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## Geographic and behavioral differences associated with STI prevalence among Indian men who have sex with men in Chennai and Mumbai

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### AUTHOR CONTRIBUTORSHIP

Steven A. Safren, Matthew Mimiaga, Beena Thomas, Kenneth Mayer, Sunil Menon, and Soumya Swaminathan developed the overall design of the parent grant, which included the data elements utilized here. Safren developed the idea for the specific data analysis project and wrote the first draft of the document, with the input and assistance of Bella Devaleenal, particularly on the introduction and discussion sections, and from Kristen Regenauer. Safren and Mimiaga, led the development of the data tool for assessing sexual risk behavior, with input from the other collaborators. Kenneth Mayer, with the input of Bella Devaleenal, Rakesh Thorat, Luke Hanna, Ramesh Karunaianantham developed and led the implementation of the protocols and procedures for STI data collection. Katie Biello oversaw and led the data analyses, with input from Mimiaga, Conall O’Cleirigh, and the team. Andres Bedoya, Conall O’Cleirigh, Alpana Dange, Shruta Rawat, Vinoth Balu, and Dicky Baruah assisted with the procedures and implementation of all data collection procedures. All authors reviewed and contributed to the manuscript.

### CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

### ETHICAL APPROVAL

The study was approved by the Partners (Massachusetts General Hospital), Boston Massachusetts, USA institutional review board (FWA00003136), the Ethics Committee of the Humsafar Trust (FWA00005331), Mumbai India, and the Ethics Committee of the National Institute for Research in Tuberculosis (FWA00025949) Chennai India.

## Abstract

**Background:** India has one of the largest numbers of men who have sex with men (MSM) globally, however, geographic data on sexually transmitted infection (STI) prevalence and associations with sexual behavior are limited.

**Methods:** Six-hundred-eight MSM in Chennai and Mumbai screening in for a behavioral trial and assessed bacterial STI (syphilis, chlamydia, gonorrhea), HIV, and past-month self-reported condomless anal sex (CAS).

**Results:** Mumbai (37.8%) had a greater prevalence of any STIs than Chennai (27.6%) (est=1.37, 95% CI:1.09,1.73). This pattern also emerged for gonorrhea and chlamydia separately but not syphilis. Conversely, Mumbai had lower CAS (M=2.2) compared to Chennai (M=14.0) (est=-11.8, 95% CI:-14.6,-9.1). The interaction of city by CAS on any STI prevalence (PR=2.09, 95% CI:1.45,3.01, p<.0001) revealed that in Chennai, higher CAS was not associated with STI prevalence, but in Mumbai it was (PR=2.49, 95% CI:1.65,3.76, p<.0001).

**Discussion:** Higher bacterial STIs but lower CAS in Mumbai versus Chennai, and the significant interaction of CAS with city on STIs suggests that either differences in disease burden or differences by city with respect to self-reported assessment of CAS. Regardless, the high prevalence rates of untreated STI and condomless sex among MSM suggests the need for additional prevention intervention efforts for MSM in urban India.

## Keywords

gay men; sexual behavior; chlamydia infection; gonorrhea; syphilis

## BACKGROUND

In India, men who have sex with men (MSM) are disproportionately affected by HIV and by sexually transmitted infections (STIs),<sup>1</sup> which cause morbidity and can potentiate HIV spread.<sup>2,3</sup> Accordingly, the HIV sentinel surveillance report issued by India's National AIDS Control Organization (NACO) found that, for 2017, MSM constituted the third largest core group of individuals living with HIV in India (with 2.7% prevalence), compared to Hijra/Transgender people (3.1%) and persons who inject drugs (6.3%).<sup>1</sup> Studies from different Indian states have also found high rates of STI – including genital warts (Delhi) and HPV (Maharashtra, Tamil Nadu),<sup>4-6</sup> syphilis (Delhi, Maharashtra, Telengana, Tamil Nadu),<sup>7-9</sup> herpes simplex virus-2 (Tamil Nadu),<sup>9</sup> chronic hepatitis B (Tamil Nadu),<sup>9</sup> gonorrhea (Delhi, Maharashtra, Telengana),<sup>6,10</sup> chlamydia (Maharashtra, Telengana),<sup>10</sup> – among MSM in India. With the second largest population in the world,<sup>11</sup> India has one of the largest concentrations of MSM, and hence studies of prevalence, transmission risk, and associated variables are of high public health significance.

