

# Male-to-male sex and HIV/AIDS in Bangladesh

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## Who is MSM – behaviour or identity?

The category “men who have sex with men” (or males who have sex with males - MSM) was developed in response to a recognition that not all male-to-male sexual behaviours falls within a framework of sexual orientation or identity. Within this behavioural category there are multiple frameworks of male-to-male sex, including those who self-identify as homosexuals/gay men, males who self-identify within a gendered framework, such as *kothis* and *hijras*, as well as normative males from the general male population who sexually access such gendered males, along with others, usually as the penetrating partner. Male-to-male behaviours also exist in a range of all-male institutions and occupational groups including prisons, juvenile homes, and the armed forces, along with truck drivers, and in other service industries. In this context, the sexual practice is primarily based on a lack of access to females, “body heat”, and immediate discharge. Further to this, there is also a concept of masti, or play, in which same sex behaviours are not seen as “real sex” but play. Significant levels of adolescent males and young men engage in this behaviours.

In Bangladesh, the primary framework of male-to-male sex appears to be that based on gendered identities: males such as *kothis* or *hijras* who self-identify with the feminine, and males from the normative male population who self-identify as men. Neither population perceive themselves as men have sex with men. For the masculine, penetrating male, his behaviour is not homosexual, since he is penetrating those who are not perceived as men.

## Size estimations

The difficulty for developing size estimations of MSM populations in Bangladesh is the confusions regarding self-identified MSM – *kothis* and *hijras*, - and that of their sexual partners who are usually non-identified MSM whose male-to-male sexual behaviours are not based on a sexual/gender identity. The confusion impacts on what is being counted, and whether it is identity-based or behaviour based, where the two are not synonymous.

While developing size estimations for the populations of *hijras* and *kothi*-identified males may be possible, this as yet has not been done for the country as a whole. In regard to their masculine sexual partners, this is an enormously difficult task because of seeking knowledge of male-male sexual patterns in such a conservative and “sexually silent” population generates an aura of invisibility and denial.

In terms of self-identified feminised males, which would include *kothis* and *hijras*, and at times those without specific identities, i.e. those who have regular male-to-male sex, global evidence indicates that some 3% to 5% of the male population would probably fall into this category (MAP Report 2005). However, this figure may also be low in the Bangladesh context because of gender segregation amongst adolescents and young men. A study conducted by Bandhu Social Welfare Society in 2002 indicated that rates of male-to-male sex was much higher and frequent amongst young men before marriage, and dropped of considerably after marriage.

In a study in Sylhet( population 700,000) conducted by NFI with Bandhu Social Welfare Society (2000), it was estimated that there were some 5000 self-identified *kothis* in the city (2% of the male population) along with some 50,000 males from the general population who accessed them for sex, a figure that concurred in other cities were similar studies were conducted. If one were to

extrapolate this percentage for the whole country, then there would be approximately 1,400,000 *kothis/hijra*-identified males, with *kothis* representing the majority.

But this is not the total number of males involved in male-male sex. If truckdrivers and rickshaw pullers are typical of the general male population, then between 7% and 15% of men over 15 (2.5 million to 5.25 million) have sex with another male at least once a month (Foreman, 2003). But in a study conducted by ICDDR,B in 2003, 22% of rickshaw drivers in Central Bangladesh (i.e. Dhaka) admitted to have sex with another male in the previous year!

Bandhu Social Welfare Society, delivering prevention services to *kothi*-identified males in six cities, reached some 300,000 such males between October 2000 to December 2004.

All attempts to provide a total sex estimation of male-to-male must be suspect until more definitive studies have been done, recognising there are several different frameworks of this behaviour involving different sub-populations.

### **Sexual Debut**

A study conducted for CATALYST Consortium in 2002-2003 on the formulation of reproductive and sexual health behaviour among young men in Bangladesh, which involved males from the general population as well as *kothi*-identified males, it was discovered that there were two distinctly separate sexual debuts. For males from the general population this was between 14 years to 19 years, while for *kothi*-identified males this was between 7 years to 12 years.

### **Sex with females**

There are two distinct patterns of MSM in Bangladesh and sex with females. For the males from the general population who access *kothis* and *hijras* for sex, their sexual activities also include sex with females, including female sex workers. Along with this some *kothis* also access female sex workers as a preliminary for their marriage. Further with marriage being socially compulsory, a majority of *kothi*-identified males will also marry and produce children. Of course, males from the general population will also get married.

### **Male-to-male sex and risk behaviours – who is at risk?**

Not all male-to-male sex involves risk activities, and not all males who have sex with males practice risky behaviours.

