sex, secrecy and shamefulness

developing a sexual health response to the needs of males who have sex with males in Dhaka, Bangladesh

Shivananda Khan

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Shivananda Khan
Naz Foundation International

This report is dedicated to all the those males who have sex with males
in Bangladesh who may be infected or affected by HIV/AIDS

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INTRODUCTION

The issue of males who have sex with males[1] in Bangladesh is politically, socially and religiously sensitive and extremely difficult to address in conventional approaches to sexual health promotion. Further such behaviours are illegal under the old British law incorporated into the Bangladesh Penal Code[2]. Further to the civil code, Bangladesh is a Muslim country with strong conservative elements framed by Islam and the Shar'ia[3]. It therefore has profound implications for the control and management of STD/HIV.

Because of these cultural, religious and social reasons male to male sexual behaviours are to a great extent invisible, if not denied, difficult to access in terms of current frameworks of sexual health promotion, with all that this implies for women's reproductive and sexual health. Further such sexual behaviours do not appear to be contained within a heterosexual/homosexual framework. In fact anecdotal and direct research indicates that levels of males who have sex with males in South Asia are significantly high[4] , that the majority of such males are married or will become married, and that many young boys and men are involved in these activities.

What appears to exist throughout South Asia is a range of sexual networks that cut across class, religion, age, ethnicity and income status. These networks may overlap to some extent, but not always. However male to male transmission of STDs and HIV will be invisible because of the low levels of testing by men, the lack of anal and oral testing and because such behaviours are denied by the males themselves. Most of male to male sex appears to be unprotected.

Very little work has been done in Bangladesh to explore these issues, to find levels of risky sexual behaviours amongst males, social constructions of male sexual behaviours, and needs assessment in the context of STD/HIV control and management[5] .

It was to address this gap in information, knowledge and services that this Project was developed towards providing a local response to the sexual health needs of males who have sex with males in Dhaka, Bangladesh.

Members of one of the local networks of males who have sex with males, recognising this need for the development of appropriate services towards the prevention of STD/HIV transmission amongst them, requested Ford Foundation for technical support and development. These discussions led to the Naz Foundation being approached for technical assistance because of its expertise in this specific area.

A proposal was developed incorporating action-based, peer-led, research, developing a risk and needs assessment amongst males who have sex with males in Dhaka, and empowering the development of a local response to these needs. This would require the provision of appropriate training for recruited individuals from the male sexual networks to conduct such research and to encourage the development of appropriate service agencies

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1. Whilst generally HIV/AIDS agencies have used the term men who have sex with to describe the context of homosexual behaviours by those who are gay-identified, homosexual identified as well as those who do not so identified, what work Naz Foundation has done in South Asia, including Bangladesh, that the term "men" was also problematic within the cultural context. Whilst legally males were adult (in a Western sense) by the age of eighteen, socio-cultural factors played a role in other definitions. For example in early marriage, is a fifteen year old husband a "man"? Is a twelve year old male working to support his family a "man"? Also the research indicated significant levels of early sexual behaviours, below the age of sixteen, much of it consensual, but also much of it not. It was therefore

with these factors in mind, that we decided to use the term male rather than the term men.

Similarly the word boy will have a different connotation in Bangladesh, and often does not signify so much a male of a particular age, but will be linked with issues around marriage, having children, status, and so on. In the context of this report I use the term male to refer to any biological male, and the term boy as used in the Bangladesh context, age not withstanding. For example in one public sex site in Dhaka, a male of 65 years, married with four children, but selling sex to others as the penetrated partner, was still labelled a "boy".

2. Section 377 of the Bangladesh Penal Code reads: "OF UNNATURAL OFFENCES: Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life or imprisonment of either description for a term which may extend to ten years and shall be liable to fine.
Explanation: Penetration is sufficient to constitute carnal intercourse necessary to the offence described in this section."

3. The Shar'ia is the legal code of Islam arising from the interpretations of the Qu'ran, the Hadith (sayings of the Prophet Muhammed and his Companions, as well as custom.

4. Panos Report, 1996, "On the Margins"

5. See:

Aziz, K.M., Ashraful & Clarence Malony: Life Stages, Gender and Fertility in Bangladesh, ICDDR,B, 1985
Breaking the silence group: non-commercial sexual abuse of children in Bangladesh, a case study report, 1997
Chowdhury, Syeda Nahid Mukith, Joachim Gomes, Sharif Md. Ismail Hossain, Strengthening STD services for men in an urban based programme, Population Council, Bangladesh
Hossain, Sharif Md. Ismail, Ismat Bhuiya, Kim Streatfield, Professional Blood Donors, Blood Banks and Risk of STDs and HIV/AIDS: a study in selected areas in Bangladesh, Population Council, 1996
However, these reports give a very limited picture on male to male sex and for several of them, the terminology used is limiting, i.e. homosexual. In one of the reports, a new term has been coined "isosexual".

MALE TO MALE SEXUAL BEHAVIOURS AND MUSLIM SOCIETIES

In the early Arab world, despite a few mild murmurings against homosexuality in the Koran, overt homosexual activity was not considered incompatible with the highest religious, legal or moral standards or the most respected social position: the revered holy man of the sixth century Ibn, al-Farra', a teacher of the Koran in Almeria, took a boy who had refused his advances to court, where the judge ruled that the youth must submit to the master, a triumph lovingly celebrated in lyric verse:

> "Then the Qadi(judge) indicated to the flowers
> that they were to be taken
> And to the mouth that it should be tasted,
> And when the beloved saw him on my side
> He abandoned his resistance and I enfolded him.
> I continued reproaching him for his long unkindness
> And he said, "May God forgive a past mistake!"

Rosalind Miles - The Rites of Man - love, sex and death in the making of the male, Grafton books, 1991

"I fell in love with a beautiful boy of Urdu bazaar, named Babri. But this love was very peculiar. As soon as Babri comes in front of me, I am so bashful that I could not raise my eyes to look at him.

One day I was passing through a street with my servant. All of a sudden I encountered Babri, but I was in an astonishing state, very shy, and passed him with great confusion.

My heart and mind completely in the clutches of his love, wandering in orchards and mountains, bare-footed and bare-headed

"Tuzk-I-Baburi'
autobiography of Babur, founder of the Mughal Empire in India (15th century)

SULTAN MAHMOOD MIRZA (Uncle of Babur)
"He took beautiful sons of his noblemen and admitted them into his 'boys harem'. He surrounded himself with scores of beautiful boys. This practice became a custom throughout his kingdom and noblemen occupied themselves with this mode."
TUZK - I - BABURI
autobiography of Babur, founder of the Mughal Empire in India (15th century)

ALI ADEL SHAH (Sultan of Beijapur, India)
He was very fond of gathering beautiful male slaves and eunuchs around himself. Once Ali Adel Shah sent his messenger to Amir Buraid with this message: "It has come to my knowledge that you keep two beautiful eunuchs. You must immediately send them to me."

Amir Buraid out him off with excuses and did not send the two beautiful eunuchs to Ali Adel Shah.

During this time Murtazah Nizam Shah Behri made an assault upon Amir Al Buraid. Buraid requested Ali Adel Shah for help. Adel Shah sent two thousand cavalry men to reinforce him.

Buraid was impressed with this help and he sent these two beautiful eunuchs whom Ali Adel Shah summoned for, from *Baider to Beijapur.*
translated from TAREKH-I-FARISHTAH
(author- Mohammed Qasam Farishtah - 16th century)

Homosexuality and Islam

Islam to a great extent continued on with the traditional attitudes and beliefs around homosexuality as expressed in Judaism and Christianity, especially in terms of the "passive" male, though the Koran does not describe specific penalties. However, this condemnation must be put into a broader context of all sexual behaviour, since Islam only sees sex between married partners as legitimate and sanctified. Sex outside marriage was condemned as much as homosexual behaviour.

Over time, Muslim religious writings became more punitive towards homosexuality. A number of Hadith (sayings and traditions attributed to Muhammed and collected or forged after his death - see Fatima Mernessi and "Women and Islam, 1987), calling for the death penalty.

The impact of these writings on broader opinion was not perceived as very great.

In an 8th century literary "duel" in which the poets Jarir and al Farazdiq exchanged extravagant sexual insults, the great majority were heterosexual, but some were homosexual. None suggested that homosexuality was sinful or evil. Women's sexual conduct, which could potentially besmirch family honour, was given far more attention than male homosexuality.

With the advent of the Abbasid Caliphat in the middle of the 8th century, we find poets writing homoerotic verse to beautiful youths.

These relationships between older men and youths were to some extent acceptable, sine the youths and boys (beardless) held the same status as women. It is where the youths became a bearded man that such relationships had to end.

Abu-Nuwas (Christian era 810) defended his own involvement:

Jealous people and slanders overwhelm me with sarcasm
because my lover has started to shave.
I answer them: friends, how wrong you are!
Since when has fuzz been a flaw?
It enhances the splendour of his lips and his teeth,
Like silk cloth which is brightened by pearls.
And I consider myself fortunate that his sprouting beard
preserves his beauty from indiscreet glances;
it gives his kisses a different flavour
and makes a reflection glisten on the silver of his cheeks.
(Jarir Ibn Jarir, the Naqaith of Jarir and al Farazdaq [1974])

There was ample literature both in Arabia as well as in Mughal India around sexual interactions between men and youths, none of which suggests that male homosexuality was stigmatised or repressed. Often they were highly visible, especially amongst the upper-circles.

Pre-Muslim stereotypes regarding male homosexual roles persisted, even though Muslim religious writings prohibited both. Though there was neither word form nor concept of, a homosexual person, an adult man who took pleasure in the anal-receptive role was scorned and thought to require an explanation. To play an active penetrating sexual role was, on the other hand, entirely normal, no matter who was being penetrated.

Despite the social pressure to condemn male homosexual relations in print, the Koran's failure to specify a punishment left some room for manoeuvre. Al-Kakam (d.AD 822) an Emir in Spain, held that sodomites should be beaten with fewer strokes than those guilty of other sexual infractions. Some authorities authorised intercourse with males provided that they were not Muslim (some Malikite jurists reinterpreted Koran 9.120 as authorising the sodomy of non-Muslims). Others concluded that the Hadith reserving the legal shedding of Muslim blood for three offences only - adultery, homicide and denial of faith - precluded any corporal punishment for homosexuality.

There exists a great deal of male and female homosexual erotica in the Mughal period, which indicates a wide-spread acknowledgement of desire. Muslim rulers of India often maintained youthful male lovers, and male brothels flourished in many Indian cities.

(David Greenburg - "The Construction of Homosexuality" - 1988)

Also see

Al-Tifashi, Ahmad : The Delight Of Hearts (translated by Edward A Lacey), Gay Sunshine Press, 1988

Bleys, Rudi C.: The Geography of Perversion - male to male sexual behaviour outside the West and the ethnographic imagination 1750-1918, Cassell, 1996

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Breaking The Silence Group: Non-commercial sexual abuse of children in Bangladesh - a case study based report, Breaking The Silence Group, 1997

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Stemmeler, Micahel L. and Jose Ignauo Cabezon, edited by: Religion, Homosexuality and Literature, Monument Press, 1992
Swidler, Arlene , edited by : Homosexuality And World Religions. Trinity Press International, 1993
Wikan, Unni : Behind The Veil In Arabia - Women In Oman, University of Chicago Press, 1982
Wright, J.W. & Everett K. Rowson: Homoeroticism in classical Arabic Literature, Columbia University Press, 1997

LANGUAGE

"the human mind cannot think a thought unless the words to express the thought exists"
George Orwell - '1984'

Language is centrally a cultural artefact. Whilst languages are learned, they are not learned in isolation. The process of learning takes place within the context of interacting perceptions, beliefs and personal experiences of the past and present as well as expectations of the future. Words themselves carry a socially constructed history of their own. All these mediate and condition the learning of language, and the meanings we imbue to the words we use.

In communicating thoughts and ideas, of sharing information, this has enormous implications. More specifically, in terms of sexual health, of HIV/AIDS, of sexual behaviours, how do we ensure a shared understanding of the issues and what we are speaking about. Bangladesh culture has tabooised sexual behaviours, of sex itself, particularly those which are not seen as socially and/or religiously acceptable, or defined as "abnormal", "sinful", "evil", words that can carry strong emotions of guilt, shame, dishonour and fear (features that are shared with the other South Asian countries). Here sex is within the invisible realm, and very often there are no commonly available appropriate terms to even discuss sex and sexual behaviours in the public arena.

Different cultures place differing values on the various sexual aspects of our lives. These values are often hidden within the words used by these cultures to describe and/or name these sexual aspects. In Bangladesh, like other South Asian countries, for many males, sex is the act of vaginal penetration with a wife. Other acts can be thought as play, fun, practice, and so on, but are not seen as sex as such.

Direct correlation between words used in one language and those used in another do not always exist. Translations between one language to another can carry enormous risks of misinformation, misunderstandings, and downright censorship. This created issues of context in translating from English to Bangla and from Bangla to English. All interviews, questionnaires, diaries, and discussions were in Bangla. Great care was taken to ensure there was mutual understanding of terms, contexts, behaviours and meanings.

In writing of people's personal experience, I have tried to avoid "softening" the language, to make it more suitable academically. Meanings, words and contexts are directly from what has been reported. Sometimes the terms are expressed explicitly because that was how it was told.

A further issue arose with frameworks of sexual orientation, desire and identities. The medicalisation of sexuality and sexual behaviour in Western cultures since the 19th century, a whole new language has evolved to describe sexual behaviours. A naming process developed that categorised and labelled peoples by their sexual practices, creating the terms homosexual, heterosexual, bisexual and all the categorisation of personality and traits for such labelled persons. A person expressing same-sex behaviours became *a* homosexual, a new construction. Procreative heterosexuality became the normative process. The dichotomised and oppositional structures of male and female, also framed the "homosexuality" and "heterosexuality", and the new language of sex was also dichotomised and made oppositional within hierarchical frameworks. One was either masculine or feminine, heterosexual or homosexual (despite the special category of "bisexual"). The discourse of sexuality carried its own seeds of self-definition and was to some extent tautological. Within all this, the heterosexual was sexually defined as *only* having vaginal sex, whilst the homosexual was defined as *only* having anal sex. For the man to have anal sex with a woman was often not considered. An invisible behaviour.

The word homosexual, as it is understood in the West, does not have a direct equivalent in Bangla, although increasingly the Bangla term *shomokami* - desiring the same sex - is used as a local equivalent. This does not imply that "homosexual" behaviours do not exist. What it does mean is that these behaviours have different histories, different contexts, different constructions, and are thus named differently.

For example, the act of penetration is a definer of phallic power, a male signifier. For a person to be penetrated is to define that person as "not man". The language then of male penetration is around gender and power. So *koti* is a word sometimes used synonymously with the term homosexual, but they are not the same. They represents males who are penetrated, who feminise their behaviour, often to attract other males, and has meanings around a perceived lack of malehood, not being a "real man". In the same way that the term *hijra* means a person who is "not a man" and "not a woman". Generally though, the word applies specifically to "men" who become *hijras*. These terms are abusive, derogatory and degrading. But in Bangladesh, malehood and femalehood is also defined by family, community and social duties. A man can be extremely "effeminate" in behaviour (as the term is defined in the West), but because he fulfils his community duties as a married man with sons, he is defined as manly, a proper man. Further a boy (male who is not yet a man in terms of social duties and responsibilities) maybe extremely masculine (in a Western sense), but is still defined as not-yet-man. He is not married with sons. In that sense there is a framework for a specific gender construction around post-pubescent boys who are not "men". The "beardless youths" of Arab and Mughul India sexual histories. This construction also has strong sexual availability overtones.

SEXUAL BEHAVIOUR RESEARCH

Before appropriate strategies can be developed for effective STD/HIV control programmes there needs to be appropriate research conducted in regard to the full range of sexual practices of individuals and the sexual behaviour patterns of families and communities. Further for such research to be **appropriately used** in such a development, then it must be contextualised within specific socio-cultural-economic frameworks. It should be recognised that sexual behaviour is not the isolated phenomenon of the individual but lies within a context of culture, social and economic conditions.

Here I quote
".... it would have to focus not only on the incidence of particular attitudes and practices, but on the social and cultural contexts in which sexual activity is shaped and constituted. Research attention would have to be drawn not merely to the calculation of behavioural frequencies, but to the relations of power and social inequality within which behaviour takes place and to the cultural systems in which it becomes meaningful.

"In relationship to HIV/AIDS, as in relation to gender inequality and sexual oppression, an understanding of sexuality and sexual activity as socially constructed has thus refocused attention on the inter-subjective nature of sexual meanings - their shared, collective quality, not as the property of atomised individuals, but of social persons integrated within the context of distinct and diverse sexual cultures. This emphasis on the social organisations of sexual interactions, on the contexts within which sexual practices occur, and on the complex relations between meaning and power in the constitution of sexual experience, has thus increasingly shifted attention from sexual behaviour, in and of itself, to the cultural rules which organise it. Special emphasis has been given to analysing the local or indigenous categories and systems of classification that structure and define sexual experience in different social and cultural contexts.

"In a remarkably short period of time, it has become apparent that many key categories and classifications used in Western medicine to describe sexual life or epidemiology are in fact, far from universal - unshared by people living in the diverse historical contexts ... or cultural settings that have increasingly become the focus for HIV/AIDS research. On the contrary, categories as diverse as "homosexuality" "prostitution" (we can include lesbian, gay, commercial sex workers, men who have sex with men...SK) or even "masculinity" and "femininity" may be altogether absent, or quite differently structured, in these societies and cultures - while other, local categories may be present that fail to fit neatly into the classification systems of Western science."
(Conceiving Sexuality - approaches to sex research in a post-modern world - page 11, 1995, Routledge)

Meanings

Further to this, Gary Dowsett in Practising Desire - homosexual sex in the era of AIDS - Gary Dowsett, 1996, Stanford University Press states that:
"It is probably not possible to know the extent of homosexual behaviour among males. What is clear from the research findings is that an incalculable number of ..... males can and do have sex with other males, some frequently, some occasionally, in the right circumstances or at certain times in their lives, in certain sites or in certain institutional settings, with certain cultural overlays, or all the above."
And that there is *"...diversity of contexts in which males pursue males."*

Whilst he relates this for New South Wales in Australia, it is even more pertinent to the situation in Bangladesh.

He goes on to state:
"Many of the standard survey techniques may never obtain sufficiently accurate accounts of the extent of such activity. This is particularly true when such sexual matters are deemed unreportable for moral or legal reasons. Political/religious/cultural dynamics will always confound attempts to uncover just how sexually active males are...."

And that
"*the search for a definitive answer on the extent to which men have had and will have sex with other men is not going to offer a clue to the likely extent of this form of possible HIV transmission, and its geographical location.*

"There is considerable doubt whether it is necessary to know the extent of homosexual practice among males in any country in order to develop public-health policy and to implement HIV and STD prevention strategies. More important is the consideration that no statistic on the extent of male-to-male sex, even of anal intercourse, should affect policy and budgetary decisions concerning prevention. This is so because it is not the extent of male homosexual behaviour that needs to be addressed, but the diversity of the contexts in which it is practices.

"So although surveys are conducted the world over to inform public health initiatives about the sexual behaviour of gay and other homosexually active men, counting condoms used, the number of partners coupled with, and sometimes even the memory of motivations surrounding sexual events, they cannot capture the complexity of sexuality or its meaning, intention, desire, and contextual contingency. Different research is needed to explore desire for, and the sexual contexts in which men seek, sex with other men."

This study on male to male sexual behaviours does not answer the question of numbers, nor does it explore all the contexts of such behaviours. It tries to avoid the trap of marginalising the behaviours through utilising only the questionnaire, but uses a variety of methodologies from collecting anecdotal stories, life histories, meanings given, exploring sexual diaries, observation and site visits, and often, participatory reporting. Questions of who, what and how are not enough if effective strategies for STD/HIV prevention are to develop and be implemented. Why, where, when, in what context, are equally as important.

DEFINITION

The World Health Organisation's definition of sexual health is:

> The integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love

PART ONE

Introduction to the project

INTRODUCTION TO THE PROJECT

Purpose

To develop a strategic response to the reproductive and sexual health needs of males who have sex with males in Dhaka, Bangladesh so that they are empowered to access appropriate sexual health information and services.

Objectives

1. to conduct an action-based study into the socio-cultural dynamics of males who have sex with males in Dhaka, Bangladesh, including the range and type of male sexual networks, types of sexual behaviours, safer sex practices, public sexual sites, marriage issues, gender relationships and access to HIV/STD information and services
2. To develop a strategic response to the sexual health needs of males who have sex with males in Dhaka, Bangladesh through the support and development of appropriate male sexual health projects
3. To facilitate males who have sex with males and their sexual partners to access appropriate reproductive and sexual health information and services.

Strategies

1. Develop and conduct sexual behaviour surveys in targeted areas to indicate levels of male to male sex and their locations, levels of safer sex practices, types and range of sexual networks and the specific entry points into these sexual networks to ensure the most effective, appropriate and localisedintervention programmes for STD/HIV education and prevention
2. Provide skills training programmes for individuals recruited from males who have sex with males sexual networks so that they can conduct the research
3. From the research analysis develop a needs and risk assessment regarding STD/HIV transmission
4. Through the provision of training and technical support empower the development of local responses to the sexual health needs of males who have sex with males in Dhaka
5. Utilise the networks of Naz Foundation to ensure that such initiatives can access appropriate donor agencies and technical support as on-going service agencies

Potential Benefits

1. male sexual behaviour study and STD/HIV/AIDS needs assessment of males who have sex with males
2. promoting behaviour change towards safer sex practices amongst males who have sex with males
3. developing counselling and support systems for males who have sex with males
4. developing appropriate programmes for the reduction in STD levels and HIV transmission amongst males who have sex with males
5. improving the reproductive and sexual health of males and females through increasing condom use amongst males who have sex with males, accessing STD/HIV testing clinics, treatment and care
6. encouraging more responsible sexual practices amongst males who have sex with males and their sexual partners

PROCESS

1. Personnel
   Recruitment of 30 individuals from male to male sexual networks.

2. Sexualities, Sexual Behaviours and Sexual Health workshop
   A four day workshop addressing
   a. STD/HIV/AIDS
   b. sexualities, sexual behaviours and identities
   c. safer sex and males who have sex with males
   d. sexual health promotion models amongst males who have sex with males
   e. local strategies for intervention

3. Survey guidelines workshop
   A two day workshop for the 30 participants was conducted on
   a action based research models
   b. questionnaire surveys
   c. appropriate interview techniques
   d. focus group discussions
   e. collection of anecdotal materials
   f. one-to-one interviews

4. Surveys conducted over a 6 month period
   This research included :
   4.1 Questionnaire Survey
   A detailed questionnaire was designed which looked at
   a. home and family
   b. sexual history
   c. paid sex work
   d. women
   e. sexual health
   f. feelings
   The questionnaire designed for self-administration, and was translated from English into Bangla.
   A total of 530 questionnaires were completed. These individuals were identified by the members of the survey group and were primarily friends, sexual partners and members of their sexual networks.

   4.2 focus group discussions
   Six focus groups were held consisting of
   a. married males
   b. *kotis*[1]
   c. *panthis*[2]
   d. gay-identified males: *do-parathas*
   e. students

f. male sex workers

Discussions focused on personal feelings, identities, behaviours, sexual practices, family, religion, family, and desires.

Each group consisted of 10 people recruited by members of the survey team

4.3 Anecdotal material
reflecting personal sexual experiences and sexual health issues

4.4 One-to-one interviews
Forty interviews with
10 rikshaw drivers
20 hotel staff
20 street males
6 tea -shop “boys"
15 males in parks
10 truck drivers
20 male sex workers
Total of 101 interviews
focusing on life histories
including sexual feelings and experience
family
current beliefs and practices
family,
marriage and children
identities
behaviour
desires
religion
health
STD management
personal sexual histories
anecdotal stories

4.5 Sexual diaries
Fifty sexual diaries were maintained for 6 months which noted
a. sexual feelings, desires and expectations
b. sexual experiences including solo masturbation/games
c. and include with whom, where, what, when and any condom usage

4.6 Identifying Sexual Networks
This included
a. site visits to a range of public sex environments
b. identifying differing sexual networks and other locations
c. type of participants: class, occupations, area of origin
d. identifying main types of sexual activity at these sites
e. condom usage within these sexual networks
f. access to STD services by those from these networks

Also brief studies were done on
street males
rikshaw drivers
students hostels
truck drivers
male sex work and gift sex
male to male incest
male rape

5. Management
A Steering Group was established, opening a survey office in Central Dhaka near several of the public sex

environments, and an Administrator was recruited to manage the process.

After the survey phase the office continued to be used for the development of the sexual health projects arising from the programme

6. Project Development Workshop
Following the survey phase, members of the survey team wished to develop a sexual health response to the issues raised by the surveys. The surveys themselves acted in coalescing a range of individuals from a number of sexual networks building a sense of community framework. This considerably aided the development of sexual health projects.

In order to aid this development a workshop was provided on capacity building towards developing specific services for males who have sex with males
The workshop focused on
a. infrastructure development for projects
b. financial management
c. monitoring and evaluation
d. education resources
e. funding proposal, budgets and work reviews

7. Project Development
Project proposals were developed and submitted to donor agencies for funding.

Two agencies developed and were registered as NGOs.
Bandhu Social Welfare Society, focusing on *kotis*, male sex workers, and males from low income groups, and providing sexual health promotion services

Association for Health and Social Development focusing primarily on advocacy and middle class sexual networks

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1. *Koti* - see Part Two, section on labelling and identities

2. *Panthi* - as Note 1

DEMOGRAPHY

Dhaka City

(data drawn from Government of Bangladesh statistics)

1. Dhaka is some 400 years old

2. 1980-1981: per capita income was Tk 1991
   1989 : increases up to Tk9000

3. 70% of Dhaka city population earn less than Tk3000 per month
   Of this 70% - 50% earn less than Tk1500 per month

4. According to 1996 study: 55% families live under poverty line
   32% extremely poor

5 poor families: average income - Tk 2389
   average expenditure - Tk2317
   Tk 612 income per month per person
   Tk 605 expenditure per person/per month

6. 70% have no savings

7 65-80% in informal sector employment

   23% in manufacturing
   17% government/non-government jobs
   14% in wholesale/retail
   13% in transport
   10% business

8. Among poor (lower class/working class)
   26% transport work
   22% retail
   15% casual worker

9. 1996 survey of ADP
   32% live in slums (jhopri)
   number of slums: 2000
   population density in slums: 1500 - 2000 people per acre

   population density in Gulshan - a "high class" area of Dhaka: 300 per acre

10. 3-400,000 people live on footpaths

11. many stay in railway station, ferry/launch ghat, and bus terminal

12. City population: (Government) 8,600,000
(nongovernment) 9,000,000

increased by 4,000,000 in the last 6 years

75% of children will be deprived of education by 2015

13. It is estimated that more the 1 - 2,000,000 people everyday comes to Dhaka as daily passengers

14. Only 19% people can afford rickshaws for transport
60% people walk

bus transport very poor: 10% people use bus

BRTA statistics - up to 1995: private cars = 367,012

15. City Corporation: transport

licensed and legal rikshaws:	79,000
illegal	250,000
total	329,000

weekly magazine Bichitra believes total rikshaws number over 400,000.

For the whole country: 52% of rikshaws are in Dhaka

They occupy 73% of street space creating immense traffic congestion

UNDP survey reports
Dhaka needs:
4000 large buses
only have 1400 middle sized buses/minibuses

amongst this 1400
only 1100 buses/minibuses are working and used as transport

double decker buses: 30

vehicle/transport: increased by 200,000 in the last two years

16. Religion

Muslim	93%
Hindu	3%
Christian	2%

Domestic Servants

Servants are called *chakor* (equal to slaves) or *kajor lok*, or sometimes employers will call them by a name they themselves will select whatever the servant's own name may be. No job security. They are considered insignificant, invisibilised and worthless. They perceive their lives as servitude.

Domestic servants include more females than males, as there is a higher demand for males as waiter "boy" in restaurants, automobile cleaners, pillow making shops, garments factory and *tokai* (rag pickers). Male domestic servants aged over 12 are also seen as threatening for the girls/females of a house, and are often seen suspiciously where they may be considered as contact person for a gang.

Servants are often locked up in the house when employers leave. If anything is stolen or a robbery occurs, the first thing the employers does is to lodge a case against the servant on charges of collaborating with the criminals. They are often beaten.

Employers are also petty. Many servants are not allowed out onto the streets except in the immediate area and many often do not know Dhaka at all. But it is most difficult to find out about the most atrocious crimes, regarding beating, rape and abuse.

They are supposed to cook, clean, wash clothes, doing daily marketing (local bazaar), grind masala, iron clothes, making beds, toilet cleaning, any job at any time (including physical services such as massage). And look after any children.

Suman, a young boy of thirteen now working in a restaurant, who had previously worked as a domestic servant, was often obliged to massage the male members which usually led to thigh sex, and sometimes anal sex.

Often if the female domestic servant has her own children, she will not be allowed to bring them into the home. These children are left out in the streets all day waiting for their mother to come out.

Dr. Selim Jahan of Dhaka University has found that 96% of servants (both male and female) have unbearably heavy workload. 80% are landless and poor and forced to work in such conditions when natural calamities or community explosions force them out of their own homes/villages. Some 95% do not get fair treatment in the homes they work in and they are only allowed to eat the leftovers from family fare and sleep in cramped kitchens.

Salaries for female domestic workers range from Tk200 to Tk500/month, although a few progressive homes pay as much as TK1000. Male servants charge more. At best servants earn half the wages of other employees. Children earn even less that adults. Salma Sobhan in a study called 'Child Employment in Domestic Service' (1992) stated that very young children are often not paid at all.

There is no law about child domestic servants. Children cannot work in factories under 15 years or shops under 12. But the law is silent on domestic help. A survey by Dr Fahmidar Rahman in 1993 shows that even 8 year old children work in peoples homes.

Children

Definition: under the age of 14 years old

1. At the lowest estimate, 10,000 child prostitutes are working in Dhaka alone.

2. Trafficking and abduction to neighbouring countries is on the increase.

3. Poverty has been generating an increase in the sale of children across the border for the past decade.

4. It is estimated that over 50 women and children are trafficked out of the country every day. It is also presumed by some evidence that they are abused by their agents before they leave the country. No data is available on boys.

5. 30% of population is aged between 5-14: approximately 35 million children in Bangladesh.

6. NGO/UN estimates: 13 million children 6-10 and 8 million 10-14 are working in some capacity. (Note: the Bangladesh government claims the figure to be only about 6 million for all children 5-14).

7. Around 10% of urban child workers are self-employed working mainly on the streets as garbage collectors (tokai), coolies and street sellers.

8. while estimates of the number of children working in garment industry varied dramatically from 3-4% (according to Bangladesh Manufacturing and Exporters Association) and 12-13% (according to Bangladesh Institute of Development Studies), widespread concern was soon raised about the tens of thousands of children sacked by garments factories in the immediate aftermath of the proposed "Harkin Bill".

9. In 1989 the International Year Of The Child
   i. half of the 165 million underweight children live in South Asia

ii. malnutrition affects 60% of children compared to 30% in sub-saharan African
iii. in Bangladesh, calorie intake has actually dropped by around 15% since 1960s

Dhaka STD Services

Government

1. Dhaka Medical College Hospital

2. IPGMR: referred cases usually come here

3. Shramajibee Hospital
   National Hospital
   Holy Family
   Shishu Hospital
   BIRDEM - diabetic patients, skin and VD issues
   Mitford Hospital
   Combined Military Hospital
   Mirpur General Hospital

NGO Services

1. Paricharja
   4 clinics: Mohammedpur, Rampura, Narayanganj, Tiejgaon
   dealing with: prevention, curative, awareness, and condom promotion

2. BWHC
   12 projects
   10 of these projects are on general female population which includes syndromic approach and partner notification of female STD patients.

3. Male STD clinic in Agargoan slum area focusing on married partners

4. Marie Stopes
   2 clinics in Dhaka: one also has male only facilities

4. CARE
   Shakti project operates in Tangail Brothel

5. Al-Falah
   clinic in Geneva camp working with Bihari refugees

6. Concerned Women Family Planning
   provides clinical services for male and female patients

At the time of the surveys, not one clinic asked about or treated anal STDs.