Self-reported HIV risk behavior, even when done via computerized assessment, can be limited by potential social desirability.<sup>12,13</sup> Although HIV and STI are transmitted by similar risk behaviors (e.g. condomless anal sex) among MSM,<sup>14</sup> there are other behaviors that transmit STI that do not efficiently transmit HIV (e.g. oral sex),<sup>15</sup> and other STI may be

more easily transmitted than HIV, with bacterial STI being generally more prevalent and having higher incidence rates than HIV.<sup>16</sup>

Given the overall size of India, both in terms of population and geography, as well as cultural differences across states, HIV and STI rates may differ widely across the country. If the background prevalence of STI in the risk pool is different in different locations, the effects of behavioral interventions on STI and HIV acquisition may differ, which could affect estimates of the efficacy of prevention interventions. The India National AIDS Control Organization (NACO) provides HIV prevalence estimates by state, for example, and the state of Maharashtra, which includes the city of Mumbai, has higher estimates (4.69%) of HIV among MSM than Tamil Nadu, which houses the city of Chennai (1.02%).<sup>1</sup> The purpose of the present study was two-fold. First, we sought to examine whether the prevalence of HIV/STI and self-reported transmission risk behaviors (condomless anal sex) differed among high risk MSM in two major urban areas in India: Mumbai, and Chennai, with different HIV prevalence rates in MSM (4.7% and 1.0% respectively, per NACO estimates). These two cities were chosen because they were participating in an efficacy trial for the target population, and are example cities in India representing two different regions, from different states. Second, we sought to examine whether the association of condomless anal sex with bacterial STI prevalence differed among high risk MSM in these two regions.

## METHODS

All procedures were reviewed and approved by the IRB at Partners HealthCare (Massachusetts General Hospital), Boston, Massachusetts, and the Ethics Committees at the National Institute for Research in Tuberculosis, Chennai, India, and the Humsafar Trust, Mumbai India.

### Participants

Participants were 608 MSM recruited for a psychosocial intervention trial focused on strengthening self-acceptance and reducing HIV risk among MSM in India.<sup>17</sup> : MSM-identified peer recruiters with years of recruiting experience from HST in Mumbai( NGO for MSM and TGS) and Sahodaran (a Chennai-based CBO for MSM and TGW) assisted in recruiting study participants. This was done primarily from the community through visits to the cruising sites which they frequented and some through virtual platforms. This included location-based apps/platforms used by communities for seeking partners and social media pages frequently visited by MSM communities. Data for the present analysis are from the baseline visit only. Inclusion criteria were 1) being a man who has sex with men (MSM), 2) being 18 years old or older, and 3) having evidence for HIV acquisition risk defined by any of the following: a) anal sex with 4 or more male partners (with or without condoms), b) a diagnosis of an STI, c) history of transactional sex activity, or d) condomless anal sex with a man who was HIV unknown-status or serodiscordant. In India, there are various culturally recognized subgroups of MSM, and for this study, *Kothi* (feminine acting/ appearing, predominately receptive partners in anal sex), *Double-Decker* (both insertive and receptive in anal sex) or Gay (identify was fluid however, and sometimes changed between screening and baseline; some participants identified themselves as Gay which aligns with

Double Decker but they ultimately preferred to call themselves Gay) . Individuals also had to speak English or Tamil (in Chennai) or Hindi (in Mumbai) fluently.<sup>18-20</sup> In addition, those unable or unwilling to provide informed consent, and those with active untreated, unstable, major mental illness (i.e., untreated psychosis or mania) that would interfere with participation were excluded.

