

Naz Foundation International

Situational Analysis: MSM in South Asia

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After South Africa, India has the second largest estimated number of people living with HIV/AIDS in the world. According to the India National AIDS Control Organisation (NACO), as of 30th November 2003, the cumulative total for AIDS cases in India was 57781, whilst the estimated numbers of HIV infection was almost 4.5 million¹, although the true figure is likely to be much higher. It was also estimated that 85% of HIV transmission is sexual².

Whilst the role of male to male sex in the pandemic has not been greatly recognised in the region, there is significant anecdotal information to indicate that there are very low testing levels of MSM, that identifying as a “homosexual” is very problematic at a testing site, and that the level of knowledge of MSM behaviours, identities and contexts is also very limited. Thus, NFI in conducting some situational assessments among MSM in 17 cities in South Asia, has found significant levels of male-to-male sexual behaviours within a gendered context (and not based on sexual orientation), high levels of multiple partners, low condom usage, significant levels of STI symptoms, low levels of accurate knowledge regarding HIV transmission, and a significant at-risk population for the spread of HIV/AIDS into the general population for a range of socio-cultural and behavioural reasons.

South Asian populations tend to be very male dominated societies, where social and public spaces are primarily male “owned”. As homosocial and homoaffectionalist societies, sexual boundaries between males can often be easily crossed in appropriate spaces and become sexualised. Further, significant numbers of males perform gendered roles as feminised males and can be accessed by those deemed as “real men”. Experience indicates that male-to-male sexual behaviours do exist in South Asia countries at substantial levels.

Most of these male-to-male sexual behaviours do not exist within a socio-sexual context of a heterosexual/homosexual oppositional binary and as exclusive categories. Rather, there appears to be an inclusive behaviour which involves a substantial level of males operating within a wide variety of categories and/or networks. These involve at times, gendered self-identities, a perceived ‘body heat’ leading to a perceived urgent need for semen discharge, ready and easy accessibility to male sexual partners, and the social contexts of gender segregation, social policing of females, delayed marriage, and concepts of masculinity and femininity.

The frameworks of male-to-male sex, often substantially divergent, usually involve males who self-identify primarily as *kothis*³ who are generally penetrated, and males who take on the penetrating role in male-to-male sex (known as *giryas* and *panthis*⁴ by *kothis*). Males who are penetrated are usually perceived by *giryas* and *panthis* to be “not-men”, which enables a *giryas* or *panthi* to maintain his sense of manliness and be seen as a part of the normative male society.

¹ From NACO's website (<http://naco.nic.in/vsnaco/indiascene/update.htm>), accessed on 12th January 2004

² Website: <http://naco.nic.in/vsnaco/indiascene/update.htm>. Accessed on 23rd September 2001

³ A self-identifying label, for those males who feminise their behaviours (either to attract “manly” male sexual partners and, or, as part of their own gender construction, and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and, or, orally. *Kothi* behaviours have a highly performative quality in social spaces. Self-identified *kothis* use this term for males who are sexually penetrated, even when their behaviour is not feminised. This is the primary and most visible framework of male to male sexual behaviours. *Kothis* state that they do not have sex with other *kothis*; however, this is not always true. They may also be married to women. *Kothis* are also called *metis* in Nepal, *zenanas* in Pakistan and *maigha* in Bangladesh.

⁴ *Giryas* and *Panthis* are *kothi* labels for any “manly male.” A *panthi* or *giryas* is by definition a man who penetrates, whether it is with a female or male. *Panthis* or *Giryas* are most likely to be married to women, and, or have sexual access to females. Their occupations vary across the social class spectrum, from rickshaw drivers to businessmen.

This gendered framework of male-to-male sex is primarily among low-income populations, where poverty, low levels of literacy, and economic disempowerment act as drivers to the HIV/AIDS epidemic. Other dynamics include males who access other males for discharge and/or desire to be penetrated, males who desire male to male sex and do not gender themselves and usually indulge in mutual sexual activity - 'giving and taking', friends having sex with friends for mutual pleasure, and males in all male institutions. Along side these indigenous forms of labelling, gay-identified males, primarily among English speaking, middle and upper classes also exist with their own networks, mainly in urban areas.

These networks of differing MSM contexts may at times overlap, where individuals may shift between different networks, but usually they are mutually exclusive. In other words there are complex dynamics and diffusion in relation to male-to-male sex.