I am grateful to Dr. Suman Lahiry who collated this data.

THE TRAINING WORKSHOP

Workshop Agenda

Day One:	**Setting The Agenda**
	Introductions
	Sexuality and Sexual Health: Definitions
	Sexuality and Identity
	HIV and AIDS - Questionnaire
	Sexual language
	Sexual behaviours
Day Two:	**Cultural Frameworks: A Local Analysis**
	Welcome
	Cultural Analysis
	Sexual Stereotypes
	Culture, Sexuality and Sexual Behaviours
Day Three:	**Sexuality and Sexual Behaviours**
	Sexual messages
	Desire or Discharge?
	Women and Marriage
	Identity versus behaviours
	male sexual behaviour patterns in Dhaka
Day Four:	**Sexual Behaviours and Safer Sex**
	risk behaviours
	HIV/AIDS and STIs
	What is safer sex?
	What is sexual health?
Day Five:	**The Dhaka Project (1)**
	Research Methodologies
	The Questionnaires
	Sexual Diaries
	Recording Information
Day Six:	**The Dhaka Project (2)**
	Observational Analysis
	Focus Groups
	Interviews
	STD services
	Project Management
	Conducting the Survey
	Results and Follow On

At certain intervals during the workshop, role play and drama was used to illustrate certain points. This was very successful. These mini-dramas included:

a. two *kotis* discussing sexual behaviours and other males
b. talking with truck driver/rickshaw driver about safer sex
c. picking up a rickshaw driver for sex
d. sexual cruising in a park

(note: *koti* - a self-identified label, based on effeminate behaviour)

Language

Language created specific problems, since the majority of participants were not English speakers. It was therefore necessary to recruit two translators and interpreters to work with myself. These were Dr. Suman Lahiry and Mr. Faraaz. The process, while extending the time frame of each day, actually worked very well. It was also necessary to translate and print workshop documents into Bangla.

Participants

Participants were aged between 18-40 and all attended the workshop consistently over the 6 days. All participants could be defined as "middle-class" and all were men who have sex with other men. Only two men were self-identified gay men.

There was a clear division within the workshop group which related to behaviour and identity. This could be defined in their own language as those who defined themselves as:

a. *Kotis*
   This is the label that many males use who are anally penetrated as the preferred sexual act and had "effeminate" behavioural characteristics as a means of "picking up" their sexual partners who may not necessarily be "homosexuals" themselves. *Kotis* have access to a code language which is similar to the language of the Hijra in the use of hidden meanings and slang terms. For the *kotis* the effeminate behaviour is usually restricted to selected sites where access to male sexual partners was available.
   10 participants
b. *Panthis*
   The label used by *kotis* to identify males who prefer to anally penetrate other males and whose behaviour could be deemed "masculine".
   9 participants
c. *Do Parathas*
   Another *koti* term meaning males who penetrate and are also penetrated
   8 participants
d. Others
   Males who do not and are not anally penetrated but prefer non-penetrative sex
   5 participants

Recruitment

Participants were recruited through using three key informants and their friendship and sexual networks. This allowed a certain random selection to come into play.

Participants Sexual Histories

All participants were sexually active, with 26 out of 32 having multiple partners and several 10 having more than one sexual partner every week.

16 were sexually active from the age of 13
10 sexually active from the age of 16 - 18
5 men had been sexually abused at the age of five by
   a. older brother
   b. uncle
   c. neighbour
1 had been "gang-raped" by a group of five males at the age of 7

5 of the participants stated that their first male sexual contact was with their older brother
7 with other male relatives

2 with their servants
10 with their neighbour
4 with strangers
4 with teachers (including two Madrassi school teachers)

Some 50% of the participants had previous sexual encounters with females
2 of the participants regularly visit female commercial sex workers
10 continue to have sex with other females
2 were married

All participants who have had sex with females reported significant levels of anal sex with them.

All participants stated that they had experienced oral sex.

90% of the participants stated that they would get married.

What was interesting was that there was clear evidence that the higher the education/income group the participant came from the later the male to male sexual activity started. This could be that those from high income groups tended to grow up with much more personal privacy (having their own bedrooms for example), whilst those from lower income groups tended to share bedrooms with other male relatives.

A further point that needs to be made is the high level of risky sexual behaviours indicated by participants personal sexual histories and anecdotal reports by them about other males. Combined with low levels of condom use, low levels of knowledge of STI/HIV/AIDS, high levels of sexual activity and multiple partners, marriage and also sex with females (including anal sex) indicates a considerable level of multiple transmission of STI/HIV between males and between males and females by males involved with male to male sexual activity.

It should also be noted that no participant had been tested for HIV. Nor were they willing to because of personal security issues.

There were clear and significant differences between what participants verbally reported of their own sexual activities and those reported in the anonymous questionnaires. What people said they did in the open forum and what people actually did reported in the questionnaire and private meetings were very different. The questionnaires reported a higher rate of sexual activity and multiple partners than the verbal reports. The above analysis reflects this.

Condom Usage
15 stated that neither they or their sexual partners, used condoms
10 stated they and their partners sometimes used condoms
2 stated that they and their partners always used condoms

All participants who had used condoms stated that Raja condoms tended to break. They estimated that such breakages occurred at least 60% of the time.

Panther was seen as better, but still tended to break for about 20%-30% of the time.

Lubricants used for anal sex were ghee, butter, vaseline, motor-oil, hand-cream and in one case Vicks Vapour Rub. Sometimes saliva was used.

No participant who had used condoms had used water-based lubricant. KY Jelly is available in Dhaka but the packaging and price were seen as inhibitors for its use. KY jelly is sold in tubes at about 80 Takka per tube. These were not very convenient to carry around.

In the condom usage test in the workshop only 2 participants out of 32 demonstrated condom usage correctly. This could indicate reasons for the high levels of breakage.

It should also be noted that no appropriate condom for anal sex is available in Bangladesh.

STD/HIV/AIDS Knowledge, Attitudes and Treatment
An HIV Knowledge and Attitudes questionnaire was used at the beginning of the workshop.

Out of 32 participants only 3 were able to distinguish between HIV and AIDS. All participants however had very limited knowledge (if any at all) about any of the issues around HIV/AIDS.

There were clear indications that none of the participants had really thought through the consequences of HIV infection and living with AIDS.

There was no knowledge about the relationship between sexually transmitted infections and the risks of HIV infection.

Apart from 3 participants, all the others had very little knowledge of sexually transmitted infections and treatment.

Those who had been anally penetrated stated that
a. none had been tested for anal infections
(We already know that at STD clinics, the clinicians never ask about anal sex)
b. 50% of them stated that they experience piles and some bleeding

Some 12 participants reported STD symptoms in the last 2 years.
2 of them went to a clinic for treatment.
3 went to pharmacies for syndromic treatment
4 went to "quacks" and used "homeopathic" remedies
2 went untreated
1 went to his uncle who was a pharmacist and also involved sexually with other males.

At the end of the workshop, participants clearly indicated a positive attitudinal change regarding STD treatment and condom usage. To increase access to STD treatment by participants, two of the participants who were also doctors agreed to give free advice and information as well as prescribe appropriate treatment at the Project Office.

Further participants agreed on the urgency of condom usage as part of a safer sex strategy, but also recognised the issue of appropriate condoms for anal sex and access to appropriately packaged and cheap water-based lubricant. Naz was requested to explore this issue and urge appropriate authorities for their availability in Bangladesh.

Sexual Knowledge
Participants indicated very limited levels of sex education and information, including knowledge concerning physical and sexual responses and anatomy (both male and female).

Their sexual information was primarily obtained from family, friends, peers, at "cruising" sites, sexual partners, cultural myths (i.e. masturbation weakens the body). Similarly knowledge about sexually transmitted diseases was obtained through such frameworks. One participant reported that a friend of his had stated that his sexually transmitted infection was the result of a neighbour's curse.

Over 26 participants asked personal questions about their own body and its sexual responses, masturbation, sexual behaviours, sexual desires and fantasies, sex with women, size and shape of their penises, and other issues. Many myths were articulated which needed to be deconstructed and shown to be only myths.

Despite all participants being educated to college level it was very clear that the lack of any appropriate sexual education, has a major impact upon psychological and sexual health and the frameworks of sexual behaviours.

Desire and Identity
A major issue within the workshop was the question who was "gay" who was a homosexual? Whilst the terms *homosex* or *gaysex* were used by participants, for the majority, their personal identities reflected primarily socio-cultural issues rather than sexual identities. There were only 2 participants who clearly identified themselves as gay men. Yet all the participants indicated that their primary sexual desire was for other males. Further in many cases the sense of sexual identity reflected whether the person penetrated or was penetrated.

For the majority of participants, identity reflected marital status, positions in a family structure and relationships within the kin/social group.

These identities placed considerable constraints on changing sexual behaviours towards safer sex practices. For example a married male would not use condoms with his wife because of she uses other forms of contraceptives and would become suspicious, or the environment in which sex takes places may preclude use of condoms, or there is no connection with the sexual partner, but a person in the dark.

The sense of personal self as a primary agent was embedded in larger frameworks of identities. This was reflected in low levels of self-esteem amongst the "koti" participants, the high levels of depression amongst all participants, the expressed need for a "partner" but the recognition of the social constraints within Bangladesh culture and society. Personal sexual health choices become limited within these constraints.

What could be understood from the workshop and personal conversations was that identity was not fixed, but rather fluid, based upon time, space and who they were with. Perhaps we could call them locational identities. A person's identity at home will be different on the street and again reframe itself in the park. This could be an important area for psychosexual research towards developing appropriate strategies for behaviour change.

Where do you go for sex?

All the participants reported visiting a number of parks, streets, religious sites, and neighbourhoods which are known amongst the male to male sex networks as places where males come to meet other males for sexual pickups. At some of the sites the sexual act takes place on location, particularly late at night and where there are many bushes/trees. Other places are also used, including personal homes, friends homes, guest houses, hotels, side streets, construction sites, dark alleyways, inside cars, trucks, and behind bushes where sex can take place unobtrusively.

Some reported encounters inside launches (ferries) during night time and when everyone else is asleep, or under the blanket when sharing a bed in the family home, or in an office.

At several places, rooms can be hired by the hour, or people can take their sexual partners home if they have privacy during the time, i.e. family is out, they have own private bedroom, or use a friends home.

Some also stated that they have sex in public/private toilets, or in restaurants and tea shops with owners/staff at an appropriate time.

There appeared to be no limited to the availability of choices depending on the need for privacy. Privacy could be a blanket covering the activity itself.

Participants identified 22 public sites in Dhaka where males go to meet other males for sex.

20 workshop participants were interviewed. These participants were all sexually active, but wished to discuss specific issues around marriage, shame, sexual dysfunctions, sexual behaviours. The issues raised by these conversations were

a. masturbation causing penis dysfunctions, size and shape problems
b. family life and growing up
c. religious beliefs and sex
d. early sexual encounters causing desire for males
e. depression
f. shame and guilt
g. treatments for homosexuality
h. early sexual encounters
i. desire and sexual practice

Whilst a significant number appeared to admitted to feel shame about their behaviours, deeper analysis indicated that this shame was more based upon social and family expectations and the need to fulfil them and not so much upon the sexual behaviours or desires themselves.

What was interesting that on those workshop days which fell on a Friday, it was those who were the most effeminate - the *kotis* - who would go to the mosque for prayers. It appeared that those who felt most unable to fulfil social expectations around marriage and children were the *kotis* - the ones who were usually anally penetrated. At the same time they all knew that they would have to get married and produce children. There was a constant fear that perhaps they would not be able to "perform" with women.

Many issues reflected relationship problems, finding a partner, holding onto a partner and the types of sexual play that would keep a relationship together.

The majority of these participants had experienced sex with other males at an early age. Usually by the age of 14 they were sexually active. Most had their first sexual encounter with a male relative who had visited their home. Many of them were also sexually active with neighbourhood males of varying ages from 13 years upwards.

Three of these participants had been sexually abused at the age of 5, one by his brother and one by his uncle. The other one had been raped by a group of older boys. All stated that they had never been able to talk about this because of their shame. It was their fault. The one abused by a group of older boys still held tremendous anger and rage. No counselling had been offered, no punishment of the perpetrators. The one abused by the group of boys always penetrated others. The other two were always anally penetrated.

None of these participants used condoms or asked their sexual partners to use condoms.

7 of these participants had sex on average with 4-5 different males every week
3 stated that they had sex at least once a week. Partners were usually different
3 had regular partners
5 had sex with different partners about 4 times a month
1 hadn't had sex for 6 months because he was "looking for the right person"
1 had sold sex both for cash and gifts. He would have sex three times a week with different partners. He liked person then he would do sex for pleasure. He was always penetrated.

Within this group of the participants, feelings of isolation and fear of the future were a constant. The stated lack of emotional support, developing friendships that would understand their problems, provide advice and information and to be there in a crisis, were clearly stated. Most of them did not want to look to their futures. What hopes have they got? Marriage, children, the social "norms"?

All expressed a desire for support systems, help with employment, help with their studies, help with their families.

Finance was also a constant feature. Whilst all participants were middle-class, many felt as if their families were on the financial edge. All felt they needed money. All stated that if someone offered them money, and if they were nice looking, they would sell sex, although only had so far. Employment, both current and future was perceived as a major issue

The first time I ejaculated was with my uncle. He would fuck me. Sometimes we would do oral sex together. My uncle would visit our house every few months.

"At thirteen, when I was started to ejaculate fully, I began to do sex with some of the neighbourhood boys, all types. I would invite a friend over to sleep the night. We shared the bed. And then we would start.

"One evening I was in my room. I must have been about fourteen. We had just taken on a thirteen year old boy as a servant. The evening meal was over and I was doing some homework. I began to think about my uncle who had just left for Dhaka a few days before. I began to get hot. I started to handle myself through my lungi. I decided to call our servant boy and the excuse I used was to bring a drink to me and to tidy my room. I said this loudly enough for my parents to hear. When the servant boy came in, I stood up and he could see my penis was hard through my lungi. I asked him to close the door. As he moved to begin to tidy my room, I went to him and put his hand on my cock. I put my hand on his cock too and felt it grow hard. I said now that we are both hot we have do to do something. He was resistant at first, but I told him if he didn't do it I would make him lose his job with us. We then did oral sex together, and then I fucked him.

"We did this at least three times a week. After a year he left. Our next servant I didn't like very much so I never tried.

"I have always like sex, particularly anal sex. No, I haven't used condoms before. I always have sex maybe three times a week. Usually with different people. Now I am a teacher, sometimes I do sex with students from my school. Sometimes I pick people up from the park, and bring them to my home. Since I have come to Dhaka I am never short of finding people to have sex with."
Abdul, workshop participant

PART TWO

Risk and needs assessment

PROFILE OF QUESTIONNAIRE RESPONDENTS

Respondents for completion of the questionnaires were self-selected by members of the survey team, and usually represented friends, sexual partners, and members of sex networks and great care was taken to ensure that no duplication occurred. This meant that the vast majority of questionnaire respondents came from middle class and educated backgrounds.

The one-on-one interviews tried to address this social bias by focusing on those from lower middle and working class groups.

Questionnaires

N=530

Table 1. Age range

Age	Frequency	% of respondents
16-21	116	21.88%
22-35	324	61.13%
35-49	77	14.54%
50-	13	2.45%

Table 2. Profession

Profession	Frequency	% of respondents
Students	186	35.09%
Professional (teacher/doctor etc.)	56	10.57%
Business (shop/restaurant/hotel)	168	31.70%
Unemployed	78	14.72%
Labourer/Working class	42	7.92%

Table 3. Language Skills		
Language	**Frequency**	**% of respondents**
Literate in Bangla	476	89.81%
Excellent literacy in English	20	3.77%
Some literacy in English	22	4.15%
non-literate	54	10.19%

FAMILY

In Bangladesh, like other South Asian countries, the family is a major focus in one's life. It is the source of one's personal identity, different from the West, where individuality is central. But here the family is much more than the immediate biological parents and siblings. It includes all the relatives; grand-parents and their relatives, all the uncles and aunts, brothers and sisters-in law, nephews and nieces, cousins five times removed. The Bangladesh family is a joint and extended family, a community in its own right, defined by, dialect, religious practice, caste, village, and so on. Often whole villages are made of one inter-connected families.

Bangladesh is still a rural country, but with a growing urban population. In Dhaka nearly 50% of the population are recent arrivals from villages carrying with them the traditions and customs of the village, yet being constantly challenged by the urban conditions which are creating fractures in these traditions. The Dhaka population is one in flux and change, psychological upheavals that often leave people vulnerable, yet challenged.

Table 4.	**Where do you come?**	N = 530
Location	**Frequency**	**% of respondents**
Dhaka	271	51.13%
Elsewhere	259	48.87%

But these familial links can still be strongly held together by custom, tradition, belief, practice and economics. Their value lies in providing a form of social security and welfare in a culture that has neither. The elders are supported, as often are the unemployed, the unmarried, the range of children, the disabled. It is considered a moral duty for the family to stay together in this mutual support system, whether the staying together is physical or psychological.

This village basis, the ancestral home so to speak, is clearly demonstrated on specific holidays, when huge numbers of Dhaka residents desert the city for their home village. There is this constant movement back and forth from the village home.

Of course such extended family systems can be a liberating experience in terms of the social conditions of individual members. To rely on the family for such support, emotional, physical, or financial, relieves much of the burden for sustaining the self. But as a consequence, the concept of individuality becomes lost. Personal choice and desire becomes subsumed within family choice and desire. Marriage, children and duty to parents is the focus.

Because of the low levels of income and the cost of living, personal accommodation is rare. Most males live with their families, or with their parents if unmarried, or share accommodation in "mess rooms" where several males will share one room.

Table 5. Where do you live? N = 530		
Location	**Frequency**	**% of respondents**
With parents/family	273	51.51%
With wife/family	142	26.79%
With others	74	13.96%
Alone	41	7.74%

For the vast majority of males living with their parents, there is no personal space. One or two room households, holding parents, other relatives and several siblings is common. And often within these households, there will be a male space and a female space, boundaries for sleeping.

These crammed conditions of sharing "male space" in a culture with high levels of homosociability[1] often create conditions of *khel*[2] or *maasti* , sexual play, as a release of "body tensions", quick and furtive sexual gropings between male relatives, sometimes consensual, often not. These are invisible behaviours, behaviours of the dark, and therefore not "real". If there are no witnesses, then in a sense they do not exist. Or they can be blamed upon some outside force. As one respondent stated "a genie made me do it".

For many Bangladeshis, you never leave the family home. You carry the psychological space within you all the time. While the crowded home will generate intense arguments, disagreements, family fights, all members of the extended family, and sometimes even the neighbours, will join in, usually on the side of the parents. This is supported by the attitude and belief that the duty of the child is to obey the parent, whatever the age of the child. Obedience to parental demands and pressures is one of the central glues that is perceived as holding the family together. To disobey one's parents is to bring shame and dishonour upon the family.

Secrecy, lies and shame control the frameworks of visibility and denial in regard to behaviours deemed outside the social and religious norm. Not talking about sex and sexual behaviours is one way of not only invisibilising such behaviours and practices, but also of marginalising them as a peripheral phenomena, particularly in regard to male to male sexual encounters.

This form of social control is constructed by traditional concepts of honour and shame. Honour, not so much as what is deemed to be personally honourable, but in terms of one's standing in the community. Honour as a possession, not a quality. Shame, not so much as what may be deemed as wrongful (or even sinful), but by behaviour and conduct which brings shame to the family and/or community as a whole. Shame is an expression of honour being lost. These two intersecting frameworks arise out of understandings of value systems around what is public and what is private. What is visible and what is invisible.

Public behaviour, behaviour which is visible, is bound within a context of family duty, honour and obligation (both familial and religious). In this context any behaviour which is visible to the community (and/or family) falls within the scope of public behaviour and therefore falls within concepts of honour and shame. If the behaviour is invisible, then it doesn't exist! Community honour can be maintained. Shame does not exist. Honour and shame are social values, not private practice.

In Dhaka during the periods of fasting that occur in Islam, you will find all the tea-stalls and restaurants with curtains over the entrance way, so the customers cannot be seen by those passing by. To be seen may cause offence to a Muslim. Supposedly these customers indulging behind the curtains are non-Muslims. But this is not necessarily true. Many Muslims will go behind the curtains during the fasting period to eat and drink. Honour can be maintained since the behaviour is invisiblised by the curtain.

Sometime an event that occurs in a public space may not be considered public if it is not observed, or if observed, not

discussed. Night time creates invisibility. Bushes, trees, dark construction sites, badly lit alleyways, behind houses, under blankets, any place where space is available for mutual sex encounters and where darkness reigns. Darkness invisibilises behaviours creating deniability. And it is in the dark that most male to male sex occurs. Darkness does not bring shame. Even where there is private accommodation, a personal home, or a rented room, many Bangladeshis will still have sex in the dark, often with their clothes on. To see oneself naked in front of another person can also bring shame.

Through all this, the daughter is the vessel of family worthiness and honour, women as vessels of male honour. Her virginity before marriage is a prized possession to be nurtured and protected, for it is upon her status as a virgin on her wedding night that will announce publicly the family honour. In this context, unmarried daughters are more socially "policed" in terms of their behaviour, especially sexual, particularly in the "public domain". Women and their honourable behaviour has to be scrutinised. This often means that sexually active males have very little sexual access to women, other than female commercial sex workers.

At the same time the public domain is the male space. After evening, usually by 7.30pm, it rare to see any unescorted females on the streets of Dhaka. It is a male space. If there are unescorted women on the streets at night, it is assumed by the males that these women are "evening women", "women of the night", prostitutes. In this male space, sexual access will often be with other males, more readily available and immediate, then having to travel to specific locations to find female sex workers.

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1. homoaffectionalism - in the sense that I use the word hear it means social acceptance to the public display of male to male, or female to female physical affection. See Hardman's Homoaffectionalism -from Gilgamesh to the present, GLB Publishers, 1993

2. Khelna - to play

MARRIAGE

In Bangladesh, marriage is a central issue within people's lives, where it is the mainstay of family and/or community life. It can be seen as a socially and religiously compulsory duty towards maintaining family and community bonds. Marital status signifies adulthood, social responsibility and the achievement of personhood.

Traditionally, marriages are arranged between two extended families, and such arrangements are based around economic and inter-family connections. Nowadays amongst middle and upper class families, parents may ask their children with regard to the suitability of their choices, and there are processes whereby the two prospective partners can meet each other regularly before a wedding. Very often such meetings will be chaperoned by some parental figure to ensure nothing untoward occurs. And even while such choice maybe significant, ultimately there no choice about marriage itself. As Herdt states in his book Same Sex Cultures, " full personhood is not achievable until people have married and produced children" (page 5).

Where there is resistance from a son or daughter towards marriage, enormous pressure is brought to bear upon the children to submit to the parent's/family's wishes. As the child gets older, such pressures increase and some families will utilise a range of options to enforce the family dictates. Emotional blackmail, financial inducements, threats, excommunication, and sometimes violence, will be used.

To remain unmarried will often be seen as an aberration, a sickness, bringing shame and dishonour upon the family, creating social and family disorder. The Qu'ran also states that marriage is a community duty to bring stability and order to society. To be unmarried is to encourage *fitna*, disorder for it would encourage "promiscuity" and "sexual sin".

Table 6. **Marital status** N= 530		
Marital status	Frequency	% of respondents
Married	198	37.36%
Unmarried	332	62.64%
N = 332		
Intending to get married	311	93.68%

Children are a social, cultural and religious necessity, particularly male children. To have no children is often seen as a curse. Children are their parent's future in a society where there are no welfare provisions. They also represent status and achievement of adulthood by both the male and female.

Table 7. Children		
Status	**Frequency**	**% of respondents**
With children (N = 198)	181	91.41%
expect to have children (N=311)	311	100.00%

Of course the pressures upon the young women are even more intense. At least the young man can often make a greater range of excuses. Business, education, travel, etc.

"I didn't want to get married. But what can I do. My parents pushed and pushed. Every day my mother would nag me, my father would nag me. They would invite other families to the house so I could "view" the daughters. I finally just gave in. And when I finally said yes, my parents were so happy. But what about me?"
Latif, 24, shop assistant

None of the married men in this survey have informed their wives about their extra-marital behaviour with other males. In the main, many believe that all they need to do is to function adequately as husbands is in terms of economic support for their wives and engaging in sexual intercourse in order to have children. There are many men who will only have sexual intercourse with their wives a few times a year specifically to get their wives pregnant. There is no joy in such intercourse. It is seen as a duty only. Duty as an adult male, duty to the wife and family, a duty to have children. For others, sex with other males is seen as an option, an opportunity for discharge, as fun. Or perhaps the wife will refuse to do certain types of sex, which could be done with another male.

The wife is seen as the bearer of children, not as a friend and lover. Marriages are not seen as companionate and egalitarian. Further, because of the dominant male ideology and male social spaces, a male should be seen spending more times with other males, otherwise he would be seen as being weak and perhaps "womanly".

Being with another male brings no suspicious, whereas being with a female not your wife brings a great deal of suspicion. In the vast majority of hotels and guest houses, taking a woman into your room would be forbidden. Taking another male is perfectly respectable, whatever the age of that male.

Children and filial duty. Reproductive sex as an obligation. As one person stated in the sexual health workshop, "I do duty to my wife".

The wife as Mother, Sister, as bearer of one's children. Sexual desires are part of another construction. Sex for procreation is what occurs in marriage. Sex for pleasure is what occurs outside the marriage. And even though the Qu'ran speaks of sexual pleasure between husband and wife, the socio-cultural patterns of South Asia as a region tends to be stronger, where often sexual relations are fraught with psychological risks.[1]

It is considered natural for men to be "lustful". Sex for pleasure and sex as lust are often seen as synonymous. This leads to significant numbers of married men who have sex outside of their marriage. And as long as this behaviour is invisible, it brings no shame and dishonour to the family. Public live is separated from private life. And if women are not accessible or cannot be afforded, then other males are. It is not so much sexual desire, but semen discharge.

Yes, I have sex with my wife, perhaps once a month. I don't enjoy it. I rather not do it. But I have to keep her satisfied. She's complained about it to me, but I just shrug my shoulders, you know, pretend that I don't really like sex. Its all very, what's the word? Perfunctory, you know, get on, get off sort of thing. What can I do? I do go out to find men with whom I can have sex with.
Karim, 29

I like sex with my wife, but we live in a crowded space, and what with the children being around, we can only do this late and night. She is often very tired, and there are things are just can't ask her to do, you know liking sucking and backside fucking. It's just not done. If I asked her she would think I was very bad. So I can go to the park and find some "boys" who can do these things.
Islam, 31

Tell my wife, are you crazy? Why should I tell her. I keep her happy.
Rafiq, 32

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1. See Sudhir Kakar, *Intimate Relations - exploring Indian sexuality*, Penguin Books, 1989

RELIGION

Table 8. Religious belief		N = 530
Religious belief	**Frequency**	**% of respondents**
Muslim	497	93.77%
Christian	15	2.83%
Hindu	18	3.40%

Bangladesh is a Muslim country and despite having a secular constitution, has strong Islamic beliefs, traditions and practices.

Here I am not attempting to define Islam in terms of its specific and particular beliefs, traditions, and practices. What I wish to briefly attempt to do is to locate Islam within the cultural context of Bangladesh, the interaction of religion and socio-cultural dynamics. For example, Bangladeshi Muslims, while having the same faith as Pakistani Muslims, will often have very different customs and traditions, which will also be different from Arab Muslims. This is because of different languages, different histories, different geographies, and so on. Further while sometimes Islam is seen as monolithic, it is not. Islam, has several different branches. Each sect will follow the Qu'ran and the Hadith[1] , but each will have its own localised traditions and customs, partly based on historical and cultural factors, of the particular locality, and partly based upon its interpretation of the Hadith and the Qu'ran, whether they are Sunni, Sh'ia, Sufi, Ishmaili.

What needs to be clearly understood is that religion, culture, tradition and social practice are not isolated from each other, nor do they represent the same thing, but are interwoven in complex dynamics. While Islam may specify particular and specific social practices, beliefs and attitudes, very often cultural traditions and customs will outweigh these religious beliefs and statements. What matters is interpretation, social customs and historical traditions. But who does the interpretation? Where interpretation of religious texts interpenetrate cultural beliefs and customs, then very often these customs and practices will take on a sanctity that never existed in the original sacred text.

It should also be remembered that in contrast to the way that Christianity is viewed and practised, where it is seen as very much a matter of personal choice and individual response, Islam relates to how the community functions as a whole. Religious and secular life centres in the mosque. Islam is a faith of community.

This, does not mean that there isn't an intense personal belief and practice for many people. Of course there is. The private namaz, the personal prayer. Islam can provide personal solace, meaning and context to one's life. But with all this goes the daily observances, the food a person eats, his or her relationships with others and the family, interactions with the

community and community structures, religious celebrations and festivals. These are all interlinked and interdependent. This is the visible side, the proof of one's religious observance and community participation. Private and public are co-joined. But there will be those for whom only the public observances matters, whose private practices may not be in line with public observance. This cannot truly be seen as hypocrisy though, because the public and private spheres have different contexts to those in the West.

Religion becomes an obligation to the community, a duty to the community. Not to accept this duty brings shame and dishonour to the family and to the community. Thus we can say that community participation, more than a personal belief, can have a greater relevance. It relates a lot more to what you are seen to do than what you actually do. Participation involves submission to the daily rituals, customs and traditions that surround a specific religious belief. It is public acceptance rather than a private knowing.

And yet....

During the workshop, on Friday, the majority of the participants went the local Mosque for prayers. All those who stated they were Muslim and were questioned and interviewed said that they participated in the religious festivals and community prayers. All accepted Allah as the one God and Mohammed as his Prophet. None could conceive anything else. I say none, but this is not strictly true. Two gay-identified men found Islam oppressive.

Yet these respondents found ways to balance their sexual practices, identities and desires within the context of being a Muslim and living in a Muslim country. Whilst many of those who identified as *koti* would speak of shame, guilt, dishonour, and fear of Allah, they also believed that what they were, who they were, and what they did, was between themselves and Allah. Islam was still important to them.

I go to mosque every Friday, and sometimes during the week. I go because I like to go. Also if I didn't it would create problems with my family.
Khobir, a sex worker, a koti, 17

And during social group meetings, often a prayer to Allah would be given to support the group.

So what we have here is a range of responses to Islam within an Muslim context. From those who will seriously question Islamic tenets around sexual behaviours and practices, to those who segregate the issues into private and public practice, to those who seek a measure of solace in the pain of their personal grief at their sense of self.

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1. Hadith - a collection of the sayings of the Prophet Mohammed and his Companions

LABELLING AND IDENTITIES

There are several male to male sexual behaviour frameworks that are interlinked and interpenetrate each other. Identities within these networks are centred around that of the feminised male who acts as the penetrated partner. All other labels arise from this context and are named by these males, except with the exception of those who defined themselves as gay.

For the majority of involved in male to male sex, the modern Western terms of gay, homosexual, bisexual, heterosexual, even transgender, or transvestite, have little significant meaning or content, except for those few who have access to Western literature and the international lesbian and gay movement.

Table 9.	**Self-identity**	N = 530
Identity	**Frequency**	**% of respondents**
Kothi	213	40.19%
Panthi	81	15.28%
Do-Paratha	56	10.56%
Homosexual	25	4.72%
Gay	10	1.89%
no label given	145	27.36%

1. Koti

Almost always self-defined, *kotis* are characterised by "feminised" behaviours (often exaggerated), particularly in specific spaces, and taking the penetrated role in anal sex. Their exaggerated behaviour make them visible in a public arena and is used as a mechanism to attract *panthi* males for sex. Males in need of sexual discharge irrespective of their gender choices, may often then respond to these *kotis* for oral sex, masturbation, and where space and a measure of privacy permits, anal sex.

The *koti* is, as Gary Dowsett states in his book *Practising Desire - homosexual sex in the era of AIDS* (Stanford University Press, 1996) "coming to his identity through practice". That is, the *koti* identifies himself with this term through social interaction with other *kotis, and* through his sexual practice. Often this is based on "the pursuit of discharge" by other males. The *koti* is a collective sexual construction, socially framed.