### Assessments

All self-reported data was collected through the CommCare application<sup>21</sup> and entered directly into tablets connected to a secure server. All measures were interviewer-administered with the exception of sexual behaviors, which was self-administered through audio computer assisted self-interview (ACASI).

**Covariates**—Demographics included city of recruitment (Chennai, Mumbai), age, MSM subtype (Kothi, Double Decker, gay), education level (no formal, primary, middle, secondary, higher secondary, college, graduate), employment status (full-time, part-time, unemployed), and religion (Hindu, Christian, Muslim, Other/none). Participants also reported on participation in a HIV prevention intervention.

**Sexual behavior**—Participants completed a 7-item questionnaire that we developed based on our pilot work.<sup>4</sup> The items include number of male partners, number of times they had anal sex with male partners and condom use with male partners. For the present analysis, we focus on behaviors that would place one at risk for an STI; as such, we calculated and report the number of condomless anal sex acts with a male partner in the past month.

### HIV and STI testing

Participants underwent standard voluntary counseling and testing (VCT) for HIV and STIs. Serological testing for HIV was performed using the Retroquic HIV Rapid card test (Qualpro diagnostics, Goa, India). All the reactive samples were further tested using HIV Tri dot kit (J. Mitra & Co., New Delhi, India) for confirmation. Both the tests used have a reported sensitivity and specificity of 100%. Screening for syphilis was performed using the quantitative serologic test (rapid plasma regain/RPR test) (Arkray Health care Private Ltd., Surat, India), and all reactive samples were retested using the *Treponema pallidum* haemagglutination assay/TPHA (Syphicheck-WB, Qualpro diagnostics, Goa, India) having a sensitivity of 95.3% and specificity of 93.7% for confirmation of results. To test for chlamydia and gonorrhea, participants provided a small urine sample and a lab staff member/trained clinician took an oropharyngeal sample and a rectal swab in Abbott multi-collect tubes (Abbott Molecular, Illinois, USA). *Chlamydia trachomatis* and *Neisseria gonorrhoea* (CT & NG) testing was performed using nucleic acid amplification test (NAAT) with the Abbott Real Time CT/NG Kit (Abbott Molecular, Illinois, USA). The samples were not pooled and the pharyngeal and rectal swabs and urine sample were tested separately. The assay was performed in accordance with the Abbott RealTime CT/NG testing protocol, on the Abbott *m2000* system, consisting of the *m2000sp* instrument for sample preparation and the *m2000rt* instrument for amplification and detection. All participants with diagnosed STI received treatment, and anyone who tested positive for HIV was referred to government HIV/AIDS program clinics where treatment was provided free of charge.

## Data Analysis

Means (for continuous variables) and proportions (for categorical variables) were calculated for all covariates. T-tests and Chi-square tests examined differences in covariates by recruitment city. Proportions were calculated for each STI, for bacterial STIs and HIV overall and stratified by recruitment city. Differences in proportions were examined with chi-square tests. A series of regression models—specifying a Poisson regression with a log link and robust variance—were used to estimate prevalence ratios to examine relative differences in prevalence of STIs: 1) by city alone, 2) accounting for number of condomless anal sex acts, and 3) accounting for all covariates. Additional regression models assessed whether the associations between CAS and STIs were modified by recruitment city using interaction terms. To further describe significant interactions, regressions stratified by city were conducted. For ease of interpretation, CAS was standardized so that the prevalence ratio equals the relative difference in the prevalence associated with a one standard deviation increase in number of CAS acts with male partners. Because the self-report sexual behavior questions focused on condomless anal sex and not oral sex, we conducted sensitivity analyses excluding oropharyngeal STIs. All analyses were conducted in SPSS 25.

## RESULTS

Table 1 presents demographics and psychosocial data overall and by city. Statistically significant covariates were included in adjusted models. The mean age of participants was 26.2 years (SD=6.3). Forty-five and a half percent identified as Kothi, 33.3% as Double Decker and 21.2% as gay. Nine and three-tenths percent of participants reported having been tested for an STI in the prior 4 months, 3.3% reported being diagnosed with an STI, and 23.4% reported symptoms associated with an STI.