The most visible of these networks are those involving *kothis* because of their highly visible flamboyant behaviour, which is a part of their self-identification. In some cities in South Asia there are also *male massage networks* and other normative masculine males working as male-to-male sex workers.

This, of course, does not tell the whole story of male-to-male sexual behaviours in these countries.

Male-to-male sex work is also significant factor in many South Asian cities and towns (and perhaps villages also). A broad range of frameworks also exists here. *Hijras*⁵, *kothis*, massage boys and men, male youth, and other males will sell sex to other males because of poverty and unemployment. Without a welfare system, and with significant levels of unemployment or low level incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they will also have a regular male or female partner.

While there are substantial networks of *kothis* in urban centres, from the very feminised and cross-dressing ones, to those who have moustaches and dress in shirt and trousers, their sexual partners could well be any masculine male, who tended to go unnoticed.

The issue of female sexual health is also highly pertinent among MSM. Cultural tradition makes marriage socially compulsory. Many MSM, of whatever framework or gender identification/orientation, are married or going to be married, even those who self-identified as *kothis*. Many manly sex partners from the general male population would also be married or going to be married and may well have other females as sexual partners. This means that the sexual transmission of HIV from males to males, and then on to females may be common, especially as the males tend not to practice safer sex with each other, and the females are either ignorant of their male partners other sexual behaviour, or unable to demand protect. Thus a key factor towards reducing risk taking behaviour is to develop levels of sexual responsibility between males, and between males and females. This means empowering MSM to reduce their own risks to HIV/STI infection through changing their risky behaviours to less risky behaviours, and creating an empowering environment where this becomes possible. This is the framework in which NFI works.

MSM and HIV

The contribution of MSM to the HIV/AIDS epidemic in India was officially set at 1 percent in 2001.⁶ But these estimates seriously underestimate the significance of MSM behaviours to the

⁵ A self-identified term used by males who define themselves as "not men/not women" but as a "third gender." *Hijras* cross-dress publicly and privately and are a part of a social, religious, and cultural community. Ritual castration may be part of the *hijra* identity, but not all *hijras* are castrated. They commonly have sex with "normal men". They also have their own language, known as *ulti*.

⁶ Government of India, Ministry of Health and Family Welfare, National AIDS Control Organisation, *Estimation of HIV Infection among Adult Population* (New Delhi, India: Ministry of Health and Family Welfare, 2001)

epidemic in India, especially since global estimates suggest that 5 percent to 10 percent of HIV prevalence is attributable to sexual transmission between men.⁷ Truck drivers are a group known to have higher levels of male-to-male sexual behaviour than the general public.⁸ Therefore, the high rates of HIV infection among truck drivers may be an indicator of the importance of male-to-male transmission in the India epidemic because same-sex behaviour also takes place outside of this particular group.

While data on MSM and HIV does not appear to be available from Nepal or Pakistan, in regard to Bangladesh, the 4th round of the national sero-surveillance reports that HIV is below 1% among MSM, while syphilis rates vary between 4% - 10%.⁹

It must be noted that the reliability of HIV infection data among MSM is influenced by: (i) the lack of knowledge and understanding of MSM behavioural patterns as many MSM do not have a sexual identity/orientation; (ii) many do not consider reporting on their same sex behaviours even when asked; (iii) many do not identify their sexual behaviour as MSM since their partners are not perceived as men; (iv) many gay-identified men as well as others who have developed a sexual identity, are reluctant to identify themselves and disclose their same-sex behaviours or sexual orientation to health care providers, fearing stigma, discrimination and exclusion.

As a SAATHI report¹⁰ stated, "There is no nation-wide data on the prevalence of HIV infection among MSM in India." National AIDS Control Organisation (NACO) of India says, "On HIV among MSM groups, little reliable data is available. Informal estimates suggest rapid increases may be taking place in this particularly vulnerable community" (NACO, 2000). Only a few studies from Mumbai have reported HIV seroprevalence among MSM. The prevalence of HIV infection among gay-identified men attending STD clinics in Mumbai metro was studied by the National Institute of Virology over a 6-month period in 1992 in collaboration with *Bombay Dost* (India's first gay newsletter). HIV prevalence was found to be 20.67%, which was very high given the fact that this studied cohort was of educated middle class and hence had the means and material to be adequately aware of the transmission routes of HIV. It therefore implies that HIV prevalence amongst MSM without a conscious self-identity of their sexual orientation would be higher (Ashok Row Kavi, 1999).¹¹

But data from NACO (2000) of 232 HIV sentinel serosurveillance sites across India, 2 of which targeted MSM, suggested HIV seroprevalence rates among MSM of 23.94% in Mumbai (in Maharashtra State) and 4% in Tamil Nadu State (in Chennai).¹² These figures can be taken as indicators of the increasing risk of HIV infection among MSM across the region as the above comments are equally valid for Bangladesh, Nepal, and Pakistan.

