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Perceptions of HIV Risk Among Monogamous Wives of Alcoholic Men in South India: A Qualitative Study

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Abstract

Objective: To understand women's perceptions of their own HIV risk and to determine the feasibility of conducting an HIV prevention study.

Methods: Two focus groups were conducted in November 2004 with wives of heavy drinkers admitted to the Deaddiction Unit at the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, India. Data were analyzed using content analysis.

Results: Results focused on (1) awareness of the women regarding HIV/AIDS and condom use, (2) perception of personal risk for HIV/AIDS and the risk of their spouses, and (3) the feasibility of a future community-based HIV prevention study. Focus group findings indicated that although the majority of the women were aware of HIV/AIDS, there were important misconceptions about the mode of transmission. Women acknowledged the potential risk for HIV associated with their spouse's drinking, as well as their extramarital sexual activities, but expressed an inability to negotiate safer sex behaviors, such as condom use, within the context of marriage. This was often expressed as fear of being physically abused for attempting such negotiations. All women agreed that the HIV prevention study we proposed, originally developed in the West, would be acceptable if tailored to specific local needs. The women provided valuable suggestions for the effective implementation of the study.

Conclusions: The findings of this study indicate a critical need to develop culturally relevant HIV prevention programs directly targeted to wives that equip them with effective skills to negotiate safer sex behaviors with their spouses.

Introduction

IN INDIA, THERE HAS BEEN a sharp increase in the estimated number of HIV infections since the early 1990s (0.2 million); in 2006, approximately 2.5 million people were estimated to be living with HIV.¹ Although the recent reports from India indicate a reduction in HIV prevalence,² with its population of almost 1.3 billion, India could still become the potential epicenter of HIV within the next 10 years. The latest surveillance report on HIV in India suggests that it is necessary to control HIV infections in India in order to control HIV infections around the world.³ Approximately 63% of the HIV-1 cases have been reported in the South Indian states of Karnataka, Andhra Pradesh, and Tamil Nadu, although these states constitute only 30% of the country's total population.^{4,5}

Heterosexual contacts have been considered the primary risk factor for HIV infection in India.⁶ Previous research has

shown a strong association between heavy alcohol use and HIV risk behaviors.⁷⁻¹² Failure to use male condoms during intercourse because of the disinhibiting effects of alcohol is cited as a primary factor for transmission of HIV.¹³⁻¹⁶ One study¹⁶ reported that heavy alcohol use increases the negative attitude toward condom use in men. Unprotected extramarital sex under the influence of alcohol, domestic violence, and a low perception of risk among married monogamous women have been reported as major risk factors for HIV infection.¹⁷⁻¹⁹ Coerced sex with a spouse and increased sterilization practices used by men and women after a couple's desired family size has been attained have led to a high proportion of married couples not using condoms. This has been noted as a significant source of HIV infection among married monogamous women whose husbands are HIV positive.^{3,20-23} Several recent studies have referred to these men as "bridge populations," in that they pass the virus to their unsuspecting wives

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after becoming infected through their extramarital sexual contacts with women on the road while performing their duties as truckers or migrant workers.^{3,6,24}

Studies of sexual activity among men have shown that many report having had extramarital sex under the influence of alcohol.^{3,6,24} These findings indicate the need to explore and understand the dynamics of HIV transmission among married couples and to develop culturally appropriate prevention interventions, starting with education about the modes of transmission, for these vulnerable women.

A World Health Organization (WHO) report on the burden and socioeconomic impact of alcohol from Bangalore, India, found that nearly one third of the adult population regularly consumed alcohol.²⁵ The report also indicated that the majority of drinkers were middle-aged men with predominantly low levels of education who were employed as skilled or unskilled workers, who were married, and who had an income less than Rs.6000/- (\$150) per month. Binge drinking and pathological drinking were reported by 40% and 25%, respectively, of the total number of men interviewed, with higher and more varied patterns of use reported by the middle-income and lower-income groups.²⁵

Studies have indicated that wives of men who engage in high-risk behaviors have inadequate knowledge of their husbands' sexual activities outside marriage and, hence, do not perceive themselves at risk.¹⁹ A woman's intense desire to have a child also prevents her from negotiating condom use with her spouse. Finally, because Indian society is largely patriarchal,¹⁸ prevention messages that target women usually require the husband's approval to be implemented successfully, especially if it is a behavior that would affect their marriage.