Risky sexual practices would include:

- Unprotected anal sex for both the penetrated and the penetrator
- Multiple partners
- Having sexually transmitted infections

Evidence from a range of studies in Bangladesh indicate that anal sex is the preferred sexual activity, and certainly in regard to *kothi/hijra* identified males, part of their feminine sensibility arises from their receptiveness in anal sex. Studies amongst *kothi*-identified males indicate that over 70% of such males practice receptive anal sex regularly. Evidence also exists that such males have a significant high rate of multiple partners (between 2-5 per week) with some of it for commercial gain. Low condom use appears to be common, along with low access to STI treatment.

It should be noted that the in general, identities based on gender and those based on sexual orientation tend to be class determined, that is those who self-identify as *kothis* or *hijras* tend to come from low-income populations, while those who self-identify as gay or homosexual tend to

come from upper-middle class. Thus, those who self-identify as *kothis*, are often poor and sexual acts can be poverty driven (such as sex work).

As the primarily receptive partner in anal sex, along with low condom usage and low access to STI treatment, their early sexual debut, frequency of multiple partners, along with significant levels of sexual abuse (see below) and harassment, with poverty concerns and frequent levels of commercial sex transactions, *kothis* and *hijras* can be seen as the most highly at risk for HIV. However, this is compounded by multiple routes of HIV infection such as injecting drug use (there is some evidence of some *kothis* and their partners injecting drugs), along with their partners accessing female sex workers.

### **Sex work**

There is no clear distinction between *kothis* who sell sex and those who don't. Often commercial sex is based on opportunity and availability. For the majority of kothi-identified males, sex for money is an essential survival strategy and is frequently conducted, but also sex is freely provided as well.

It is clear from the a range of studies that partner rates for *kothis* who do sell sex and those who don't are not significantly different

### **MSM, vulnerability and stigma**

Stigma, discrimination, illegality, harassment, and violence, impede access to HIV/AIDS/STI prevention, treatment, care and support services where they exist, as well as impeding development of appropriate services.

In a study (2003, 2005) conducted by NFI and Bandhu Social Welfare Society with *kothi*-identified males in several cities in Bangladesh, exploring the social, legal and cultural impediments to HIV/AIDS interventions among them, the following was found:

33% of respondents had experienced sexual assault or rape from their masculine friends

64% experienced harassment by the police

48% reported being sexually assaulted by police

65% reported being sexually assaulted by *maastans*

Further it was clear that because of being a kothi had a significant impact on educational and employment opportunities.

Fear of blackmail, denial, social exclusion, violence and abuse leads many MSM not to access services, self-identified or otherwise. For the manly penetrating partner who only acknowledges his 'heterosexuality', accessing services would be within this normative dynamic. These factors could also have an impact on HIV sentinel data being collected.

### **HIV/AIDS and male-to-male sex**

Evidence from the regular BSS studies conducted in the country continues to show an HIV prevalence rate of below 1%. However, the 2005 study provides an indicator that this may not stay this low much longer, and the possibility of an Indonesian scenario arising in the country in the near future must be considered a strong possibility, where HIV amongst 'MSM' remained very low for several years only to rise very rapidly in the last few years, where it had reached 21.8% amongst transgendered (*waria*) in 2002. *Waria*-identified males in Indonesia (a Muslim country) would be the equivalent of *kothi/hijra* -identified males.

## **STD prevalence amongst MSM**

The fourth round of BSS in Bangladesh indicated 12% syphilis prevalence amongst 'MSM'. NFI/Bandhu studies amongst kothi-identified males indicated that some 50% reported anal bleeding, and some 20% were reporting gonorrhoea symptoms.

In the Bandhu sexual health clinics, some 31% of patients were treated for STIs between October 2000 and December 2004.

## **Conclusion**

It is clear that greater attention needs to be placed on scaling up coverage and increasing condom use amongst kothi-identified males, along with hijras, while at the same addressing stigma, discrimination and violence against such males to ensure that appropriate services are being delivered at point of need. Efforts need to be intensified to support self-help organising to provide prevention services and mobilising of *kothi* sexual networks. At the same time, STI clinics need greater skills-building towards addressing a range of anal problems including anal STIs.

# ANNEX I

## Strategies to address vulnerability and risk to HIV/STI amongst MSM

NFI suggests the following comprehensive service package towards reducing risk and vulnerability to HIV/AIDS/STIs amongst MSM. Along with technical support, these include:

### 1. Knowledge generation

The need for more knowledge is abundantly clear, involving anthropological, sociological, behavioural and epidemiological studies, along with good practice methodologies. It is also suggested that such research is conducted with MSM HIV/AIDS agencies as partners.

### 2. Increasing Coverage

A rapid increase in coverage, and scaling up of interventions is urgently required. The model suggested here is the provision of technical support and assistance to MSM networks to develop and manage their own HIV/AIDS community-based interventions. Appropriate NGOs can provide development, capacity-building, and technical assistance, as well as mentoring.