Observations of *koti* in a variety of settings, walking down a street, in a restaurant, in a hotel, at a railway/bus station or in public sex environments, it is noticeable that in the vast majority of cases, soliciting another male for sex appeared

to be extremely easy. The sexual urgency of many of these males was clearly obvious. Such responses relates to discharge sex.

However, many *koti* are also married with children . Further a significant number of these *koti* also sell sex in certain environments. While this appeared to be class related, it is not always so, but in general male sex networks were primarily *kotis* from low income groups. The difference was defined by

a. civil *kotis* - those who do not sell sex
b. professional *kotis* - those that do sell sex

It is not unusually for a *koti* to speak of having between five and ten sexual partners in one evening, where sexual penetration and ejaculation takes between five and ten minutes.

Kotis speak of wanting "real men", a *panthi*, where "real men" do not show desire for other males. They just penetrate. To show desire is to indicate that they are not real *panthis* but are really *kotis*. In the sexual act, the penetrator does not touch the genitalia of the *koti*. This of course is the public discourse. In privacy, affection and desire between *koti* and *panthi* does happen.

Similarly *kotis* will also state that do not have sex with each other. Named by them as *chapati-chapati*, for them such behaviour is considered shameful. However in personal and private discussion, several have admitted that they do so but they can never discuss this with their peers.

Kotis have their own language, terms that appear to arise from that used by *hijras*. A secret language that binds *kotis* together as an emergent sexual "community".

2. Gay and/or homosexual men

A few educated men have begun to use the term gay as a form of self-identity. All those in the survey who identified themselves as such were English speaking, educated and from an upper-middle/middle class background. These males have a considerable access to privacy and personal economic power, and are often in regular contact with gay men in the West.

However, it was noted that in terms of response to the cultural need for marriage and children, the majority of the self-identified gay men stated that they would get married and have children.

In the surveys there were also some males who have sex with males who may desire long term relationships with other males based on equality of status and power, or at the very least sexual encounters with other males based on mutuality. It is in this context that the word *gay* or the term *homosexual* could possibly be used, where such males have developed or are developing some sort of sexual identity recognisable in the use of Western terminology. Such males like those who are self-identified as gay men, are primarily from middle and upper classes.

3. Panthis

This label is given to "real men" by *kotis* and is <u>not</u> a self-identification marker. They are males who are actual or potential sex partners of *kotis* through anal penetration, or as recipients of oral sex and/or masturbation, Such males generally do not label themselves, and for most of them do not have a sexual identity. Likewise, for most of them, they have sex in the pursuit of semen discharge.

These are males who exhibit so called "normative" behaviours, and while some may sexually desire other males, it is the act of sexual penetration and discharge that is important. For many the gender of the partner is less important that the act itself.

Many males sexually penetrate based upon concepts of sexual need and semen discharge. In a culture where masturbation is seen as producing weakness and disfigurement of one's penis, where ejaculation produced by masturbation is seen as wasteful, the need to ejaculate <u>into</u> something becomes a necessity. The something can be a male, a female, or in some cases, an animal.

"Real males" are perceived as lustful, constantly needing to discharge and many *kotis* will often state that getting a man, any man, is easy. Here the ability to sexually penetrate defines manhood, not the age of the person.

Some *panthis* may well visit specific locations where he knows *kotis* are available for sex, whether he has to pay for it

or not. Or they may be sexually active in social and working environments, i.e. hotels, restaurants, shops, or solicit young sexual partners in bazaars and streets. But in many cases a male may just be present at a particular place without specifically looking for sex, and will respond to an approach by a *koti*. This can happen outside public sex environments. On the street, shop, restaurant, park, cinema, bus, railway, wherever.

In interviews and discussions many of these males have stated that they like anal sex because it is "tighter" than vaginal sex. And recent anecdotal evidence has indicated that several of these males see females as vectors of sexual diseases and therefore unsafe to have sex with, where vaginal sex is seen as more dangerous than anal sex.

Within the socio-cultural frameworks of Bangladesh, these *panthis* will centralise their lives around marriage and children. Further it should also be noted that many of these males do not see this sexual behaviour as "real sex", not even as sex, but rather as *khela, or* play.

4. Do-Paratha

Another *koti* term is the *do-paratha* male. Here the defined male indicates desire for mutuality in the sexual act, and willing to be both penetrator and penetrated.

5. Hijra

Hijra is a self-identified term used for those males who define themselves as "not men and not women", people of a "third gender". Such biological males have a social, religious and cultural identity within which they will dress up as women with exaggerated behaviours, and are often religiously castrated as a sacrifice of malehood to the goddess Renuka Devi. They are often seen in some streets of Dhaka (but also exist throughout South Asia) aggressively begging. Some will also act as sex workers. They will often be called to the birth of male son or to a wedding where the belief is that their blessings will bring prosperity and good luck.[1]

This report does not explore the issues of *hijras* and sexual behaviours, but it has been mentioned here as one aspect of identities.

In a spectrum of "masculinities" involved in male to male sex we can then see the following:

hijras - koti - do-parathas - panthis

1. See Nanda, *Neither man nor woman - Hijras of India*, Wadsworth, 1990.

SEXUAL HISTORIES

Table 10	Age of first sexual encounter	N = 530
Age	**Frequency**	**% of respondents**
5 - 10	102	19.25%
11-14	245	46.23%
15-18	173	32.64%
18 +	10	1.88%

Table 11	Gender of first sexual partner	N = 530
Gender of sex partner	**Frequency**	**% of respondents**
with a male	468	88.30%
with a female	62	11.70%

Table 12 First sexual act		N = 530
Sexual act	**Frequency**	**% of respondents**
being anally penetrated	144	27.17%
anal penetration of partner	7	1.32%
vaginal penetration	62	11.70%
masturbation (to ejaculation)		
a. receive only	15	2.83%
b. give only	45	8.49%
c. mutual	77	14.53%
oral sex given to partner	53	10.00%
receiving oral sex	25	4.72%
give thigh sex	102	19.24%

Table 13 Age of first sexual partner		N = 530
Age	**Frequency**	**% of respondents**
14-16	70	13.21%
17-21	112	21.13%
22-30	214	40.38%
31-45	97	18.30%
45+	37	6.98%

Table 14 Relationship to first male sexual partner		N = 530
Relationship	**Frequency**	**% of respondents**
friend	116	21.89%
neighbour	82	15.47%
relative	265	50.00%*
stranger	67	12.64%

* Table 15 Actual family relationship		N=265
Relationship	**Frequency**	**% of respondents**
older cousin	53	20.00%
younger/same age cousin	26	9.80%
father's brother	21	7.92%
mother's brother	39	14.72%
older brother	48	18.11%
sister's husband	31	11.70%
mother's sister's husband	14	5.28%
other male relatives	24	9.07%
father	9	3.40%

The sexual histories of the respondents were explored; when respondents first had sex, with whom and what they did. This was to provide a framework for exploring personal constructions of concepts of childhood and "sexual abuse, "as well as constructions of shame, and the whole framework within which sex takes place.

Consistently early sexual activities were found, where in the survey over 65% of the respondents had at least one sexual experience by the age of 14. Significantly nearly 20% of the respondents had a sexual encounter by the age of 10.

When asked about their feelings about these early sexual encounters, 15% of the respondents expressed feelings of outrage, whilst 85% expressed feelings from indifference to increasing levels of guilt and shame. Out of these 85% of respondents, 62% just stated that this was a part of sexual play, and saw nothing wrong with it at their age.

What can be seen here are high levels of "sexual abuse" of young children[1], the majority within the family. Apart from any psychological or physical damage that may have occurred, this also reveals increasing potential risks for STD/HIV infections within families brought about by the sexual behaviours of one or both male partners outside of the family context. An uncle, or brother, or cousin may well be having sex with others, female and/or male. Patterns of infection become complex and difficult to untangle, since there are no clear boundaries between so-called heterosexual, homosexual, bisexual behaviours.

There is a lack of recognition by government and NGOs on this whole issue of early sexual activities, or what is often being termed as non-commercial sexual abuse.

This report is not focused on child sexual activities, nor looks at child prostitution, child sexual abuse or any related issues. What does become clear through the interviews, questionnaires and focus groups is that for the significant majority of respondents, early sexual activity was a fact of their lives. They had no recourse to any person to talk about the issues such sexual activities brought for them. As one workshop participant stated:

I was raped by my brother and his friend when I was five years old. And for several years after that he or his friend would want to do sex with me. I could tell my family, because of my shame. For several years I thought I must be a woman for my brother to do this to me. I just feel this tremendous rage whenever I think about it. It was he who made me want this type of sex.

Several people reported bleeding incidents in that first penetrative act. Their lungi[2] protected them from shame of discovery. Varying degrees of pain were also reported. There were also reports of feelings of shame, of lying, of secrecy.

The trauma of such an early encounter appeared to be focused on the potential shame of the experience as much as the experience itself. Out of the 347 respondents who reported sexual activity by the age of 14, some 55% reported differing levels of feelings of shame that they learnt to deal with and discharge. 45% saw this behaviour as *khela*.

There appeared to be some links with early sexual activity and class and privacy, that is where an individual had his own personal bedroom, levels of early sexual activity dropped, although this depended upon sexual access to male servants.

Further to this links could be made between early penetration by another male and the development of *koti* identities. Some 68% of the respondents who were *koti* identified reported early and regular penetration by the age of 14. Sexual practice appears to be a determining factor for such an identity construction.

These sex acts were not prolonged, ending upon the semen discharge of the partner, usually after a few minutes. That is they fit into a construction not so much of desire for a child - a paedophile framework, but rather one of immediacy, availability, and “heat”, that is of discharge sex. This is not to deny that there are not paedophiles amongst the Bangladesh population.

Other issues that arise from such sexual activity in Bangladesh are the differing cultural meanings and frameworks around the terms, child, adult, sexual maturity, sexual abuse, and so on.

This may well be different if a more randomised sampling had been done. All respondents in this survey were males who have sex with males within identified male to male networks. It should also be noted that of the first sexual partner of the respondents, some 74.21% were between the ages of 14-30, the vast majority would have been unmarried males. Whilst 13% were of similar ages as the respondents, 21% were between 17 and 21.

What this survey pointed out was the high level of anal sex being practised in first sexual encounters, some 27%, which seemed to be the most common activity, whilst, 20% of the respondents experience thigh sex, that is the penis placed between the respondent’s thighs. There was also significant levels of sexual activity with females, some 12% of the respondents reporting that this was their first sexual encounter.

What can be said from this survey is that early sexual activity with young males below the age of 14 is not uncommon, that anal sex is often the preferred choice of their sexual partners, that definitions of sexual abuse, incest, and childhood sexual activities need to be explored within the cultural framework of Bangladesh, and that risks of STD/HIV transmission to young male children (and female of course) are significant within the context of such early sexual activity.

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1. See *Non-Commercial Sexual Abuse Of Children In Bangladesh,* produced and published by Breaking The Silence Group, Dhaka, 1997

2. Lungi - a sarong like piece of thin clothe which the male wraps around his waist and which reaches to his ankles. Most males wearing lungis do not wear any underwear.

SEXUAL BEHAVIOURS

It is impossible to determine the numbers of males who are involved, or have been involved, in male to male sex, for a number of reasons that include, sampling techniques, honesty of responses, levels of denials, invisibility and so on. In a culture where shame, secrecy and lies affect public discussions on sexual behaviours, all that could be determined from the respondents, focus groups and one-on-one interviews was the social spread of male to male sex. Hence in relation to the question, "who is engaged in male to male sexual activity from your actual experience?" the answers given included:

teachers with students
students with each other
brothers
uncles with nephews
cousins
neighbours
with domestic servants
between domestic servants
between friends
"elder brothers".
i.e. residential school hostels, community groups
students
truck drivers with helpers/others
rikshaw drivers
construction labourers
amongst bus/launch/train passengers
professional kotis with clients
civil kotis with any male
hijras with males
police/army/airforce
security guards
doctors
hotel staff amongst themselves and with customers
expatriates
foreigners
tokais[1] with each other and with others
landlord with tenant
students in hostels
street children with each other and with others
private tutors with their students
amongst prisoners and prison staff
in orphanages
in Madrassi[2] schools
in boarding schools
between shopkeepers and staff,
i.e. restaurants/tea shops
beggars
businessmen
politicians
actors
dancers

One can see from this list of people's professions and occupations which respondents had stated that they had sex with, it is clear that male to male sexual encounters are not some small marginalised behaviours within selected social and occupational groups but rather appears to ubiquitous and part of the male social space.

At the same time, the question was asked as to "why do males have sex with males in Bangladesh from your personal experience?", the answers included:

personal desire for other males
sexual pleasure
fun
by accident
females don't do anal/oral sex
males are more easily available for sex
anus is tighter than vagina
males are more available than females
nobody is suspicious if we mix with other males
females are more socially controlled
sexual adventure and curiosity
sexual play
no chance to be friendly with girls
females unavailable
meeting physical needs
males can sleep in the same bed without a problem
to be aloof from girls
girls virginity must be protected
no chance of being pregnant
easier to seduce boys than girls
easier to get along with males than females
no financial involvement
no marriage involvement
living together with other males
poverty leading to selling sex
attraction to other males
migration and separation from wife
maintaining chastity
girls must remain virgins
sexual practice before marriage

The breadth of response is amazing, and indicates that social constructions of male to male behaviour can be extremely broad and extensive. These responses give a clear indication that the use of the terms homosexual/heterosexual/bisexual do not reflect the reality of the situation. It is clear that the frameworks of male to male sex are complex, particularly when developing appropriate sexual health responses. Who do you target? What do you target? How do you target?

Respondents reported high rates of sexual encounters and number of different partners

Table 16	**How many times have you had sex with males over the last six months?**	N = 530
Sex acts	**Frequency**	**% of respondents**
0	21	3.96%
1-5	78	14.72%
6-14	161	30.38%
15-30	65	31.13%
over 30	105	19.81%

Respondents stated that it was very difficult to stay with one partner, because social conditions did not enable this to easily happen. Meeting spaces were often sexual spaces, and so many opportunities existed for a range of sexual encounters.

Group sex was also reported by over 25% of the respondents, where numbers in an particular group situation could be anything between 3 and 20. Most of these activities would take place at sex parties, private homes, hotel rooms or guest houses.

Table 17	**How many different males have you had sex with in the last six months**	N = 530
No. of partners	**Frequency**	**% of respondents**
0	10	1.88%
1-5	21	3.96%
6-14	106	20.02%
15-30	121	22.83%
30 - 60	136	25.66%
60 - 90	136	25.66%

This means that almost 26% of the respondents were averaging over 10 different sexual partners a month.

Table 18	**Relationships to sexual partners** (excluding those self-defined as *professional kotis*)	N = 509
Relationship	**Frequency**	**% of respondents**
strangers	369	72.50%
friends	186	36.76%
relatives	154	30.26%*
neighbours	146	28.68%
male sex workers	51	10.02%
domestic servants	47	9.23%
paying clients	26	5.11%

Note that 5% of the respondents would be paid for sex but did not define themselves as *professionals* (sex workers).

* see Family sex section - Table 27, Page 70, for breakdown

Table 19 **Where did you meet sexual partners** N = 509 (excluding those self-defined as *professional kotis*)		
Location	**Frequency**	**% of respondents**
parks	396	77.80%
“cruising areas” (not parks)	356	69.94%
neighbourhood	305	59.92%
bazaars	152	29.86%
personal home	131	25.74%
cinemas	127	24.95%
hotels	117	22.98%
street	115	22.59%
friends home	105	20.63%
railway/bus stations	35	6.88%
toilets	27	5.31%

With the large numbers of male to male sex taking place amongst strangers, with multiple partners of high frequency, there is a clear indication of high risks for STD/HIV transmission.

From focus groups and interviews with rikshaw drivers, commonly sex partners were those they either slept with, male sex workers, and/or those in the work place.

All student respondents and interviewees indicated that they were having sex with other students in “mess rooms”, student hostels, and teachers, as well as amongst those they meet at “cruising sites” and parks. Some 25% of student respondents indicated that they were also selling sex to earn money towards their studies.

Such frameworks of sexual encounters indicate that intervention strategies should not only include specific sites, but look at other spaces such as schools and colleges.

Anther issue of sexual partnering and identities indicate that whilst a significant number seek male sexual partners, either to be penetrated or to penetrate, there are a significant number of males who sexually respond opportunistically as and when they are directly approached or in certain situations, such as sharing a bed. This means then that two significantly different approaches towards intervention and promotion of safer sex amongst males who have sex with males need to be explored. That of targeted interventions towards specific behavioural and identified groups, i.e. *kotis, panthis*, gay identified men, and that of a general programme aimed at behaviours within the general male population, i.e. anal sex.

Table 20	Where did you have sex N = 509 (excluding those self-defined as *professional kotis*)	
Location	**Frequency**	**% of respondents**
park/cruising area	349	68.49%
partner's home	214	42.04%
hotel/guest house	211	41.45%
friends home	198	38.90%
street/alley	167	32.81%
hostel	155	30.45%
own home	146	28.68%
relatives house	136	26.72%
cinema	98	19.25%
construction site	89	17.49%
in a car	46	9.04%

Issues of space and time would constantly arise. Parks were the most popular because of their poorly lit spaces, and opportunities for anonymous encounters, but we can see that a wide variety of spaces are also used. Condom usage was extremely low in such environments because of the possibilities of being seen by others, or through police, security ad hooligan harassment.

Table 21	Current sexual practices	(N= 530)
Sexual practice	**Frequency**	**% of respondents**
body rubbing	376	70.94%
anally penetrate partner be anally penetrated	220 396	41.51% 74.72%
masturbate partner receiving masturbation	484 476	91.32% 89.81%
give oral sex receive oral sex	382 237	72.08% 44.72%
thigh sex	376	70.94%

Deep kissing was only reported by 42% of the respondents, but some 80% reported kissing on the lips and cheeks. The reason for the relatively low level of deep kissing was that many of the sexual partners of the respondents did not like kissing and saw this as "effeminate", and acting like a *koti.*

The difference in being penetrated and penetrating is quite clear. A primary behaviour appears to be anal penetration where some 75% reported this behaviour whilst 72% reported giving oral sex to their partner. This discrepancy may well arise from the nature of the identities of the respondents, where 40% were *koti* identified.

Further the reported behaviours show indications that sexual partners include opportunistic encounters in a variety of locations of males who wish discharge only.

Sex with females

Over 37% of the respondents stated that they were married. All reported continued sexual activities with their wives.

Table 22	**Sexual behaviours** N = 198
Sexual act	**% of respondents**
vaginal penetration	98%
anal penetration	32%
receiving oral sex	21%
deep kissing	54%
cunnilingus	9%

The majority of married males felt that sex with their wives was a duty to perform, and could not ask them to do anal or oral sex.

Of these 198 married males, some 56 (28.28% or 10.56% of the total respondents) reported also have sex with other women, primarily female sex workers.

Table 23	**Female sexual partners of married males other than their wives** N = 56
Sexual partner	**% of respondents**
female sex workers	72%
other females	28%

Table 24 Sexual behaviours with these other women N = 56	
Sexual act	**% of respondents**
vaginal penetration	100%
anal penetration	28%
receiving oral sex	36%
deep kissing	64%
cunnilingus	5%

All anal sex and oral sex was between female sex workers and male partner.

In terms of the unmarried males, 15% (50 respondents) stated that they had sex with females of which some 11% (36 respondents) stated frequently.

Table 25 Female sexual partners of unmarried males N = 50	
Sexual partners	**% of respondents**
female sex workers	76%
female relatives	23%
other females	36%

Table 26 Sexual behaviours with these other women N = 50	
Sexual act	**% of respondents**
vaginal penetration	85%
anal penetration	36%
receiving oral sex	36%
deep kissing	64%
cunnilingus	3%

Total number of respondents reporting sex with women (wives included) is 248 (47%). Whilst the majority of respondents were unmarried, the majority of these intended to get married. Not one respondent stated that they would stop male to male sex once they were married.

1. Tokai - a person who lives on the streets and earns money from collecting discarded, but useful, rubbish which he/she can sell - a ragpicker.

2. Madrassi schools - Islamic schools where students are instructed on the Qu'ran.

SEXUAL NETWORKING

Public sex environments

Some 25 specific sites in Dhaka were identified by the survey team where male sexual partners are available at various times during any given week. These sites vary from large parks to sections of a particular street, to areas of significant male congregation. Many males who are in these areas are not necessarily there for sex with another male. Often they will be approached by a *koti*, and with the opportunity and availability will agree to a sexual encounter, either on site if the conditions are suitable (darkness, invisibility, bushes, etc.) or they will go into some local dark alleyway, construction site, or nearby guest house/hotel which rents rooms by the hour. There are many such facilities available.

An interesting note was that during *Ramzan,* a religious period of fasting and abstinence, the level of sexual activity drops in all these sites.

Site One

A very large park situated in the central Dhaka, well tended and groomed with many trees, bushes, benches and footpaths. It also has an artificial lake which is used for public bathing by many males during the daytime. The park is badly lit during the evening times, and while officially closed at 9.00pm, there are many males who wander through later than this. During the day time, it is popular with lower income group males who come to bath, children, and couples. There is some anecdotal evidence that female sex workers pick up clients in the late afternoon and early evening period.

This park is popular with males looking for sex with other males, both from middle classes and lower income groups. Active every day between 6.30pm till about midnight. On any one day about 200 - 300 males will go through the park looking for sex between these times.

Also in the park between 8pm-midnight are a group of male sex workers, between 30 - 50 per day, whose clients tend to come from lower income groups, and who may have come into the park not necessarily looking for sex. On average these male sex workers have between 5 to 10 clients per night. They will have sex in the park, or go with a client to a nearby hotel which rents rooms out by the hour.

Sex can and does take place inside the park in the dark, or individuals will meet in the park and go elsewhere for sex. Sex in the park includes oral and anal, as well as mutual masturbation. Condoms are not used in the park.

Sometimes local police will conduct a raid in the park and arrest specific individuals "for causing a nuisance". Often those arrested will be blackmailed for money and/or for sex. There are also at time, several *mastans* (young thugs), who harass the *kotis* physically and verbally, and take money from them, sometimes demanding sex as well.

Kamal is 21 years old, lives in Dhaka and works as a lift boy in one of the larger hotels. He goes to the park 3 or 4 times a week, where he averages 5 clients an evening. He identifies as a koti and has many friends in the park, all who sell sex. Like the other boys[1] *in this park he has been taking oral contraceptives so that he can develop his breasts, which are now quite enlarged. He states that the men like him to have big breasts because they like to squeeze them when they fuck him. They do the same to girls he stated.*

"I was 14 when I started coming to this park. The first time I came here it was early evening. It is close to my home and I had come to see a friend. Usually I would come in the afternoons. As I walked through the park, I saw several boys,

you know, walking in that way. Some of them were even wearing lipstick. I was interested, so I sat down on a bench. Then I noticed a man go to one of these boys, talk for a few minutes and then go into the bushes, there.

Then just after that, when I was wondering what was happening behind the bushes, one of these boys came and sat next to me. We started talking, and he told me what was going on. He took my hand, looked at me and said that I could make money like this. He described himself as a koti and the men as panthis. He said he would help me. I forgot about meeting my friend and that evening I had my first client.

My new koti friend explained to me the prices, how to do in the park, who the panthis were. I got to know the other kotis who were also selling sex; there are about 50 of them here every night. Between us we do about 300 men every night. I also get to see the other kotis, the ones that are not professionals. They have their own section of the park though, and we don't mix too much. They are all from higher up, you know students, shop-keepers and so on. They wear jeans and shirts, live in nice homes. Not like us.

When I was 17 I had this customer who used to work in this hotel. He said he could help me get a job. That's how I started working as a lift boy. I left my uncle and moved into this man's home. He had a little room to himself. We started living as husband and wife. He is really married with four children, but they are all in his village near Comilla. He buys me nice clothes sometimes.

I stopped going to the park for a little while, perhaps for 6 months when I moved in with my "husband". But I missed all my friends. So I started coming back for an hour or two each day and did not tell my husband. Then a client would approach me and I would do and get extra money. I never tell my "husband".

I have also had offers in the hotel. Sometimes I take a hotel guest in my lift and if we are alone they will invite me into their rooms. This is difficult since I am not allowed into any guest's room. But usually I can get 15 or so minutes after my duty shift, when I can say I am in the toilet or whatever. Then I go to the guest's room. I can make quite a lot of money that way.

I send something like 2500 taka[2] *a month to my family, and use the rest to buy make-up, clothes and help with the room rent and food. My "husband" thinks I give him the money from my job at the hotel.*

I like it here in the park. We kotis stick together, help each other. There are some very poor kotis here and sometimes I will give them some money or buy them a gift, or give them food, when I have had a good week and have extra money."

Site Two

A major religious shrine in central Dhaka and very popular with the general populace. Hundreds go there every evening. It is most active for males seeking male sexual partners on Thursday evenings. No sex goes on at this site, but "pick-ups" occur, sex taking place at other locations. There had been a small park nearby which used to be available for sex, but this is now closed. On average about 50-100 males seeking sexual partners. It also acts as a social meeting place for males who have sex with males, particularly those from the middle classes.

At the *majmas* (circular crowds around someone singing religious songs) people will often make physical contacts. Penetrative sex has been seen to occur in these groups, and although a few next to these individuals appear to be aware of this, it is ignored.

Outside the site it is possible to secure male and female sex workers through the rikshaw drivers who are present. Rikshaw drivers are also available as sexual partners.

There appears to be very little harassment either from police or from local security

Site Three

A central Dhaka street popular for shopping and for young students. Most crowded between 6.00pm-9.00pm with shoppers and students. Very popular for "cruising" for sexual partners - *panthis* - by *kotis*. Sex takes place in local homes, or nearby areas (i.e. construction sites). This is middle class group. Students are between the ages of 16 - 25.

Site Four

A very large park and popular local attraction in North Dhaka. Many trees, bushes, pathways and a large lake. The layout creates many private spaces within and amongst bushes where sex takes place in the late evening. While the park is supposedly closed after 6.00pm, this is only true at the main gate. There are many gaps in the surrounding fences which makes the park easily accessible and where males go for sex. Sexual activity takes place in the park, is primarily anal sex, but also includes oral and mutual masturbation. Very little lighting is available in the park. Sex is in the dark. There is some male prostitution. No condoms are used in the park. Between 50 -100 males per night will go through the park for sex.

Site 5
A small park between two main roads in the southern part of Dhaka. No lighting and with open access from these roads. Many bushes and trees. Used by males looking for sex after 6.00pm. On average about 50 males during this period use the park. Sexual activity takes place in the park or "pick-ups" are made and sex takes place in local guest houses or a person's home. No condoms used in the park..

Site 6
A major public venue for males looking for other males, particularly on a Friday night, but also used by the general public during the evening hours. Mostly young people and students. Used by many *kotis* to "cruise". No sex in this area. Pick-ups are made and sex is elsewhere. A social space as well for males who have sex with males. Primarily a middle class venue. Not all males coming to this space are looking for sex with other males, but will often be "picked up" for sex, if the other person has the space available.

Site 7
This is a major launch ferry area, very busy all day with rooms available at local guest houses. Massage boys are available outside the terminal as well as within the launches themselves. Active all day.

Site 8
A railway station with many street children. Whilst all the street children are involved in some causal work helping passengers with luggage as well as begging, some of the males (and females) will sell sex. For the males this is usually anal. This sex takes place away from the station, but on occasions will occur on the railway tracks late at night. No condoms used. The ages of these boy sex workers are between 8-15 years old.

Shopan is 12 years old, living and working at the station. He has been here since he was 6 years old. He is street-hardened, often taking phensydyl (a cough medicine which is highly addictive) to relax/ He primarily earns money doing odd jobs around the station, acting as a baggage carrier for some of the passengers for 2 taka. He also sells sex to the older boys at the station, usually for 10 taka, but has older clients as well on an irregular basis, where he may get food and shelter for the night. Sometimes these clients will also give him clothes.

Site 9
A major religious site in a suburb of Dhaka. This place is crowded every evening with those seeking spiritual solace, but also at least 25% come for sex. On Thursday evenings there are about 120-150 *civil kotis*, *professional kotis,* and a few *hijras* operating from this site. Female prostitutes operate also but usually in the afternoons. The average number of clients per night for *kotis* will vary between 3-12.

Kotis and *panthis* here are usually from lower income groups. After making contact people will go close by to an area where sex can take place, usually anal sex, but sometimes oral sex also. Otherwise they will go to local places and rent a room for an hour.

There appears to be no harassment either by police, local people, or worshippers.

Jibon is 15 years old and has been going to .... since he was 14 to sell sex. He averages between 10-12 clients a night and charges between 50-100 taka per client. He has sex sometimes inside the site, but will often rent a room nearby for 20-30 taka per hour.

He works in a garment factory with an monthly income of 1600 Taka (£35) and is the sole breadwinner for his family of 4 brothers and two sisters. He has no father. The money he earns at the site he keeps for himself. Sometimes, he states, he has been raped by clients who have refused to pay. He was first sexually penetrated by his 22 year old uncle when he was 7.

Alam is a 9 year old boy living in Dhaka, Bangladesh. Every evening you will find him at M.... "Customers" are local rikshaw drivers, truck drivers, shop-keepers, worshippers, and other men, who also come there for sex. He will charge anything between 20 - 100 taka per customer. On an average evening he will get about 5 customers. Sex is penetrative, and no condoms. The boys vary in ages from 8 to 60, and call themselves koti . Not all sell sex in this place. Some also come to find panthis for "fun" sex and penetration. The differentiation between those kotis who sell sex, and those who come to have sex is very narrow. Many of these seeking fun sex also receive small gifts, such as a item of clothing or some other gift.

Alam now wears lipstick, acts in a feminine manner, sways his hips seductively at passing men, and hopes one day to find a panthi to take care of him. The money he earns helps feed his family as well as buys him his make-up and "sexy" clothes. His parents don't ask where he gets the money as he tells him he has a job working in a rikshaw repair shop. They need his money to help feed his five brothers and sisters. The father has no work and drinks heavily. The mother is pregnant again.

" I have been coming here for a year now. The first time I came here with a friend. He left after a little while and I stayed behind because I saw all these "boys" who had make-up on. A man approached me. He offered me 20 taka,. I was hungry so I did it. The other kotis here are all my friends. Yes, I am a koti now. I will find a nice "husband" for myself one day. He will look after me and my family and then I will stop this life. But that might be hard because I like all these men."

Zahid, a tokai, is 62 years old and operates in the same place. He has a wife and four children, and is a pavement dweller. He calls himself a koti too, but only in this place. While he likes to be sexually penetrated he will charge for it to supplement his daily income to buy food for himself and his family.

"I can only ask for perhaps 5 or 10 taka a shot because now I am old. What can I do? Look at me, I only have this old lungi. I can't afford to buy myself another piece. I have my family to feed, look after my wife and children."

Site 10

A major cinema in central Dhaka, which often shows "sexy" European films. When these films are playing sex will take place in the stalls (mutual masturbation) or sometimes in the toilets (masturbation, anal or oral sex). Outside, is also a "cruising" area for several kotis and male sex workers who will be picked up by those coming out of the cinema from the late evening show, or by customers and staff of nearby restaurants. Sex takes place in local guest houses and hotels.

Site 11

This rectangular park is situated at the busiest connecting road junction in Dhaka. There is also a large market for lower middle class people. There are long walkways with many trees, and one end several large bushes where sex can take place. Males will come here seeking sex, selling sex, or just meeting other males. The park is busy six days a week (not Fridays) and those using the park for sexual contact tend to be primarily middle class. *Kotis* are not so common here, and a number of sexual networks operate from here to. There has been police and *mastans* (local thugs) harassment from time to time.

Site 12.

This is the forecourt in front of a major Mosque in central Dhaka. The area is faced by a large number of small shops and commercial buildings. A large amount of sexual contacts made here in the evenings, with many *panthis* and *kotis* "cruising" each other. Male sex workers also operate from this area. No sex occurs at this location. Such "cruising" is over the week.