The most effective strategy for HIV and sexually transmitted infection (STI) prevention is creating adequate awareness among wives about the risks related to their spouse. Indian women perceive a need for culture-specific skills to negotiate safer sexual behaviors within the context of their marriage. As 85% of the HIV transmission in India is through heterosexual contact,⁴ condom use seems to be the best strategy to reduce HIV transmission, but there are sociocultural barriers that prevent discussions about safer sex behaviors between a husband and wife. For example, it is socially inappropriate for a wife to discuss her husband's whereabouts or to attempt to negotiate condom use with him.^{3,18} Such attempts, which could be misinterpreted as an allegation of infidelity, could lead to violence. Consequently, many women remain in high-risk relationships. Finally, many Indian women are economically and emotionally dependent on their spouses because of their own low educational background and the lack of employment opportunities^{18,26}; this further leads to a subordinate role.

To tailor HIV prevention interventions to the specific culture and needs of each group, it is important to have a clear understanding of the cultural, social, and interpersonal contexts of sexual behaviors.^{18,27} Qualitative methods, such as focus groups, have been identified as an effective way to elicit accurate information about the social context of behaviors, including sexual interactions.^{27,28} Community-based studies have highlighted the need to involve the recipients of the HIV prevention intervention from the initial stages of planning in order to make the intervention more acceptable to the targeted group.²⁹

In spite of the recently reported increasing trend of HIV infection among the various groups of married monogamous women in India, most studies have focused on the development, implementation, and evaluation of HIV prevention programs among commercial sex workers or sexually abused or homeless women. There has been a scarcity of work and, thus, published literature on effective HIV prevention programs for the monogamous wives of male heavy drinkers, a group at high risk for HIV and other STIs.

The current study, funded by the World AIDS Foundation, was launched to understand, from a woman's perspective, the sociocultural barriers that prevent successful safer sex negotiations. It was also conducted to evaluate how a successful Western intervention could be applied to Indian women who had not been exposed previously to any HIV interventions. The first aim of the study was the formative stage, to conduct focus groups with the wives of heavy drinkers to discuss (1) their awareness of HIV/ AIDS and other STIs, (2) their use of the male condom, (3) their perceptions of their own risk for HIV infection and the risk of their spouses, and (4) the feasibility of a planned intervention for wives of men who drink heavily.

Materials and Methods

Two focus groups were conducted with the wives of heavy alcohol users who were admitted to the Deaddiction Unit of the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, India. NIMHANS is a 600-bed psychiatric hospital with a specialized Deaddiction Unit for persons with substance use-related problems. The Deaddiction Unit provides detoxification, treatment, and psychosocial interventions for alcohol, drug, and other substance abuse problems. It has both inpatient and outpatient care. Routine group intervention by the deaddiction team is conducted with wives/partners/family members about alcohol and drug addiction, its causes and treatment, sobriety, and relapse. NIMHANS also serves as the regional center for the National AIDS Control Organization (NACO) of India. According to the 2001 census report, Bangalore had a population of more than 1 million, which makes it one of the fast-growing metropolitan cities in India. The city has a large population of migrants from the rural areas of Karnataka and other neighboring states, who have come in search of better employment and socioeconomic opportunities. As in other Indian metropolitan cities, the urbanization of Bangalore that has occurred in the last decade has distinctly changed the lifestyles and behaviors of the people in Bangalore. These lifestyle changes include increased tobacco use, alcohol abuse, lack of physical activity, high-risk sexual behaviors, and many other changes that contribute to the occurrence of various communicable and noncommunicable diseases.²⁵

