



Know Violence

Exploring the links between violence, mental health and HIV risk among men who have sex with men and transwomen in South Asia



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Contents

Forewords	6
Acknowledgements	10
Acronyms and abbreviations	12
Glossary	13
List of tables, figures and boxes	16
Executive summary	18
Background	19
Study	20
Study results	20
Recommendations	22
Chapter 1: Introduction	24
1.1 Violence, mental health and HIV among sexual and gender minorities	25
1.2 About the study	25
1.3 Objectives and methods	26
Chapter 2: Regional context	28
2.1 Laws and policies related to sexual and gender minority groups	29
2.2 SOGIE-based violence	39
2.3 HIV prevalence	42
2.4 Mental health among sexual and gender minorities	44
2.5 Research gaps	44
Chapter 3: Methodology	46
3.1 Conceptual framework	47
3.2 Study design	49
3.3 Sample, recruitment and data collection	50
3.4 Ethics and safety measures	52
3.5 Strengths and limitations	53
3.6 Sample demographics	55

Chapter 4: SOGIE-based violence: Forms, impact and coping	58
4.1 Types of SOGIE-based violence	59
4.2 Sources of SOGIE-based violence	62
Chapter 5: Resilience and coping strategies	74
5.1 Living a dual life	75
5.2 Coming out	75
5.3 Self-exclusion and leaving the community	77
5.4 Resilience	78
Chapter 6: SOGIE-based violence, HIV and mental health	82
6.1 SOGIE-based violence and mental health	83
6.2 SOGIE-based violence and HIV risk	84
Chapter 7: Life course pathways between violence, mental health and HIV	90
7.1 Power and status in society	92
7.2 Family context	92
7.3 Trajectories into a dual life, or not	93
7.4 Mental health problems, substance abuse and unprotected sex	94
Chapter 8: Recommendations	96
Bibliography	106
Appendices	110
Appendix I: Rationale for site selection at each study site	111
Appendix II: Ethical review procedures across study countries	113
Appendix III: Focus group discussion guidelines for men who have sex with men	114
Appendix IV: Focus group discussion guidelines for transwomen	120
Appendix V: Key Informant Interview guidelines	125

Forewords

Violence based on sexual orientation, gender identity and expression (SOGIE) is a grave violation of the human rights of sexual and gender minorities worldwide. It has severe consequences for the survival, safety and freedom of gender and sexual minorities, disrupts development opportunities, and can also increase HIV risk and prevalence, particularly among men who have sex with men and transwomen. SOGIE-based violence also impacts the mental health and well-being of members of sexual and gender minority groups. While there are well-documented trends in some regions of the world, less is known about SOGIE-based violence, HIV risk and mental health among sexual and gender minority groups in South Asia.

This type of violence reflects homophobic and transphobic beliefs, norms and institutions prevalent in all countries. Beliefs that same-sex sexual activities, preferences and identities are deviant or pathological are commonly held across the Asia-Pacific region. These beliefs permeate all levels of society – from institutions and communities to families and individuals – and constrain the ability of sexual and gender minorities to live free from violence, harassment and discrimination.

Some progress has been made to advance the rights and protections of sexual and gender minority groups in the Asia-Pacific region. Recent legislative progress is the result of decades of activism by grassroots

organizations and community activists, along with support from legislators and policymakers, international development partners, UN agencies and others who work to advance the rights of sexual and gender minorities.

The United Nations Development Programme (UNDP) initiated this regional study to better understand the lived and perceived experiences of SOGIE-based violence among men who have sex with men and transwomen in South Asia, and to explore the effects of this violence on mental health and HIV vulnerability. The results are integral to informing evidence-based policy and programme work to prevent SOGIE-based violence, reduce HIV prevalence and incidence, and enhance the mental health of sexual and gender minorities in the region.

The UNDP Strategic Plan 2018–2021, which sets out the direction for a new UNDP and is optimized to help countries achieve the 2030 Agenda for Sustainable Development, emphasizes that reducing gender inequalities and empowering vulnerable groups is vital to achieving the Sustainable Development Goals. This report is aimed at supporting these efforts and contributing to action to create a world in which sexual and gender minorities live free of violence, and enjoy good health and well-being and in doing so, deliver on the commitment to “leave no one behind”.



Valerie Cliff – Deputy Regional Director for Asia & the Pacific – Director, Bangkok Regional Hub

Globally, there has been great progress over the past few years with respect to the acknowledgement and recognition of issues relating to sexual orientation and gender identity and expression. There is greater acceptance of gender fluidity and lesbian, gay, bisexual, transgender and intersex (LGBTI) communities across the world. While awareness of SOGIE-based matters has increased phenomenally, the resources available to address SOGIE-based violence and its drivers and to ensure redress for individuals and communities that face such abuse have been limited, particularly in regions such as South Asia.