Table 2 presents the prevalence of STI, HIV and CAS overall and by city. Baseline STI overall ranged from 9.5% for HIV to 15.5% for syphilis. Nearly one-third (32.7%) of participants had at least one bacterial STI diagnosed at their initial visit. Mean number of self-reported CAS acts in past month, were significantly lower in Mumbai compared to Chennai (mean difference=-11.8, 95% CI=-14.6 - -9.1,  $p<.0001$ ). Conversely, however, prevalence of HIV, all bacterial STIs combined, gonorrhea and chlamydia were significantly higher in Mumbai compared to Chennai; syphilis did not differ by city ( $p=.654$ ). We also looked at prevalence by anatomical site. For Chlamydia, there was a 2.0% (12 infections) prevalence for urethral, 12.1% (73 infections) prevalence for rectal, and 1.7% prevalence for oral (10 infections). Chlamydia, there was a 1.0% (6 infections) prevalence for urethral, 7.1% (43 infections) prevalence for rectal, and 7.9% prevalence for oral (48 infections).

Table 3 presents the prevalence ratios for STIs by CAS and city. Notably, after controlling for number of CAS acts, city differences remained for any bacterial STI, chlamydia, and gonorrhea, but CAS was only associated with prevalence of gonorrhea (PR=1.16, 95% CI=1.01-1.33,  $p=.035$ ) and was borderline associated with prevalence of chlamydia (PR=1.12, 95% CI=0.98-1.28,  $p=.096$ ).

In multivariable regressions adjusting for covariates (Models B in Table 3), prevalence of gonorrhea was associated with living in Mumbai (PR=3.50, 95% CI=1.55-7.89,  $p=.003$ )

and increased number of CAS acts (PR=1.19, 95% CI=1.03-1.38, p=.019). Neither city nor CAS acts were associated with prevalence of chlamydia, syphilis, any bacterial infection combined, or HIV (all p's>.10).

We examined interactions of the effects of CAS acts and city on STI prevalence (Table 3, Models C). The effects of CAS acts on the prevalence of any bacterial STI was moderated by city, as evidenced by the significant interaction term (p<0.0001). The interaction terms were borderline significant for chlamydia (p=0.097) and syphilis (p=0.056), and not significant for gonorrhea and HIV.

To further explore the interactions, we stratified analyses by city where significant or marginally significant (Table 4). Accordingly, in Mumbai greater CAS acts was significantly associated with being diagnosed with any bacterial STI (PR=2.49, 95% CI=1.65-3.76, p<0.0001), chlamydia (PR=2.09, 95% CI=1.06-4.13, p=0.033) and syphilis (PR=2.43, 95% CI=1.04-5.71, p<0.0001), but in Chennai CAS acts was not associated with STI prevalence (all p's>0.300).

Across analyses, the sensitivity analyses excluding oropharyngeal STI revealed the same pattern of results with respect to statistical significance.

## DISCUSSION

In this sample of MSM from two major Indian cities (Mumbai and Chennai), nearly one-third (Table 2) had at least one previously undiagnosed bacterial STI. This is higher than the rates found in other studies with Indian MSM (e.g.,<sup>6,7</sup>) and substantially higher than the national average.<sup>22</sup> Additionally (Table 1), substantial percentages of participants, particularly in Mumbai, reported having participated in an HIV prevention program. Accordingly, additional efforts to screen for, diagnose, and treat STIs in this population in these settings are urgently needed. Additionally, there may be room for improvement in the potency and effectiveness of existing HIV prevention programs (they may be limited to outreach messaging and condom distribution) that these men report they have participated in.