A purposive sampling strategy was used to select the names and addresses of the male drinkers from the inpatient files according to these criteria: (1) a diagnosis of alcohol dependence based on ICD-10 criteria, (2) at least two admissions in the last 12 months, and (3) a resident of Bangalore city (our potential study target site). A short list of 34 male drinkers who were not currently in inpatient treatment and who fulfilled the inclusion criteria were identified from the files as our first sampling pool. During the period of study, all the men who were contacted were in the process of recovery and were

attending posttreatment follow-up with the Deaddiction Unit treating team at NIMHANS. As discussed previously, because of the cultural norm for the women to have their spouse's approval to participate in any research activity, the 34 index patients were sent a brief letter requesting permission to allow their wives to attend the scheduled focus group in the Deaddiction Unit. The letter briefly stated the purpose of the study, the focus groups, who would be conducting the groups, and what information would be elicited from the women. Confidentiality of the information was assured. Sixteen women contacted us in response to the letter sent to their spouses and expressed their willingness to participate in the focus groups. It is unknown whether or not our letter reached the other 18 men; none called to say their wives could not participate. Appointments were scheduled for two focus groups with 8 women in each group; 14 women were able to make it to the discussion at the appointed time.

Focus groups were planned on 2 consecutive days of the same week during the period of visit of the Washington University collaborating team. Formal informed consent was secured from each woman when she reported to NIMHANS to participate in the focus group discussion. Women were assured of confidentiality of the information they shared within the group. Sessions were audiotaped with the participants' consent. The protocols were approved by the Human Studies Committee of NIMHANS, Washington University, and the Indian Council of Medical Research (ICMR).

The groups were conducted in the conference hall of the Deaddiction Unit, away from the patient rooms and outpatient clinic in which their husbands were being treated. The research staff conducting the focus groups included two facilitators, a translator, and an observer (L.B.C.). One of the two facilitators (W.R.) did not speak the local language (Kannada), so the translator, who was fluent in both English and the local language, translated the conversations simultaneously without interrupting the tempo of the group session. Because of the uniquely multicultural setting at NIMHANS, patients and families are frequently interviewed by health professionals who do not speak the local language. Thus, this methodology was an expected and acceptable practice.

Nearly all the responses obtained from the first focus group were repeated in the second group. Given that there was repetition of the same themes by the women who attended the focus group discussions, we believed there was no need to recruit additional women for further focus groups. The first and the second focus groups had 8 and 6 participants, respectively; women were between 25 and 40 years of age. Besides being married, the women were from an urban background and, on average, had reached to the tenth educational grade level. One woman in the first group and 2 women in the second group reported 5 years of college education. More than half of the participants belonged to lower-income groups; the rest belonged to the middle socioeconomic group. All the women were unemployed at the time of the focus group.

Data analysis

The transcribed audiotapes and the field notes were coded manually and analyzed by the first author with assistance from the Indian and U.S. teams. A thematic coding system

was developed based on the objectives of the study. Themes were identified, and quotes from the group interactions were listed for each theme. Themes that represent the most salient ideas are reported; outliers that did not emerge as common group ideas, yet seemed important, are also detailed. Observations about the nonverbal interactions, comfort levels, and enthusiasm of the group members and their satisfaction with the focus group process as a whole were also analyzed.

Results

The data from both focus groups are presented in the following order: (1) awareness regarding HIV/AIDS and condom use, (2) perceptions of personal risk for HIV/AIDS and the risk of their husbands, and (3) the feasibility of a future HIV prevention study, funded by the World AIDS Foundation.

Awareness about HIV/AIDS

All but one woman (in the first group) reported some knowledge of HIV/AIDS and its modes of transmission. Women in both groups were aware of injection drug use and the use of nonsterilized syringes as a mode of transmission of HIV, even though they reported that injection drug use is not as common as alcohol use in India:

I know that when my husband goes to other women for sex, he can get HIV infection. . . .

I have heard that HIV infection occurs mainly through blood, from husband to wife through sex, from injections, and from mother to child.

Multiple sex partners, syringes, and contacts with prostitutes cause HIV infection.