Who are MSM?

What do we mean by the term "males who have sex with male"? Who are these "males who have sex with males"? Does this include males who have only had sex with another males once, twice, three times? Does this include males who just masturbate with other males?

⁷ *AIDS and Men Who Have Sex With Men (UNAIDS Point of View)* (Geneva, Switzerland: UNAIDS, 1998)

⁸ A.D. Bryan, J.D. Fisher, and T.J Benziger, "HIV Prevention Information, Motivation, Behavioural Skills and Behaviour among Truck Drivers in Chennai, India," *AIDS* 14, no. 6(14th April 2000):756-8

⁹ Background document on the dissemination of the fourth round (2002) of national HIV and behavioural surveillance, National AIDS/STD Programme, Bangladesh, June 2003

¹⁰ HIV Prevention Among Men Who Have Sex With Men (MSM) In India: A Review Of Current Scenario and Recommendations – background paper prepared by SAATHI (Solidarity and Action Against The HIV Infection in India) working group on 'HIV prevention and care among Indian GLBT/Sexuality Minority communities', revised draft, April 2002

¹¹ *Ibid*

¹² National AIDS Control Organisation of India's website (<http://naco.nic.in/vsnaco/indianscene/overv.htm>). Accessed on 23rd September 2001

For many service providers and agencies the term MSM it has become synonymous with “homosexuals”, of “gay” men, and at the least, of *kothi*-identified males (however their masculine partners are usually invisible and thus not recognised), while it is often signified within the context of discussions of “vulnerable groups”, or “target groups”, or “at risk groups”. In other words MSM is often taken to mean a specific and exclusive “sexual identity” in opposition to “heterosexuality”, where MSM form an exclusive and bounded group/community. Too often programmatic decisions are taken within this limited view of what is essentially a behavioural term.

Male-to-male sex then includes those who do, or do not identify with same-sex sexual desire, often through gendered sex roles, as well as those who do not. It involves biologically adult males, as well as adolescent males. If we only address HIV/AIDS risks for MSM based on identity/sexual orientation, then what happens to those males whose sexual behaviours with other males are outside the purview of such frameworks because they do not see themselves possessing a sexual orientation other than a normative masculinity as men?¹³

To attempt to reduce this complexity will just lead to a greater invisibility of many divergent contexts of male to male sexual behaviours, expressed in an often bewildering variety and range of personal identities, behaviours, gender identifications and practices, which defy such a simple categorisation. In this context, and from the reality of experience in South Asia, Euro-American understandings and discourses on “gay identities”, heterosexuality, homosexuality, bisexuality, or even the term “sexual minorities”, will be misleading.

Contemporary research on sexualities and genders have clearly shown that the bipolar categories, such as ‘man’ or ‘woman’ or ‘heterosexual’ or ‘homosexual’, are not useful to describe the range of identities, desires and practices¹⁴ existing in India. The terms “gay” or “homosexual” are too contextualised by a specific history, geography, language, and culture to have any significant usefulness in a different culture from their source. In this we should be talking about sexualities, genders, and at the least, homosexualities and heterosexualities, and about behavioural constructions. Where UNAIDS and others speak of behaviourally homosexual, we can also talk about behaviourally heterosexual in the South Asian context.

Whereas some of the male to male sexual acts could perhaps be called ‘homosexual’ (within the context of a local sexuality based upon a feminised gender identification - self-labelled as *kothis*) in that a sexual sense of self is operating within a framework of gendered sex roles and desires, a significant majority of the male sexual partners of these *kothis* should be seen within a context of semen discharge rather than desire for another male. It should be recognised that within a gendered construct of male to male sex and desire, there are *giryas/panthis* who form emotional and sexual relationships with *kothis*. These *giryas/panthis* do not see themselves (nor are they perceived as such) as homosexuals, but rather as “real men”, defined by their supposedly exclusive penetrating role that they take in the sexual encounter with a *kothi*.