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1. The term boy as used throughout this report reflects a South Asian context and meaning, in that it does specifically refer to those below the age of 18 years. A "boy" can be any age in this context where it is referenced by socioeconomic class, marital status, custom, tradition and sexual behaviour, i.e. a male who is sexually penetrated - a *koti* - will be referenced as a "boy".

2. Taka - Bangladesh currency. 45 taka is equivalent to approximately US$1.00

OTHER SEXUAL FRAMEWORKS

Not all *kotis* got to these sites looking for sex. They get their *panthis* through other *kotis.*

" When a good looking relative or friend visits, kotis have a way of getting intimate with them by making unnecessary body contacts or talking about sex/marriage. The intention here is make the panthi "hot", that is to encourage an erection, after which sex usually occurs. After having sex with a panthi, the koti will tell these panthis to bring over their handsome friends in future

When middle class kotis visit a shop or restaurant they may also ask the telephone numbers of handsome men and make contacts later. A friendship will develop which often becomes sexual

Some high class kotis will also pay lower class kotis to get them panthis for sex. There are many such kotis who offer this service.

Mohammed L., 27, artist

How kotis pick up panthis on the streets

" Kotis are usually very effeminate and they make it a point to be more effeminate when they go out. They tend to dress in a flamboyant manner in order to attract attention. When they sit in a rikshaw their behaviour also tends to be flamboyant. It is always better for two kotis to roam together because that way it is easier to hunt the panthis down and they feel more courageous.

When kotis sit in a rikshaw they usually warm up the rikshaw driver with small talk. At one point they ask whether he likes boys or not. If he says he likes boys they grab his penis. Otherwise they get busy attracting other passers-by. They usually shout out greetings to a passer-by. If he responds they stop the rikshaw and go over to meet the man. Some of these men oblige by taking them along with them. Others exchange telephone numbers for later meetings.

Many kotis will also stand by a cinema hall or sidewalk to attract panthis. They tend to talk in signs/body language or go over near to their target male. If there is an agreement then they go off for sex."

Ahmed S, 24

In direct observations of this behaviour there appears to be very little abuse of these *kotis* in such scenarios. Mostly it may be some ragging, joking, and a great deal of flirtation. But more often then not sexual contact is made, and the two, three, or four males will go of somewhere to find accommodation for sex.

Over a period of four days, I was able to follow one such *koti* as he made direct approaches in a variety of situations, including several restaurants, street corners, tea-shops, and other shops. He was able to pick-up a total of 42 men for sex. These men ranged from rikshaw drivers, students, two police officers, business men, shop assistants, traffic police, two soldiers and a variety of others in differing occupations.

"I don't like parks, so I don't go to them to find sex. Finding sex in Dhaka with another boy is very easy. Usually what I do if I see someone I like, is to follow him to a restaurant or tea shop and then sit next to him. I get into a conversation, and then I will invite him to my home, where I have my own room. Once I get him into my room, I give him a cold drink and then I start a conversation, you know about anything. I will sit next to him, very close, but I won't do anything. After about an hour I will say I have something to do and that he will have to go, but I invite him back the next day.

I do this for a couple more days, you know, and then I will start saying how handsome he is, what a nice body he has, that I am jealous of him, can I see his chest. If he agrees, and most do, he takes of his shirt, then I touch his nipples,

stroke his chest. Then I ask does he do sex with girls. Just about everybody says no, because it is so hard to get a girl. So I ask what he does, and I tell him I just masturbate, and how nice that feels. By the time I finish I know he is hot and wants sex. You can see it clearly. So I put my hand on his thigh, and if he doesn't remove my hand, and no one has every done that so far, then I move my hand slowly up his leg until I am holding his penis.

Then looking into his eyes, I unzip his jeans and begin stroking his penis. Usually I give oral, and then I ask him if he will fuck me. By then the answer is always yes.

After sex, I always tell him how good he is, how much I enjoyed it, and he must have enjoyed releasing body tension. Then I invite him back again. Some of them want to come back every day for sex. They are so "hot'.

After a couple of weeks I then introduce him to a couple of my friends. They make friendship with him, invite him to their own homes and do sex with him. That is how the networks build up. We always share the guys we do sex with, and then he brings his friends into the network.

Condoms? No I haven't really though about condoms. Anyway I can't keep them in my home."
(23 year old student living at home)

"Look, most of my friends cannot go to parks or public places to look for guys. They are too well known. So I pick up guys from the streets, do sex with them and then take them to one of these friends homes so that can do sex with them. My friends tell me what they want, you know, height, colour, build, age and so on and I get them. Its easy. All these guys want sex. It doesn't matter whether it is with a girl or boy. They just want. Always hot.

You saw. If I like someone, or he is the type a friend of mine wants, then I just go up to him, and within five minutes I can get him. You saw. I just touched his thigh, and if he doesn't push my hand away, I know. And the majority never push their hand away.

Where? On the streets, shops, hotels, restaurants, anywhere. I have done it on a bus, in a train, anywhere.

How many? Let me see. OK last month I picked up maybe 40 guys. Did sex with them all, and then took them to see my friends. No I don't charge. Most of these guys don't ask for money. Sometimes they like a small present though."
(hairdresser/dancer aged 24)

Jaani Dosti

Also known as *jiggery dost* in India, this framework primarily relates to young unmarried males, who, in a homosocial[1] and homoaffectionalist environment find themselves sexually aroused through physical contact, either through play or sleeping next to each other.

The sharing of a bed by two males in South Asian cultures is very common, where space can be at a premium. Where males are of a different age, then usually both males are part of the same joint and extended family, i.e. uncle and nephew, cousins, brothers. Where they are of a similar age, then usually they are close friends - *jaani dosti.*

M was a graduate working in the hotel, aged 24. He had been working in the hotel for the last 8 months, coming straight from his village to the hotel. He got the job through a "relative" from his village who was also working in the same hotel.

M had been sexually active since the age of 13. His first sexual encounter was with a female neighbour who was also thirteen. He had sex with her regularly for three years until she got married. He has had sex with other girls in his village until he came to Dhaka to go to college, but not very regularly. After college he went back to his village until he came to Dhaka to work in a hotel. He has not had sex with a female since he was 18.

He has had sex with his male friends since he was 16. He said,
"It all started by accident. I hadn't had sex with my girlfriend for over three months, and I hadn't masturbated either. That night I had got hold of this blue magazine from a friend of mine who had brought from Dhaka. All these naked women and men doing things. It made me really hot. I wanted to handle myself, then a friend of mine came over so that we could do our homework together.

The time got late, so my friend stayed the night and naturally he had to share my bed. My little brother went to sleep with my parents, so we had the room to ourselves. During the night I couldn't sleep. I had this erection, but was to scared to touch it as my friend might find out and then I would be ashamed. I had fallen asleep when I woke up suddenly. My friend's leg was over my leg and my lungi was right up, so my erection was free. I put my hand down there, and as I did I felt my friends cock, which Pretending to be asleep I pushed myself closer which allowed both our cocks to touch. At this my friend stirred and pushed himself closer, and I opened my eyes. In the dim light coming into the room, I could see his eyes were also opened. We both grinned together and started pushing against each so that our cocks rubbed each other. We then masturbated each other.

Since then we have done anal sex with each other and oral sex, and also thigh sex. We never used to plan on having sex together. He or some other friend of mine would come to my house, or I would go to their house, and perhaps stay

the night. When we go to sleep naturally our lungis rise up and our legs often cross each other. Usually we wake up in the night feeling 'hot' and with erections. Naturally then we do something to release the pressure. What can we do? We can't always find a girl. I prefer sex with girls. I know what it is like. I have done it. But if there is no girl around then and if an opportunity is available and I am 'hot' then I will do it with my friend.

The line between homoaffectionalism and male to male sexual acts is very narrow in this context, particularly at night, where it is easily transcended in a variety of sex acts, which once again are not seen as sex but as *khela* - play. Where there is a similarity of age and power the sexual act is usually mutual masturbation or thigh sex, but may also include mutual oral and anal sex. Where there is an age hierarchy, oral and anal sex usually will occur, the younger partner acting as the receptive partner. This type of sexual activity can be called *Dosti* sex and is to some extent linked with semen discharge. Mutuality is a main aspect of this sex. Both partners give each other sexual release, but there is no construction of sexual identity. Desire is primarily focused on females, possible future wives, whilst the sexual behaviour will be with other males who are friends, but maybe, perhaps, acquaintances. The issue here is immediate accessibility and the naming of the process. "This is not sex. Sex is what you do with your wife".

Spaces for such sex acts were in homes where male relatives may sleep together, in mess (shared accommodation) rooms, dormitories, hostels, student halls of residence, and even on streets amongst street males.

Love, Romance, Sex and Discharge

What has love got to do with marriage? This question is often heard amongst sexually active males. The socio-cultural expectation and hope is that love will grow after the marriage. Anecdotal evidence indicates that for many women and men, this only remains a hope.

Bangladesh is filled with romance, always visible, always present. Watch any of the ubiquitous Bombay style films. The hero and the heroine sing romantic and chaste love songs to each other. They go through the trials and tribulations that the three hours demand, and if their families will agree to the match, then they can get married and sexual fulfilment will follow. The key is if the families agree. For if such romance cuts across race, religion, class, or economic group, then the likelihood will be that such a romance cannot be fulfilled. The family wins.

In terms of Bangladeshi cultural norms, direct relationships between men and women before marriage, social or sexual, are frowned upon and socially unacceptable. Such socialisation is seen as increasing the risks of dishonouring the woman's family. While men are seen as naturally lustful and uncontrollable, young women are seen as being able to arouse that lust. Women must be protected from men's lust, whilst men must be protected from "women's wiles" to generate that lust.

In Bangladesh the public domain is owned by males. For a woman to be seen with man who is not a relative or husband can create damaging and dishonouring gossip. Families will police their young women. To be seen out in the evening on her own as a woman, can give her the label "an evening person", a prostitute. To kiss a woman who is not married to you, or hold her hand in public, is to risk dishonouring her, and in some cases the man may also be at risk of abuse and violence. Physical affection for a woman, if any at all, must be behind closed doors. But if there isn't that privacy available....?

For many young males, women are just not accessible. Romantic longings are at a distance, unfulfilled, and chaste. Visits to female commercial sex workers are not romantic and love does not enter the equation. It is just sexual release, quick, with a cash transaction which for many males, may be beyond their financial reach. The visit to the prostitute will be infrequent after saving the necessary amount. For the many urban males, these are the only socially sanctioned females sexually available.

For many males all this emotional and sexual energy, and romantic longing and affectional needs, tend to be channelled between themselves. Intense friendships are formed within homoaffectionalist frameworks which includes extensive male to male touching, holding of hands, body contact, and sleeping together in crowded spaces or in shared accommodation.

This does not imply that all males in Bangladesh are having sex with each other! Bangladesh, as a male homosocial culture where women are difficult to access either for friendship or for sex, has male social spaces where it is acceptable, if not encouraged, for males to show affection to each other, both publicly and private.

Despite these intense friendships which produce visible physical affection between males of all ages, and which

sometimes may well led to sexual acts between friends (and if there is an age difference between the two males, the older one may penetrate the younger), and where such feelings may be defined in Western terms by the word "gay", this identity is just not there in the person. Sex with another male is not so much a permanent feature but an additional outlet. The constant expectation is that one day the person will be married and have children, and that perhaps on occasion, they may be able to afford sex with a female prostitute. Here sex is discharge.

Discharge Sex

This is primarily based on releasing sexual tension, and is primarily opportunistic and immediate. There are many males who will visit specific locations when they feel sexually "hot", because they know that there will be other males present whom they can penetrate. Or males will be directly approached by a koti for sex in any number of situations. Situational sex is prevalent here in a male social spaces, i.e. restaurant owners who will sexually penetrate table boys, and so on. Many males will use koti for semen discharge at any opportune moment. These males may also have sex with females other than their wives if they are married, and may often visit female sex workers when they can afford it.

"what chance have I got to go get a girl. It is too expensive. I have to send all my money to my family, and I don't have enough to buy any nice clothes for myself. What girl would want me? One day when I am older, my family will find me a girl, but that is many years away. Now is important. I get 'hot', the boy next to me gets "hot', then we do. If he is younger than me I fuck him. If he is older, he fucks me. I like fucking, so I try to sleep next to a younger boy. It never takes long."

Gift Sex

This could be seen as a form of male prostitution which will range from gift payment for sexual service to sex as a barter mechanism for small gifts such as a piece of clothing, a present, or even a meal or sleeping space.

Male prostitution certainly exists in Dhaka at what appears to be relatively high, but at as yet undetermined levels. However, the sensing was that gift sex was more prevalent than that of full time male prostitution. Where such male sex work exists, many of the boys are gendered through effeminate behaviour and are also called kotis.

Gift sex is casual, opportunistic, unplanned, whereas male sex work for money is the opposite. A lot of gift sex appears to be happening in hotels and guest houses through room service and house-keeping, through assignations made in restaurants and tea-shops with table boys and waiters, through massage boys and young barbers, through chance encounters with cycle rikshaw and auto-rikshaw drivers, through street males needing food or shelter. Much of this appears to be because of low income issues, but evidence exists of discharge and desire based frameworks as well, operating through such opportunistic encounters. The exchange of gifts can frame a mutuality of desire with sex as one side of the gift exchange.

Latif is a cycle rikshaw driver. His net income is about 1500 taka a month. He is 27, has a wife and three sons living in his home village in Comilla. He sends about 400 taka every month.

" There was this man, younger than me. He was very nice. We did sex. He started talking to me about my wife, and how can I stand it without my wife, and things like that. I could guess what he wanted but I said nothing. But he was making me feel "hot" , you know, and it started getting strong. When we stopped, I got of the rikshaw and stood so that he could see my cock through my lungi. That's how it started. We went to this nearby construction site and did sex there. After that he took me to the bazaar and bought me a new lungi and shirt.

In one month I will get this opportunity perhaps 2 or 3 times. I like the sex as well. Also every month, I go to one of the girls in my area and have sex with her also. But this costs me 50 taka. This way I get more sex, I get a gift or money, and I get to release my "body tension[2] ".

" Oh, I like sex, whenever I get it. Sometimes, if a rich man want sex with me when I am driving my rikshaw, he will buy me a shirt of something after we do sex. An added bonus."
Salim, rikshaw driver, 16

" OK, the hotel guests will sometimes give me a watch, or a nice shirt, or perhaps a pair of jeans. I don't earn enough money in my job to get these things. The sex is fun, but the extras are worth it."
Mohammed, hotel waiter, 25, married

1. Homosocial - the term homosocial is used to mean a social framework of strong male bonding or female bonding, and gender segregation of social spaces.

For example in Bangladesh, it is very common to see two women or two males holding hands, or putting arms around each other, of sharing beds, sleeping together, and so on. At the same time, the public space is socially owned by males. Sufficient anecdotal evidence exists in the work that I have done to indicate the boundary line between homoaffectionalism and homosexual behaviours, particularly "under the blanket" in the shared spaces. See Khan's chapter Under The Blanket in Bisexualities and AIDS, edited by Peter Aggleton, Taylor and Francis, 1996.

2. Body tension - a term often used to signify an erection and desire for semen discharge. Another term used in Dhaka was "my dhon is strong" - my penis is erect.

AND OTHERS....

Hotel staff

A total of 20 hotel staff from 3 different hotels were interviewed.
5 room waiters
8 housekeeping staff (including room cleaning and lobby staff)
5 reception staff
2 security guards

These discussions were held at a local park during the day time. Whilst conversations related to general topics, sexual issues could easily be discussed once a friendship and trust had been built.

The average age of these hotel staff was 19-25, all having finished school and were literate, whilst several were able to speak English to varying degrees.

1. 15 our of twenty of these staff were currently sexually active with others.
2. 12 of the staff have had sex with other males, either in their village and/or in student hostels. For 8 of the staff this included anal and oral sex. For the 4 others it was only mutual masturbation or thigh sex.
3. 8 of the staff have had sex with male hotel guests, usually for cash of gifts, but sometimes because they liked the guest, and responded when the guest made a sexual contact. This involved anal sex, oral sex, thigh sex and masturbation.
4. All these staff masturbate themselves regularly to "release night pressure".
5. 15 of the staff have had sex with females, usually a girlfriend in the village. 4 had girlfriends in Dhaka. In the villages, vaginal and anal sex was practised. In Dhaka, this sex was usually "breast pumping" and masturbation. "Its hard to find a space to do "real sex" was one comment.
6. 2 staff use female sex workers twice a month.
7. 5 stated that they never had sex with either male or female
8. No condoms were ever used except by those using female sex workers.
9. None of the staff involved in male to male sex saw themselves as homosexuals or "gay". All saw male to male sex as "not real sex", but "sex" as a way of releasing "body tension, as "play".
10. None of these staff were married
11. None of these staff felt ashamed about their sexual behaviours. Shame would only arise if others found out. Those sexually active staff believed that no one else in the hotel or their family or friends knew about their sexual activity.
12. None of the staff had close friendships in the hotel with other staff.
13. None of the staff admitted to having sex with another staff member. This would be difficult they felt since the staff quarters were shared accommodations. However, certain comments were made to indicate that at least mutual masturbation did go on late at night. There was no privacy, except in the toilets.
14. Those staff who stated that they were not involved in any sexually activity on further questioning felt too "shy", or "ashamed", or "don't know how to go about it", or "to frightened of causing a problem once they got married". They would like to do sex (they never stated with what gender), but were self-disciplined they stated. However they did masturbate regularly.
15. 3 of the staff involved in male to male sex visited parks to meet other males on their day off.
16. None of the staff, including those who stated they did not have sex, felt that male to male (or as they called it *boy-*

boy sex or *chela-chela* sex) was intrinsically bad or wrong. They understood it as a sexual need and release. However, all felt that a girl who had sex before marriage was not a "good girl".

17. Several of the staff asked about *girl-girl* sex, where two used the term lesbian. The interest was one of curiosity and there appeared to be no judgement.
18. The word gay and homosex was only used by 2 of the staff. The others talked about *boy-boy* sex.
19. All these staff expressed personal concerns about the shape and size of their penises, about possible physical consequences of their sexual behaviours, and expressed the range of sexual myths existent in Bangladesh, i.e. masturbation causes weakness and deformation of the penis. Further sex diseases were seen as a curse or could be cured by drinking certain potions, and that females are vectors of disease.
20. 4 of the staff stated that they had sex with boys because it was safer than having sex with females.
21. One staff person stated that he had sex with boys because he wanted to remain a virgin until his marriage as demanded by the Qu'ran.
22. None had any knowledge of STD/HIV/AIDS, although some of them had heard the term AIDS before.
23. Discussions with these staff about other hotels indicated that behaviours were not significantly different. At some of the higher star hotels taxi drivers located outside the hotel also acted as "pimps" enabling guests to have access to males to females for a fee.
24. In most hotels there is no suspicion in taking a male into your room. However if you take a female into your room it is automatically assumed that she is a prostitute and may well be barred, and unless a payment is made to the appropriate person or you can prove otherwise.
25. There appeared to be a constant sexual tension within these staff. Their fears about their sexual ability and capacity, their penis size and shape seemed to require constant reassurance that they were "normal" and could function even though they masturbate or have sex before marriage.
26. Many of the staff watch blue films regularly, which are easy to get hold of locally.
27. All these staff expressed psycho-social issues and problems around sex and sexual behaviours, describing a series of psychological and physical symptoms relating to penile size and shape, ejaculation frequency, content and type, masturbation, vaginal and anal sex, lack of sexual knowledge, anatomy, females, desires, discharge, and night discharge.
28. One room cleaning staff has been taking homeopathic remedy since the age of 12 because of night discharge. Recently married, but cannot get an erection. He does not masturbate but admits to having had thigh sex with other younger boys, and also anal sex. He is constantly worried about night discharge. His doctor has prescribed mega doses of Vitamin B

M was a graduate working in the hotel, aged 24. He had been working in the hotel for the last 8 months, coming straight from his village to the hotel. He got the job through a "relative" from his village who was also working in the same hotel.

M had been sexually active since the age of 13. His first sexual encounter was with a female neighbour who was also thirteen. He had sex with her regularly for three years until she got married. He has had sex with other girls in his village until he came to Dhaka to go to college, but not very regularly. After college he went back to his village until he came to Dhaka to work in a hotel. He has not had sex with a female since he was 18.

He has had sex with his male friends since he was 16. He said,

"Have I done it with any hotel customer? Twice so far over the last six months. Both accidentally. Both times I was called to the guest's room. On each occasion the guest had a sex book on his bedside table, and I was invited to look after the query was done. Of course I would get 'hot' and I knew the guest could see my erection through my trousers. Then the guest would say that he could relieve me, so I let them. I fucked both of them. It was OK. Used a condom? No why should I? You get diseases from girls not from men."
Tofil, 23, house-keeping

" I like the foreigners, you know Arabs, Japanese, Indians, sometimes Europeans. They always give me a nice tip and often will buy something nice. I can always tell when they want sex with me. Then I usually hang about the room for a little bit longer, make a sign, and usually they respond."
Shaidal, 21, room service waiter

Says, Salem, a housekeeping "boy" working in a hotel in Dhaka:
"Its very hard to find a girl who will give you sex, here. Everybody watches what a girl will do, who she is with and so on. I have been having sex with my friend since we were 13. We had been sharing a bed in my home in our village, and he started holding my cock. Well it was nice so we did. Then I came to Dhaka to go to a school here and the boys in the

hostel were all doing sex with each other. We would watch a blue film, get hot and then start to play. Sometimes we would save up some money and go to a woman prostitute. A clean girl, but very costly. Girls here don't give you sex. You can kiss them, you can "breast pump" them, but getting it inside. Very hard and difficult with no privacy. Then I started working here at this hotel and this hotel guest offered me 100 taka for a massage. Well money is money. So after my duty shift I did it. The man was only wearing his under-shorts when I came in. I started the massage and he got hard very quickly. He offered me more to shake him. So I said whatever, and did. I got 200 taka from him. Now I get perhaps 3 or 4 hotel guests a month. Sometimes they want to fuck me, sometimes I fuck them. Sometimes its thigh sex. Its great. I get regular fun and extra money. I know there are several other boys who also do this, and I have a friend in this 5 star hotel who gets quite a lot of money this way."

Male Street Children

Discussions were held with 10 male street children between the ages of 8 - 14 years over a period of two months, where these conversations would also include their sexual behaviours following a period of trust building. This was also facilitated by one 13 year old boy who appeared to be some sort of leader amongst the other boys. S. was very authoritative, 'bossy' and at times aggressive. At other times he expressed care and attention to the others.

Results

1. All were homeless.
2. 5 were orphans.
3. 5 had run away from home because of family violence.
4. They earned their living by begging, doing odd jobs, thieving, or selling sex.
5. All sold sex usually for between 10-50 taka depending on client's ability to pay, but usually it was at the lower end of the scale, and usually older street boys, street workers, porters and railway workers.
6. All have been regularly anally penetrated.
7. Condoms had not been used
8. Use of drugs was common, primarily "phenysdyl", but some of the older boys also used ganga.
9. The boys spoke of a number of older boys sharing needles for drug use
10. Four of the older boys, i.e. 13-14, stated that they have had vaginal sex with some of the street girls. This usually costs them 10 taka.
11. The boys are sexually active amongst themselves as well, with the older boy penetrating the younger boy.
12. The boys reported a great of physical and sexual violence against them by older people, police, officials and others.
13. 6 of the boys reported cases where they were forced (raped) to have sex
14. The boys were malnourished, dirty and under-clothed.
15. They appeared to have little access to washing facilities.
16. Whilst the boys all put on a bravado act, in several instances and in some of their responses, it was obvious that they desired some sort of affectional support from a "family" structure and love. The boys social support system comes from the other street children.
17. 6 of the boys reported previous STD symptoms
18. 7 of the boys reported anal bleeding
19. 4 of the boys reported current STD symptoms
20. All the boys believed that society had disowned them, so why should they care. They were hungry, without a home or clothing, and people just spat at them. Who cared for them?

"I don't know my age, maybe ten, maybe nine. It doesn't matter here anyway. I ran away from home perhaps four years ago? Anyway, I landed up here at the railway station. I haven't been in touch with my family since then. My father always would get drunk and then beat me. I had a younger brother than me when I left home, probably there are more now.

We beg here, a few taka here and there every day, from passengers coming on the trains. Or we can help the passenger with his luggage and get a couple of taka. Or we can take things, you know, wallets, purses, handbags. But that is a bit risky because of the station cops.

I am part of a gang here. We look after each other. I first joined the gang when I got here. Fazlul was the boss. He was 12 then I think.

We all sleep together you know, huddled closely. The first time Fazlul did it to me was when I was perhaps seven. Fazlul must have been 14 then. He asked me to sleep next to him. It was cold and we pushed together to keep warm. Sometime in the night he woke me. I could feel his thing really hard. Fazlul told me to be quiet and he would do something nice to me. He asked me to hold his thing and move my hand up and down. He was the boss. So I did it. And then I felt this warm, sticky feeling on my hand. Fazlul told me what it was, and then turned over and went to sleep.

Many of the boys here do this with each other. Sometimes they fuck each other. Sometimes they fuck the girls too.

Fazlul showed me where men go to do it with each other, or with the street boys here. They can make money from it also. I have done it for money also. I can only get maybe 15 or 20 taka a time. Usually it is a coolie or rikshaw driver. Sometimes they want me to shake them, sometimes I have to suck, and sometimes they fuck me. I don't like the fucking because it is painful, but I get more money for that. I have to give some money to Fazlul though every time. He is the boss."
Mohammed, approximately 10, railway station

Male Domestic Servants

A considerable amount of sexual activity between male domestic servants, as well as between male domestic servants and their male patrons, including adolescents was reported by several of the respondents in the surveys. In one family, the 30 year old male cook was penetrating the 13 year old male house boy who was also soliciting sex from outsiders, whilst the 20 year old son of the household admitted being sexually penetrated by his father's driver when he was 11, the sexually activity continuing for several years. Who seduced whom appeared to be a debatable point.

"One evening I was in my room. I must have been about fourteen. We had just taken on a thirteen year old boy as a servant. The evening meal was over and I was doing some homework. I began to think about my uncle who had just left for Dhaka a few days before. I began to get hot. I started to handle myself through my lungi. I decided to call our servant boy and the excuse I used was to bring a drink to me and to tidy my room. I said this loudly enough for my parents to hear. When the servant boy came in, I stood up and he could see my penis was hard through my lungi. I asked him to close the door. As he moved to begin to tidy my room, I went to him and put his hand on my cock. I put my hand on his cock too and felt it grow hard. I said now that we are both hot we have do to do something. He was resistant at first, but I told him if he didn't do it I would make him lose his job with us. We then did oral sex together, and then I fucked him.

We did this at least three times a week. After a year he left. Our next servant I didn't like very much so I never tried.

I have always like sex, particularly anal sex. No, I haven't used condoms before. I always have sex maybe three times a week. Usually with different people. Now I am a teacher, sometimes I do sex with students from my school. Sometimes I pick people up from the park, and bring them to my home. Since I have come to Dhaka I am never short of finding people to have sex with. "
Arif, 27

Rikshaw drivers

The following conclusions were drawn from a series of conversations with 8 rikshaw drivers between the ages of 17-35 years.

1. All were sexually active.
2. All had visited female sex workers
3. None knew of HIV or AIDS
4. None used condoms
5. Out of the 8 drivers, 6 have had anal sex with women
6. 3 were married
7. None had ever gone to an STD clinic
8. All had come to Dhaka from villages
9. 5 have had sex with other males in their villages
10. 4 have had sex with males since they came to Dhaka
11. 3 stated that they only penetrate, and 2 stated that they penetrate and also are penetrated.
12. 4 have done oral sex with other males
13. 5 reported previous STD symptoms of discharge and "fire" in the penis.
14. Currently none reported a symptom
15. 3 have had sex with male passengers who "touched me and I got hot". This had happened several times a month. The customer routine was to make friendly chat, then ask if the driver is married, and if not what does he do for sex. If driver is married, the customer will ask whether he gets enough sex. After this talk about sex, the driver gets "hot". When the customer gets off the rikshaw, the customer will either touch his leg or brush his hand against the driver's penis. Negotiations then ensue as to where they can have sex, and if there will be a fee/gift involved. Sometimes sex is at the customer's home, and sometimes at any nearby park, alley, construction site.
16. All 3 stated that they had been penetrated by the customer, but sometimes they would also penetrate the customer.
17. Monthly income was between 1500 - 3500 taka
18. The drivers reported that the age of their first sexual encounter was between 14-

19. The gender of the their sexual partner was
    2 female
    6 male
20. Age of their sexual partner was between 14-35
21. The sex act was:
    2 had penetrative sex with females
    3 had been penetrated by males
    1 had sucked the other males
    2 penetrated the other male
22. Relationship to the partner
    1 friend
    3 cousins
    1 male prostitute
    2 uncles
    1 neighbour
23. currently 6 have paid for sex with female sex workers
24. Over the last six months, the rikshaw drivers reported and average of 20 sex acts.
25. The drivers were living with
    family 2
    shared rooms 6
26. None new what HIV was, but 3 had heard that AIDS was a "dangerous disease you catch from women".
27. Central concerns reflected money and family issues

Reported from a rikshaw project in South Dhaka
1. only 20% live with family
2. 80% live in shared accommodation (mess rooms)
3. some of the garage managers and mess managers are MSM
   they get unemployed boys working as commercial sex workers near ....
4. sex happens in mess and garage
5. rikshaw drivers rather do it on the street from late night up to dawn and do it in gang

Truck drivers

Several workshop participants and other males reported that they often go to truck stops to have sex with truck drivers, usually anal sex where the truck driver penetrates the other male. Certain truck stops have a notorious reputation for the easy sexual availability of truck drivers. Condoms are used very rarely, and if so, they are at the insistence of the partner being penetrated. Most of the drivers are married, many with children. They are away from their wives and female sex workers cost money. It was also reported that many of these truck drivers also have sex with their helpers.

The following information was obtained from interviewing 8 truck drivers.
1. Age range of interviewees was between 26 - 40
2. The truck drivers lived with
   a. wives and family 3
   b. mess rooms 3
   c. alone 2
3. Monthly income ranged between 5000 Take to 20000 taka
4. Age of first sexual encounter
   3 at 14
   3 at 15
   2 at 18
5. Gender of partner
   5 were male
   3 were female
6. Sex act with first partner
   1 was thigh sex
   5 penetrated partner
   2 were penetrated
7. Relationship to first partner
   1 was brother

1 was female prostitute
1 was male friend
5 were cousins

8. Age of first partner
   2 were 10 years old
   1 was 13
   3 were 15
   2 were 17
9. Currently 6 are paying for sex
10. Average number of sex encounters in the last six months was 15
10. 4 did not know anything about STDs
11. 4 did know anything about HIV
12. All defined AIDS as a dangerous disease you catch from women

"I started doing sex when I was thirteen. First it was my older cousin-brother, then I did it with my uncle, then I did it with my female cousin. I also used to have sex with my friend who only lives two houses from me. All this happened in my village.

When I came to Dhaka I started helping out at the truck stop. I was 'adopted' by one of the truckers, and I used to clean his truck as part of the deal. I also had to be available for him to fuck me sometimes.

Then I started to learn to drive a truck, and this malik took me on as a driver. Now I work for him. I save money so one day I can get my own truck. I still do sex, but now I can afford women. I still do sex with boys, usually my cleaner. But sometimes this girlish boys come around here and offer sex to me."
Arif, driver, 29

Tea shop/restaurant "boys"

Conversations were held with 6 boys who worked in tea shops or small restaurants, where after a period of trust building there could be some brief discussions on issues around sexual behaviours. The ages of these boys were between 13 and 18 years old.