The knowledge was not always correct. A few women in the groups reported misconceptions related to transmission and treatment:

I have heard that it [HIV] comes through *ahara* [food].

I don't know much about HIV. Last time I heard was when husband goes with other women for sex, it comes.

HIV is a woman's illness.

The main source of information about HIV/AIDS was reportedly the mass media, including television, movies, and newspapers:

I heard about HIV and AIDS from newspapers, TV programs, and cinema.

Women also reported that TV or newspaper messages were less effective in conveying information than someone personally explaining the risks:

Somebody should come and tell me. Even if it is in TV, somebody should tell me, and then I would understand. We don't like to watch these subjects on TV in front of children. We would rather learn them from a personal contact.

Awareness about condom use

Although all women understood that condoms prevent pregnancy, most were unclear about whether condoms prevented HIV infection:

I think if we use condoms, maybe we are safe. I think it is directly related [to HIV] and they are effective. I don't know

how effective is this method of prevention. There are other ways of transmission also, such as genes and blood. Condoms prevent only the transmission through sexual contacts.

Several reported not using a condom because it interfered with getting pregnant, and this was very important to them. One woman wept and shared that she could not use a condom even if she wanted to because she “needed to have a child.” Childlessness, in the Indian context, can be as distressing and stigmatizing for women as HIV.

Consistent with other studies, participants reported difficulty convincing their husband to use a condom; a few who had tried reported that their husband had refused. Women thought that men should take steps to protect their family without being asked to do so:

If they know they are at risk, they themselves have to take the responsibility to use condoms. If we [wives] ask them to use condoms, they would say no.

Men should be advised to use condoms and have sexual contacts only with their wives.

The majority of women echoed the aforementioned finding that discussions about condoms and sexual behaviors are very limited, if not absent, in most marriages. Most reported that they had never directly asked their husband to use a condom, but all reported that if it were suggested, their husband was likely to refuse. One woman stated that “men should just be faithful to their wives.”

Perception of personal risk for HIV/AIDS and risk of husbands

Thirteen of 14 women suspected their spouse of having extramarital sexual relationships; they associated these activities with alcohol use. These women reported implementing strategies, such as having their spouse drink at home rather than out in the community, to try to keep their husband from having sex with other women. If their husbands did drink outside of the home, the wives reported being afraid to discuss their husbands’ behaviors regarding sexual practices. Most said that their husband became suspicious when they (the wife) questioned them concerning their behaviors while drinking. This suspicion frequently resulted in the husband physically or verbally abusing them. The women said that their husbands often assumed such questions reflected the wife’s own infidelity, which further angered the husbands. We heard that:

In India, the wife will not have a say in many matters that affect her family. Even if we tell certain things like condom use the husbands won’t accept. They will start asking back why we are asking such questions. Those who drink are suspicious, and they may suspect that we are having extramarital relations ourselves and that’s why we are asking them to use condoms.

Sex is a delicate matter. Once the suspicion starts, one will have to repent for life. They will go on talking about it, saying the woman must have had such relationships. If they are educated, they may continue relationships but still will be suspicious in their mind.

Sometimes my husband goes out in the night, gets drunk, and won’t come back. He could be doing things like having sex with some other women. I do worry about such things and remain awake. When I ask him the next day about what he had been doing, he asks why I doubt him and then we have a fight. Sometimes it leads to physical abuse also.

Women reported interest in obtaining an HIV test but were apprehensive to ask their partner to take the test because that might indicate a lack of trust, leading to immediate problems such as those discussed. One woman reported that her husband had been tested; she was unwilling to further discuss this.

Several women reported being unable to refuse to have sex with their husbands, even if they were concerned about STIs. Women reported not having the courage to question their husbands about outside sexual contacts:

Can we say no to sex? I don’t think so. Even if you say no, they [husbands] react very badly to it. They will say that they will go to some other women for sexual contacts, and maybe that’s our weakness. Actually, no woman would want to have sex with a man after he drinks. I think all women do it as something to be done as a necessity and hence get it over with.

