about ART only after seeing the CD4 count. Before that, no one talks about ART.

Individual-level barriers to ART access

Delays in HIV testing

Knowing one's HIV status is pivotal to getting appropriate treatment, including ART. However, low HIV risk perception and a preference not to know one's status, intertwined with fears of stigma, discrimination, and rejection from others, including one's own community, presented barriers to HIV testing among kothis and aravanis. An aravani participant reported the reason for not undergoing HIV testing: "if our community comes to know [about testing HIV-positive], they will isolate us." Consequently, some got tested for HIV only after experiencing severe or prolonged symptoms suggestive of HIV illness; even then some declined follow-up or treatment for fear of disclosure of their HIV status.

Fatalism

Even after learning of their HIV diagnosis and medical eligibility for ART, fatalism among some kothis and aravanis fostered reluctance to initiate ART. Fatalism appeared to be related to lack of social support from (and non-disclosure to) family members and not having a steady male partner. A kothi key informant reported a typical reaction:

"We don't have a married life. Why do we have to live?" However, learning about people on ART who were living healthy lives encouraged some to initiate ART. A kothi participant reported:

We will tell them [other kothis], "See, there are people who live for 20 years with HIV. We will not die immediately after becoming positive. If we take proper food and ART we shall live for many years."

Alcohol use

Kothis and aravanis reported that family/social-level factors, such as eviction from home, rejection, economic hardship, and violence, led them to use alcohol as a coping mechanism. As described by an aravani key informant:

You asked us why we consume alcohol . . . several reasons: we were evicted from our home by our own family members. Now . . . we don't have a decent job for our livelihood. On top of everything, we face problems from our [sex work] customers and *beelis* [ruffians]. To forget all these sufferings, we drink. If we need to stop drinking alcohol, you need to stop all these problems we face.

Because health care providers emphasized that patients on ART should not consume alcohol, some kothis and aravanis did not initiate ART to avoid the need to stop drinking alcohol and associated withdrawal symptoms. Some also feared side effects if they resumed alcohol use while on ART.

Insufficient knowledge about ART and beliefs in alternative "cures"

Key informants reported that kothis and aravanis lacked in-depth knowledge about ART, including benefits, when to initiate therapy and medical eligibility criteria. Although health care providers stress that there is no cure for HIV, some alternative/traditional medicine practitioners promise such cures, which lures some kothis and aravanis to try these remedies instead of ART. As a kothi participant explained, "In Siddha and Unnani they [some practitioners] say that they cure it [HIV] 100%; they do what the English medicine cannot. So [people] believe this and they go."

Discussion

HIV-positive kothis and aravanis in Chennai face multi-level barriers that prevent or significantly delay their accessing ART, even with free ART programs operational in government hospitals.

In order to access a life-saving intervention, many aravanis and kothis must confront formidable risks of losing family and peer support, and economic subsistence, in addition to bureaucratic challenges, outright discrimination and affronts to their human dignity. Failure to access ART seems less contingent on individual-level misunderstanding, fear and lack of information, and on balance may constitute a reasonable choice given the monumental risks. The imperative of ensuring equal access to ART among kothis and aravanis raises the need to radically shift this balance so that accessing ART, despite potential challenges, becomes a well-supported and sensible option.

Barriers to ART access emerged at family/social, health care system and individual levels. The primary individual-level barrier was integrally linked to the family/social and health care system levels: many kothis and aravanis feared serious adverse consequences if their HIV-positive status were revealed to others. Strong motivations to keep one's HIV-positive status and same-sex attraction secret were interconnected with sexual prejudice against MSM and transgender women, and HIV stigma prevalent in families, the health care system, and the larger society (Chakrapani et al., 2007; Newman, Chakrapani, Cook, Shunmugam, & Kakinami, 2008a). HIV stigma was present within kothi and aravani communities as well (Chakrapani et al., 2008). Anticipated consequences of disclosure – rejection by family, eviction from home, social isolation, loss of subsistence income from sex work, and maltreatment within the health care system – presented powerful disincentives to accessing ART. As a result of wide-ranging fears of disclosure, many kothis and aravanis postponed initiating ART or even learning their HIV status for as long as possible, until they became symptomatic. Thus, stigma and discrimination were central to multi-level barriers to ART access.

Fatalism also led some kothis and aravanis not to pursue ART. This psychological challenge was linked to fear of adverse consequences of HIV disclosure, which posed an intransigent dilemma: forego one's family, friends, community, and income from sex work, or forego treatment.

Secondary to stigma and discrimination was limited knowledge about ART. Many kothis and aravanis in Chennai have adequate general knowledge about HIV (NACO, 2007b; Newman, Chakrapani, Cook, Shunmugam & Kakinami, 2008b), and receive appropriate peer counseling about HIV and positive prevention; but the present study indicated a lack of knowledge/education about ART.

Given multi-level barriers to ART access related to stigma and discrimination, interventions to

facilitate ART uptake should address multiple constituencies: the general public, health care providers, and the kothi and aravani communities themselves. In addition to public campaigns to promote acceptance and combat discrimination against kothis, other subgroups of MSM, and aravanis, both those living with HIV and HIV-negative, targeted interventions are needed for health care providers and staff at government ART centers. Provider and staff education should include training on: (1) non-judgmental, non-discriminatory counseling and treatment services; (2) specific challenges faced by kothis and aravanis regarding ART access and adherence; and (3) counseling needs regarding mental health, alcohol abuse, and disclosure of HIV status and sexuality to family and peers. Training and utilization of kothi and aravani counselors would also fill an important gap. Health care system guidelines should be developed in consultation with aravani and kothi communities to address discrimination based on sexual orientation and gender identity. Improvement of infrastructure and staffing levels at government ART centers is also necessary to allow adequate time and privacy for counseling.

HIV-related stigma and discrimination in kothi and aravani communities should also be addressed, with the help of community leaders, through targeted interventions aimed at creating supportive peer norms.

A limitation of this study was the small purposive sample of kothis and aravanis recruited from CBOs. Kothis and aravanis not associated with CBOs may experience greater barriers to ART access than did kothis and aravanis in our sample. In addition, other subpopulations of MSM, such as gay- or bisexual-identified MSM (Chakrapani et al., 2007; Setia et al., 2008), may experience different barriers to ART access.

In conclusion, we identified an array of barriers to accessing free ART at government centers among kothis and aravanis in Chennai. Interestingly, many of these barriers were similar to barriers faced by female sex workers in Chennai (Chakrapani, Newman, Shunmugam, Kurian, & Dubrow, 2009). India needs a national policy and action plan to address barriers to ART access at family/social, health care system, and individual levels for all marginalized groups.

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