While Mumbai had higher STI prevalence compared to Chennai, levels of self-reported condomless anal sex acts in Mumbai were lower than Chennai (Table 2), and in Chennai, unlike Mumbai, CAS acts was not associated with STI prevalence (Tables 3,4). This pattern might reflect a higher disease burden in Mumbai, so that any new partner was more likely to transmit an STI than in Chennai. But, given the sensitivity which still exists around self-reporting of sexual acts, the higher reporting of CAS in Chennai cities could be attributed to the fact that participants in the Mumbai site were recruited directly by a local NGO (Humsafar Trust) and the assessments were done in the same site where MSM could accessing other services. This could have resulted in the fears around privacy which could have led to more socially desirable responses. In Chennai, recruitment was done through a community-based organization, which referred participants to a research site (NIRT) in a different location, and assessments were done by investigators from the institution where the research was conducted. In this case, there was potentially more opportunity for anonymity.



The current study documented a high prevalence of asymptomatic bacterial STI in a population of Indian MSM who were either HIV infected at rates greatly exceeding national averages, or were at high risk for becoming HIV infected (Table 2). National guidelines for STI management in MSM focus on presumptive treatment of symptomatic infection, which would not be sufficient for the MSM in this study, given that the majority of diagnosed infections were extragenital, similar to MSM cohorts in other parts of the world.<sup>16,23,24</sup> These findings suggest that the routine testing of extragenital sites for STIs using NAAT is indicated in order to decrease STI transmission and acquisition in this high risk population. The NACO program for testing and monitoring high risk and HIV infected MSM includes recommendations for syphilis testing twice a year, but does not address screening for gonorrhea and chlamydia. The high rates of asymptomatic genital and extragenital infection in this population suggest that this policy needs to be reconsidered, given the documented potential of STI to facilitate HIV transmission and acquisition. A reframing of HIV prevention programs to a broader concept of promoting sexual health may lead to increasing testing, diagnoses, treatment and better control of the bacterial STI and HIV epidemics among Indian MSM.

Lastly, over the past decade the use of antiretroviral pre-exposure prophylaxis has been shown to decrease HIV incidence among at risk MSM.<sup>25-28</sup> Unfortunately, PrEP uptake has been limited in India to date, with no demonstration project yet underway for Indian MSM, despite their increased HIV risk.<sup>29</sup> Guidance from the WHO and US CDC recommend PrEP for MSM who report condomless anal sex and bacterial STI, so a significant number of the participants in the current study would be appropriate PrEP candidates. Wider STI testing among Indian MSM could help address the Indian HIV epidemic by identifying appropriate candidates for this evidence-based HIV prevention intervention. In India, the HIV prevention programme tends to focus extensively on HIV testing as an important tool for HIV control. Our study points to the need for propagating STI testing not only for syphilis but also for other bacterial STIs.

The present paper is limited by its cross-sectional presentation reporting the prevalence of baseline STI. We do not know how long participants may have harbored these infections, so estimates of incidence need to await the follow-up assessments, which will present a broader picture of STIs over time across the 2 sites. Additionally, despite using ACASI the concerns of sexual history can still be a challenge with socially desirable responses.<sup>12,13</sup>

Despite these limitations, the results clearly show an STI high burden in this MSM study population. Interestingly, results varied across two urban areas: Mumbai and Chennai – where Mumbai had significantly higher numbers of bacterial STIs but lower levels of self-reported condomless sex acts than Chennai. Future investigation and replication would be needed to determine if there is increased disease burden in Mumbai or if there are difference by city with respect to the validity of self-report of sexual behavior. Nonetheless, the high prevalence of untreated STI in both cities suggests that more prevention intervention efforts for MSM in urban India are needed.



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## DATA AVAILABILITY

The data are not currently in a repository. However, request for de-identified data can be made by contacting the first author (ORCID 0000-0002-0121-0806; ssafren@miami.edu). We anticipate that these data will be made available approximately 2 years after publication of the primary outcome paper for the trial, however conditions of use/reuse will be in place with respect to prioritizing research ideas of the study investigator team for secondary data analysis projects, projects already planned with the data for secondary analysis, and relevant institutional data use agreements will need to be in place.

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**Table 1:**

Demographics and psychosocial factors, overall and by city.