In numerous workshops conducted by NFI held with groups of *kothi*-identified males in a number of cities in South Asia, when asked with whom they had sex, the response was a long list of occupational groups which ranged from street dwellers to businessmen, from the unemployed or low income groups to very wealthy men. These were primarily identified as *panthis*.

Thus what does exist in South Asia are a range of masculinities and genders with differing contextualisation of sexual behaviours, sex partner choices, perceived sexual needs, pleasures and desires, where male-to-male sex is seen primarily within a gendered dynamic, rather than in terms

¹³ See: The risks of categorisation, Shivananda Khan, Pukaar, Issue 21 April 1998; Varieties of homosexuality in Bangladesh, paper presented by Dr. Carol Jenkins at the 12th World AIDS Conference, Geneva, June 28-July 3, 1998, Pukaar, Issue 24, January 1999; Men and HIV: sociocultural constructions of male sexual behaviours in South Asia, Shivananda Khan, Pukaar, Issue 28, January 2000; Males who have sex with males in South Asia – a *kothi* framework, Pukaar, Issue 31, October 2000. Pukaar is the quarterly journal of Naz Foundation International and available on its website www.nfi.net

¹⁴ Personal discussion with Dr. Carol Jenkins, Care Bangladesh, 1999

of sexual orientation or identity. This means that for many whom could be categorised as MSM would not define themselves as such because they would see themselves as normative penetrative males.

Sexually accessing masculine partners by *kothis* is not considered difficult. All urban areas appear to have sexualised spaces, such as parks, toilets, railway and bus stations, specific bazaars, streets, and other public areas where *kothis* would go to meet potential *giryas/panthis*, often marketing sexual availability through their feminised social behaviours. Many 'real men' also go to these sites, not only to meet such accessible males, but often for quite legitimate purposes, where they can get caught up "in the heat of the moment" and access *kothis* there at the time.

Estimation of the numbers of MSM

As discussed above MSM as a category is highly complex, diverse, and for many significantly gendered which makes it extremely difficult to make any effective size estimation. Simplifying this complex scenario, it is composed of two or more fairly distinct populations, those that are relatively visible, i.e. *public kothis*, and those invisibilised because they are a part of the normative male population, as well as non-public *kothis*, males in all male institutions, neighbourhood encounters, and so on.

At the same time, the issue of who is being defined as MSM is extremely pertinent. Do two males who only mutually masturbate each other defined as MSM? Does a single male-to-male sexual encounter define the participants as MSM? Indeed, how frequently does a male have to sex with another male to be defined as MSM? Should risk to HIV infection be taken into account?

Behavioural surveillance studies are often problematic, inadequate and badly designed. Many procedural and ethical issues are problematic where inappropriate questioning is the norm, poor formatting of studies, lack of confidentiality, stigmatisation by researchers, or even no mention of same-sex relations. This poverty in information and knowledge is further enhanced through a lack of understanding of the dynamics and frameworks of same-sex behaviours in an Indian context.

This leads to a lack of sensitivity to the realities of male-to-male sex and thus inadequate programming, which can often further socially exclude many MSM from service provision, treatment and care, as well as significantly underestimate the number of at-risk MSM in any given population along with a lack of resources to support HIV intervention programmes.

The qualitative and quantifying studies regarding MSM in any given population depends very much on the sensitivity of the methodology used, who conducts such studies, how they are conducted, and the groups of males being accessed.

Sexual behavioural studies in India have classified homosexual as anything from 1% of the sexually active male population to nearly 28% of the 'occasionally homosexually behavioural males'.

Quantitative studies conducted in India include:

- A survey at Patna medical college in India in 1992 revealing that 25% of male medical students and doctors had had same-sex relationships (H.V. Wyatt, 1993)
- A postal survey of the readership of 'Debonair', an English men's magazine from Mumbai revealing that of 1500 men who replied, 29.5% had sex with another man, before the age of 20 years in 80% of the cases (Roy Chan, et al, 1998)
- A survey of 527 truck drivers in northeast India revealing that 15% had sex with men (S.I. Ahmed, 1993)
- A major study conducted in Pune cities, where only 1.2% of men interviewed said they had homosexual relations although the authors did add, "we do feel it is extremely difficult to get an accurate estimation of homosexual experience in a general survey like we did". The

- researchers agree that a completely different kind of questionnaire has to be designed to get more information on the prevalence of homosexual behaviour (Roy Chan et al, 1998)
- A postal survey of rural and semi-rural men in Tamil Nadu to which 1200 men replied found that 8% had sex with other men (Shreehar Jaya, 1994)
 - According to a report on MSM in developing countries, the prevalence of MSM behaviours in the Indian male population range from 8 to over 50% (Neil McKenna, 1996)
 - In a study of sexual behaviour among 1600 college students in Chennai, (Hausner D, 2000) it was found that approximately 20% of male students reported having had sex at least once in their lifetime and among these, 35% had their first experience with another male.