1. All the boys had come to Dhaka from villages looking for working.
2. They found work by going from restaurant to restaurant asking the owner, or through a village friend/relative who also worked in the same place.
3. All the boys sleep at their place of work with other staff, usually in one room.
4. What money they earn they send to their families. Usually the younger boys earn about 30 taka a day with food and lodging provided.
5. The boys work seven days a week, but can get time off to visit their families.
6. There were younger boys working in their teashops and restaurants, some aged as young as 8 or 9.
7. 2 of the boys stated that they had to have sex with the owner before they could get a job. They both stated that this still goes on about every one or two months.
8. 3 of the boys said that sex between the boys goes in the restaurant/tea-shop at night after closing.
9. The sex is usually anal.
10. Condoms are not used.
11. After a lengthy process, all the boys stated that they have had sex with another boy. The oldest stated,
    "What chance have I got to go get a girl. It is too expensive. I have to send all my money to my family, and I don't have enough to buy any nice clothes for myself. What girl would want me? One day when I am older, my family will find me a girl, but that is many years away. Now is important. I get 'hot', the boy next to me gets "hot', then we do. If he is younger than me I fuck him. If he is older, he fucks me. I like fucking, so I try to sleep next to a younger boy. It never takes long."
12. All the boys said they masturbated. One said
    "look we never get a chance to play, to go to the cinema. Always somebody is yelling at us, or hitting us around our heads, or making us do things. What pleasure do we have in life. It is always work. To have 'mal out" (ejaculation) makes my body feel nice and I can sleep. What is wrong in that ?"

Khobir is 14 years old works as a table boy in a small tea shop/restaurant in Shantinagar, Dhaka. He has been working in the shop since he was 8 years old. He came to Dhaka with his oldest brother who is a rikshaw driver.

Khobir lives in the tea-shop with the other boys who work there. There is an age hierarchy, the young boys cleaning the tables, then those older serving the tables. There are several boys who are in their late teens and early twenties. None of the boys working in the tea-shop are married, except for the owner who also sleeps in the tea shop.

"My brother first fucked me when I was 5 years old. I was the youngest and he was the second oldest at 15. He would do this about twice a month.

It was my oldest brother who took me to Dhaka. He had already been in Dhaka for several years and worked as a rikshaw driver. He had a friend who worked in this tea-shop and that is how I got this job. I earn about 500 taka a month and I send 400 taka a month to my family.

When I first came here to the tea shop and my brother left me, I was scared but I had a duty to my family so that was that. After a couple of months, one of the older boys called me over to him when we were going to sleep, and asked me to sleep with him. This wasn't unusual as several of the boys slept together under their blankets. When I got under the blanket with him, he started to pull my lungi up. I resisted, but he whispered that if I didn't obey him he would tell the owner I was a bad boy and I would lose my job. So I stopped resisting. I knew what to expect because of my brother, so when he started fucking me, I didn't make a noise. It was over in a few minutes and he turned around and went to sleep. This boy would fuck me 3 or 4 times a month. Some of the other boys would also fuck me. The owner has done it several times too.

When I was fourteen my thing grew large and I started fucking the younger boys in the shop.

Sometimes, a customer comes in who likes me and gives me a tip, maybe 5 or 10 taka. They usually ask my name and then go on to ask me to meet them outside later. If they are nice I do, and then we go somewhere and he fucks me. Usually he will give me another 10 or 20 taka for this. This money I save and send to my family every month also.

My family are very poor. They are farm labourers, and have no land of their own. My brother who is a rikshaw driver also sends money. My other brother is still in the village. The rest are my sisters. One of my sisters is already married, but with the other two we have to collect enough money for dowries. And that is a lot of money, easily 50,000 taka.

I would like another job which pays more money. I ask some of the customers quietly, especially the ones I do sex with if they can give me a job. I want to earn more money. Here I get very little time to myself. I work 7 days a week, usually from early morning to late night. I get some time to go to mosque, which is when I get a chance to meet some of the customers who want sex with me. I also want to save for my marriage when I get older, perhaps when I am 25.

I have never had sex with a girl, because there is no chance to. Where can I meet girls? And I can't afford a prostitute. So all my sex at the moment is with the boys in the shop or with some shop customer. I have had sex with a foreigner once. He was German and had come into the tea-shop. He was very nice to me. And I got a lot of money from him. He bought me some nice clothes as well. I was very sad when he had to go back to his country."

Overseas workers

" Many Gulf workers stay in all male hostels. Often the younger boys are sexually used by older males. The sex is mainly anal sex. No condoms are used. This is because meeting women for sex is very hard and can be dangerous. In the hostel it is easy for males to have sex with other males. A lot of masturbation goes on as well. Sometimes there is group sex where one younger boy will be anally penetrated by several men, one after the other, especially if he is pretty. In my hostel, all the men were doing it.

I have also had sex with local Arab men as well. I am walking down a street. A man looks at me, you know, the usual way when you know by his look that he wants sex, and then he takes me to his home for sex. It is always anal sex and they never use a condom."
(returned worker from the Gulf aged 25)

Students

" I live in a students hostel with about 50 other boys all aged between 18-21. Sometimes a group of about 5 of us hire a blue film and we watch it in one of the rooms, getting really hot. Then we have to do it. We masturbate as a group. Comparing, you know. Sometimes we do anal sex with each other, sometimes we suck. I don't think any of us thinks about using condoms.

We also have had sex with other boys as well. I think maybe most of the boys in the hostel has done sex with other boys at some time or another. But we don't talk about it.. Four us share a room, and we always are having sex with each other, almost every day. At least it is free. We don't have to bring girls back, which is impossible anyway. As for the hostel warden, well I know he likes sex with boys, so he keeps quiet. Not that he really knows what happens here."
(18 year old student living in a hostel)

"I have had sex with my teacher. He had invited me to stay on after school hours to help me with my studies. We sat together reading through a book, and he put a hand on my thigh and began to rub it. I didn't resist because he's my teacher. Then he moved his hand up my thigh. By then I had an erection. He felt it, and looked at me, and asked me to do it. If I agreed he would help me. He wanted me to fuck me. This happened when I was 14 years old."
Sopan, 19, male sex worker

"Look, I have several friends who have been to Madrassi schools. They have told me what happened to them. There is this one teacher at M....... who used to have sex with so many boys. Any age would do. Some of the boys were only 10."
Rafiq, survey respondent, 24

Foreigners

" You know there is this foreigner staying near the construction where I work. There are about five us from the same village, all the same age, working on this site. We are always together, and yes, when we were in the village and younger all of us used to play together, you know, handle each other. Much easier than having sex with a girl and less dangerous. Women carry so many diseases. And with my wife in the village, I am always needing it. Its the same with my friends. Anyway, one day I saw this foreigner watching us from his flat while we were working. His flat overlooked the site where me and my friends worked. He was only wearing shorts, and I could see clearly his 'thing' bulging from his shorts. It was definitely hard. Well that got me hot so I looked up at him and smiled at him. He smiled back and his hand went down there.

That evening when everyone else had gone to sleep I told my friends about this man. We all got excited, you know hot, so we all got up and climbed the stairs to the next empty floor. There we did sex together like back in the village.

The next day the white man was at his balcony again looking at us work. I smiled at him, and he beckoned him to go to his flat. I shook my head, because I couldn't leave the site. I didn't tell my friends. I waited till lunch time and then I walked to his flat telling my friends I needed to go for a walk. He was standing by the door and invited me in. I was nervous, but when I looked at the man's crotch I could see his thing was hard, so I knew he wanted to do sex with me. I also wanted to do sex.

He took me upstairs . He didn't speak Bangla and I didn't speak English. He brought me a cold drink and asked me to sit down. He sat next to me. He put his hand on my thigh and said in English hullo. From there we did sex. He wanted me to fuck him which I did.

The next day I brought one of my friends to his flat and we did sex. All my friends have now gone to him for sex."
(Bashir, construction worker aged 30)

Video games parlours

The growth of video game parlour in Dhaka over the last couple of years is astounding. Many young males go to these parlours to play the machines. Several males have reported that they sometimes can persuade boys at these parlour to have sex with them for a few taka which is then used for the games.

Pornographic films

"Look it is easy to get blue films. Most video shops which stay open late at night have them. And you can rent them for only 30-50 taka a shot. So what's the problem?"

One young man of 17 years, a student and English speaking, told of small groups of male students hiring blue films regularly, and then having group masturbation. If there were only two of them then they would possibly have mutual oral sex or anal sex. He also stated that he has had sex with older men, including anal sex whom he has met at restaurants, tea stalls, or just walking on the streets.

Shared accommodation: 'mess rooms'

" There are many young men/boys who have to share rooms in Dhaka. Rent can be very high and their income may well be low. Sharing rooms means that there are opportunities for sexual play. I share a room, and I have sex with my room friends. Sometimes we can't afford a girl, and we can't bring a girl back to our room. The neighbours watch and would make problems. So it's easy. At night maybe two of us get together under the same blanket and we play. Sometimes we may bring a blue film to our room. Then we all watch. At night we may then do a group. It all depends. No-one knows. No-one is watching."
Sunan, student, 24 years old.

This work did not look at a range of male to male sexual networks that included:
prison populations, both inmates and prison guards
police
military barracks
orphanages
boarding schools
Gulf workers
sailors

garment factory workers
business travellers

There is enough anecdotal reports to indicate that male to male sexual encounters occur within these frameworks at significant levels

FAMILY SEX

Intra-family sexual encounters between males is very common in South Asia, Bangladesh is not different.

Table 14 Relationship to first male sexual partner N=530

Relationship	Frequency	% of respondents
friend	116	21.89%
neighbour	82	15.47%
relative	265	50.00%
stranger	67	12.64%

Table 15 Actual family relationship N=265

Relationship	Frequency	% of respondents
older cousin	53	20.00%
younger/same age cousin	26	9.80%
father's brother	21	7.92%
mother's brother	39	14.72%
older brother	48	18.11%
sister's husband	31	11.70%
mother's sister's husband	14	5.28%
other male relatives	24	9.07%
father	9	3.40%

Here, as can be seen, the first sexual contact was primarily through a family member. These sexual encounters with family members will also continue in later years.

Table 18 Relationships to current male sexual partners N= 509		
Relationship	**Frequency**	**% of respondents**
friends	186	36.76%
strangers	369	72.50%
neighbours	146	28.68%
relatives	154	30.26%
domestic servants	47	9.23%
male sex workers	51	10.02%
paying clients	26	5.11%

Table 27 Actual family relationship N=154: multiple choice		
Relationship	**Frequency**	**% of respondents**
older cousin	38	15.77%
younger/same age cousin	45	18.67%
father’s brother	15	6.22%
mother’s brother	21	8.71%
older brother	11	4.56%
younger brother	35	14.52%
sister’s husband	24	9.96%
mother’s sister’s husband	14	5.81%
other male relatives	35	14.52%
father	3	1.25%

When K’s uncle visited his home in A.... a medium sized village in Comilla, he would always share the bed with him. There was no where else for him to sleep.

“I was about eleven I think, and I had gone to bed. I had my own room as the only son.

“My uncle who was 25 at the time came to bed. He had been married for a year living in Dhaka, and had come home to see our family, leaving his wife in Dhaka. I wasn’t asleep, but I pretended to me. I don’t know why I did this. My uncle took of his shirt switched the light of and climbed into the bed. When he got in he put himself right next to me. My back was to him and I could feel his cock underneath his lungi. It felt strange to feel his cock, but somehow it also felt nice. After about an hour of not moving, I don’t know what came over me. I felt tight. I slowly pushed back against him, and felt his cock was hard against my backside. Then he pushed against me, and I felt his hand on my thigh. I stirred pretending to be asleep, but without moving my position. A few minutes later, I felt his hand move slowly along my leg, lifting my lungi until it was raised to my waist. All the time he was pushing his cock against me. Then I felt his hand on mine and he began to handle it. He moved a little bit, and I felt him naked against me. He had lifted his lungi too. I turned to face

SEXUALLY TRANSMITTED DISEASES

The level of awareness regarding STDs, HIV/AIDS was generally very poor amongst the respondents, as were issues regarding safer sex practices.

Table 28 Knowledge of STDs/HIV/AIDS		N=530
Knowledge	**Frequency**	**% of respondents**
Good knowledge	27	5.09%
Poor knowledge	256	48.30%
No knowledge	247	46.60%

Good knowledge of STDs was defined as understanding the relationship between specific symptoms for sexually transmitted diseases, such as gonorrhoea and syphilis, and their connection to sexual behaviours. In terms of HIV/AIDS, good knowledge was understood to mean a clear understanding of the difference between HIV and AIDS and what the terms meant, the means of transmission of HIV, and methods of protection and safer sex.

The survey indicated that possession of "good knowledge" did not necessarily relate to income group and class. Of the 5% of the respondents who had "good knowledge" some 30% were from low income groups. These individuals' sexual experience included contact with foreigners. The remaining 70% stated that they got their information from literature, usually from abroad.

But 95% of the respondents had poor knowledge, or no effective knowledge at all.

In terms of HIV and AIDS, about 20% of the respondents had heard about AIDS, citing newspapers and friends as their principal sources of information. However, there was a great deal of confusion and mythology between HIV and AIDS. These included:

* you catch STDs and AIDS from dirty people
* you catch AIDS from having vaginal sex
* you are safe when you do anal sex
* you catch STDs from doing sex with females
* washing with lime water after sex will protect you from sex diseases.

Further to this were the usual mistaken beliefs about catching "AIDS" from toilet seats, mosquitoes, shared utensils, etc.

There was also the myth that you could be cured from STDs/AIDS by having sex with a virgin female, or a pre-pubescent male. Some 5 respondents stated this.

What was worrying was the number of respondents who did not believe that you can get HIV from anal sex with males. It appeared that what HIV/AIDS information was available related only to sex with female sex workers, so women were seen as disease carriers and vectors for HIV transmission. Sex with males was seen as safer for many.

Further, many middle class respondents stated that they were safe because they only had sex with those from the same class background. That is, that they only have sex with “clean men”. This reflected class prejudices very strongly prevalent amongst upper/middle class males, who labelled those from low income groups as “dirty” people.

Another issue that arose was that the term STD, or even sexually transmitted disease was problematic in terms of understanding. Very few respondents had heard of these terms. The phrase “secret disease” was more common.

Awareness of risky sexual practices was extremely low, if existent at all.

Table 29 Condom usage N=530

Condom usage	Frequency	% of respondents
never	351	66.23%
sometimes	146	27.54%
all the time	33	6.23%

As can be seen almost 94% of respondents did not use condoms at all or used them inconsistently. This is particularly worrying when over 40% of the respondents identified themselves as *kotis* - males who are penetrated - whilst a further 30% admitted that they are also penetrated with varying degrees of frequency, and a high proportion indicating multiple partners. This demonstrates the very high risk of STD/HIV transmission that many males who have sex with males take.

Reasons given for not using condoms were

no time
loss of feelings and pleasure
condoms are for family planning
how? - by the time he will put a condom on he will come
he won’t agree

Lubricant

Saliva appears to be the primary lubricant used, if any is used at all.

Table 30 Use of Lubricant		N = 530
Primary Lubricant	**Frequency**	**% of respondents**
saliva	323	60.94%
ghee (clarified butter)	170	32.08%
vaseline	164	30.94%
no lubricant	132	24.91%
cream	115	21.70%
motor oil	16	3.02%
KY jelly	10	1.89%

As reported from the focus groups and interviews, the methodology of sex also increased the risks taken. Many males who are penetrated reported rapid penile thrusts of the penetrating partner increasing risks of anal fissures and bleeding. Initial penetration was extremely quick and often painful.

Further, high numbers of males reported multiple partners, often several in an evening, with a rapid succession of males. This means that the penetrator was also increasingly at risk, not only from the potential bleeding of his partner and his possible STD/HIV status, but also from previous sexual partners whose semen would still reside inside the rectum of the person he was penetrating.

The issue of the wife's vulnerability seemed not to be a factor of concern amongst the married males, or those who would become married. It was rarely ever mentioned. Yet over 37% of respondents were married. None of them reported using condoms with their wives. Some 15% of the males reported having sexual encounters with other females, primarily female sex workers, and here too, no condoms were used.

Among the 32 workshop participants, only 3 knew how to used condoms correctly. This also appeared to be true amongst focus group participants and those interviewed. Over 70% of these males did not know how to use condoms correctly. This lack of education about condom usage is itself a problem that needs to be addressed.

One factor that affected condom use was the high level of anal sex taking place in public spaces where time and space is a critical factor. Location was important. Sex encounters usually takes place in the dark and for many, sex takes place in spaces where others are around. At the same time for many, penetration to ejaculation takes place within 5 minutes or so. Putting on a condom under these conditions could be difficult, if not impossible for some. A constant refrain from many males was the issue of "premature ejaculation". Many *kotis* spoke of looking for males who could last more than a few minutes!

It should be noted that there are no water-based lubricants packaged in sachets available in Bangladesh, use of which, with condoms, would make anal penetration safer. Further, there were no extra strong condoms available which also might increase the safety factor.

Sexually Transmitted Diseases

Incidence of STDs amongst males who have sex with males cannot be quantified, since no private or government clinic monitors male to male sexual behaviours. At the same time, no clinical service actual asks their patients about anal sex behaviours. The survey attempted to gather some information about experiences of sexually transmitted diseases amongst respondents.

Table 31 Experience of STD symptoms N=530		
Experience	**Frequency**	**% of respondents**
Yes	187	35.28%
No	343	64.72%
Piles	143	26.98%

Table 32 Symptoms experienced N = 187	
Primary symptoms	**% of respondents**
bleeding from anus	40%
burning around anus	24%
itching around pubic area	21%
pain or burning sensation during urination	15%
rashes around pubic area	15%
lesions around anus	15%
discharge from penis	11%
warts on penis	3%
lesions on penis	12%
jaundice	8%
several times multiple symptoms were reported	

The high level of piles was also producing bleeding during defecation and during anal sex. It should also be noted that genital hygiene amongst low income groups appeared to be very low due to lack of access to clean water and inadequate genital washing techniques. A saving factor here was the fact that 95% of the respondents were Muslim and would be circumcised, which aids keeping the glans penis clean.

Table 33 Previous treatment for STD infections N=530		
Experience	**Frequency**	**% of respondents**
Yes	244	46.08%
No	286	53.96%

Out of the 54% who reported that they had no previous treatment for STD infections, 15% (43 respondents) had stated that the did have previous symptoms. This means that the majority of respondents reported some form of STD symptom in the previous two years.

Table 34 Where did respondents go for treatment N= 244		
Location	**Frequency**	**% of respondents**
STD clinic	66	27.05%
Private	*44*	*18.00%*
government	*22*	*9.00%*
personal doctor friend	12	4.92%
street kobiraj	132	54.10%
friend's remedy	34	13.93%

Apart from the approximately 5% of respondents who sought advice from personal doctor friends, all others stated that they did not admit possible STD infection from anal sex with other males. Those who did go to STD clinics stated that they always would say that they had sex with a female sex worker. It should also be noted that 15% of respondents who reported previous STD symptoms (see table 34) did not seek treatment. None of the respondents reported having an HIV - antibody test.

MALE SEX WORK

There are no estimates as to how many "boys" sell sex to other males in Dhaka, whether it is for cash, clothing, food or shelter. Nor of how many male customers they may have. This would be impossible to obtain, but estimates given by several male sex workers in Dhaka range form 2000 - 10000. In conducting this survey at a range of sites, some 1500 male sex workers (*koti* -identified) were physically counted. There will be many more in other sites not visited, those from middle-classes, those with different identities, as well as those who operate irregularly, or opportunistically, or in hotels, tea-shops, restaurants, slum areas, bazaars, and other localised areas. Such male sex workers would include the full-time workers in many parks and other sites whose main income would be from selling sex, to those who do sex work but also have a regular job, whether full-time of part-time, to those who are students, rikshaw drivers, taxi drivers, truck drivers, hotel boys, tea/restaurant boys, and other service industries who may also offer sex when an opportunity arises for some form of payment as a supplement to their regular income. Further, many of the male sex workers we met spoke of anything between 3 to 12 sexual partners in any particular day. The number of customer events every week would therefore run into several thousands.

Table 35 Number of customers per week N= 30	
No. of customers	**Frequency**
1- 6	0
7-15	3
15-20	13
above 21	14

Making a simple calculation, and taking at the lowest end of the scale, 1500 male sex workers in Dhaka, who average 3 customers a day for 5 days week, for 50 weeks a year.

The total number of customer events would be: 1,125, 000.

In Bangladesh the majority of males who sell sex are considered "passive", sexually penetrated by other males. The range of sexual practices of these *kotis* selling sex was from masturbation of their customers, giving oral sex and receiving anal sex. Anal sex occurred always where there was a measure of privacy and space. A room, behind a bush in the dark, in a deserted construction site.

Table 36 Primary sexual behaviours with clients N=30	
Sexual activity	**Frequency**
giving oral sex	30
receiving anal sex	30
giving anal sex to customer	2
masturbate customer	30
customer masturbating you	2

Table 37 Where do you usually perform sexual acts with your customer N= 30	
Location	**Frequency**
parks	30
bus/railway stations	5
cars	5
customer's home	15
hotels/guest houses	20

These *professional kotis* service a broad range of males from different income groups, classes and educational levels. However, *civil kotis*, those who do not sell sex, especially those from the middle and upper income groups, will sometimes buy sex from a range of *panthis* who will oblige the offer. These *panthis* (labelled so by *kotis*) are not sex workers, but should be considered opportunistic sex workers. Such *panthis*, those who penetrate, could be students, policemen, soldiers, shop-keepers and assistants, teachers, rikshaw drivers, truck drivers, in fact any male who wishes to discharge through anal penetration, and who may need money or gifts to supplement his income.

Classifying males who have sex with males as gay men, homosexuals, or even as male commercial sex workers can be problematic. Whilst there were clear identities such as *kotis*, *panthis*, and even *do-parathas,* mostly these identities are spatially as well as behaviourally constructed. There were also not clearly delineated. That is whilst *panthis* and *kotis* both stated that their sexual behaviour was distinctly and always "one way", private anecdotal evidence indicated that these were just public statements to what were deemed shameful acts, i.e. for a *koti* to admit that he also penetrates, or for a *panthi* to state that he also gets penetrated was considered shameful and causes one to lose their identity. When two *kotis* have sex with each other it is called *chapati-chapati* and is likened to sisters have sex with each other.

Further often these identities are mobile and situational. That is there will be a site/park identity, a street identity and home/family identity. There is no continuity, where space, time, location frames a specific operational identity. And many *kotis* speak of exaggerating their behaviours, their *koti* identity, within a given location as a means to attract males.

Many *professional kotis* will also take oral contraceptive pills (easy to buy over the counter from pharmacies) as a means to increase the size of their breasts. They state that their customers like to squeeze their breasts while doing sex. In fact "breast pumping" is a common sexual behaviour whether between males or between males and females. Enlarging the breasts, the *kotis* believe, makes them more attractive to the *panthis.*

But this is usually done during the winter season where they can hide their enlarged breasts under a shirt or sweater from those outside the sex site. During the summer they will stop taking these pills to reduce their breasts to normal size as usually this is the time when they will often need to be bare-chested because of the heat.

The physiological and psychological implications, and any medical consequence, of males taking oral contraceptives need to be urgently explored. Many of the males identified taking such pills were under the age of 18 years.

At the same time, those *kotis* who are penetrated and receive cash or gifts are situationally within a context of family need, marriages, poverty, hunger and sometimes homelessness.

As stated previously, a majority of *kotis*, including those selling sex, had their first sexual encounter at a very early age, usually before puberty. Their first sexual partner was usually a male relative, an uncle, cousin, older brother, a male in-law, or perhaps a neighbour . Many *professional kotis* start selling sex at a young age.

From the initial sample survey of 30 sex workers, 53% started selling sex before the age of 16, whilst 60% stated that such work pays better than any other work.

Table 38	**At what age did you begin to charge for sex?** N = 30
Age	**Frequency**
11-16	16
17-21	12
22-30	2

The *professional kotis* spoke of their family needs and economic conditions. Getting cash or gifts for sex was a method of sustaining themselves and their families. Only 2 sex workers spoke of keeping all the money from sex work for themselves, but they would send the money from their regular jobs to their families.

Table 39	**Reason for doing sex work** N = 30 **(allowed a choice of up to 4)**
Reason	**% of respondents**
only work I can find	30%
I enjoy it	30%
most of my friends do it	30%
this is all I know	25%
pays better than other work	60%
I need the money	80%

Table 40	Do you have other work? N = 30
Response	**Frequency**
Yes	23
No	7

Average monthly income from sex work

2500-4000 taka

The family context and poverty were two major parameters that shape the marketing of male to male sex, whilst the issues of gender segregation, homosociability, homoaffectionalism, male power and social spaces, as well as male to male desires, shape the buying and the doing of sex.

There appeared to be few boundaries between the differing sexual dynamics. What boundaries did exist as such were based on social class, education, economic power and "feminine" gendered behaviours. *Panthis* and gay men do not socialise with *kotis* except - perhaps - in sexual environments. And *do-parathas* were seen as potential *kotis* by both *panthis* and *kotis*, or as potential gay men by other gay identified men, and were often more stigmatised than either in these park sexual/social networks as those who "can't make up their minds" or were "confused" or were "secret". These identities for many of these males, were also clearly separated by time and location. A park identity and a street identity, a home identity, a family identity, a marriage identity.

A majority of *professional kotis* (primarily those above 30 years), like the *civil kotis*, are married, often with children, while those who are not married will take it as a fact that they would get married at a later date. This is a cultural, social and religious obligation a necessity to sustain family honour and duty. However, getting married, being able to perform as a husband, maintaining the family create specific psycho-sexual issues of concern for the majority of the *professional kotis* .

Table 41	Age of respondents N=30
Age	**Frequency**
up to 16	2
17-21	10
21- 25	10
25- 30	6
above 30	2

Table 42 Marital status N = 30	
Marital status	**Frequency**
Not married	25
Married	5
Would get married	20
Would not get married	5

A significant number of *professional kotis* speak of a *koti* friend taking them to a particular park or other site for the first time where they discover male sex work going on. Often these *koti* friends were also selling sex at the particular site.

Table 43 Who taught you about sex work and to bargain? N=30	
Teacher	**% of respondents**
older male sex worker	60%
younger male sex worker	25%
self-taught	15%

At many sites there are emergent social networks amongst *professional kotis* operating at that site. Often there will be a *guru* (teacher, leader), a focal point of this network, usually represented by the oldest worker at the site. It is this person who acts as a social glue amongst the network, controlling site prices, dealing with the police and security, acting as "aunty" to the network, offering advice and information, as well as controlling the framework within which sex work operates.

When a new *koti* comes into a site he will be quickly absorbed into the social network and taught the rules of the site by a member (s) of the network.

This is not always true of all sites or of all *professional kotis*. Many are independent, or on the fringe of these networks, or working at a different section of a specific site. However, competition can be quite severe, and the networks reduce the levels of friction between *professional kotis* that could arise from such competition. Prices however tend to be consistent within a specific site.

I was 14 when I started coming to this park. The first time I came here it was early evening. It is close to my home and I had come to see a friend. Usually I would come in the afternoons. As I walked through the park, I saw several boys, you know, walking in that way. Some of them were even wearing lipstick. I was interested, so I sat down on a bench. Then I noticed a man go to one of these boys, talk for a few minutes and then go into the bushes, there.

Then just after that, when I was wondering what was happening behind the bushes, one of these boys came and sat next to me. We started talking, and he told me what was going on. He took my hand, looked at me and said that I could make money like this. He described himself as a koti and the men as panthis. He said he would help me. I forgot about meeting my friend and that evening I had my first client.

My new koti friend explained to me the prices, how to do in the park, who the panthis were. I got to know the other kotis selling sex., there are about 50 of them here every night. Between us we do about 300 men every night. I also get to see the other kotis, the one that do not charge. They have their own section of the park though, and we don't mix to much. They are all from higher up, you know students, shop-keepers and so on. They wear jeans and shirts, live in nice homes. Not like us.

I send something like 2500 taka a month to my family, and use the rest to buy make-up, clothes and help with the room rent and food. My husband thinks I give him the money from my job at the hotel.

I like it here in the park. We kotis stick together, help each other. There are some very poor kotis here and sometimes I will give them some money or buy them a gift, or give them food, when I have had a good week and have extra money.
Kamal, 21, professional koti

When I was 14, my father sent me to stay with my older brother in Dhaka There he was living with his wife and his two children. We only had one room and all slept in same room. I started working in my brother's cycle rikshaw shop, cleaning, bringing tea, helping to mend rikshaws. I had been in Dhaka for about 6 months when one of the rikshaw drivers took me to this park. It was a very large with many trees and bushes. It was in the evening and just growing dark. There were few lights in the park, and there seemed to be many men walking around. I could sometimes see two men go behind a bush, or behind a tree where it was much darker, then after a few minutes they would come out and move away from each other. I didn't know, but I sort of guessed what happened. Then my rikshaw driver friend took me behind this bush and did me. When he finished, we came out and he gave me 20 taka. It was the first time someone had given me money for doing this. He said he had to go just around the corner to see a friend, that I was stay here in the park and wait for him.

When he went away, I was excited. I now knew that men come to this park to do sex. I sat on a bench and within a few minutes another man came sat next to me. He asked me the usual questions, you know, where I am from, where do I live, what I am doing in the park. Then he said he wanted to do sex with me and would give me 50 taka. So I did it.

Now I have been coming to this park for the last four years. I have made many friends here, and am a koti like the others. There are about 40 to 50 kotis here in the park and we look after each other, help each other and so on. I make maybe 800 taka a week. Some of this I send to my family in the village. I still work in the shop. Because I had picked up some koti habits, the boys in the shop would also fuck me. But they don't pay. Maybe they would gift sometimes, or take me to the cinema. Without my sex in the park, I would not have enough money for myself and my family.

My sisters here have taught me a lot about sex. What to do, what not to do, who is dangerous, who to look our for. With them I have learnt to be koti which brings me more men for sex and more money. I walk this way, I use my hands that way, my voice I make higher.

It is like two lives, one is my park life with my friends, one is my street life with my job. I am like two people, and this gate is the line. Maybe I want to stop, because now I want to find a friend who I can be with as my husband. My other friend here, he has a husband.

Once this man came to the park, and he liked me. He said that he would fuck me, but then he wanted me to fuck him as well. I had not been asked to fuck anyone before. We went to a nearby guest house and we did sex. And I fucked him. I am not sure if I enjoyed it really. But I did not ask him for money. I felt that when the boy asked me to fuck him, I was honoured by his request. Me a koti. Fucking him was like being a man. Sometimes I think I am a man, but when I come to the park, I am not a man. I never told my friends here.

I will have to get married soon. This is a problem. What to do. For my family I have to marry. I have never had sex with a girl. Maybe I should go to prostitute and do sex with her just to see if I can do it. But I don't think so. I will keep putting my family off as long as possible. It is hard when everyone is saying get married, get married, all the time. I am only 18, but still they want me married.

How long will I come to park for money? As long as the men like to do sex with me and give me money. Sometimes I see a very handsome man, and I want to do sex with him, then I do not ask for money. I think maybe this man will choose me as his wife. Some men want to see me regularly, once a week, once a month, whatever. Sometimes I have been taken to the man's home, or he takes me to the guest house just around the corner. Maybe God will punish me, but what to do. I need money. My family needs money. They need food to eat. How can God punish me for that.
Kazol, 19

Most of the *professional kotis* shared similar needs. Food, shelter, clothing, love, affection, acceptance. "I want a husband, a real man who would love me and look after me. I would make him a good wife", was a constant refrain from so many of the *kotis* working the parks. "I only like "real men" was another. To receive or give anally or orally becomes the measure of one's identity.

Conversations held with 10 self-confessed male sex workers in one park area.

1. Location: a large park in the central area of the city frequented primarily by males .
2. Used also in the afternoons by male/female couples and to some extent by female prostitutes in certain areas of the parks.