	Total (n=608)	Chennai (n=304)	Mumbai (n=304)	p-value
	Mean (SD)			
<b>Age, in years</b>	26.2 (6.3)	27.1 (6.8)	25.5 (5.6)	0.001
<b>Number of male partners</b>	11.9 (46.3)	18.4 (64.5)	5.5 (7.8)	0.001
<b>Number of times CAS with male partners</b>	8.1 (18.3)	14.0 (24.2)	2.2 (3.7)	<0.0001
	%			
<b>MSM subpopulation identity</b>				<0.0001
Kothi	44.5	71.3	17.8	
Double decker	33.3	27.1	39.5	
Gay	21.2	0.7	41.8	
Other	1.0	1.0	1.0	
<b>Religion</b>				<0.0001
Hindu	72.7	78.6	66.4	
Christian	9.4	6.3	19.7	
Muslim	13.0	14.8	3.9	
Other/Agnostic/Atheist	4.8	0.3	9.9	
<b>Education</b>				<0.0001
Graduate or professional degree	14.1	19.7	8.6	
College degree	24.0	24.0	24.0	
Higher secondary	24.2	14.8	33.6	
Secondary	20.1	20.4	19.7	
Middle	12.5	15.5	9.5	
Primary	3.6	4.3	3.0	
No formal education	1.5	1.3	1.6	
<b>Employment status</b>				<0.0001
Full-time	48.4	36.8	59.9	
Part-time	16.1	25.0	7.2	
Unemployed	28.5	37.2	19.7	
Other	7.1	1.0	13.2	
<b>Participation in any HIV prevention interventions, past year</b>				<0.0001
Yes	51.3	8.3	94.4	
No	48.7	91.7	5.6	
<b>HIV positive</b>				0.053
Yes	9.5	7.2	11.8	
No	90.5	92.8	88.2	
<b>STI test, past 4 months</b>				0.789
Yes	9.3	9.6	9.0	
No	90.7	90.4	91.0	
<b>STI diagnosis, past 4 months</b>				0.069

	Total (n=608)	Chennai (n=304)	Mumbai (n=304)	p-value
	<b>Mean (SD)</b>			
Yes	3.3	2.0	4.6	
No	96.7	98.0	95.4	
<b>STI symptoms, past 4 months</b>				<0.0001
Yes	23.4	31.9	14.8	
No	76.6	68.1	85.2	
<b>HIV test, ever</b>				<0.0001
Yes	64.0	52.0	76.0	
No	36.0	48.0	24.0	

CAS=condomless anal sex; reported for past month

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**Table 2:**

Baseline STI Positivity and Sexual Risk Behaviors \*, Overall and by Site

	Overall N=608	Mumbai n=304	Chennai n=304		
	Mean (SD)			Mean difference (95% CI)	p-value
Number of times CAS	8.1 (18.3)	2.2 (3.7)	14.0 (24.2)	-11.8 (-14.6 - -9.1)	<0.0001
	N (Prevalence %, 95% CI)			Prevalence ratio <sup>**</sup> (95% CI)	p-value
CHL	88 (14.7, 11.9-17.5)	54 (18.2, 13.8-22.6)	34 (11.3, 7.7-14.8)	1.62 (1.09-2.41)	.018
GON	73 (12.1, 9.5, 14.7)	48 (16.0, 11.9-20.1)	25 (8.3, 5.2-11.4)	1.93 (1.23-3.05)	.005
SYP	94 (15.5, 12.6, 18.3)	45 (14.8, 10.8-18.8)	49 (16.1, 12.0-20.3)	0.92 (0.63-1.33)	.654
ANY BAC <sup>x</sup>	199 (32.7, 29.0, 36.5)	115 (37.8, 32.4-43.3)	84 (27.6, 22.6-32.7)	1.37 (1.09-1.73)	.008
HIV <sup>†</sup>	58 (9.5, 7.2-11.9)	36 (11.8, 8.2-15.5)	22 (7.2, 4.3-10.1)	1.64 (0.99-2.71)	.056

CHL = Chlamydia; GON = Gonorrhea; SYP = Syphilis; CAS=Condomless anal sex

<sup>x</sup>BAC = Presence of 1 or more sexually transmitted bacterial infections;