In Bangladesh, in a study conducted by the International Centre for Diarrhoea Diseases Research, Bangladesh (ICDDR,B) in 2002 indicated that over 22% rickshaw pullers had sex with other males¹⁵.

In Pakistan, AIDS Analysis Asia, reported in July 1996¹⁶ that:

- 20% of men in one rural area have male-to-male sex
- 40% of men living in a Karachi squatter settlement had male-to-male sex
- 72% of truck drivers in central Karachi had sex with other males, while 76% had sex with female sex workers

NFI has conducted a number of surveys among MSM in a range of cities across Asia, where in each site 200 *kothi*-identified males were interviewed. From these situational assessment reports (which can be accessed on NFI's website, www.nfi.net) the number of "real" men partners accessed in one month were:

Sylhet, Bangladesh	8800
Hyderabad, India	8100

Similar levels were reported in other cities.

Thus, direct evidence and anecdotal reports from across South Asia suggests that male-to-male is common and substantive, and that there are a broad range of reasons for this, including gender segregation, social policing of women, delayed marriage, difficulties accessing females, overcrowding, poverty, unemployment amongst unmarried males, as well of course, desire for specific sex acts, as much as desire to have sex with another male.

MSM and risk behaviours

From all the studies that NFI has conducted it is clear that for certain MSM populations, anal sex is the common practice, along with multiple partners, low self-risk assessment, and significant levels of STI symptoms.

For example, in a 2000 study in India and Bangladesh, where NFI conducted social and risk assessments of MSM in a range of urban settings within networks of the most publicly visible of MSM, i.e. Bangalore, Hyderabad, Pondicherry, Sylhet¹⁷ where 200 such males were interviewed in each city:

¹⁵ presentation by ICDDR,B at the 2nd National Male Sexual and Reproductive Health Consultation Meeting organised by Bandhu Social Welfare Society, Bangladesh, August 2003

¹⁶ reported in AIDS Analysis, Asia, July 1996, Focus on Pakistan, page 6

¹⁷ see *Situational Assessments among MSM in four cities in South Asia*, 2000: Bangalore, Hyderabad, Pondicherry and Sylhet, an NFI study for Family Health International

Multiple partners in previous month

No. of partners	Hyderabad	Bangalore	Pondicherry	Sylhet
1-3	4%	22%	22%	1%
4-6	6%	18%	20%	6%
7-10	6%	13%	26%	15%
11-15	5%	12%	14%	20%
16-20	15%	13%	10%	19%
21-30	25%	13%	7%	12%
31-50	19%	7%	1%	6%
51+	20%	2%	0%	21%

Anal sex in previous month

	Hyderabad	Bangalore	Pondicherry	Sylhet
Insertive	24%	35%	23%	22%
Receptive	76%	65%	77%	78%
Total number	7029	3754	2182	6692

Condom used

	Hyderabad	Bangalore	Pondicherry	Sylhet
Insertive acts	35%	45%	34%	33%
Receptive acts	29%	45%	36%	31%

Reported symptoms

	Hyderabad	Bangalore	Pondicherry	Sylhet
Pus/discharge in stools	7%	0%	0%	16%
Penile pus/discharge	13%	2%	0%	4%
Genital sores	16%	1%	9%	6%
Oral sores/blisters	16%	3%	3%	1%
Bleeding when defecating	22%	2%	16%	16%
Rash on genitals	25%	5%	13%	11%
Pain when defecating	28%	7%	0%	20%
Pain while urinating	29%	10%	31%	54%
Rectal itching/burning	30%	9%	28%	51%

Treatment

	Hyderabad	Bangalore	Pondicherry	Sylhet
Nothing	40%	62%	30%	22%
Pharmacy	20%	1%	7%	42%
Private doctors	20%	7%	35%	9%
Hospitals	27%	27%	28%	31%
Others	24%	3%	0%	7%

Knowledge and awareness

	Hyderabad	Bangalore	Pondicherry	Sylhet
Have you heard of AIDS?				
Yes	71%	85%	57%	69%
No	29%	15%	43%	31%
What have you heard?				