3. Bathing areas used by "footpath" people. It was noticed that there was a significant degree of sexual play and teasing amongst the adolescent youths whilst bathing. There were no discussions with these bathers at this times
4. Used by males looking for sex with other males from 7.30pm till midnight.
5. They reported an average of between 200 -300 males visit the park in the evenings looking for sex.
6. All forms of sex will take place in the darkest areas, including anal sex.
7. Also the park was used as a pick up area where the males will go from the park to a another place, such a guest house, personal home, or car, for sex.
8. The park has some 30-50 male prostitutes working their every day
9. The youngest is 16 and the oldest 40
10. These *boys* are self-defined as *koti,* often calling themselves *professional kotis*
11. Prices vary for sex in the park - between 50-100 taka.
12. Outside park, the minimum stated was 200 taka.
13. However, if they like the client, the price would go down or the sex would be free.
14. The younger the *koti* the higher the price would be.
15. Indications were that for several of the *kotis* preference was for middle class clients(because of price?).
16. Working class clients have sex in the park, whilst middle class clients tend to have sex outside
18. The *kotis* indicated that they have a park identity and street identity which are different from each other.
19. There was a *guru* system operating, where all the *kotis* belonged to the social group within the park . The group maintains price levels and provides advice and support.
20. Reported use of condoms for anal sex by one of the *kotis* was 50%, but only outside the park. But he stated that he was an exception and the other boys rarely asked their clients to use condoms.
21. Most sex practised is anal where the *koti* is penetrated.
22. Average number of clients per night per person is 5-6
23. So on a daily basis average number of clients for the whole group would be 100-150
24. Other males come to the park to look for sex but don't use the male sex workers. They find sexual partners amongst themselves.
25. All the sex workers were from lower middle class/working class
26. Most of the *kotis* have other jobs also, i.e. garment factory worker, lift operator, shop assistant.
27. 6 of the *kotis* are married, 2 with children
28. 7 of the *kotis* in this group have used contraceptive pills to enlarge their breasts.
29. The *kotis* seem to experience some gender conflict and shame. They have 'sadness' because they believe they should have been born a woman.
30. However, several of the *kotis* stated that they also penetrate men when they are asked to, but they don't charge because this is seen as an 'honour' request.
31. 7 of the *kotis* in this group use contraceptive pills to enlarge their breasts. They stated that their clients like the larger breasts, which they squeeze while having sex.

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Rofiq

Rofiq is 24 years old and is a member of this group

1. He first had anal sex at the age of 12 with his 13 year old brother-in-law where he was penetrated.
2. Has been in the park for the last 6 years.
3. Has a day job as a lift operator in a major hotel.
4. When a customer takes him outside the park to a hotel, R. will charge 200 taka for anal sex and 250 for oral sex. Sex is mainly anal.
5. Rofiq states that he doesn't get an erection during such sex. The customer does not touch his penis or gives him any satisfaction.
6. He has a regular partner who buys him presents but does not pay for sex.
7. Rofiq calls him "husband".
8. He states that he can average some 10-12 clients a night on some occasions.
9. He has done sex in the park, primarily anal sex.
10. 50% condom use by customers outside park.
11. Inside park no condoms are used.
12. Uses saliva for lubricant.
13. Does not like the customer to use oil because penis slips in too easily.
14. Likes to feel slight pain on entry.
15. Has done group sex in the park with up to four men accessing his body at one time.
16. Used contraceptive pills for breast enlargement.
17. Clients also include local police officers who he charges only 10-20 taka. They come to the park out of uniform.

18. He states that he has had several Mullahs from local Mosques as clients. H always asks them to remove their *topi* (head-covering) as this will cause him some shame.
19. On average he states there are some 300 males who come to the park every day for sexual encounters/pick-ups.
21. The park *darwan*(security guards) has free access to the *kotis*.
22. While stating that he has never had an STD(described as anal sickness) he reports that other boys have had ulcers, sores, "and pimples" in the anal passage. They do not go to doctors because of shame. They use a range of ‘'homeopathic’ remedies, or sometimes will go to pharmacy for tablets which friends tell them about.
24. R. is articulate and intelligent, but has no knowledge of HIV/AIDS.
25. A person came to him for sex and told him he had AIDS. R. stated that he spread some sort of cream around his anus and this cured him from AIDS.
26. A few *hijras* also go to the park to seek clients. There are often verbal conflicts with local *hijras*.
27. Rofiq is a part of the social support group in the park amongst the *boys*. They also meet with other *kotis* in other parks and visit each other homes.
28. Rofiq states that all the *kotis* want to have "husband".
29. He states that his "husband" does not know he has sex with other males.
30. R. only does sex with older males. He feels shame if a person younger than himself asks for sex.
31. Ages of males accessing sex in park is 19 years and older.
32. Several of the *kotis* are married and Rofiq expects to get married to a woman one day. He is worried whether he can "perform" his "duty".
33. Rofiq uses the phrase "In the line" several times to indicate he does sex with other males.
34. Rofiq does not go to Mosque. He feels shame and guilt and wonders whether Allah will forgive him.
35. He works in the park between 8pm till midnight.
36. He lives with his uncle in a small room and he sometimes has sex with him as well.
37. He stated that police sometimes come to park and take money, but will also demand sex.
38. Generally, however police action does not happen very much. Usually they are warned by the *darwan* before hand.

Other stories

These life stories have been translated into English from their Bangla originals by Dr. Suman Lahiry. All names have been changed.

Rani, 15, is from Comilla and is the 4th oldest of 2 brothers and 5 sisters. He used to stay in M. slum where he came to at the age of 8. He was first anally penetrated at this age by a man of about 33, who was drunk and who picked him up from the street in front of his slum where he was sleeping. The man forced him to take the full length of his penis anally, and he was bleeding while he was being raped. Rani tried to scream from the fear and pain, but the man kept his hand over his mouth and threatened to kill him. After the man discharged, he paid Rani 10 taka. That was his first earning out of sex.

Very soon after this incident he started selling hashish and phencydyl, joining his room partner who was also from the same village and with whom he shared the bed. He also had to have sex with this older man.

He started selling sex since then and has been operating in SG railway station. Clients (*parees*) will take him to their rooms in the slum, open boggies in the railway station, inside launches (ferries) in dark corners and also in guest houses/ hotels. He has also had experience of street gang sex and he is really bothered about gang behaviour during sex. Gang members force him to drink their semen. Though he sells phencydyl, he has never had sex with hashish. But those who sexually penetrate him (mainly working class) take drugs and local liquor and hurt him a lot. He is really unconscious about cleanliness. He has no idea about STDs, HIV, or safer sex. I found that he has anal/rectal prolapse and an ulcer over it. He has used Dhol company ointment which he buys from the footpath.

He knows if he leaves his home, he will have to come to live on the street and will probably have to have a painted face permanently. He sells drugs although he says he doesn't want to. Ad he bribes security people through sex.

Biplop, 16, stays in Mirpur 1. He comes from Savar where his brothers and parents still stay. He is the youngest of 3 sons. In Mirpur he is learning embroidery in exchange for food only. He stays in a dormitory with several other workers.

He usually comes to R.P. once a week and earns what he considers a "good" amount. He tells his clients (if they ask) that he is 11 or 12. He gives oral sex and says that he can also take smaller penises anally. Because it helps him earn more he first wants to know about the size.

He came to know about this park through a *koti* he met in Mirpur.

He operates in a lungi and believe he has got an advantage over the "commercials" because of his younger age. He had his first sexual experience at the age of 5 or 6 with his older brother in the village.

As yet he has not been able to establish a sexual/romantic relationship with anyone, although he want to. "I would like to have a husband that would look after me" he constantly states. He has heard of AIDS but thinks himself too clean to get it. He never uses condom although he admitted that once his anus was torn.

Aarzoo is 21, and was born in Sirajdikhan, but now he stays in Maghbazar in Dhaka. He is very dark and so he deliberately puts on strong makeup and lipstick. Recently he was beaten up by a police and a couple of guards while he was operating wearing saree, makeup, and a wig. This is because he refused to go with them. "If I do sex with these police they never pay" he says. But in the end they always force him to have sex, or they take him to the police station and charge him.

He has never used contraceptive pills for building up his breasts (a practice very common amongst male sex workers in Dhaka), but he folds a cloth (*gamchha*) and keeps it under his shirt in a bra so that people can get confused about his gender. He also can speak in a very feminine voice.

Arzoo also works in a garments factory. Selling sex he says, is his pastime. He said that he does not demand anything before having sex, but while doing it, will ask for money, but only from men whom he thinks will cheat. He has never ask a client to use condom. He states that he has never had any sort of venereal diseases, but his anus has been torn on several occasion He state that it heals automatically, but he loses some of his "professional" days.

Shameem, 21, living in Gandaria was born in Srinagar. He came to Dhaka with his elder brother when he was 3 or 4 when both his father and mother died at that time(1979). He stays with his brothers, but the house is owned by his elder brother who is married.

Shameem works in a tailoring shop. A fellow worker brought him to the front of a cinema hall 1993. There Shameem found it to be a fabulous world of commercial sex. He and his work friend usually gossip at a table in a nearby restaurant, and they both operate around cinema hall.

He never loves anyone, never gets involved. He thinks its a luxury or outrageous for poor people, people like him. He has heard of AIDS, but no idea what it is. He gets anally penetrated without condom. He gives oral sex, but charges the same. Clients will take him to local guest houses/hotels for sex.

He does not operate in the parks because he thinks park operators are thought to be blackmailers.

In terms of STD's, he only knows that they can be transmitted through vaginal intercourse, and is represented by and ulcer on the head of the penis.

He stays with his younger brother in the same bed, and with whom he has had sex with. He may have to marry some day. He thinks himself a *koti*. He appears to be quite happy to take anal sex as a way of earning money.

Kalam,23, was born in Daudkandi, Comilla. He came to Dhaka three years ago for a job and started staying in his uncle's house in Noyatola, Maghbazar. He had studied up to high school, but couldn't continue due to financial shortage. He started with a part-time business and later joined a garment's factory, where gets 1800 taka per month salary.

He was introduced to the production manager of the garment factory when he started there and got sexually involved which developed into a deeper relationship. The manager is 35 and has recently married. Kalam now thinks he is being deprived of romance, but believes it is the moral obligation of his friend to make his wife happy.

Kalam does not like females. He only likes older males especially who can continue to do sex - anal sex (he called it *kopano* (digging with a spade) for long till he can ejaculate.

He is quite frank about his profession which developed around R.P. since he came to Dhaka. He had came with an older *koti* whom he had met on the street near where he lives.

Whenever he operates, he gets 50-100 taka per client, and gives oral sex and *putki vasa* (renting anus) usually in the darker

corners of the park. But he also admitted that he will agree to receive 20 taka if he "really likes the guy".

He usually does not like security guards and police as they treat him real badly and try to get sex free. If they pay him at all, it is usually no more than 5-10/ taka.

He likes to be penetrated. He does not like 'sucking' because he says "it chokes his throat", and he gets nausea and usually vomits when customers ejaculate in his mouth.

He once experienced tearing around his anus which eventually turned into an abscess and had developed haemorrhoids. It was so painful. Around anus there were ulcers from where discharge and bleeding continued over a period. He got it from an army captain who later took him to combined military hospital, where he received "12 lakh penicillin" and "Prednisolone injection"(?) and some capsules which he can't remember now. He has got piles (He calls it 'Gezz').

He has heard of AIDS. He used to keep condoms with him after he heard from a journalist that he might get AIDS from anal sex. This journalist had interviewed him in a tricky fashion, took his nude snap and got it printed and published in a weekly magazine (Tarokalok) with the heading "In the elite society of Dhaka, boy business is in top shape". He does not use condoms or asks his customers to use it. He has a strong dislike towards journalists as they will do nothing for him or other prostitutes, but will publish their names and will make money.

He does not trust anybody. He knows at least 12 *koti* prostitutes who blackmail, pick pockets while sucking and getting fucked. He takes contraceptive pills in the winter season only to develop breasts (3 strips over 3 months - November to January) and actually develops a lump which he later (after winter season) asks customers to break by biting and pressing in order to get back to normal size. When taking these pills he loses his erection and when he stops taking it during summer time (as in summer he has to strip off and get topless in front of family members and others) he again gets back his erection.

He is very anxious about financial problems and his relationship with his parents. He has a sister for whom he arranged a bridegroom and spent 13000 taka on the wedding occasion. He has to send money to his parents in his village every month.

He thinks people loose their erection if they masturbate and get permanently impotent.

He says that maybe he will have to marry if his parents, and especially his uncle, want. He wears a lungi whenever he comes to park and he comes to park almost everyday.

He used to stay in the park all night previously, where he used to wear salwar kameez and saree. Now he stays only in summer time. Guards on evening duty have sex in the evening. Maximum number of customers have sex then. Truck drivers do sex after midnight. Night guards and rikshawalas do sex after 3 am.

Kajol, 20, of Kaliganj now stays in Tanbazar, Narayanganj, with his sister and her husband. Recently he has rented one separate room for 400 taka per month.

He dresses in feminine style with *ghagra choli* and *urnah* and if asked says he has 100 names - say Sundari (beautiful). He has started to operate in this park for 1 year. He came to know about it when he first entered here with a *koti* fellow.

He has fallen in love on a number of occasions. But recently for the last one month he is love with a pharmacy doctor who is not as yet sexually involved with him.

He gets more customers in summer time. Winter is really bad for business, only police and guards dare to roam because of a fear of blackmailing which happens, he says, almost every night. He does not associate with a certain group in the park who are involved in such type of blackmail and blackmailing sex.

Prostitution is his only source of income although he states that many customers have not paid him after having sex. He calls himself *khanki hijra* and sometimes *koti*.

He calls his customers *Mama* (uncle), *Nana* (grandfather), *Dada* (elder brother). He has heard of AIDS, but never anything like STD or HIV. He thinks "homosexual" and other terms are terms used by upper educated class, which he is no part of. Regarding condoms, he thinks it is a threat for his business.

There are also middle class frameworks of males selling sex.

Arif is a student studying in university. He is 19 years old, comes from a middle class family, speaks English fluently, watches MTV, wears Maz jeans and likes ice cream.

"I was in this park one evening and this man approached me and offered me 200 taka for sex. I was feeling "hot" and I thought why not? The last time I had done anything like this with another guy was when I was 16, when over several months, I and my friend would play together. So I did this guy, got the money, and thought what an easy way to get some money. My parents never give me enough pocket money. So perhaps a couple of times a week I will come here. Here there are "good people", you know clean, come from my class. No "dirty" people here. I usually get taken to a local hotel, or sometimes to the guy's home when his wife or family are not in. Sometimes I will also go to nice, posh hotels and sit in the lobby. I know some to the staff in these hotels, and they sometimes will arrange a meeting with a particular hotel guest. I have to give them a percentage though. Or sometimes I get invited to sex parties .

With more experience and knowledge , and meeting the right people I can get 1000 taka a time. I usually spend the money on clothes or music, but I am also saving what I can for my future. My parents don't notice anything anyway. I tell my mother I have a part-time job. My father is not interested."

Sameer is also a student, 21 and from a middle class family. His father died two years ago, and his mother struggles to get enough money for his family and for Sameer to finish his college education.

"I have to do this if I want to finish my education, and get a good job afterwards My mother tries in her job, but it is a real struggle. If I didn't sell my arse, we wouldn't really have enough money for me to finish my studies.

How much do I get in a month? Well perhaps 10000 taka if I am lucky, but usually between 5000 to 6000. I know this other guy, a top-class model. Sometimes he can get 10,000 taka from a rich businessman or film star. He stays the night with him. This guy is going to introduce me to someone like that soon."

But in these frameworks, privacy, money, and other luxuries of the middle-class operate and the "sex workers" are less visible than those from the lower income groups. Middle class male sex workers organise themselves individually in different ways, through the telephone, through magazine adverts, through social/sexual networks, through parties.

STDS

All the *professional kotis* mentioned the speed of anal sex and the rapidity of penetration. From their statements, the average time was about 5 minutes for penetration and ejaculation. Penetration was immediate. Condom usage was extremely low, and levels of symptoms of sexually transmitted infections very high. Use of water- based lubricants was non-existent. What lubricants were used varied from motor oil to cooking oil, from vaseline to spit. On some occasions the use of Vick's vapour rub "because it makes the hole tighter" was reported.

Table 44 Do customers use condoms? N = 30

Response	Frequency	% of respondents
Yes	6	20%
No	24	80%

Table 45 Do you ask customers to use condoms? N = 30

Response	Frequency	% of respondents
Yes	3	10%
No	27	90%

Table 46	Current experience of STD symptoms N = 30	
Response	**Frequency**	**% of respondents**
Yes	11	37%
No	19	63%
Piles	23	77%

Table 47	Previous treatment for STD infections N = 30	
Response	**Frequency**	**% of respondents**
Yes	21	70%
No	9	30%

Table 48	Method of treatment	N= 21
Method	**Frequency**	**% of respondents**
Kobiraj	15	71%
STD clinic	6	29%

Table 49	Knowledge of HIV/AIDS N = 30	
Knowledge	**Frequency**	**% of respondents**
Good knowledge	3	10%
Poor knowledge	5	17%
No knowledge	22	73%

Sometimes it is hard. Each night, maybe 5 or 6 men come and fuck me. They are so fast, and they don't use anything, and sometimes I bleed. I always have problems there. Piles. Yes, I have had these diseases. I go to a friend of mine who gives me something. A few days, or maybe a couple of weeks, it goes away. I have heard about condoms, but many men don't want to use. Anyway, sometimes it is difficult in the park, you know to take time to put on condom. And who is carrying condom anyway?
Khobir, 25

Many *professional koti* complained of piles. Where they took notice of their symptoms due to personal discomfort, very few would actually go to a doctor for treatment because of shame. Further, in discussing some of these issues with a number of STD specialists in Dhaka, none had asked their patients, male and female about anal STD transmission.

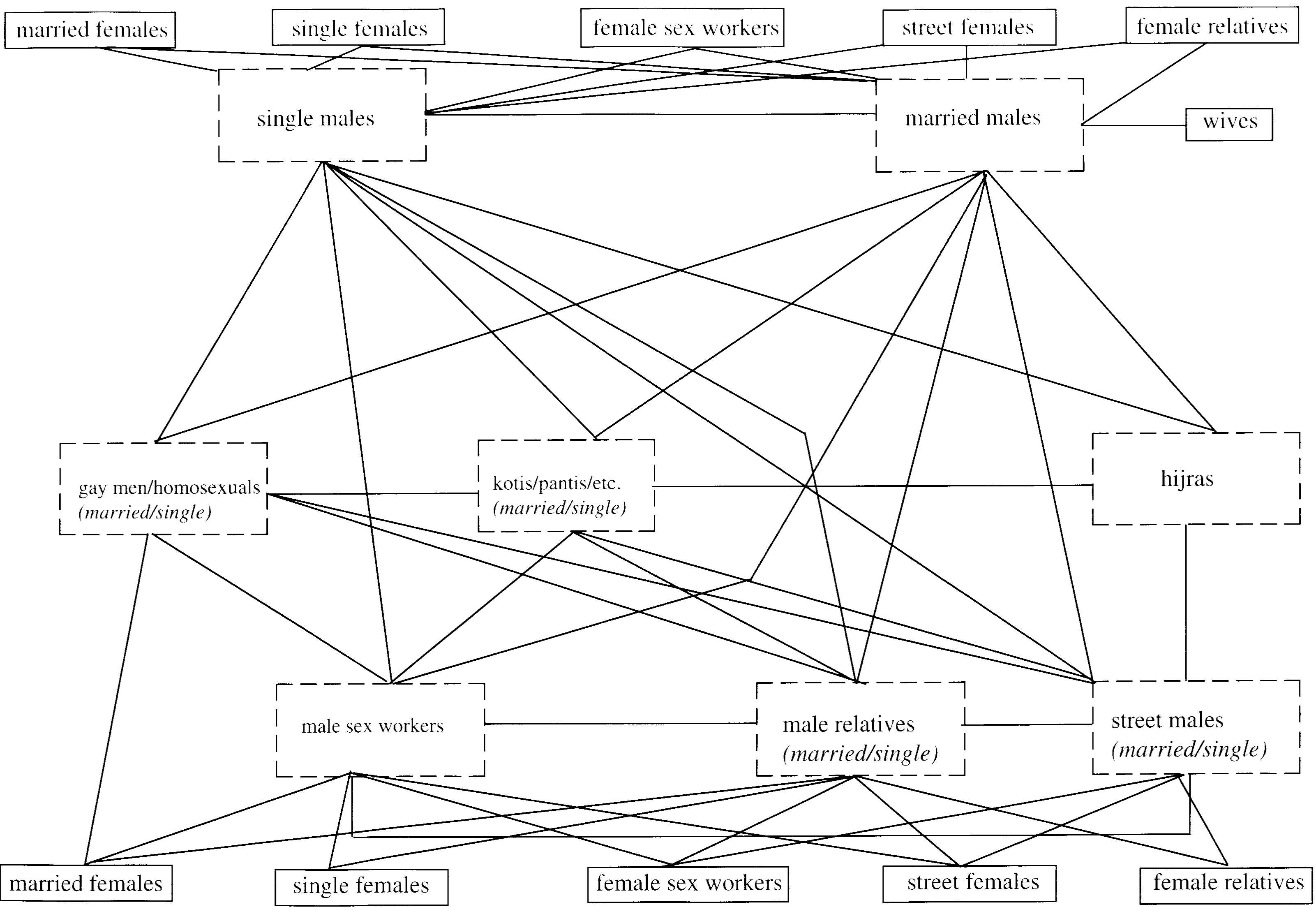
What the *kotis* will do, if they do anything at all, is to go to a friendly pharmacist or a "street doctor" - a *kobiraj* - and

take what is given. They may be lucky enough to personally know of a *koti/panthi* doctor, usually a client, and would go to them for treatment. But many of the *kotis* stated that they would follow whatever remedies their friends told them about. There was significant evidence to indicate that many of the *kotis* had a range of sexually transmitted infections, whilst continuing to sell sex.

Knowledge of HIV and AIDS was almost non-existent. Many had heard of AIDS but did not know anything about HIV. Several *panthi* clients I spoke to said that doing anal sex was safe because only vaginal sex with women was dangerous. This was what they had heard.

It can be clearly seen then that the risks of transmission of STDs and HIV are very high, not only from *koti* to *panthi*, but also from *panthi* to *koti*, and from *koti/panthi* to wives, other females, children and youth.

MAPPING MALE TO MALE SEX



PSYCHO-SEXUAL ISSUES

The following letters were received by a health magazine published in Dhaka, and is read throughout Bangladesh. None of these letters were published because of their content. This means that none of the respondents received answers to their queries.

The letters were randomly selected for their MSM content, but reflect a range of general psycho-sexual problems that many of the readers write about. Issues of penile size and shape, of premature ejaculation, and of anal sex have been a constant refrain from the respondents. These questions cause enormous psychological stress, and where certain physiological issues are raised, they don't treated or resolved, because too often the person is ashamed to address the questions to his local doctor, or the doctors do not have the knowledge, skills or desire to answer. Psycho-sexual stress, misinformation, and untreated sexual problems are a major concern.

The letters raise a range of questions regarding sex education, psycho-sexual counselling, and who can these men speak to resolve their medical, sexual and psychological issues. What skills are available within the medical profession to appropriately address the questions raised in these letters?

These letters were translated into English from Bangla by Dr. Suman Lahiry

Letter 1

I am 22, unmarried. I don't have any body hair or moustache. I have seen all of my cousins and friends. They have ancillary hair, chest hair, pubic hair and even hair around anus, even at a very early age (around 16). The size of my paternal cousin's penis is 6". My one is only 3". I have heard that I am the premature baby of my mother. Am I in a wrong gender? People tease me. One of my cousins forcibly had anal sex with me. I sometimes feel suicidal. Please tell me what to do. Please consider me your younger brother.

Letter 5

I am a student. I am 21. I have two problems.

1. I am masturbating for last 5 years. I used to think loss of semen means physical deterioration. So I tried to avoid masturbation, but never succeeded.

   I used to stop the flow of semen by squeezing the root of my penis, pressing it hard while it starts coming. I think now, because of that I have grown taller. Now I am 5' 11" and 55 kg. Should I reduce my length a bit? How can I do it? What should be the ideal weight and length?
2. My wrist and ankle gets cold after masturbation during both summer and winter season. I have never used any medication for it. My palm and sole also sweats after any sort of sexual act.

Letter 7

With due respect I pay my salaam. I am 24, average built, but no development of my body. My chest is very much narrow. Before I was adult, I used to have sex with same sex people. But at the later half of 1993, when I had a chance to mix freely with females, I used to experience whitish cold discharge and after that my penis gets small and flaccid. Afterwards I get angry and feel immense tension, especially when I "kiss". I always come before I go for sex.

For the last two years I have given up everything illicit. My penis is curved on the left side. Now my question is, am I suffering from any disease. If I have any, what to do? I have never taken any advice from any doctor.

I am very weak as well, and feel pain all over my body. I feel pain when I walk. I have taken "rheumacap' and 'rumacid' suppository. If I don't take these capsules I get sick out of intense pain. Please advise what I can do.

Letter 10

I am 15. For last 4 - 5 years I was engaged in some sort of illicit work (he wrote no. 2 graded work - prostitution). Now I am at the stage of almost giving it up.

Now I feel pain 3/4" below my umbilicus.

I think it is semen of different clients that have been stored in my intestine for last couple of years. I think this semen causes the pain.

Am I right? Please let me know in details regarding the remedy even if my idea is wrong.

Letter 11

I am 21. Now I am working in a factory. My duty hour is from 8am - 9pm. Sometimes, night duties in every alternative week. My disease description is:

1. I feel headache, burning sensation in eyes, pain around ear, blurring of vision, heart burn, vertigo, nausea, lump in abdomen, borborygny around umbilicus, constipation, dyspepsia, burning sensation during urine, pain in whole body getting kyphosed day by day.
2. Both my testis is getting smaller, pain in spermatic cord (?). If I lie down testes enters in my abdomen. This is for 8/9 years.

I had two bad habits before I got this sort of problem. I used to have anal sex with boys. The second is masturbation. I have practised these for a number of times. Please don't mention these two problems, only the solution. I have taken a lot of medication from a medicine specialist, but of no use. Please prescribe me the right medication

Letter 12

I am married, I am 32, slim and healthy but I have a problem.

1. I feel pain during defecation. I have constipation.
2. Sometimes bleeding during passing stool and it is fresh blood.
3. Burning sensation around anus, but I think there is no ulcer or wound there.
4. Sometimes headache.

I have never told something out of shame to any doctor. My husband is very sexy. For the last 12 years during my menstruation he goes for boys and do anal sex. He has also done anal sex with men at least 25/30 times in our married life. Now my suffering knows no bounds. I take neoceptin R, Rococid forte, Duralex, and Ermex, according to the prescription of a local doctor. But as soon as I give up, I get all the problems back. Now what can I do for this?

Letter 17

I am 28. I am married for the last 9 months. But our conjugal life is very unhappy. I have been suffering from sexual and gastrointestinal problems for long. I have done a lot of male to male sex and masturbation before marriage. Later I got intense nocturnal emission. Anyway, this is no more a problem.

My penis is real small, curved and weak, black as coal. Very often I feel pain around umbilicus and left testicle.

Semen discharges during urination (especially when I forcibly urinate). Semen is very dilute and watery. Can't stay long in having intercourse with wife. I am very, very depressed. Please answer me soon.

Letter 19

I am 22. I am an examinee. My marriage proposal is on air. For the last 8 years I am having sex with little boys. Now I have done these mistakenly. For last 3 years I also started going to brothel and given it up for last three months. But when I first have been with females 3 years back, I got small rashes over my glans. Now, whenever I go to a female, I come as soon as I get close to her. My health has been broken terribly. How to get back my health? I have been to a number of venerologists, no result.

Letter 27

I am 20. I will sit for HSC this year. My sexual desire knows no bounds. I am masturbating since I was in class VIII (13 years). Don't take it otherwise, but I also had male-male intercourse because that very guy used to male me hard on. Now my penis is curved on left side. Once I was along in my home, I rub my penis against the body of our 8 year old maid servant and I come. I don't have habit of masturbation. I am very much weak, still my libido is excessive. If I bathe and use cold water I feel an itching sensation in urethra. It happens occasionally. I am taking vitamins.

I have shown my penis to many kobiraj (street herbal "doctor"). They could not find any solution. Please solve my problem, otherwise I wont be able to sit for the test examine.

NB. I feel pain in my spine.

Letter 31

I am 19. I am suffering from a sex disease. I have taken a lot of medication, but no result.

I am fucking boys for the last 7-8 years. Till now I do it. Can't get rid of this bad habit, but it has lessened to some extent recently. I used to do it 4/5 times a week. Now it is 1/2 times a week. Now my problem is:

1. semen is dilute/liquid
2. penis is curved to left side; it never gets iron hard
3. if I think of sex, I come
4. semen discharge during urination
5. burning urination
6. I get black out if I stand up from sitting position

I think if I don't solve these problems I can never marry and can never satisfy my wife.

Does semen discharge lessen cerebral power? I can't remember things like I could before. Please let me know.

Letter 32

I am a new reader of your magazine. I am 28. I got anal fissure (piles? - he states 'vagandar') at the age of 14. Still I suffer from constipation. If I sit for defecation and pressurise, blood drops from my anus and dilute semen by the urinary passage.

I always like 15-20 year old boys and desire to have intercourse with them. Can't tell these things to others out of shame. Now I have had intercourse with a female incidentally. I used her only from backside (anal sex). Now she comes to me every day. But I fear will I be able to marry?

I am getting sick and weak day by day. Please solve my problem.

Letter 37

I am 19. I have a lot of problems. I am masturbating for last 5 years. If excitement gets to its peak I mate with male. In order to get rid of my homosexuality, I have tried to have sex with a female and I tried her for quite a long time. But I can't and I don't get an erection. One day I could manage penetrating her after quite a long effort.

How can I get rid of this problem? I am always agonised by the thought of this very disease. Please save me Doctor.

A SUMMARY

Bangladesh is a male dominated society where the social and public spaces are male. As a homosocial and homoaffectionalist society, sexual boundaries between males are easily crossed and often can become sexual acts. Whereas some of these acts can perhaps be called homosexual (within the context of local identities based upon penetration) in that a sexual sense of self is operating based upon a desire for anal penetration by another male, such appears to be a minority framework. The majority of sexual activity between males should be seen as opportunistic discharged based. Sexual tension is palpable in many environments, and the personal sense of sexual urgency of many males is a potent factor for the speedy crossing of boundaries.

The majority of males in this study were married or will get married, but apparently there was no significant evidence that marriage actually substantially decreased the levels of male to male sexual activity. Several males that this was discussed with stated that when they got married they believed they would stop, but because they received little sexual satisfaction from their wives they continued. Partly this was because they felt they couldn't ask their wives to perform certain sexual acts, and partly because sexual opportunities with their wives were not always available because of social conditions, such as appropriate accommodation, religious and cultural customs, joint families, and so on.

Sexual health issues both for males and females through the primacy of male sexual behaviours, including male to male sexual behaviours, should be seen as a major and urgent concern. The fact that nearly all (to be generous) of the STD treatment services did <u>not</u> address anal transmission of STDs, is a cause for deep concern.

Appropriate service delivery of STD testing, treatment, care and counselling need to be developed as a urgent necessity, in order to formulate strategies that can effectively deal with different sexual behaviours in a confidential and sympathetic manner. Promotion of sexual health amongst males who have sex with males will be particularly challenging, but necessary, because of the frameworks discussed in this report.

The lack of understanding and knowledge by many of the NGOs, donor agencies and other institutions regarding male to male sexual behaviours, and frameworks of their identities, creates many barriers to the development of appropriate services. Such lack of knowledge may well be based on denial and homophobia, but much of it is also because these individuals and agencies utilise Western constructions of sexuality to attempt to define such behaviours. In a Bangladesh cultural context such constructions do not "fit", and therefore increases the invisibility of the behaviours. It is necessary to separate behaviour from identities, and in developing appropriate responses focus on risk behaviours to a large extent, rather than only on "risk groups". Sexual behaviours between males is certainly not a minority practice.

Socio-cultural frameworks of male to male sexual availability
In terms of the socio-cultural frameworks, both contemporary and traditional, that appear to shape and construct male sexual behaviours in Bangladesh, the following points need to be remembered:

1. Marriage is considered a social and religious duty and family obligation, not one based upon personal desire and choice. It is therefore seen as compulsory and a social necessity.
2 To remain unmarried is seen as an aberration and against Islam. Further cultural and religious beliefs dictate that a male achieves social responsibility and thus personhood upon marriage.
3. Marriage is often delayed till the male is in his late twenties or thirties, because of the economic costs.