\* Self-reported sexual behavior in past month

<sup>\*\*</sup> Estimated using Poisson regression, log link, robust variance

**Table 3:**

Prevalence Ratio of STIs by Site and Condomless Anal Sex (standardized) with Male Partners (CAS)

		Models A (no covariates/interaction)		Models B (+ covariates)		Models C (+ interaction)	
		Prevalence ratio ** (95% CI)	p-value	Prevalence ratio ** (95% CI)	p-value	Prevalence ratio ** (95% CI)	p-value
CHL	Mumbai Site	1.76 (1.16-2.67)	.008	1.33 (0.58-3.03)	.497	1.47 (0.66-3.29)	.344
	Std_CAS, times	1.12 (0.98-1.28)	.096	1.09 (0.97-1.23)	.154	1.08 (0.95-1.22)	.230
	Mumbai Site* Std_CAS					1.63 (0.92-2.89)	.097
GON	Mumbai Site	2.18 (1.36-3.50)	.001	3.50 (1.55-7.89)	.003	3.26 (1.42-7.48)	.005
	Std_CAS, times	1.16 (1.01-1.33)	.035	1.19 (1.03-1.38)	.019	1.20 (1.03-1.38)	.016
	Mumbai Site* Std_CAS					0.73 (0.24-2.29)	.594
SYP	Mumbai Site	0.91 (0.62-1.34)	.629	0.91 (0.41-2.02)	.821	1.09 (0.51-2.32)	.827
	Std_CAS, times	0.98 (0.84-1.15)	.829	1.01 (0.87-1.17)	.952	0.98 (0.82-1.16)	.789
	Mumbai Site* Std_CAS					2.26 (0.98-5.20)	.056
ANY BAC	Mumbai Site	1.43 (1.12-1.83)	.004	1.32 (0.81-2.15)	.267	1.54 (0.98-2.44)	.064
	Std_CAS, times	1.07 (0.97-1.18)	.210	1.07 (0.98-1.17)	.156	1.04 (0.95-1.15)	.372
	Mumbai Site* Std_CAS					2.09 (1.45-3.01)	<.0001
HIV	Mumbai Site	1.35 (0.78-2.34)	.290	1.65 (0.69-3.94)	.258	1.72 (0.65-4.53)	.276
	Std_CAS, times	0.66 (0.37-1.17)	.156	0.66 (0.37-1.15)	.144	0.64 (0.34-1.20)	.168
	Mumbai Site* Std_CAS					1.16 (0.29-4.72)	.834

CHL = Chlamydia; GON = Gonorrhea; SYP = Syphilis; CAS=Condomless anal sex

× BAC = Presence of 1 or more sexually transmitted bacterial infections;

\*\* Estimated using Poisson regression, log link, robust variance

Covariates include: age, sexual identity, religion, education, employment status, past behavioral intervention

**Table 4:**

Prevalence Ratio of STIs by Condomless Anal Sex (standardized) with Male Partners (CAS), stratified by site

		Mumbai		Chennai	
		Prevalence ratio ** (95% CI)	p-value	Prevalence ratio ** (95% CI)	p-value
CHL	Std_CAS, times	<b>2.09</b> <b>(1.06-4.13)</b>	<b>0.033</b>	1.03 (0.90-1.18)	.659
SYP	Std_CAS, times	<b>2.43</b> <b>(1.04-5.71)</b>	<b>.041</b>	1.01 (0.87-1.18)	.890
ANY BAC	Std_CAS, times	<b>2.49</b> <b>(1.65-3.76)</b>	<b>&lt;0.0001</b>	1.05 (0.95-1.16)	.348

CHL = Chlamydia; GON = Gonorrhea; SYP = Syphilis; CAS=Condomless anal sex

<sup>x</sup>BAC = Presence of 1 or more sexually transmitted bacterial infections;

\*\* Estimated using Poisson regression, log link, robust variance

Covariates include: age, sexual identity, religion, education, employment status, past behavioral intervention