An STD	5%	5%	3%	14%
Multiple partners	7%	2%	0%	0%
Sex with an FSW	7%	15%	10%	0%
Not using condom	10%	38%	3%	4%
No idea	14%	7%	36%	30%
Dangerous disease	57%	30%	42%	36%
Bad sexual relations	-	3%	6%	0%
<u>Personal risk assessment</u>				
Large	47%	3%	54%	0%
Small to medium	7%	39%	7%	19%
Don't know	46%	58%	39%	81%

The situation is similar in other cities in South Asia.

MSM, Vulnerability and Stigma¹⁸

It needs to be recognised that the male being anally penetrated by another male is highly stigmatised, both by the penetrator, as well as general society, and those who are perceived to be recipients of penetration are usually treated with contempt. A *giryapanthi* or any man/male who is sexually penetrated, orally or anally, will make extensive efforts to hide his practice and/or desire, both from his friends as well as from *kothis/hjiras* and others in their sexual networks to avoid such stigmatisation. It cannot be assumed that gendered sex roles are exclusively maintained at all times. It further needs to be recognised that a similar crossing of “gendered” boundaries exists amongst *kothis*. It is also not unknown for some *kothi*-identified males to penetrate other males. But like the penetrated *giryapanthi*, this behaviour would also be kept secret from other *kothis*.

Such stigmatisation around feminisation produces a range of human rights abuses, blackmail, violence, and male-on-male rape by local men, thugs and local police.

Not only does poverty, class and education levels stigmatise individuals along with the fact of HIV infection, but also the specific gendered role and identity that some MSM identify with. Thus are doubly stigmatised because as biological males they are sexually penetrated – and thus not perceived as men. Their feminisation, their crossing of the gender roles and barriers accepted as social norms, reinforces the stigmatisation, leading to exclusion and denial of access to services and to the social compact. This often results in such males who are living with HIV/AIDS to be stigmatised by others who are also living with HIV/AIDS but whose routes of infection are deemed “normal”.

On the other hand, the masculine partners of *kothis* easily merge into the general normative male society, their sense of masculinity maintained because they are the penetrators, not of other men, but of “not-men”.

Power inequality dynamics arising from South Asian constructions of masculinity, social attitudes towards feminised males and their sexual practices, sexual abuse, assault and rape, stigmatisation and poverty, discrimination and disempowerment, all configure the lives of most *kothis*. As a consequence they play a significant role in the emotional, sexual, physical and economic exploitation of feminised males, and give rise to a range of physical, psychological, and emotional problems, which further increase vulnerability and disempowerment. This disempowerment creates significant levels of suicidal impulses and self-damage, an expression of self-hatred and despair. And this of course leads to significant increases to risks of STI/HIV as well as impeding successful implementation of risk reduction strategies.

¹⁸ See also NFI Briefing Paper No. 7: Social Justice, human rights and MSM, available on the NFI website (www.nfi.net)

Many *kothis* not only face harassment, sexual violence and rape from law enforcement agents, but also from those whom they have called friends in schools and colleges, from those in positions of trust such as relatives, neighbourhood elders, elder friends, and teachers. Gang rape is not uncommon. And of course such forced sex is always unsafe and often results in serious physical injury such as a ruptured rectum, internal haemorrhage and so on.

One of the central issues that have arisen from NFI research and understanding is that often it is effeminacy and not the factual knowledge of male-to-male sexual behaviour that leads to harassment and violence. That harassment and sexual violence results from the fact that many *kothis* do not live up to the expected normative standards of masculine behaviour. It is this belief that leads to the notion that those who are feminised can be exploited and abused and that being feminised somehow weakens the person, a notion often harboured by the *kothis* themselves.

Accepted notions around effeminacy are therefore one of the major factors that lead to disempowerment and opens *kothis* to abuse and assault and to a refusal of service provision. The fact that *kothis* themselves have internalised these notions so strongly, means that specific tools will need to be developed for *kothi* in order to empower them to start valuing their lives and enhancing their self respect so as to reduce their risks for HIV infection.

Little official documentation of abuse of MSM has been undertaken, but more documentation is now occurring, and indicated in the 2003 Human Rights Watch report on HIV/AIDS related abuses in Bangladesh¹⁹.

¹⁹ Human Rights Watch website (<http://www.hrw.org/reports/2003/bangladesh0803/>). Accessed 26/5/2004