The majority of the women in the group thought that consuming alcohol was more risky than taking any drugs, including cannabis (*ganja*). According to participants, drug users, like cannabis users, are more interested in acquiring drugs than having sex:

Ganja doesn’t cause HIV. [All the women nodded in agreement.] Those who use ganja don’t even have senses, so they will not feel like going to any woman and having sex. They are more interested in the drug itself than sex.

Feasibility of future HIV prevention program

The discussions about the feasibility of a proposed intervention program were centered on three main topics: the location of the program, who could attend the program, and the content of the survey and the program. Some women reported already attending programs in their community conducted by such organizations as the Lion’s Club. Most believed that the safest study protocol for interviews and interventions involved meeting the research team in the community, such as at a primary health center, rather than having the interviewer come to their home, where they would feel uncomfortable talking openly. Women thought that a survey that addressed their husband’s drinking and sexual behaviors could cause a fight between them if it were conducted within the home. Additionally, many mothers-in-law lived with them, which would cause further upset if she were to hear the wife’s responses to questions. Furthermore, women reported that once their husbands were aware of the survey topics, they might not allow them to participate.

Because of these factors, meetings in a community site could provide the opportunity for women to participate, especially if they went under the pretext of attending a meeting regarding the health issues of their children:

If you go to each woman’s house, it could create problems at home. Hence, it is better to call all the women in that area to the nearby ladies club or some such places and ask questions or ask them to attend classes so that husbands don’t suspect.

Women were divided on opinions about the appropriateness of surveys enquiring about different types of sexual practices, such as anal or oral sex. They also indicated that having programs without their husbands would give women an opportunity to openly discuss various personal issues and gain health information that had been previously unobtainable:

Women in general would answer questions regarding sexual health. Women in the cities would be aware of HIV/AIDS and how to prevent it, but in the village, women would not know such things. It is possible to conduct studies related to these in India.

Women would be more willing to learn about various safer sexual practices than answering questions about such sexual practices:

Among people who are very traditional, there will be some kind of resistance [to discuss sex]. You can tell them indirectly that if you do certain things, you will get HIV.

It was thought that women in general needed educational programs about STIs. All the participants believed that women in urban areas knew more than women in rural areas and thought because women always have more interest than men in the family's health, it is important for them to know how to protect the entire family. Thus, it was suggested that the intervention study focus on family wellness. They specifically recommended a focus on reproductive health, especially if presented by a health professional, such as a nurse.

When asked if their husbands would allow this educational opportunity, women reported that their husbands would allow them to be educated about health topics because it is commonly assumed that women "do not know anything and need to be educated." Some also reported that children should attend these programs with their mothers so they can be educated as well. Most women considered involvement of local community leaders or village heads to be vital to a program's success. They also endorsed the use of documentary films, dramas, slide shows, and pictures to make a clear point. They recommended the use of case vignettes, such as: "*a patient coming to see a doctor with these complaints. . .*"

Finally, the participants reminded investigators that their suggestions should not remain on paper but should be acted upon. They expressed excitement about potential educational programs and were willing to participate again to help develop the educational programs that would help other women in similar situations.

Discussion

The three major findings that emerged from this study were (1) the majority of the women were aware of HIV/AIDS, although some had misconceptions about transmission, (2) most women reported difficulty in negotiating condom use with their husbands and, despite their awareness of personal risk, were unable to protect themselves by negotiating safer sex practices with their husband, and (3) the majority of the women reported the need for more information about HIV/AIDS and the feasibility of developing and implementing an effective community-based prevention intervention program. The analysis also revealed that women in both focus groups provided identical responses to certain questions.

The findings of the present study indicate that the majority of the women in these focus groups were aware of HIV/AIDS, although some of them had misconceptions regarding the mode of transmission of HIV, such as it is a woman's illness or it is spread through food. This corroborates the reports^{3,30} that indicate that in spite of the large amount of effort and money

channeled by the governmental and nongovernmental organizations into HIV prevention, penetration of knowledge about HIV/AIDS among Indian women is still very low. This also reinforces the need to incorporate an informational component into any proposed prevention intervention program for women.