4. The central objective of marriage is the production of children, specifically male children. Marriage is thus seen not as egalitarian and companionate and based upon mutual friendship, but rather as a source of reproduction of children.
5. In this context sex is seen as reproductive. Whilst Islam is sex-positive, in that it speaks of mutual sexual pleasure, the socio-cultural traditions of South Asia, often over-ride this, where women are seen not as equals, but as inferior vessels of male honour, to be sexually controlled, if she is allowed any form of sexuality. Sex with one's wife is often seen as a duty, rather than as pleasure. The statement "I do duty to my wife" is quite common, meaning I have sex with my wife. Also asking one's wife to perform certain sexual acts, such as oral sex or anal sex becomes shameful. She is the vessel of one's children.
6. This often lead to a concept of sexual pleasure as only available outside of marriage for men, as long as this remains invisible. Others would be asked to perform sex acts that could not be asked of a wife.
7. Here what matters is not the pleasure of the partner, but the pleasure of the self. Sexual behaviour becomes one of sexual discharge.
8. Gender segregation, female virginity, loss of honour, and so on often makes it easier to access other males for sex than females in a homosocial and homoaffectionalist society, because women are more policed and socially controlled.
9. Bangladesh (like other South Asian countries) culture focuses on public shame rather than personal guilt as frameworks of social control. It should be recognised that fulfilment of social, religious and family duty is central to a Bangladeshi. Here duty is seen as a public duty, to be visibly performed. Thus the sense of shame and dishonour arises from a public (community) perception about visible personal behaviours.
10. Concepts of sexuality, sexual behaviours and sexual identities are bound up within concepts of penetration (the penetrated and the penetrator) and semen discharge. Such a framework will often leads to high frequency of sexual partners.
11. For many males who sexually penetrate, the gender of the sexual partner can be irrelevant. What matters is to penetrate and to discharge.
12. Because Bangladesh culture is homosocial and homoaffectional, both in public and private, it is not uncommon for two or more males to share a bed. This makes opportunities for sexual encounters much more easier. Very often this takes place in the dark, under the blanket, when partners can disassociate themselves from the act - "it was in my sleep".

These characteristics of Bangladeshi culture, which also include the extreme over-crowding, poverty, males sharing spaces, a substantial number of males below the age of thirty and unmarried, low sexual access to females, lack of privacy, low incomes, create conditions which frame its male to male sexual behaviours, and in a sense encourage its differing manifestations.

Age can play a significant role in terms of penetration. As Michael Rocke states in his book *Forbidden Friendships - homosexuality and male culture in Renaissance Florence,*
"the restriction of the 'womanly role' to adolescents actually permitted all mature men to engage in sex without jeopardising their 'manly' identity".
(page 13, Oxford University Press, 1996).

The same framework exists to some extent in Bangladesh, whilst Mughal history is replete of "boy love" as can be seen from examples quoted in the section on Islam and homosexuality earlier.

All the evidence points to significant numbers of males engaged in sexual encounters with other males, from extremely young males to much older, from close relatives to the domestic servant, from the rikshaw driver to the businessman. Many will engage in these behaviours sporadically, or over relatively brief periods of times. Many will also continue this behaviour infrequently over longer periods of time, beyond even their marriage. And many will engage in male to male sex as either an exclusive sexual behaviour or as part of the sexual repertoire over their sexual active life.

To quote Michael Rocke again, "homosexual activity formed part, at one time or another and with varying significance and degree of involvement, of the life experience of many males" and that there was "an absence of conceptual categories based on sexual object choice" (page 15). Rocke then goes on to say that male to male sex "....did not constitute a separate world or a truly distinctive 'subculture'. Both casual sexual encounters and more durable relationships occurred or evolved in largely familiar everyday social contexts and were tightly insinuated into other forms of male sociability from the camaraderie of gangs of youth or bonds of work and neighbourhood to relations between patrons and clients or the sodaliture of kin and friendship networks (page 115).

All this does not imply that loving bonds between males does not exist. It does. Intense emotional and sexual relationships do exist, but these will be framed by the cultural necessity of marriage and children. Very few males are able to escape this cultural necessity. There are frameworks for desire for a specific gender, i.e. males who specifically desire other males and seek other males for sex (and sometimes love). These males will often frame their relationship as "husband and wife", a *panthi* with a *koti* (with a very few exceptions of mutuality and equality between gay-identified men). Such seeking can often only occur in public spaces. There are no "gay" bars, clubs, discos. Bangladeshi public spaces are supremely male. The street, the bus stand, the park, the railway or bus station, these are the arenas of contact. Such publicness leads to quick sex, penetrative or otherwise, in the darkness of parks, behind bushes, in alleyways.

Many workers in the service sectors also join in these networks. Whether just for sexual release, money, or actual desire for sex with other males is a difficult question to answer. Taxi-drivers, rikshaw drivers, barbers, room service and housekeeping males in hotels, waiters and table boys at restaurants, shop assistants. The framework is ubiquitous. The glance, the second glance, the smile, the appropriate questions, sometimes "for a few taka more", sometimes just *khela*.... In Dhaka urban culture, male to male sex does not exist in a few selected areas as in Western cities. It is anywhere, in the right conditions, the right time, the right space. Perhaps we could conclude that Bangladeshi "sexualities", are time and spacially based!

In the middle classes, domestic servants can also make male sexual availability easier. The employer has a power based relationship with the domestic servant and there are significant numbers of such employers sexually accessing male (and female) domestic servants. Anecdotal evidence also exists to indicate that some male domestic servants will sexually access the employer's male children as well. Sex between the young male sons and the young (and sometimes not so young male servants) is not as rare as people believe.

We could perhaps label male to male sexual frameworks to some extent (and with trepidation) in the following manner:
age stratified
gender structured
status stratified
professional defined
religiously or culturally based
egalitarian and companionate
economically framed
transgenerational
patron-client
situational
opportunistic
discharge based
same sex desire
penetrative

But perhaps we should accept that Bangladesh male sexualities are amorphous, opportunistic, spatially bound, discharge orientated, time-based, as well as those based upon same sex desire and love. We need to move away from the reductionist, scientific, and naming process, and accept a more wholistic approach to the issues.

In doing so we have to recognise that the impact upon any STD/HIV/AIDS prevention and control programme which does <u>not</u> address male to male behaviours will be doomed to failure. To deny their existence will ensure that no such programme will successfully contain the spread of AIDS.

Unfortunately, Bangladesh still primarily focuses on targeted groups and within these targeted groups only on vaginal sex as a transmission route for STDs/HIV. Truck drivers, female commercial sex workers, intravenous drug users (but all their education material is about the risks of shared IV use and nothing on their sexual behaviours). It forgets that males also have sex males as well as with females, that for significant numbers of unmarried males, sex between males is often their only sexual outlet, either desire based or discharge-based. That males also have anal sex with females. It has adopted Eurocentric constructions of identities and sees things in a heterosexual/homosexual framework, and thus misses the majority of male to male sexual behaviours. It continues to invisiblise and deny significant levels of male to male sex.

Further its STD services often denies anal transmission of STDs, where there apparently are no investigations into rectal gonorrhoea. STD clinicians have no training on such issues, where shame and denial will invisibilise these behaviours and make them difficult to access in terms of such services.

In exploring male to male sex in Dhaka, Bangladesh, this report has highlighted the following issues (in no specific order):

1. Significant levels of males who have sex with males
2. These behaviours are invisible because of secrecy, shamefulness and denial
3. High rates of anal sex between males and between males and females
4. Significant levels of male commercial sex work
5. High rates of STD symptoms
6. Low levels of health seeking behaviours
7. Non-existent or totally inadequate STD treatment services regarding anal transmission of STDs
8. No appropriate condoms and water-based lubricants available suitable for anal sex
9. Many males who have sex with males having pre-pubescent sexual encounters, where often the first sexual partner was a male relative
10. For the majority of males involved in male to male sex there is no specific sexual identity construction
11. Those who evolve an identity based upon anal penetration call themselves *kotis* and label their sexual partners as *panthis*.
12. Shame and dishonour create the conditions for secrecy, lies and shamefulness around male to male sex
13. No previous work has been done on sexual health promotion amongst males who have sex with males
14. No appropriate education resources dealing with male to male sexual behaviours and/or anal sex is available
15. Poor knowledge of STDs/HIV/AIDS amongst males who have sex with males
16. Low levels of condom usage
17. Many males who have sex with males will be married and many will get married
18. There are no agencies providing sexual health promotion services for males who have sex with males
19. Female partners (including wives) of males who have sex with males are very vulnerable to their sexual practices
20. The Bangladesh legal code prohibits non-reproductive sex (defined as 'carnal intercourse')
21. Whilst Islam prohibits male to male sex, socio-cultural frameworks appear to over-ride this prohibition

The development of a range of preventative strategies that are necessary if there is not to be the huge potential personal, social, cultural and economic impact, is now an urgent necessity. Is Bangladesh to enter into the next millennium with an uncontrolled spiral of illness and death which it can ill afford, as increasingly individuals, families and communities do not have the capacity to cope?

RECOMMENDATIONS

The challenge of HIV/AIDS confronts all countries and communities globally. Bangladesh stands before the abyss of an uncontrollable epidemic. Government, nongovernment and community-based agencies, as well as many other institutions, must work together to face this challenge if there is to be any hope of effective strategies to control and manage HIV transmission so as to reduce the levels and rates of infection and thus AIDS.

There is no vaccine for HIV, and whilst there are a range of medical treatments available to prolong life and reduce the impact of HIV related illnesses, treatment costs are prohibitive, particularly so for Bangladesh.

The only real hope then is to ensure that Bangladesh has an effective STD/HIV prevention strategy that addresses all risky behaviours and practices. No country can afford to ignore or deny what occurs within it, whether it is a particular risky sexual practice or a stigmatised identity that is deemed to be immoral, illegal or against its culture. Such denial creates ideal conditions for a rapid spread of HIV infections across the country.

This report is based on a sexual health risk and needs assessment conducted amongst males who have sex with males in Dhaka, Bangladesh. In this, the issues that were being explored included anal sex behaviours amongst males who have sex with males, sexual health seeking behaviours, access to condoms and lubricants, social constructions of sexual behaviours, sexual identities, and sexual health service availability.

It is clearly recognised that because of denial, invisibility, stigmatisation and illegality (both religious and secular), males who have sex with males already face considerable risks of harassment, violence, and perhaps imprisonment. HIV/AIDS could create another framework for further victimisation. It was therefore perceived to be incumbent upon the National AIDS Programme and AIDS service organisations to work towards preventing stigmatisation and victimisation of males who have sex with males, as much as towards preventing STD/HIV infections amongst, them as one of their issues of concern.

But is also recognised that Bangladesh, as a highly religious and conservative country, with a strong focus on Muslim beliefs and traditions, could well be under considerable pressure to present a religious approach to STD/HIV/AIDS, that is to develop a strategy based upon deterrence and punishment. The government and the Bangladesh AIDS Prevention and Control Programme have courageously resisted such moves and to include males who have sex with males as a target "community in prevention strategies following lobbying by members of the survey team and supportive individuals and agencies. It was recognised that a deterrent strategy for the prevention of STD/HIV/AIDS would only drive male to male sexual behaviours even further underground than they already are. This would effectively prevent effective education and awareness programmes, rather than prevent HIV/AIDS.

It needs to be clearly recognised that whilst many would prefer to promote sexual abstinence before marriage and faithfulness within marriage, an obedience to Muslim law and values and the promotion of Muslim ideals, there will be those for whom these are essentially public acts of obedience, whilst in private other behaviours may well come into play.

The corollary to this is to accept that the only effective and appropriate HIV/AIDS education and prevention strategy would be to promote safer sex behaviours amongst males who have sex with males and ensure that appropriate and accessible sexual health services are available and accessible to them which respect their confidentiality and anonymity

and build upon their trust and respect.

This will require a clear understanding of the difference between religious values and beliefs, stated public opinions, socio-cultural values, and actual practice.

Such a pragmatic approach (despite all the issues that this might raise within the socio-cultural contexts of Bangladesh) would necessarily include a respect for human rights which would require the government and other institutions and agencies to develop cooperative, trustful, and working partnerships with representatives and peer leaders from the male to male sexual networks, ensuring safety, security and confidentiality. It is only through such partnerships that males who have sex with males can be accessed and provided with appropriate information, advice, counselling, support towards behaviour change, and STD/HIV prevention and treatment services.

But it is also understood that not all males who have sex with males will access services provided by sexual health agencies for a range of reasons. It would be more appropriate and effective if the beneficiaries of services acted as agents of change. This means that it is necessary to support the development of peer-led community-based AIDS service organisations working with males who have sex with males.

Following on from these principles and the evaluation of the risk and needs assessment conducted in Dhaka, Bangladesh, the following recommendations are being made.

1. Behavioural and anthropological research

1.1 The need for qualitative information on sexual histories and behaviours amongst males who have sex with males towards developing strategies for sexual health promotion amongst them must be urgently addressed as a priority.

1.2 This will require developing appropriate behavioural and anthropological research methodologies that include the subjects of such research both as subjects and as observers.

1.3 Such research should recognise the wide diversity of sexualities, identities and sexual behaviours of the "target population" which would include those whose primary sexual behaviours will be male to male, as well as those whose male to male sexual behaviours are intermittent, secondary and discharge based.

1.4 If individuals, sexual networks, social groups and "communities" involved in male to male sexual behaviours are to be empowered towards an increase in health seeking behaviours, then more effective research needs to be done to identify as to who, how and why various sexual identities are constructed, there specific meanings, and how they can determine sexual behaviours.

1.5 Such research should also need to identify key informants in these sexual networks. Understanding these social constructions of sexual behaviours enables more effective designs for intervention strategies that promote sexual health amongst males who have sex with males.

1.6 Peer-led research also needs to be conducted with regard to developing appropriate messages, sexual health products, and sexual health services.

1.7 This research should look at frameworks of support for males who have sex with males towards encouraging them to practice safer sex as a normative behaviour, the levels of knowledge, understanding and acceptance by medical staff and social service agencies regarding males who have sex with males and their sexual practices, and what would work in promoting sexual health in the differing sexual frameworks and networks of males who have sex with males.

1.8 Areas of research should include:
- 1.8.1 prison populations
- 1.8.2 military personnel
- 1.8.3 overseas workers
- 1.8.4 rural male populations
- 1.8.5 males in educational establishments
- 1.8.6 occupational groups
- 1.8.7 male sex workers in a variety of settings
- 1.8.8 males in refugee camps

1.8.9 male domestic servants
1.8.10 male street children
1.8.11 male garment factory workers
1.8.12 male child sex abuse
1.8.13 male rape
1.8.14 early male sexual activities
1.8.15 male suicides

1.9 In conducting any such research several significant questions must be asked:

a. who is going to conduct the research
b. how is it going to be conducted
c. how is information going to be collected and by whom
d. what questions are going to be asked, how are they asked, and in what language
e. what terminology will be used
f. how will the information be analysed and who will do the analysis
g. how will the data be used in developing appropriate STD/HIV prevention and sexual health services
h. who will develop such services and who will work in them

Any research into male to male sexual behaviours, must answer these questions adequately.

2. Risk and needs assessments

2.1 There is an urgent need to develop appropriate risk and needs assessments amongst males who have sex with males within different sexual networks, and expressing differing sexualities, identities and behavioural frame works.

2.2 These assessments need to be done through the auspices of appropriate peer researchers to ensure the validity of data, an appropriate analysis of the data, and adequate protocols on confidentiality.

2.3 It is important to ensure that adequate funding is made available for these risk and needs assessments to be conducted.

2.4 Such research must assure respondents that data collected will not be used against them, that their confidentiality and anonymity will be respected, and that the information will only be used to develop appropriate strategies for the prevention of STD/HIV/AIDS amongst them with their assistance.

3. Developing community-based AIDS service agencies

3.1. To be fully effective, prevention strategies must incorporate the means to stop the spread of HIV infection. However many of these issues are taboo, and to publicly discuss them creates issues of shame, fear, anger and hostility which will lead to resistance and denial.

3.2 Community based agencies developed by males who have sex with males need to be supported in ensuring that they can provide such HIV prevention programmes without undue harassment or hindrance and within the rubric of "harm reduction", individuals, networks and groups who are involved in differing frameworks of male to male sexual behaviours must be empowered to address these issues for themselves and develop their own service agencies.

3.3 Acknowledging the lack of technical skills in developing such community-based sexual health promotion agencies addressing male to male sexual behaviours, whether it be infrastructure, developing service delivery and implementation, project management, financial accountability, appropriate outreach strategies, monitoring and evaluation, resource design and development, needs assessments, or producing budgets and accounts, such emerging agencies must be provided with technical assistance to access these skills through training and capacity building from appropriate consultants.

3.4 Further appropriate agencies need to be developed that work with prisons populations, juvenile homes, young offenders institutions, orphanages, the military, police, and migrant workers, around STD/HIV/AIDS and issues involving male to male sex.

3.5 The Bangladesh AIDS Prevention and Control Programme must be involved with community based agencies developed by males who have sex with males in distributing appropriate sexual health products and educational

resources (such as condoms, lubricants and literature) targeting male to male sexual behaviours.

3.6 Different distribution strategies will need to be explored by these community-based agencies, such as social marketing, free distribution as well as distribution in a wide variety of private and public locations. These differing strategies must be supported by Government and other non-government agencies.

3.7 Appropriate peer education initiatives must be encouraged and supported. Safe spaces need to be developed where individuals and groups can gain access to confidential information a well as discuss issues around sexualities and sexual health within an appropriate context.

3.8 Psycho-social support programmes need to be part of any on-going sexual health programme for males who have sex with males. These would include telephone lines ("hotlines") providing free and anonymous advice and information, social support groups, sexual health discussion groups, and other services deemed appropriate and needful by males who have sex with males themselves.

3.9 In terms of risky sexual practices, and because of the nature of the koti identity being based upon anal penetration where there are high levels of multiple partners and multiple acts of penetration, kotis represent an identified network and an emerging community which is at particular risk of STD/HIV infections.

Kotis can access many other males with differing identities and different sexual behaviour frameworks.

Koti networks must be supported through appropriate empowerment processes to develop their own sexual health promotion services amongst several sectors of males who have sex with males. For this to occur they would need institutional and government support because kotis represent publicly stigmatised behaviours and identities.

3.10 Effective relationships with local police will need to be developed in regard to the levels of harassment and blackmail that many face in public sex environments, and also to ensure that outreach and field workers from such an agency themselves would not be harassed by either police or local people.

3.11 Further, attitudes of doctors and other medical staff towards such stigmatised identities must be addressed through sensitisation programmes and appropriate regulations

3.12 Issues of human rights abuse, freedom to receive information that will protect lives, advocacy for the right to services, and other male to male sexual communities who would not access services provided by the koti networks will need to be developed. Such service development could be organised by the other emergent male to male sexual community, those who are gay-identified, with appropriate support and assistance.

3.13 Because so much male to male anal sex takes place outside "cruising" sites and external to *koti/panthi* dynamics, other NGOs developing sexual health services will need to promote safer sex behaviours that include anal sex in the programmes of education and prevention. These include rikshaw drivers, female sex workers, truck drivers, educational establishments, factory workers, overseas workers, prison populations, et al.

3.14 Government institutions and services will also have to address these issues through the provision of appropriate training and sensitisation.

3.15 Because of the religious political and social issues that such intervention work may raise, it will be important to recognise that different and non-public strategies may need to be developed for such interventions.

3.16 There should be regular consultation between such community-based AIDS service agencies and Bangladesh AIDS Prevention and Control Programme to ensure that issues, needs and service development for males who have sex with males is always reflected in any National AIDS programmes and strategies.

3.17 Networking enables the sharing of appropriate skills, educational materials, knowledge and information which can enhance the capacity of an AIDS service agency. This should be encouraged and supported by Government through the provision of any necessary technical assistance so that these agencies addressing the needs of males who have sex with males can access and actively participate in local, regional, national and international forums dealing with their issues of concern.

3.18 Such community-based AIDS service organisations should be provided with long term funding which would include core costs as well as project costs and sustainability issues must be thoroughly explored with such AIDS service organisation to ensure programme continuity.

3.19 All agencies providing HIV/AIDS education, prevention and support should be effectively monitored for the quality and appropriateness of their services and their accessibility in regard to males who have sex with males

3.20 In order to ensure that these agencies can deliver a high quality of service, it is essential that appropriate skills training be offered to the policy makers of these agencies, management boards, staff and volunteers on the sexual health needs of males who have sex with males. Such skills training should include issues on developing appropriate outreach programmes, community involvement, designing education and intervention strategies, needs assessments, project management, monitoring and evaluation, and educational resource development.

3.21 This will require a multi-sectoral approach including the provision of good quality sex education, easy access to appropriate and cheap sexual health products and information, accessible STD services that are appropriate to the needs of differing males who have sex with males, appropriate counselling and support, and development of support structures for those living with HIV/AIDS.

3.22 Such approaches should be consistent with each other, delivering a high standard of quality, non stigmatising, and supportive.

4. Education and Prevention

4.1 There is an urgent need to address the high levels of incorrect beliefs about sex, sexual functioning, the male and female body, and all aspects of sexual behaviours. These beliefs are damaging and impede any effective development of STD/HIV prevention.

4.2 Within Islam it is recognised that it is the parent's responsibility to provide their children with effective sex education, but this is not always done. This lack must be addressed and therefore requires governmental action to provide an effective sex education programme which should be made available for both the formal and informal education sectors. Such a programme could be called "Life Education" in order to gain acceptability and be available in educational establishments such as schools, colleges and universities, as well as the education of parents.

4.3 Appropriate peer education initiatives should be encouraged and supported and individuals and families should be able to access premarital counselling on reproductive and sexual health issues.

4.4 Society as a whole should be mobilised in creating appropriate awareness of HIV/AIDS. It is essential for the whole community to work together to ensure that education and prevention strategies are effectively implemented to prevent the spread of HIV.

4.5 These education and prevention strategies should utilise a wide number of formats including posters, electronic and print media, leaflets, videos, audio-cassettes, cinema, theatre and so on, and involve political and religious leaders, doctors and hakims, kobiraj, business and union leaders.

4.6 Religious, political, medical, social, community, media, and business leaders should all be offered awareness programmes on HIV/AIDS and related issues in order to incorporate them into community education.

4.7 Specifically targeted resources should be developed that are aimed at differing social, economic and behavioural groups, including medical staff, family planning clinics, religious teachers, educational staff, factory workers, hotel staff, and so on.

4.8 This would also mean educating and updating all health and social care workers skills with regard to prevention, care, management, counselling and related issues on HIV/AIDS, including issues on anal sex and males who have sex with males.

5. Education resources

5.1 There is an urgent need for a broad range of educational resources, reflecting the sexual practices of males who have sex with males, as well as specifically anal sex, to be made available in appropriate formats and be distributed as widely as possible.

5.2 Males who have sex with males community-based agencies must be empowered to develop and deliver their own sexual health education resources appropriate to their needs.

5.3 Resources also need to be developed that cater for those who are not literate, who are visually impaired and other marginalised and physically impaired groups. For example, in one city, a young male of 16 years, with a below normal mental age was being regularly sexually accessed for anal sex by other young males in his neighbourhood.

5.4 Further to this there should be educational campaigns that de-stigmatise the public discussion of sexual behaviours through multi-media efforts that involve government, non-government and business institutions and agencies.

5.7 The following questions should always be asked in developing appropriate education resources

a. how appropriate is the framework of education?
b. what language is it in?
c. what words and images are used
d. is it appropriate to the cultural frameworks and context of delivery?
e. who controls the agenda
f. who produces the information?
g. who receives the information?
h. who delivers the information?
i. how is this information delivered?
j. can we differentiate between culturally sensitive and culturally appropriate?
k. do services exist to cater for expressed needs that such information may generate?
l. who staffs these services
m. what do they deliver?
   how do they deliver services?
n. how are appropriate are they?
o. what skills do they have?
p. what messages are being delivered?
   don't do it
   do it safely
q. what is the objective?
   to inform?
   to change behaviour?
   to reduce the rate of HIV transmission?
   to halt the spread of HIV?
   to increase reproductive health of women?
   of men?
   how will this be achieved?

6. Sexual Health Products

6.1 Condom promotion is usually left to family planning clinics (which are primarily visited by women), some ad-hoc local government poster campaigns (which of course necessitates literacy), STD clinics (if you attend them), and a range of HIV agencies, either through free access or through social marketing principles.

There needs to be a more vigorous approach to condom promotion through on-going multi-media campaigns and by all sexual health services and HIV/AIDS agencies.

6.2 Appropriate stronger condoms suitable for anal sex behaviours and which are cheap and easily accessible, must be made available to the general public.

6.3 An urgently needed requirement for the promotion of safer sex is the availability of a suitable water-based lubricant in appropriate packaging that allows for a low market price and is easy to carry and use.

6.4 Issues of distribution, availability and easy accessibility need to be addressed. Price and distribution would need to reflect accessibility for the poorest and the sexually active at locations where sexual activities take place.

6.5 It is an urgent necessity to ensure that future campaigns on condom promotion also address condom usage for anal sex.

6.6 Considerable education needs to be done on the correct use of condoms.

7. STD Services

7.1 All STD medical staff should be trained in the issues surrounding anal sex behaviours, whether between males or between males and females, in regard to symptoms, treatment and counselling. Further abuse and harassment at such services by staff must be stopped. All staff should be sensitised to the needs of males who have sex with males, particularly those with stigmatised behaviours and identities. Confidentiality and anonymity must be available in accessing such services.

8. Women And Sexual Health

8.1 There is an urgent need to address issues of gender, empowerment of females, anal sex behaviours, and male sexual behaviours in any strategy for reducing STD/HIV rates, if women's sexual health is to greatly improved.

9. Psycho-sexual counselling

9.1 Trained personnel providing psycho-sexual counselling should be available, perhaps through the establishment of Sexual Health Centres which can offer non-judgmental, appropriate and accurate advice, information and support.

10. The Role of the Bangladesh Prevention and Control Programme

10.1 Bangladesh AIDS Prevention and Control Programme (BAPCP) must play a lead role in encouraging, and enabling the development of peer-led community-based AIDS service organisations by investing in, and empowering them, to deliver appropriate STD/HIV prevention and sexual health services for males who have sex with males.

10.2 Such an investment in the development of appropriate sexual health services for males who have sex with males would be in the form of:

- 10.2.1 provision of long term financial support
- 10.2.2 provision of, or unhindered access to, technical assistance and financial support
- 10.2.3 access to capacity-building training
- 10.2.4 addressing legal and regulatory constraints which may hinder the development of such peer-led community-based agencies

10.3 In order for this to occur, BAPCP and other agencies will need to ensure that they can gain the trust and confidence of males who have sex with males by ensuring confidentiality, safety, security and anonymity.

10.4 Recognising that not all males who have sex with males will be accessible to sexual health services, whether provided by government or community-based agencies, BAPCP will need to develop appropriate frameworks for a national programme on sexual health education amongst the general public that takes into account the sexual behaviours of males who have sex with males.

10.5 BAPCP should provide training and awareness programmes to government and non-government agencies providing sexual health services on the social and sexual health needs of males who have sex with males in order to address the lack of knowledge and understanding. Such programmes will provide unbiased information, sensitisation, as well as destigmatise the issue.

10.6 Where laws, regulations and policies hinder males who have sex with males to access sexual health services, or discriminate against them through intimidation, fear, harassment, violence, denial or the risk of imprisonment, then these should be amended or repealed to empower such males to access these services. This should include the:

- 10.6.1 Repeal of the specific section in the Penal Code on "carnal intercourse" as a step towards increasing the confidence of males who have sex with males to access legal, judicial and sexual health services.

10.6.2 Training of police staff and the judiciary on issues regarding males who have sex with males and sexual health concerns.

10.6.3 Developing and/or supporting advocacy programmes for males who have sex with males to ensure the human rights of individuals are being respected, and that those who are harassed or violently abused can seek legal redress.

10.7 BAPCP should include in any advisory and/or technical committee appropriate representatives from non-governmental agencies and community-based agencies delivering sexual health services specifically working with males who have sex with males.

10.8 BAPCP should also develop national educational strategies to educate the general population against discriminatory attitudes towards HIV/AIDS and sexual behaviours as well as to de-stigmatise male to male sexual behaviours through the use of mass-media.

10.9 All sexual health programmes should include male to male sexual behaviours and anal sex issues, and should also involve schools, colleges and universities, families, business, the military and prisons.

10.10 BAPCP and associated agencies need to ensure that appropriate condoms suitable for anal sex and suitably packaged water-based lubricants are readily available and accessible to males who have sex with males, ensuring good quality, affordable prices and adequate distribution in a variety of locations. Such distribution should also include appropriate educational materials in the correct usage of such products.

10.11 BAPCP should ensure that all STD services staff, private or government, as well as all sexual health services provided by government and non-government agencies receive appropriate training on ALL frameworks of sexual behaviours which must include anal sex as a practice both between males and between males and females towards improving the quality, accessibility and delivery of these services to all sections of society.

10.12 Such training should also include the sensitising of staff regarding the needs of individuals and families in regard to possible infections through anal sex, and that the quality of service delivery regarding this issue should be regularly investigated to ensure that all individuals can access sympathetic and high quality services.

10.13 There should be effective collaboration between the National AIDS Programme, community-based agencies, and international agencies such as UNAIDS, UNDP, UNICEF, UNHCR and others, towards implementation of agreed policies, recommendations and guidelines, locally adapted to address concerns of human rights abuse, service development for males who have sex with males, accessibility to these services and to reduce discrimination.

PART THREE

Developing a response

DEVELOPING A RESPONSE

Introduction

The surveys indicated that:

1. a high degree of risk taking behaviours amongst males who have sex with males
2. low levels of health seeking behaviours, such as accessing STD treatment services and condom use
3. high levels of STD symptoms
4. polymorphous sexual behaviours amongst males
5. a socio-cultural framework that "encouraged" male to male sexual encounters
6. significant levels of male to male sex taking place
7. low levels of knowledge and awareness of STDs and HIV/AIDS
9. high degree of risks for the spread of HIV infection
10. increased risks for young males and women partners of males who have sex with males.

This was an action oriented risk and needs assessment which included the following objectives:

1. to develop a strategic response to the sexual health needs of males who have sex with males in Dhaka, Bangladesh through the support and development of appropriate male sexual health projects addressing these needs
2. to facilitate males who have sex with males and their sexual partners to access appropriate sexual health information and services through the development of community-based HIV/AIDS agencies.

The principles to be adhered to were that of:

1. beneficiaries of services acting as providers of services
2. community building
3. normalising safer sex behaviours within these emergent communities

Service Development

Following the completion of the risk and needs assessment phase of the programme, it was now essential to complete the remaining objectives. These were:

1. Establish an appropriate service agency to respond to emerging sexual health needs of males who have sex with males
2. Secure financial support for such an emerging service
2. Develop a supportive network amongst international, national and local agencies to provide support to this new agency and to act as an link with government institutions. This was believed to be necessary because of the stigmatised nature of the behaviours and identities within Bangladesh. Any agency emerging from this work would be vulnerable to harassment and denial by government as well as by local agencies and communities.

By January 1997, the research office had developed strong rapport with several male to male sexual networks, and was being regularly accessed by members of these networks, not only as research participants, but also for social reasons. Over one hundred males were using the office space every week.

However, by this time several issues of concern and conflict between differing networks had emerged. A range discussion were held at the Project office to attempt to resolve these arising conflicts and disputes. But what emerged from these meetings was a clear division between agendas, class, frameworks of identities and behaviours which were incompatible

to the felt needs of what were two very divergent community-based agendas.

As identified in the recommendations, the two primary emergent sexual communities were that of the *koti*-identified and those who were gay-identified. Each network represented different focuses, different issues, different approaches. It was strongly felt by all concerned that to a large extent within a Bangladesh context, and they could not be represented through one agency.

This division can be represented as follows:

a. Frameworks of emerging gay identities and those of the ko*ti/panthi* frameworks showed clear separation of partner choice, nature and constructions of sexual behaviours, frequency of sexual partners, locations of sexual activities, methodologies of partner selection and "pick-up" in selected sites.
b. Behaviourally and socially, those with emerging gay identities and those who sustained the *koti/panthi* frameworks were significantly different, these differences including language, social behaviours, sexual behaviours, and sexual identities
c. Class divisions between those with emerging gay identities and those with *koti/panthi* frameworks were clearly distinct
d. Different agendas, goals and objectives were being expressed by the two emergent communities

These heated discussions finally led to a recommendation to the whole group that because of these difference, two different service agencies should be developed reflecting the different objectives and networks. This would enable the development of choice and personal empowerment as well as satisfy the expressed needs of the individuals concerned. To attempt to unify the responses would create to many divisions which would result in the failure of the Project.