Many definitions of gender-based violence focus on women as victims of such violence; for example, the Committee on the Elimination of Discrimination Against Women (CEDAW) states that gender-based violence is “violence that is directed against a woman because she is a woman or that affects women disproportionately.” Definitions of gender-based violence are also pertinent to all forms of violence that are related to social expectations and social positions based on gender, or to not conforming to a socially accepted gender role or expression.

In South Asia, gender expression, sexual orientation and identity, as well as sexual behaviour are diverse, which makes it crucial to have an informed definition of violence to ensure inclusivity and redress for all individuals who are vulnerable.

While instances of violence faced by men who have sex with men and transgender persons and the impact of such experiences on the lives of these communities have been documented both by media and research, there is an urgent need for enquiry in order to understand the impact and complexity of such experiences, and the threat they pose to individuals and communities.

This cross-cultural qualitative study is a first such attempt to understand and identify various patterns of violence experienced by men who have sex with men and transwomen and the linkages of such experiences and drivers with HIV and mental health across seven countries in South Asia: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka.

The scope of the present study limits itself to uncovering experiences of men who have sex with men and transwomen, through their narratives, at several levels with respect to their exposure to violence, its impact on their mental health and how such experiences are both directly and indirectly linked to increasing their vulnerability to HIV.

We hope that the recommendations that emerged from the study’s insights pave the way for more such efforts and endeavours in the future.



Ravi Verma – Regional Director, Asia
– International Center for Research
on Women

APCOM Foundation began its work over a decade ago to respond to the HIV epidemic among gay men, bisexual men and transgender persons in Asia and the Pacific. Along the way, these communities taught us two important lessons that are relevant for our work today. The first is that we will not be able to address large public health issues without addressing the issues that impact the rights of these communities. The second is that we need to adopt a more intersectional approach that speaks to the lived experiences of all individuals of diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC).

The violence, discrimination and exclusion experienced by many SOGIESC people across Asia and the Pacific is one such burning issue. It has an immensely deleterious effect on these communities. Just because of how they express love or their gender identity, many people across our region are separated from family and friends, harassed in their workplaces, abused by their intimate partners, ostracized by their neighbours or assaulted on the street. Many suffer physical injuries and mental anguish. Some are killed and others harm themselves. Both empirical and anecdotal evidence suggests that young people are especially vulnerable. APCOM's work around sexual and gender-based violence against SOGIESC persons in humanitarian settings is exploring

how these individuals are not only affected but made invisible.

The direct impact this has on the health of those who experience SOGIESC-related violence and prejudice is painfully obvious. However, there is also an indirect impact on the mental health of SOGIESC persons more broadly, as their experience of violence and discrimination can impact the way these individuals engage with services meant for them and service providers who engage with them. Among other things, we hope this study will provide insights on how SOGIESC persons can be reached and served better by recognizing their experiences with violence and speaking to their needs for improved health and well-being.

The gaps in provision of HIV prevention, testing and treatment services for transwomen and transmen who have sex with men in South Asia is a prime example. Across the region, these communities account for the majority of new HIV infections. However, the violence, persecution and discrimination experienced by men who have sex with men and transgender women in many places throughout South Asia means low or no access to effective service provision. This, in turn, drives the HIV epidemic among these communities to even higher levels.

It is a bleak picture to have to paint, but sadly this is the distressing everyday reality for hundreds of

thousands of people across South Asia as well as the rest of the Asia-Pacific region. However, due to the hard work and dedication of activists, advocates and allies, progress is being made. Reports such as this are vital to creating an informed response to this very serious issue and APCOM commends all involved for their contributions. As we move towards the goal of ending HIV by 2030, I urge all relevant agencies and authorities throughout Asia and the Pacific to help us create an HIV-free future by ensuring that all people across the region have the health and safety to which they are entitled as citizens of their countries, and the compassion and dignity to which they are entitled as human beings.



Midnight Poonkasetwattana
– Executive Director – APCOM
Foundation

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Special thanks to Dr Priti Prabhugate for spearheading the research initiative and Ms Ketaki Nagaraju for editorial support from ICRW.

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The development of the report was supported by UNDP through the Multi-Country South Asia Global Fund HIV Programme (MSA-910-G02-H), a regional programme that operated in seven South Asian countries: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. The overall goal of the programme was to reduce the impact of, and vulnerability to, HIV of men who have sex with men, *hijras* and transgender people through community systems strengthening. In Afghanistan, the programme focused on HIV prevention services for men with high-risk behaviour. The UNDP Bangkok Regional Hub served in the role of Principal Recipient for the programme from 2014 to 2016.

The report was also supported by the UNDP Being LGBTI in Asia programme, a regional programme aimed at addressing inequality, violence and discrimination on the basis of sexual orientation, gender identity and expression or

intersex status, which promotes universal access to health and social services. It is a collaboration between governments, civil society, regional institutions and other stakeholders to advance the social inclusion of lesbian, gay, bisexual, transgender and intersex people. The programme is supported by UNDP, the Embassy of Sweden in Bangkok, the U.S. Agency for International Development, the Australian Department of Foreign Affairs and Trade and the Faith in Love Foundation (Hong Kong).

Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
APF	Asia Pacific Forum of National Human Rights Institutions
CBO	Community-based organization
FGD	Focus group discussion
HIV	Human Immunodeficiency Virus
ICRW	International Center for Research on Women
IDLO	International Development Law Organization
ILO	International Labour Organization
KII	Key informant interview
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MHRB	Men with high-risk behaviour
NGO	Non-government organization
NHRI	National Human Rights Institution
OHCHR	Office of the United Nations High Commissioner for Human Rights
SOGIE	Sexual orientation, gender identity and expression
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNDP	United Nations Development Programme

Glossary

<i>Chhalla and Badhai</i>	Terms used to describe various livelihood options practised by transwomen who identify as <i>hijra</i> . <i>Chhalla</i> is clapping and seeking alms. <i>Badhai</i> is a ritualistic blessing for newborns and dancing at weddings.
cisgender	Relating to a person whose sense of gender and personal identity corresponds with their birth sex.
<i>Hijra (Kinnar)</i>	<p><i>Hijra</i> is one of the terms used in South Asia among a specific group of assigned-male-at-birth, transfeminine or (less often) intersex individuals, who identify either as women, not men, in-between men and women or neither man nor woman. Contrary to popular belief, all <i>hijras</i> are not castrated, and 'eunuch' is not an appropriate translation.</p> <p><i>Hijras</i> have traditional matrilineal communities, by which the ritual of <i>reet</i> (christening ceremony) formalizes a person's membership. There are several <i>hijra</i> clans or <i>gharanas</i> or <i>deras</i> across South Asia. <i>Hijra</i> clans consist of <i>gurus</i> (leaders) and <i>chelas</i> (disciples) who often live in close-knit, governed, self-created families.</p> <p><i>Hijras</i> are mentioned in several Hindu legends and folklore. They once occupied key positions in the royal courts. However, they were removed from their esteemed positions and criminalized during the time of British colonialism.</p> <p>Apart from the traditional occupations of <i>chhalla</i> and <i>badhai</i>, many <i>hijras</i> are compelled to rely on sex work (often exploitative) for a living. The term '<i>hijra</i>' itself has many regional variations, for example, <i>kinnar</i> in parts of India.</p> <p>While <i>hijra</i> are usually transgender women, the two expressions are not interchangeable.</p>
<i>Khwajas siras, Khusras, Zenanas</i>	<p>These are terms used to describe male-assigned-at-birth, transfeminine individuals in Pakistan.</p> <p>While <i>Khwajas siras</i>, <i>Khusras</i> and <i>Zenanas</i> are usually transgender women, the expressions are not interchangeable.</p>
<i>Kothis, Metis</i>	<p><i>Kothis</i> is the term used in South Asia to describe individuals assigned male at birth who show varying degrees of femininity and who often (but not always) play a receptive role in sex with men.</p> <p><i>Metis</i> are considered the counterparts of <i>Kothis</i> in Nepal.</p> <p>While <i>Metis</i> and <i>Kothis</i> are usually transgender women, the expressions are not interchangeable.</p>

1 Afghanistan National AIDS Control Program. National Strategic Plan – Investing in the Response to HIV 2016–2020.

Men who have sex with men (MSM)

For the purpose of this study, the following definition is used:

Men who have sex with men is an umbrella term used to categorize men who engage in sexual behaviours with other men. The term is most often used in public health. Some men who have sex with men may also have sex with women, so the term does not indicate sexual orientation.

Although the term ‘men who have sex with men’ is used to denote behaviour, in some South Asian countries, the acronym ‘MSM’ has increasingly being used to denote a sexual identity. For example, sometimes men use the term ‘MSM’ interchangeably with ‘gay’ to describe their sexual identity.

As men who have sex with men include a heterogeneous group of males that have varied gender expressions ranging from masculine-presenting to feminine-presenting males, different subgroups may be at different levels of risk of violence compared to others.

In the context of Afghanistan, the phrase ‘men with high-risk behaviour’ is used for this key population, in line with the Afghanistan National Strategic Plan: Investing in the Response to HIV 2016–2020.¹

In this report, the term ‘men who have sex with men’ excludes transmen who have sex with men, not because of a belief that transmen are not men but because not enough information is available about this subgroup. The report also distinguishes between men who have sex with men and transwomen. While transwomen are often conflated with men who have sex with men in public health literature, they face unique challenges and experiences based on their gender identity. This report distinguishes between the two subgroups, highlighting issues pertinent to each specific subgroup and pointing out commonalities only where relevant.

Panthei, Giriya, Parikh

Terms used to describe penetrative male sexual partners.