### 3. STI Clinical Services

While HIV/AIDS interventions amongst MSM can refer potential patients to appropriate clinics, take-up of such services may be higher if such clinics were housed within community-based projects. Further intensive training will be required for clinicians regarding male-to-male sex, anal STIs and their treatment, developing a sympathetic and empowering environment, along with reduced costs of treatment.

### 4. VCTC

Appropriate Voluntary Testing and Counselling Centres are an essential component for any effective intervention strategy. This is even more so for at-risk MSM. However, it will be essential to ensure that all staff at such a Centre are thoroughly sensitised to the issues of MSM, have a clear understanding of the dynamics of MSM constructions, can provide strict confidentiality, appropriate counselling (both pre- and post-test), as well as ensure that such MSM can access appropriate support and care services. Well-supported links will need to be established with MSM service providers.

### 5. Condoms and lubricant

Many at-risk MSM have significant levels of penetrative sex on a regular basis, so it will be essential that sufficient good quality condoms are easily and cheaply available at different outlets, including places where sex takes place. Further since condoms suffer additional stress when used for anal sex, it will also be essential to ensure that adequate supplies of affordable water-based lubricants suitable packaged are also readily accessible.

### 6. Counselling

Any MSM intervention must include appropriate counselling on psychosexual and personal concerns. Many MSM such as *kothis* and *hijras* have low-esteem and a deep sense of disempowerment and self-hatred which leads to higher levels of risk and self destructive behaviours. With all this there are deep issues of concern around families, wives and children that also must be addressed, particularly in regard to family knowledge of sexual, STI and HIV status.

### 7. Advocacy and legal issues

Stigma, discrimination and social exclusion are central in the lives of many at-risk MSM, particularly those with feminised identities, such as *kothis* and *hijras*. Legal and judicial impediments to effective community-based interventions amongst MSM will need to be address.

Advocacy will need to be conducted with legal and judicial services, as well as parliamentarians towards addressing these concerns, in particular Section 377 of the Indian Penal Code.

Further, advocacy work will need to be conducted with the media and the public to destigmatise MSM behaviours, while MSM will need to be trained on their legal rights.

## **8. Training of the judiciary and law enforcement agencies**

As an urgent necessity, the judiciary and local law enforcement agencies will need to be sensitised to the issues of MSM, their own STI/HIV risks, and the needs of specific MSM sexual health interventions. This will mean a closer relationship between Home and Health Ministries as well as the judiciary and police forces.

## **9. Working with other NGOs who provide services for the general male population**

The MSM behavioural category does not only include self-identified MSM, but also non-identified MSM, many who identify as “heterosexual” and from the general male population. While it will be possible to access many of these males/men through their *self-identified* partners, it will also be necessary to ensure that any HIV/AIDS awareness programme and specific interventions with particular occupational groups, such as rickshaw drivers, auto-drivers, truck-drivers, factory workers, street children and so on, must include anal sex as a risk factor in HIV and not only discuss female sex workers and vaginal sex. This will mean collaborative work with other HIV/AIDS and sexual health NGOs working with the general male population. This will further require that these NGOs will need to be sensitised and educated about the dynamics of male-to-male sexual behaviours in Indian society.

## **10. IEC materials**

Education and sexual health promotion materials can be an effective component of any intervention towards preventing the spread of STI/HIV/AIDS. However to be such it requires that such resources are meaningful to their users. This will mean ensuring that appropriate language and imagery are used that makes sense to those accessing these resources.

## **11. Funding and commitment**

It is clear from what has been discussed above that at-risk MSM form a substantive population that is extremely vulnerable to HIV in terms of themselves, but also in regard to the general population through their bridging role. Therefore, it makes sense to ensure that support for MSM led interventions is also substantial, significant, and that a strong commitment from government and donors is made. Funding needs to be adequate and at appropriate levels to achieve this, and should be provided to the appropriate agencies, while assistance is also provided to develop such agencies. UNAIDS and others strongly believe that community-based agencies are the appropriate and best interventions agencies. In the case of this paper, this means MSM based and owned agencies would be appropriate.

## **12. Women’s sexual health**

Behaviourally bisexual activities appear to be common, where not only many MSM also have sex with women, but also anal sex between men and women are not uncommon. These issues will need to be addressed appropriately.

Certainly these primary recommendations for action are not the only areas that need to be developed. There are others that perhaps can be seen to be as equally important. Discussions should be initiated with local experts in the field of MSM HIV/AIDS and sexual health so that a comprehensive strategy can evolve that is significant, sustainable, and well supported. It will require a strong political and social will to achieve this.

## ANNEX II

### Documents

Bandhu Social Welfare Society, 2003, 2004, 2005 Annual Reports.

National Behavioural Surveillance Studies, ICDDR,B, 1<sup>st</sup> – 5<sup>th</sup> surveillance rounds.

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