The data from the focus group were consistent with the hypothesis that the degree of awareness of women about HIV and other STDs is not associated with actual behaviors because husband's alcohol consumption plays a significant role in preventing women from discussing or negotiating safer sex behaviors. Additionally, women's discomfort in talking about sex with their partners is evident in the comments they made, such as "sex is a delicate matter." As reported earlier, this study also found that the complexity of gender relations and the sociocultural status of these women act as barriers in translating their awareness into the ability to discuss and negotiate safer sex with their husbands.^{17,18,30} These observations underscore the fact that mere awareness among wives of heavy drinkers may not have any significant impact on preventing the spread of HIV infection.

With regard to condom use, the findings indicated a lack of awareness of how condoms protect from STDs as well as an inability among women to negotiate condom use with their husbands, especially when their husbands are under the influence of alcohol. Most women considered condoms more of a barrier against pregnancy than as a protection against HIV infection. The majority of these women were also aware that HIV was associated with multiple sex partners or having sex while using alcohol and that their husbands' behaviors increased their own vulnerability to HIV infection. As previously mentioned, however, the majority of these women reported their inability to negotiate safer sex behaviors, such as condom use. Those who were aware that condom use protects against HIV infection had a hard time convincing their spouse to use condoms because of the fear of such requests being interpreted as a lack of trust between them. Women in these focus group were no different from many other Indian women who believe it is their social duty to agree to have sex on demand.³¹ Observations made by the women in the focus groups corroborate the popular belief that a spouse "will go to some other women for sexual contacts" if sex on request is denied. They also believed, as it had happened before, that failure to comply to their demands could result in sexual violence.

Consistent with findings from Pallikadavath et al.,³⁰ women in our groups reported that mass media, such as radio, television, and print, were their primary sources of information about HIV. This suggests that there is a need to incorporate the media into programs that would prevent HIV infection among wives of alcoholics; however, any media campaign would also need to be coupled with face to face presentations that discuss the methods. Similar to the women in a previous study from India,¹⁸ women in our study mentioned that community-based activities, such as street plays, dramas, and movies, would be more effective and appropriate for women in socially disadvantaged communities. Many women said that "somebody should come and tell me," which suggests that personal educational sessions are more relevant to the women than acquiring the information through mass media. They also recommended including the HIV prevention and awareness programs under the larger umbrella of

children's health or family health issues, as that would be more acceptable in the eyes of their male partners.

It is important to remember that despite their heavy drinking habit, the male partner remains the functional head of the family. Such quotes as "They themselves have to take the responsibility to use condoms" and "Men should be advised to use condoms and have sexual contacts only with their wives" reflect the wives' inability to communicate with their husbands. These findings corroborate the fact that several socio-cultural factors play a significant role during sexual encounters between married couples: the relationship between the man and the woman within the larger context of the society where they live, the cultural norms that regulate the husband and wife interactions, and the degree of economic and emotional dependence of the woman. Expressions such as "In India, the wife will not have a say in many matters that affect her family" reveal the strong patriarchal influence of the society on women. Specifically, almost all the recommendations provided by these focus group participants reflected their belief that males control almost every aspect of their lives. It is understandable that any intervention planned for this group of women should take into account this sociocultural context.

Despite societal and spousal pressures, Indian women are requesting HIV-related information, which is heartening. Although our study uncovered these feelings and perceptions, it was conducted with a small sample and represented only wives of men who were being treated for heavy drinking in Bangalore city. Hence, the findings may not be extrapolated to other women.

The focus groups helped us not only to elicit first-hand information about which types of prevention messages are preferred but also to understand the most effective channels of communication for the quantitative study. In addition, these focus groups gave us insights into how we should proceed with equipping the women with the necessary skills to discuss sexual health without jeopardizing their marriages and safety. This will be the challenge for our next study.

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Disclosure Statement

The authors have no conflicts of interest to report.

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