Sexual and gender minorities

A sexual minority is a group whose sexual identity, orientation or practices differ from the majority of the surrounding society. A gender minority is a group whose gender identity, expression and practices differ from the majority of the surrounding society. Examples of sexual and gender minorities include men who have sex with men, women who have sex with women, and transgender women and men.

<i>Transgender/ Transgender Person(s)</i>	An umbrella term for people whose gender identity does not coincide with the sex they were assigned at birth. It may include people who identify as a man, a woman, or alternative genders, a combination of genders or no gender at all. Common terms used to describe transgender identities include transmen and transwomen. Other definitions of transgender also include people who belong to a 'third gender' or conceptualize transgender as a third gender.
<i>Transgender women (Transwomen)</i>	A term used to refer to a transgender person who identifies as female (i.e. a person whose sex was assigned male at birth who identifies as female). The term does not denote sexual orientation. 'Transgender women' (or transwomen) is often used as an umbrella term for all types of transfeminine identities, regardless of their sexual orientation. For the purpose of this study, the term 'transwomen' has been used for male-assigned-at-birth transfeminine individuals who have sex with men.

List of tables, figures and boxes

Table 1	Snapshot of country contexts with regard to SOGIE concerns	35
Table 2	Participant profile: MSM and MHRB	56
Table 3	Participant profile: Transwomen	57
Table 4	Forms of SOGIE-based violence mentioned in focus group discussions	60
Box 1	United Nations entities call on States to act urgently to end violence and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI) adults, adolescents and children (excerpts)	30
Box 2	SDG commitments particularly applicable to the context of SOGIE concerns	33
Figure 1	Timeline of global commitments in the context of SOGI-related rights	31
Figure 2	HIV prevalence among MSM and transgender people	43
Figure 3	Types of SOGIE-based violence	47
Figure 4	Socio-ecological model	49
Figure 5	Sources of SOGIE-based discrimination based on focus group discussions in Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka	62
Figure 6	Coping strategies	80
Figure 7	Connections between SOGIE-based violence, HIV and mental health across the life course	91

Executive summary

Background

While some progress has been made on the legal and human rights of sexual and gender minorities in South Asia, members of these groups continue to face persecution, harassment and discrimination in this region. Their exposure to adversity can lead to greater risk of HIV and mental health disorders.

Across South Asia, there is a common belief that homosexuality is abnormal or pathological. Often, these beliefs are sanctioned by influential religious, political and community leaders. Sexual and gender minorities face violations of their human rights due to their actual or perceived sexual orientation, gender identity and/or gender expression (SOGIE). SOGIE-based violence occurs at multiple levels of society. Individuals might experience violence from family or friends, in health care institutions, by law enforcement and by the judiciary system. As well as a human rights violation on its own, exposure to SOGIE-based violence can lead to increased mental health problems and HIV risk behaviours among sexual and gender minority groups. Addressing discrimination, therefore, is crucial for improving the public health of a nation.

Men who have sex with men and transwomen bear a disproportionate burden of HIV compared to the general population. In 2010, the regional prevalence of HIV among

men who have sex with men was 14.7 percent compared to close to 1 percent in the general population.² Transwomen are likely to experience higher rates of HIV prevalence compared to men who have sex with men or the general population. Comparable regional data is still difficult to come by, as transwomen are often subsumed under the category of men who have sex with men, rather than being disaggregated. However, in countries where disaggregated data exists, transwomen have the highest prevalence of HIV.

Men who have sex with men and transwomen also experience considerable mental health issues. One regional study found that men in Asia-Pacific from sexual minorities are more likely to report symptoms of depression compared to heterosexual men.³ Men who have sex with men and transwomen also report high rates of alcohol and substance abuse, anxiety-related disorders, and thoughts of suicide.^{4, 5, 6} Little is understood about the pathways by which SOGIE-based violence impacts both mental health and HIV risk across the culturally diverse countries of Asia.

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- 2 Beyrer, C. et al. (2012). Global epidemiology of HIV infection in men who have sex with men. *Lancet*, 380, pp. 367–77.
 - 3 Miedema, S. et al. (2017). Integrating male sexual diversity into violence prevention efforts with men and boys: evidence from the Asia-Pacific Region. *Culture, Health & Sexuality*, 19(2), pp. 208–224.
 - 4 Sivasubramanian et al. (2011). Suicidality, clinical depression, and anxiety disorders are highly prevalent in men who have sex with men in Mumbai, India: Findings from a community-recruited sample. *Psychology, Health & Medicine*, 16(4), pp. 450–462.
 - 5 Logie et al. (2012). Adapting the minority stress model: Associations between gender non-conformity stigma, HIV-related stigma and depression among men who have sex with men in South India. *Social Science & Medicine*, 74, pp. 1261–1268.
 - 6 Reisner et al. (2016). Global health burden and needs of transgender populations: A review. *Lancet*, 388, pp. 412–36.