This grouping had already begun to occur through individual choices. The Project, by is construction and framework of operating had already provided a community-building strategy. The questionnaire surveys, the focus groups, the interviews and the access to a safe space for meetings, discussions and awareness sessions had generated a positive response amongst males who have sex with males. Natural development has already occurred whereby these two networks solidified into the two emergent communities.

The announcement of the development of two separate service agencies made such a development "official" and released the tensions that had developed over the previous months between members of the Project.

Clearly, this process brought to the surface the wide and divergent felt needs of differing sexual/social networks amongst males who have sex with males. To deny one or the other was not possible within the frameworks of project development. It would also be immoral to do so.

It was therefore necessary to accept these divergent agendas and work with them towards achieving the goals of the Project.

The two organisations were:

a. The Bandhu Social Welfare Society

This group is primarily *koti* identified, and intended to develop sexual health and social support for those with a *koti* identity and their sexual partners. Such support would include female partners and wives, male sex workers, those from low income groups, such as rikshaw drivers, sexually active male street children and youth, and *hijras*.

Primary Objectives

1. to develop STD/HIV prevention programmes for males who have sex with males through outreach activities in a range of environments which will include condom and IEC materials distribution, peer education and support
2. to provide sexual health services targeting male sex workers and their clients, as well as *hijras*
3. to develop an STD treatment service and to enable the improvement and accessibility of other STD services
4. to provide a range of social support groups, awareness sessions, and a range of community-building activities
5. to work with a range of women's sexual health agencies to ensure the provision of appropriate services for the female partners of males who have sex with males
6. to collaborate with agencies providing HIV/AIDS education and prevention services with a range of low income groups, such as rikshaw drivers, truck drivers, and street children

7. to work with the Bangladesh AIDS Prevention and Control Programme towards ensuring that issues of anal sex and associated STD/HIV risks are incorporated into all sexual health programmes
8. to work with other agencies towards developing a national and local approach to the sexual health needs of males who have sex with males in other parts of Bangladesh.

b. Association for Health and Social Development

This group is gay-identified and seek to provide community development, advocacy, social and sexual health services for gay identified men and men who have sex with men with emergent gay identities.

Primary Objectives

1. to develop a range of social support systems for gay men and those with emergent gay identities towards community-building
2. to provide sexual health promotion and support services to gay men and those with emergent gay identities
3. to advocate for appropriate changes in the law regarding male to male sexual behaviours
4. to work with human rights organisations and advocate on behalf of men who have sex with men who have experience human rights abuse, harassment and violence
5. to work with STD treatment services towards improving their quality of service delivery and ensure that issues of men who have sex with men are being addressed.
6. to provide psycho-sexual counselling
7. to network locally, nationally and internationally in addressing issues affecting gay men and men who have sex with men

Through group discussions each group developed a sense of its own identity and named their emergent agency which would represent their own interests and needs whilst individuals were identified co-opted to become Trustees for the two organisations. At the same time, the objectives of each agency were clarified and determined.

Since the research phase of the Project was over seed funds were used to maintain the office to enable the development of the two emergent agencies as fully fledged sexual health and social support providers. This required registering the agencies as nongovernment organisations with the Government, develop programmes of activities, clarify aims and objectives and begin to construct service programmes appropriate to each agencies objectives.

Seed funding was also made available in order to register both organisations, and the research office was given over to both emerging agencies to use as part of their individuated networking and social development through offering a range of support and social group meetings.

This developmental process enabled the two emergent agencies to identify appropriate individuals to recruit as peer educators, volunteers and staff.

Both agencies were then provided training by the Project on institutional capacity building, programme design, development and management, financial management procedures and monitoring and evaluation.

At the same time discussions with potential condom suppliers were also held to ensure that the emergent agencies could offer condoms as an on-going process to those who attend the group sessions as well as utilised the drop-in space.

Developing Donor Support

Discussions were held with the Norwegian Development Agency, ODA, CIDA, UNAIDS, and UNDP to begin to identify potential donor agencies who may be willing to financially support either of the emergent agencies being developed.

These discussions also included frameworks of support with regard to the Bangladesh Government and its departments and agencies involved in sexual health issues. This was because the target “populations” of these new service agencies involved substantially stigmatised behaviours and identities which are publicly invisible if not denied any existence. This process was considered to be extremely important since Government institutions may deny funding availability for these organisations because of the behaviours and issues being addressed and/or create institutional barriers for any appropriate implementation of services, including legal, judicial and police harassment.

Bandhu Social Welfare Society developed a project proposal to provide sexual health promotion services for males who have sex with males, focusing on *kotis* and their sexual partners which was accepted for full funding.

This proposal also included extensive access to Naz Foundation technical assistance for the first year to enhance the capacity of BSWS to provide the services they wished to develop.

The Norwegian Development Agency had initially offered 50% financial support to Bandhu Social Welfare Society, but after potential partner agencies (including the then Overseas Development Agency) turned down the request for support, offered a 100% funding support for an initial three years.

The Association for Health and Social Development also developed a project proposal focusing on advocacy work and community building through social support mechanism. However, at the time of writing this report, they have been unable to secure funding for their agency. A short term action based research proposal was submitted to CIDA, but this was also rejected. Currently further attempts have been made to secure funding for AHSD through other international donor agencies. Local funding for such work is not believed to be possible because of the nature of behaviours being addressed.

Part of this process of securing financial support was to develop a Technical Advisory Group accessed by both agencies which would include representatives from local, national and international agencies based in Dhaka to act in a supportive and advisory capacity.

This has now been established and includes representatives from UNAIDS, CCDB. ICDDR,B, Medicine Sans Frontieres as well as a number of independent consultants. Representatives from a number of local agencies, including the Bangladesh STD/HIV/AIDS Network are also being approached to participate in this Advisory Group.

Follow-on technical assistance

Recognising that the two emergent agencies working in the field of sexual health promotion and human rights for males who have sex with males were inexperienced in the field of community-based services, it was clear that the level of technical assistance which was required for both agencies to become effective in achieving their objectives and for services to be implemented would be extensive and relatively long term.

In reviewing what technical assistance was need, what could be provided, and how and who would provide such assistance, it was also clear that local agencies and consultants were not appropriate for the following reasons:

a. a substantial lack of appropriate knowledge regarding male to male sexual behaviours, their social constructions and the range of identities that configure these behaviours
b. the significant levels of denial of the existence of male to male sexual behaviours by these agencies
c. factors of shame in dealing with these behaviours from members of these agencies
d. a lack of empathy, sympathy and understanding by these agencies
e. the use of American/European constructions of sexuality which are inappropriate and inadequate to discuss and understand the male sexual behaviour dynamics
f. the fear of exposure and vulnerability by members of the Project creating resistance to local assistance

As a consequence, it was decided by the two agencies that the technical skills of Naz Foundation would be accessed towards developing appropriate strategies to ensure the provision of technical assistance for

a. on-going institutional capacity building
b. programme design and implementation
c. upgrading skills of programme staff
d. monitoring and evaluation
e. resource development

This technical assistance programme would ensure that institutional skills towards independence and local management were developed. However such assistance was dependent upon funders recognising the need and financial supporting such assistance.

Project management and development training

Training programmes were offered to Bandhu Social Welfare Society and Association for Health and Social Development by Naz Foundation as part of the initial technical assistance. These were:

1. ORGANISATIONAL DEVELOPMENT

Day One: Setting The Agenda
Agency Goals and Purposes
Mission Statement
Outputs and Outcomes
Constitutions and Boards of Trustees
Organisational structures

Day Two: Programme Development
Service Aims and Objectives
What services are being offered
What is sexual health promotion?
What is education? What is Prevention?
What is Outreach?
Advocacy and support
Resource development

Day Three: Management and Staffing
Staffing Levels and development
Organograms
Job Descriptions
recruitment procedures
Management Procedures and Policies
Budgeting and financial management
Quality Statement

Day Four: Monitoring and Evaluation
Quality Assurance
Outputs and Outcomes
Monitoring The Project
Developing a Project Timetable
Evaluating Your Project
Producing Reports

In this workshop, frameworks of institutional development and capacity building were developed. This involved taking the participants through a process to increase understanding of the nature of community-based service organisations, framing constitutions and structural contexts, which included management, lines of authority, boundaries, service descriptions, outcomes, job descriptions, financial reporting, and levels of responsibility.

With this, both agencies explored goals and objectives and development of project proposals and service implementation for each agency, developing work plans, implementation time-tables, budgets, outputs and outcomes to be achieved, as well as monitoring the services and evaluating the outcomes.

Because of the contexts of *koti* sexual dynamics, Bandhu Social Welfare Society felt that there should be two separate (yet interlinked) projects, one working with c*ivil kotis*, the other working *professional kotis.* Project development plans took this into account.

2. STD SERVICE DEVELOPMENT

developing knowledge and skills of participants towards a programme for enabling STD clinical services in Dhaka become more accessible and relevant to the needs of males who have sex with males

Day One: Developing Sexual Health
Purpose of Workshop
Sexual health - meanings and definitions
Sexual Behaviours and STDs/HIV/AIDS
Treatment, Management and Counselling

Day Two: Working with STD Services:
Sexual Behaviours, Anal Sex and STD service
Training STD clinicians
Accessing STD services
Support and referral systems
Needs
Strategy for Development

Through role play, discussions on risks and needs around sexual health - particularly on anal sex behaviours - definitions and developing consensus on understanding, the issues of providing appropriate and accessible STDS treatment, counselling and management, were elaborated.

The research conducted by members of the training group on the existence of STD services that dealt with anal sex risks, and the quality of such services, had found no such service in Dhaka. As far as it was investigated, no clinician either enquired (both male and female clients) about previous and/or current anal sex behaviours, and no treatment for anal STDs was being offered. Further to this the attitudes and behaviour of staff was stigmatising and abusive when confronted by people with anal sex behaviours or koti/hij*ra* identities. It was believed that neither agency could refer any individual to such services.

This significant gap in STD services was seen as a priority. Discussion in the workshop explored possibilities of:

a. the new agencies providing their own STD services through recruitment of appropriate doctors involved in male to male sex for treatment, advice and counselling
b. empowering sympathetic doctors (if any could be found) to provide such services
c. providing training and sensitisation programmes to currently existing services
d. working with supportive nongovernment agencies providing STD services, such as Marie Stopes Clinics Society and Parachaja
e. working with the Bangladesh AIDS Prevention and Control Programme to upgrade the skills and capacity of current government and non-government STD services to take on board issues of anal sex behaviours and males who have sex with males and develop appropriate service delivery to increase accessibility.

The workshop explored how such services could be developed, their content and the manner of service delivery, both from the professional and client perspectives.

From this it was agreed that all the above strategies would be followed through with AHSD focusing on b, c and e whilst BSWS would focus on d. Both agencies would work towards self-provision of STD services themselves as well.

Discussions raised another issue regarding accessibility of any STD service whether current or ones that could be developed. It was noted that many males may find it difficult to access appropriate fixed site services because of distances and travel costs. The concept of developing and providing mobile STD services that would take the service to where a) male sex workers were, b) local areas in the suburbs of Dhaka, were explored and developed. It was agreed that Bandhu Social Welfare Society would take this initiative further and develop a project proposal for such an initiative.

3. STAFF TRAINING

Day One: organogram and management structures
responsibilities and duties
boundaries
financial management and book-keeping
terms and conditions of employment

Day Two: disciplinary procedures
grievance procedures
confidentiality
monitoring records and methodology
service provision

The participants not only included potential staff, but also members of its Board of Trustees.

4. METHODOLOGIES FOR INTERVENTION IN PUBLIC SEX ENVIRONMENTS

Day One: definitions of terminology
methods of outreach
what IEC materials?
use of IEC materials
methods of talking

Day Two: condom distribution
principles of social marketing
dealing with STD symptoms
psycho-sexual counselling and support
STD treatment referrals
referrals to Bandhu and/or AHSD
monitoring treatment compliance
monitoring and evaluation

Impact on the National AIDS Programme.

Male to male sexual behaviours is now accepted as part of the national five year strategic plan.

During the period of this Project, the author and representatives of the Bandhu Social Welfare Society and Association for Health and Social Development had been invited to participate in a multisectoral consensus workshop on national policy on HIV/AIDS and STD related issues critiquing the draft National AIDS Policy Document. Through direct interventions and statements made at this workshop by these representatives the issues of male to male sexual behaviours, anal sex, appropriate condoms and lubricants were included in the deliberations.

A second consensus workshop organised by the Bangladesh AIDS Prevention and Control Programme of the Ministry of Health on the draft five year strategic plan for National AIDS Programme was also attended by these representatives.

As a consequence it was clearly recognised that issues of the sexual health of males who have sex with males have to be considered as a part of the national strategic plan, and that appropriate condoms and lubricants will need to be made accessible for them, if the Government of Bangladesh was to achieve its stated goal of reducing the impact of AIDS, and halting the spread of STDs and HIV. This can be seen as a major achievement in a conservative society, and can be directly attributed to then influence of the work of the Project and the establishment of Bandhu Social Welfare Society and Association for Health and Social Development.

A further impact of the work could be seen in the growing awareness and interest regarding the issues of male to male sexual behaviours and their impact on sexual health generally. Several nongovernment agencies are now exploring taking this issue on board within their own agendas, whilst several others including, women's reproductive and sexual health programmes had expressed strong interest in developing cooperative relationships and partnership programmes with the two agencies that have been developed through this work. Bandhu and AHSD will be developing these relationships and potential programmes as they grow in experience and field work.

IEC Resource Development

Naz Foundation had developed a range of educational materials focusing on male to male sexual behaviours and sexual health issues arising from them which had been used by South Asian communities in the UK. Several of these were translated into Bangla by agency members, and field tested amongst both *civil* and *professional kotis*, *panthis*, as well as amongst those with emerging gay identities.

It was found that these resources were very useful and Bandhu and ASHD asked permission to reproduce them for their own use. This was granted. However, non-literate forms of resources will need to be developed, an area of concern that Bandhu is exploring.

The resources that are being made available in Bangla are:

1. HIV/AIDS the facts: pocket-sized
2. How to use a condom (illustrated): pocket sized
3. STD Guide for males who have sex with males: pocket sized
4. STD Guide for males who have sex with males: A5 size

5. STD guide for women: A5 size
6. HIV/AIDS: a cartoon booklet
7. HIV/AIDS Information booklet: A5 size
8. Hepatitis B: pocket leaflet
9. Condom pack for males who have sex with males

Networking

Naz Foundation sponsored the visit to Dhaka of Deep Purkayastha who is Project Coordinator of Naz Calcutta Project (now renamed Prajaak) which provides sexual health services for males who have sex with males in that city. The development of this agency was also a Naz initiative.

The Prajaak representative was able to meet several members of Bandhu and AHSD, discuss issues of similarity and difference between Calcutta and Dhaka (both Bengali cities) and develop cooperative relationships between the two agencies. This framework would give opportunities towards sharing of resources, education materials, training and information.

Conclusion

Both Bandhu Social Welfare Society and Association for Health and Social Development are now established as registered non-government agencies developing sexual health services for males who have sex with males in Dhaka, Bangladesh.

BSWS is being funded by the Norwegian government for at least three years whilst the Association for Health and Social Development, whose task in many ways is more difficult in terms of human rights and advocacy, is still as yet to secure financial support.

However, the Social and Sexual Behaviour Unit of ICDDR,B is now exploring several of these issues and is willing to offer support for these service developments, as well as conducting a major research project on male sexual behaviours nationally. Further to this, many of the local NGOs are now developing working relationships with both BSWS and AHSD to include male to male sex and anal sex into their service delivery.

The impact brought about by the Project in making visible the issues of male to male sexual behaviours related sexual health concerns has also affected government strategy on HIV prevention through the inclusion of males who have sex with males as a target population in their strategic document.

Naz Foundation continues to work with and support BSWS and AHSD through partnership agreements and service contracts on technical assistance, evaluation, and consultancy.

Both these agencies are also now a part of the Asian network of MSM (males who have sex with males) Sexual Health Projects being developed with technical assistance from Naz Foundation, and have begun establishing working relationships with other MSM sexual health projects in Asia.

These results indicate that a tremendous achievement has been made in developing appropriate responses to the sexual health needs of male to male sex in a Muslim country, a response that is beneficiary led. Community-owned and empowered to respond to their own needs and agendas, Bandhu Social Welfare Society and Association for Health and Social Development have taken up the challenge and shown the courage to fight for their own lives, and the lives of their friends, sexual partners, and families.

This would not have been possible with the vision and support of Ford Foundation.

Based on the experience in Bangladesh, it is the firm belief of the author of this report and Naz Foundation that the model evolved in developing this work has shown itself to be an effective an appropriate methodology for the development of community-based sexual health services for males who have sex with males, in South Asian countries, as well as possibly in other countries in the Asian region.

It is hoped that Ford Foundation and other donor agencies will seek to use this report as a mechanism to fund other such initiatives in differing Asian countries so that males who have sex with males, wherever they may be, will be able to access appropriate sexual health services that arise from their felt needs and issues.

Further to this, it is hoped that governments in Asia will recognise that whilst a behaviour and/or local identity may be invisible or denied, this does not mean it does not exist. Male to male sex, and local sexual identities that express this behaviour will not go away just because we do not believe in its existence, or try to marginalise it as a periphery phenomena. And unless governments, donor agencies, international AIDS agencies, local HIV/AIDS services ensure that the issues of sexual health for males who have sex with males are included as a central component in any STD/HIV/AIDS prevention strategy, then they will also ensure that the spread of HIV/AIDS will never be controlled.

People will die because we don't care. Because they behave in ways we do not like, or find offensive. If we are to be judged in the future about our response to HIV/AIDS, is this how we want to be known? I don't think so.

And always we remember the old ACT-UP New York adage.

SILENCE = DEATH

This is never far away when dealing with the issues of male to male sex in our countries.

PART FOUR

APPENDIX

AGENCY MEETINGS

During the lifetime of this project meetings in Dhaka were held with a number of institutions and donors, including

1. HASAB
2. ACTIONAID
3. Paricharja
4. Marie Stopes Clinic Society
5. Marie Stopes male STD Clinic - Elephant Road
6. Voluntary Health Services Society
7. UNDP
8. City STD clinic
9. Theresa Blanchet Social Anthropologist
10. CARE Bangladesh
11. Christian Commission for Development in Bangladesh
12. Dr. Sarah Hawkes, International Centre for Diarrhoeal Diseases Research
13. SIDA, Swedish Embassy
14. NORAD, Norwegian Embassy
15. Ford Foundation, Bangladesh
16 STD/HIV/AIDS network of Bangladesh
17. Raddha Bhavan
18. Peter Godwin, USAID/JICA representatives
19. Centre for Rural and Social Development: Rickshaw Project
20. UNAIDS
21. Sophie Foreman, ODA Bangladesh
22. Adrienne Brown, ODA Bangladesh
23. Pratyasha, Drugs Awareness Project
24. Population Council
25. German Embassy: Dr. Levenrenz
26. Swedish Embassy: Karl Hagstrom
27. Canadian International Development Agency: Nancy Guerin
28. Medecins Sans Frontieres: Razia Ali Hamm
29. USAID, Zaren Khair
30. Australia High Commission: Jason Reynolds, First Secretary
31. Social Marketing Co.: Parven Rashid
32. Save The Children Fund (UK)
33. Carol Jenkins, ICDDRA,B
34. Lena Hulterstrom, Radda Barnen
35. Nova Consultancy Bangladesh
36. Fawzia Rasheed, independent consultant
37. VSO Bangladesh
38. Advocate Reefat Ahmed
39. Vital Kellens, Belgium Embassy

IMPACT UPON THE BANGLADESH NATIONAL AIDS PROGRAMME

During the period of the Dhaka survey and the follow-on work in developing a sexual health response, several members of the team participated in a range of workshops conducted by the Bangladesh AIDS Prevention and Control Programme, UNAIDS, UNDP, UNICEF and others, raising the whole issue of male to male sexual behaviours and their impact upon male and female reproductive and sexual health.

Despite experiences of stigmatisations, marginalisation, and often levels of abuse, the members courageously persisted with the support of many individuals and agencies participating in these meetings. Several of the workshops were on developing the Action Plan for the National AIDS Programme.

Because of their efforts, there was a considerable impact upon the Draft Action Plan, which enabled issues of male to male sexual behaviours and sexual health to be included, if not in any great detail, at least to be mentioned. This was seen as a great achievement.

The following comments are included in the Draft Action Plan.

Page 9 - Introduction

In spite of the low prevalence of HIV in the country, many factors suggest that HIV may spread rapidly in tile near future. For example, studies have shown high rates of STD in various populations. In 1989, a syphilis rate of 56% and 39% were found among floating and institutional CSWs respectively. In 1997, 54% of 980 CSWs gave a history of present or past STD. Recent reports indicate high levels of STDs amongst various other groups. As with many other Asian countries, condoms are not generally the preferred method of contraception. Furthermore, knowledge of condoms as a means to prevent STDs is very low.

Moreover, sex outside marriage is far more widespread than traditionally acknowledged.

Documented practices include premarital extramarital a**nd male-to-male sex** particularly among youth in Bangladesh. For example, some studies indicated fifty per cent of youths with experience of sex before marriage and occurrences of induced abortions among unmarried girls; sixty percent of long distance truck drivers had sex with commercial sex workers about twice a month without knowledge of HIV/AIDS. Extra-marital sex appears to be quite common in rural societies and in particular where husbands are absent for long periods. Important studies of the sex industry identify large numbers (clOO,000) of generally non-literate commercial sex workers (CSWs) whose customers represent all segments of society. Female CSWs have an average of between 2-5 clients a day, making the number of clients about half a million men a day.

Bangladesh has large numbers of international and national migrant labourers, transport workers and uniformed personnel. These individuals spend extensive periods away from their families which contributes to getting involved in new and different types of sexual relationships. Trans-border mobility is high. Bangladesh also hosts large communities of expatriate refugees while itself having nationals with refugee status in bordering countries.

Further in the Support Document for the Draft Strategic Plan the following was included:

Behavioural Change Interventions: Page 7

In view of the fact that there is a near negligible supportive presence of the Government amongst sex workers, drug addicts, along national highways for transport workers, etc. and that when present, it’s role has been one of enforcing

law and is, therefore, often an adverse influence to the group's interests, the necessity of having NGO's undertake the task of health education and provision of services among these groups would be critical. Government's first task will necessarily be to motivate, encourage and support

NGO's to undertake these tasks as a matter of priority. National Policy has thus far identified the need for separate interventions for:

commercial sex workers, injecting drug users, men who have sex with men (MSM), street youth, migrant workers, prison inmates, land/river and sea transport workers, armed forces, refugees, minority communities, men and women (see "Gender and HIV'), children, and adolescents

Opportunities to maximise the impact of resources and manpower on the spread of the epidemic, must be taken to reach those groups most vulnerable and easiest to reach as a matter of first line priority. That said, concurrent creative methods will need to be sought to reach those less accessible to intervention, probably through lEC.

If the spread of the epidemic is to be curtailed through behavioural change support, a concerted, coordinated national approach is required. To allow for the rapid dissemination of successful strategies nation-wide, model interventions/ institutions could be quickly identified and supported to provide training and guide similar intervention approaches across the country

Support Document
Draft Strategic Plan
Page 14
Strategies
The existing national strategies seem to addressing certain needs but requirement for additional strategies have been articulated as follows:

I. To enable advertising and discussion on condom use on national television
2. To widen the publicity channels to include billboards within communities
3. To identify means to facilitate women, young and otherwise reluctant persons to obtain condoms through motivating those working closest with these communities to assist with information and providing supplies.
4. To provide and market extra strong condoms needed for certain sex practices and techniques.

It should be noted that the Draft Action Plan has been accepted by the Bangladesh Government as a framework for the Bangladesh AIDS Prevention and Control Programme.

KOTI LANGUAGE

A brief study was done on the words used by *kotis* in Dhaka, who have their own terms and words different from Bangla I am indebted to Dr. Suman Lahiry for this work.

Koti term	English meaning
Julfi, chulfi	Muslim
Baital Pari, Chaitan	Hindu
Baitan	Christian / the guy who is born in parents house and brought up in maternal grandfather's house.
Khatia Pari	foreigner
Lambitaler Pari	"fucker" from a different place, active men in different language
Difference in Panthis & Pari	
Panthi	Noun used in separate word
Pari	Noun used in a sentence
Jarina Panthi	Active who is feminine / fashion conscious
Chaakma Pari	Indigenous, Buddhist
American Chaakma Pari	Japanese, (Mongolian Foreigners) Chinese
ADJECTIVES OF ORGANS	
Akkhar	big, handsome (i.e. a big cock)
Arial Se Khari	Man with a big strong penis, panthi, an ever erect penis
Billa	bad looking (used to describe looks)
Buddi, Shutti	old (as in age)
Chishya, Chish	good looking
Elbel	ugly (as in a person's looks)
Kachchi	wrong (done something wrong)
Motu matur, Motka Motki	medium (reference to penis size)
Nattu, Lukkhar, Pukki	small (reference to penis size)
Nilki/milki Nattu	small breast, retracted nipple small pegs (sic!)
Sadarghat, Borosava	loose anus, overused anus
Sitti	diseased, ruined, rubbish (e.g. penis in syphilitic ulcer)
Tona, Tunni	small (as in penis)
Yog nattu	small & curved (as in penis)

SEXUAL ACTS

Aankhi maasi jire	blinking eyes to show sign
Bigaar	libido, sexual desire
Dhur chapani	fuck (anally)
Dhur pit	fuck (anally)
Gynae khol chish	rimming
Khoma takani	sucking a penis
Kopano	fucking for long time (digging with spade)
Laalee Laalee	mouth sucking, tongue sucking/sucking whole body
Lali maasi potey	ejaculating over body, spreading semen over body
Lali machi chish	body sucking
Likaam jiraani	taking penis into anus
Nishithey Thunkaaisa	fucking at the nighttime
Sodran Taka	drinking semen
Sodrani gamasi	who force to take their semen whether the koti is willing or not
Takki	sucking the body and creating marks
Thun kaano	fucking

LABELS

Aarial Dingu	Judge, Barrister
Do parata, Mandira	is both active and passive in sex
Kaajhi	hijra
Lukkhar Dingu	police, guard
Motur,Koti, Hijra, Hijla	passive male
Parekh, Parikh	customer (may be panthi , or do parata)
Panthi, chishya korani panthi	doctor, who can cure disease
Panthi, Pari	active male, sex customer
Tona	children

CALLING NAMES

Aachooda	not capable of erection, impotent
Baatli-te aangool niya jonmaisos	born with a finger in his anus
Baatli - te(se) -khurpi	shoe in your anus
Bakkhar, Bakhri	poor customer
Balghooti khanki	who rents his anus everywhere, even in Barobhataricwho has a dozen of “husbands”
Bechooda	doesn’t have a definite father
Bhookchood	premature ejaculation
Borhani Jirni	koti who always call names or always insult other kotis/ customers
Chhinal	low class male prostitute or koti
Chhinalani	low class very feminine male prostitute
Chutmaraani	who rents his anus
Khaanki	prostitute, promiscuous koti
Khail Khoora	cheat
Khuma Bechish	ugly looking
Sirithi	hypocrite
Sopro	prostitute
Vel khutni	who backbites/ speaks ill of others

ORGANS

Baatli	anus
Bhatti Maanki	good hips/good glutens, good buttocks
Bhatlu	arse, arsehole
Chippu, Sippu	any opening, hole
Chyamra	skin of penis, foreskin of uncircumcised penis
Likaam	penis
Mang	vagina, pubis

Manger Aatha	vaginal fluids
Moni	glans penis
Nilki	breast
Sippu, Foolki	vagina

RELATIONS

Baiuu	brother
Gothama	brother
Gothia	female friend/companion
Lunni	girl friend/fucking female companion
Nehaarun	women/girls
Paansi	close friend
Shuddi	old women

COMPLIMENTS

Aakha	who can inflict more pain usually in anus
Bhatti	sympathiser whose condition same as the speaker
Bool booli (little bird) Aamasi	nonsense, but caressing call.
Chishya, Chis, Akkhar	good , good and big
Chishya Thyakani	who can fuck for long time and in good fashion so that enjoyment is divine(sic)
Dhurni chishya	who can fuck for long time and in good fashion
Ganga Jamuna	good friends (koti friend)
Paangash Machher Petli	nice curve of abdomen/belly (the belly part of a fish "pangaash")
Pamela	international prostitute
Raani Sarkar	older prostitute(Above 40)
Sholo rathi jaibon	kicking in youth, very sexy, kicking in sex

VERBS

Bila	out
Chaamo	excite the man to give him erection
Darshan Aachhe	I have glamour.
Ei taali chatak	the glamour, all you have is merely hijra's one.
Elbel Khutni, Kachchi Khutni	calling names during back biting.
Fir kai na, For kai na	does not get erected.
Ghurni Ghar Ghar	passing stool while fucking.
Jirani	come in the mouth.
Kari	be quiet
Khil Khil Maasi	laugh
Khil Massi	laugh
Khutni	back biting
Khutni Khutish Na	don't bite back.
Naarthu	no, don't
Nathu Chabaisa	to bite penis during sucking if the person is forced to do it.
Pottasi, Potaya Dao	bye, to make somebody driven out.
Taakni	eating
Tandani	insertion
Thei kona	don't go (with him).

OBJECTS

Aaakashi	high class wine
Danki	cigarette
Gamasi	drinking (wine/semen). (If he does not pay, make him drink your stool)
Gynee, Ghunni	stools (faecal matter)
Kelwar	low class wine
Khurpi	shoe
Maail (mile)	Taka, Rupees.

Rubber maasi	condom
Sadra	dress
Vaangi banglaa	local liquor
Upar maasi	condom

ANIMALS

Bhyabani maasi	goat, mutton
Kobra	beef
Kok kok	chicken
Pyaak pyaak	duck

SOME ARTICULATED SENTENCES

HAMSI BAIGOON MAASI SIRMOO TOBU TUMSI LIKAAM JIRMOONA
I'll better use brinjal/egg plants, still won't take your penis in.

GUYNEE KHOLE HAMSI BIGAR UTHLEY SITTI MAASI HOGE
If I get sexy and I don't get anybody, I'll better do finger fucking.

AASISR LOGEY THAIKONA
Don't go with them (they may be cheat).

SARAA NISHITHEY 20 MILES 20 MILES SI 40 MILES JIRBE
Whole night they will use you but will only pay 20 taka 20 taka = 40 taka.

LIKAAM AISI SITTI
Skin disease/sexual ulcer on glans.

DHURAYA GUYNEE BAIRAI GAAMSIRE KOIRA DISEY
He fucked me so terribly that stool came out of arsehole.

AISI RE TUMSI BORHANI JIRKA
Are you going to insult such a narthoo (cheat).

KAWA TAKNI KAWA
Crows never eat another crows flesh (kotis can never fuck other kotis).

BICHCHI TAKNI BICHCHI CHAMAO!
Take contraceptive pill and make nipple or feel whether there is lump or seed like feeling in nipple.

HIJRA TERMS

MEYE MEKRA	sissy boys (often people confuse them with Hijras).
AANCHLI	to shelter a boy as son of hijra mother (usually boy prostitutes).
DHYAMNA! DANRIYA KYAN?	sissy hypocrite (impotent in disguise of friend) What's the point in standing if you're a marad (potent) prove it. Lets have sex/ screw me.
SINA	chest (I'll get my "husband's" chest tonight).
FALNA	penis
FALNAKHAN FAKHRAISEY NA!	the penis is not getting erected.
FORA	injection
SITAPATI, SONA ROG (RAMA)	syphilis
GONOPATI , GANI ROG (GANESH)	gonorrhoea
TANGO TORNA	Hindi word used for the ritual where boys/men get castrated.
VAGANDAR GEZZ	piles, haemorroid
MAKHAIN BILA	pectal prolapse with ulcer (sic)

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