Study

This study was commissioned by the United Nations Development Programme (UNDP) under the Multi-Country South Asia Global Fund HIV Programme to better understand the lived and perceived experiences of SOGIE-based violence among men who have sex with men and transwomen across seven South Asian countries, and to explore the effects of this violence on mental health and HIV risk. The study was implemented by the International Center for Research on Women (ICRW) from November 2015 to February 2016. The seven countries are Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. The study was conducted in 12 sites across these 7 countries.

The objectives of this study were to:

- 1 Map the experiences of SOGIE-based violence among men who have sex with men and transwomen
- 2 Explore the connections between SOGIE-based violence, mental health and HIV transmission risk among men who have sex with men and transwomen
- 3 Identify violence prevention and response priorities targeted toward these populations
- 4 Develop recommendations to mitigate and minimize the effects of violence on mental health and HIV vulnerabilities through

programme and policy efforts in the study countries.

The study used qualitative methods to collect in-depth data on the experiences and perceptions of SOGIE-based violence among men who have sex with men and transwomen in the seven countries. A total of 12 focus group discussions (FGDs) were conducted with men who have sex with men and 9 focus group discussions were conducted with transwomen across the seven countries. The study underwent ethical review at the regional and national levels.

Study results

Men who have sex with men and transwomen face multiple forms of SOGIE-based violence across their life course

Participants discussed various forms of psychological, physical and sexual violence faced by men who have sex with men and transwomen, including, but not limited to verbal abuse, being hit, slapped and thrown out of running buses, assault by weapons, and sexual harassment. The most commonly discussed forms of violence facing men who have sex with men and transwomen communities were sexual harassment in college, blackmail and/or extortion, violence in public places, sexual assault by a sexual partner and sexual harassment in the workplace. Transwomen tended

to discuss sexual harassment in the workplace and sexual assault by a partner more often than men who have sex with men.

Variation in SOGIE-based violence emerged across countries. Participants in Bhutan reported the fewest forms of SOGIE-based violence, while participants in Pakistan reported the most. These results do not suggest that SOGIE-based violence is more prevalent in one country compared to the other, but rather that participants are more aware of this type of violence occurring. In Bhutan, in particular, limited community outreach means that men who have sex with men and transwomen are relatively isolated from one another and have limited knowledge of community-level issues. Thus, awareness of what types of SOGIE-based violence face their communities is contingent on the level of community organization among men who have sex with men and transwomen in a given context.

Men who have sex with men and transwomen face SOGIE-based violence from diverse sources

Participants report that their communities face SOGIE-based violence across multiple domains of their lives. In particular, key domains in which men who have sex with men and transwomen communities experience discrimination and violence included legal and law-related institutions, education,

religious spaces, health care, employment and the wider community. Police were commonly discussed as a source of violence. In communities, men who have sex with men and transwomen reported abuse by the general public (for example, on buses), intimate male partners, and the family; housing discrimination; harassment and abuse in schools as children; and workplace-related discrimination.

Implications for HIV risk and mental health issues

Men who have sex with men and transwomen reported that in their communities, they see how SOGIE-based discrimination causes mental health problems, and also leads to conditions in which behaviour that increases HIV risk is more likely. The participants said that a lifetime exposure to violence and discrimination, including social exclusion and marginalization negatively impacts the mental health and well-being of men who have sex with men and transwomen. According to the data, psychological issues ranged from poor self-esteem and self-doubt to attempts at suicide, and occurred due to the gradual build-up of stress, coupled with a lack of recourse, acceptance or support systems in face of discrimination or abuse.

Participants also described a number of situations in which SOGIE-based violence led to greater HIV risk.

Three major themes that emerged were (1) SOGIE-based violence and discrimination driving men who have sex with men and transwomen into sex work and risky sexual situations with clients and police; (2) barriers to accessing health care in cases of sexual assault; and (3) the processes of finding sexual partners in contexts where same-sex activities were illegal or socially unacceptable.

Strategies for resilience and coping

Despite the multiple challenges that men who have sex with men and transwomen in the seven countries face, they all reported various forms of resilience and coping. Transwomen participants from countries like Bangladesh, India and Pakistan stated the support of their own community was their biggest resource and instrument of coping. Often, transwomen discussed leaving home and joining the “family of [their] choice”, in order to fully embrace their identities. Community-based organizations were another major form of support for participants, in terms of social connections, economic support, and access to health care and legal support.

Recommendations

The results of this study point towards a number of key recommendations for action. The full set of recommendations, by target group, can be found in Chapter 8: Recommendations.

Policymakers can:

- Repeal laws criminalizing same-sex behaviour
- Provide legal gender recognition of third gender and transgender groups
- Pass anti-discrimination policies to support the rights of sexual and gender minorities

The health care industry can:

- Train and sensitize health care providers around SOGIE-based health issues
- Integrate the rights of sexual and gender minority patients into professional codes of ethics
- Foster supportive and welcoming health care environments
- Strengthen networks of community organizations with the formal health care system

The education system can:

- Develop and implement policies to prohibit SOGIE-based violence in schools
- Build the capacity of teachers, faculty, administrators and staff

to respond to and prevent SOGIE-based violence

- Integrate sexual orientation and gender identity topics in school curricula

- Conduct research not only among men who have sex with men and transwomen, but also sexual minority women and transmen

Workplace managers and industry professionals can:

- Implement inclusive policies and practices in the workplace
- Develop and implement response mechanisms against discrimination in the public and private sector

Programme teams that address gender-based violence, sexual and reproductive health and HIV can:

- Promote definitions of gender-based violence that acknowledge the specific experiences of gender and sexual minorities
- Sensitize practitioners to the overlaps between gender-based violence and SOGIE-based violence
- Build gender-based violence response services tailored to the needs of sexual and gender minorities
- Synchronize gender-based violence prevention and HIV prevention work, rather than keeping them siloed

Researchers can:

- Conduct more research on the connections between SOGIE-based violence, HIV and mental health

Chapter 1: Introduction

1.1 Violence, mental health and HIV among sexual and gender minorities

Members of sexual and gender minority groups face considerable discrimination, abuse and trauma across their life courses.^{7,8} This violence is often a result of their sexual orientation, gender identity or expression. The term 'SOGIE-based violence' is used to refer to all acts of violence related to (a) the social status of one's gender identity, (b) not conforming to socially accepted gender roles, and (c) non-binary gender identities.

Global evidence over two decades has shown that SOGIE-based violence is linked to the spread of HIV through factors including trauma to the body and an increase of sexual risk behaviours.⁹ SOGIE-based violence can also lead to poor mental health outcomes, including depression, anxiety and suicidality. Mental health challenges often occur at the same time as HIV risk behaviours and situations.¹⁰ So, reducing and eliminating discrimination is critical for addressing the HIV epidemic, and more broadly for improving the public health of a nation.

Currently in South Asia, men who have sex with men and transwomen often experience violations of their human rights due to their actual or perceived sexual orientation, gender

identity and/or gender expression. This violence occurs at multiple levels of society – from family and friends to health care institutions, law enforcement and the judiciary system. Under conditions of daily risk of trauma and violence, men who have sex with men and transwomen may have little power to negotiate safer conditions and have poor access to health services and health education, which can heighten their vulnerability to HIV. Depression and other mental health disorders due to violence may exacerbate HIV vulnerability.

1.2 About the study

This study was commissioned by UNDP under the Multi-Country South Asia Global Fund HIV Programme to better understand the lived and perceived experiences of SOGIE-based violence among sexual and gender minorities across seven South Asian countries, and to explore the effects of this violence on mental health and HIV risk.

The study was implemented by the International Center for Research on Women from November 2015 to February 2016. The seven countries are Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. The study focuses specifically on the experiences of men who have sex with men and transwomen.¹¹ There are important distinctions between these two subgroups. While transwomen are often conflated

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- 7 Miedema, S. et al. (2017). Integrating male sexual diversity into violence prevention efforts with men and boys: evidence from the Asia-Pacific Region. *Culture, Health & Sexuality*, 19(2), pp. 208–224.
 - 8 Chakrapani, V., Newman, P.A., Shunmugam, M., McLuckie, A. and Melwin, F. (2007). Structural violence against Kothi-identified men who have sex with men in Chennai, India: a qualitative investigation. *AIDS Education and Prevention*, 19(4), pp. 346.
 - 9 Andersson, N., Cockroft, A. and Shea, B. (2008). Gender-based violence and HIV: Relevance for HIV prevention in hyperendemic countries of southern Africa, *AIDS 22 Suppl 4*, pp. S37–86.
 - 10 Safren et al. (2009). Depressive symptoms and human immunodeficiency virus risk behaviors among men who have sex with men in Chennai, India. *Psychology, Health & Medicine*, 14(6), pp. 705–715.
 - 11 In Afghanistan, the study focused on men with high-risk behaviour.

with men who have sex with men in public health literature, they face unique challenges and experiences based on their gender identity. This report distinguishes between the two subgroups, highlighting issues pertinent to each specific subgroup and pointing out commonalities only where relevant.

This study uses qualitative research methods to explore links that have so far not been explored enough between experiences of SOGIE-based violence, its impact on mental health and how violence directly and indirectly increases vulnerability to HIV among the study populations in seven Asian countries. This study serves as an important cross-country comparison of SOGIE-based violence among groups that are underresearched and marginalized.

1.3 Objectives and methods

The objectives of this study were to:

- 1 Map the experiences of SOGIE-based violence among men who have sex with men and transwomen
- 2 Explore the connections between SOGIE-based violence, mental health and HIV transmission risk among men who have sex with men and transwomen

- 3 Identify violence prevention and response priorities targeted toward men who have sex with men and transwomen
- 4 Develop recommendations to mitigate and minimize the effects of violence on the mental health and HIV vulnerabilities of men who have sex with men and transwomen through programme and policy efforts in the study countries



Chapter 2: Regional context

This study explores the connections between SOGIE-based violence, mental health and HIV risk in seven countries across the Asia region. This section provides the regional context including regional and national laws and policies related to the human rights of sexual and gender minorities; the state of evidence on violence against sexual and gender minorities; and up-to-date HIV prevalence statistics for each of the study's countries.

2.1 Laws and policies related to sexual and gender minority groups

2.1.1 Global state of SOGIE human rights

The human rights of sexual and gender minorities are increasingly being considered and included in international instruments and human rights standards. Figure 1 provides a timeline of global commitments related to SOGIE rights. Notably, in 1994, in *Toonen v. Australia*, the United Nations Human Rights Committee held that “sexual orientation” was a status protected from discrimination under the International Covenant on Civil and Political Rights (ICCPR) equality clauses.¹² Additionally, the Human Rights Committee has held that the reference to “equal and effective protection against discrimination on any ground” in Article 26 of the ICCPR includes discrimination on

grounds of sexual orientation.¹³ Specifically, the Committee held that “the reference to sex in Article 2(1) and Article 26 is to be taken as including sexual orientation.”¹⁴ This was later reaffirmed in United Nations Human Rights Council (UNHRC) resolutions in 2011 and 2014.¹⁵ In 2015, the United Nations issued a joint agency statement demonstrating commitment to upholding the human rights of sexual and gender minority populations and providing a framework to end human rights violations, such as violence and discrimination, against these groups (See Box 1 for excerpts).¹⁶

Since UNHRC's first resolution in 2011 to bring specific focus to human rights violations against sexual and gender minorities, attention to SOGIE-related rights continues to increase exponentially. The 2011 UNHRC resolution led to a groundbreaking study that shed light on the wide range of discriminatory practices and laws being used against lesbian, gay, bisexual, transgender and intersex people around the world. It showed that violence, including sexual violence, perpetrated by law enforcement authorities and society at large, was a pervasive problem in many countries.¹⁷ In 2012, the Global Commission on HIV and the Law report went further to acknowledge that while the law has the power to protect the dignity of those living with HIV, it also has the potential to harm, by perpetuating discrimination and

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- 12 *Nicholas Toonen v. Australia*, Human Rights Committee, 50th Sess., Case No. 488/1992, UN Doc. CCPR/c/50/D/488/1992.
 - 13 Human Rights Committee: Views of 31 March 1994, Case of *Nicholas Toonen v. Australia*, Communication No. 488/1992, paras. 8.2–8/7. See also: Views of 6 August 2003, Case of *Edward Young v. Australia*, Communication No. 941/2000, para. 10.4; and Views of 30 March 2007, Case of *X v. Colombia*, Communication No. 1361/2005, para. 7.2.
 - 14 *Nicholas Toonen v. Australia*, Human Rights Committee, 50th Sess., Case No. 488/1992, UN Doc. CCPR/c/50/D/488/1992.
 - 15 Human Rights Council, Human rights, sexual orientation and gender identity. A/HRC/17/L.9/Rev.1, 17 June 2011. Human Rights Council, Human rights, sexual orientation and gender identity. A/HRC/27/L.27/Rev.1, 26 September 2014.
 - 16 The statement titled *Ending Violence and Discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex People* was issued by ILO, OHCHR, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP, WHO and UNAIDS
 - 17 OHCHR (2011). *Discriminatory Laws and Practices and Acts of Violence against Individuals based on their Sexual Orientation and Gender Identity*. OHCHR. Available at: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-41_en.pdf.

18 Global Commission on HIV and the Law (2012). *HIV and the Law: Risks, Rights and Health*. UNDP.

isolating those most vulnerable, so that they cannot access the preventive or curative services they critically need.¹⁸ The adoption of the latest UNHRC resolution on 30 June 2016 on the appointment of an Independent

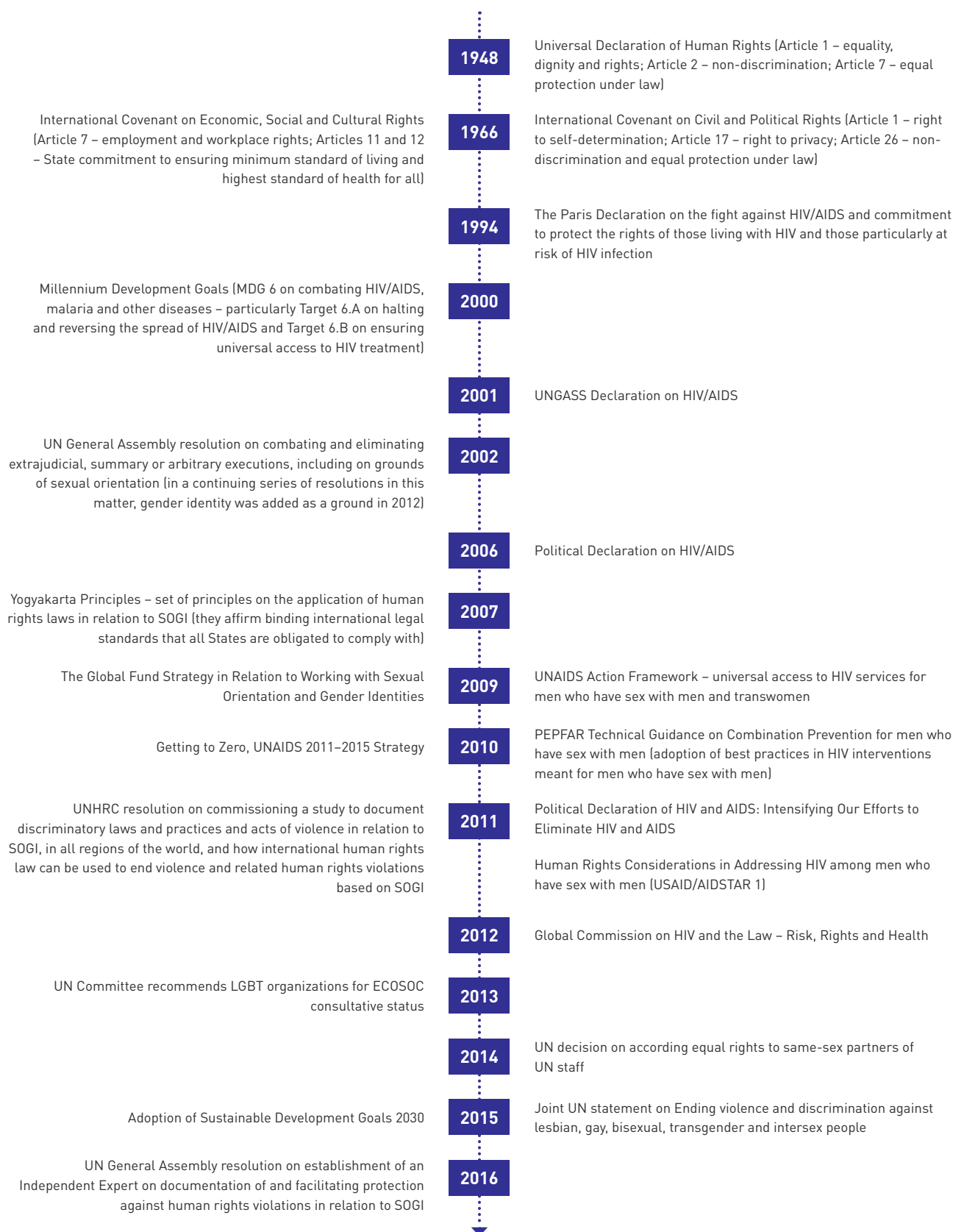
Expert dedicated to monitor human rights violations on the grounds of SOGIE strengthened the UN’s commitments on the protection of SOGIE-related rights.

Box 1: United Nations entities call on States to act urgently to end violence and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI) adults, adolescents and children (excerpts)

“All people have an equal right to live free from violence, persecution, discrimination and stigma. International human rights law establishes legal obligations on States to ensure that every person, without distinction, can enjoy these rights. While welcoming increasing efforts in many countries to protect the rights of LGBTI people, we remain seriously concerned that around the world, millions of LGBTI individuals, those perceived as LGBTI and their families face widespread human rights violations. This is cause for alarm and action.

“Failure to uphold the human rights of LGBTI people and to protect them against abuse, such as violence and discriminatory laws and practices, constitute serious violations of international human rights law, having a far-reaching impact on society. It contributes to increased vulnerability to ill health including HIV infection, social and economic exclusion, putting strain on families and communities, and impacting negatively on economic growth, decent work and progress towards achievement of future Sustainable Development Goals. States bear the primary duty under international law to protect everyone from discrimination and violence. These violations, therefore require urgent response by governments, parliaments, judiciaries and national human rights institutions. Community, religious and political leaders, workers’ organizations, the private sector, health providers, civil society organizations and the media also have important roles to play. Human rights are universal – cultural, religious and moral practices and beliefs and social attitudes cannot be invoked to justify human rights violations against any group, including LGBTI persons.”

Figure 1: Timeline of global commitments in the context of SOGI-related rights



Sources: South Asia Regional Advocacy Framework and Resource Guide: HIV, Human Rights and Sexual Orientation and Gender Identity, UNDP, SAARCLAW, 2014; various UN website links.

19 Mills, E. (2015). *Gender, Sexuality and the SDGs: An Evidence-base for Action*, Institute of Development Studies. Available at: <http://www.ids.ac.uk/opinion/gender-sexuality-and-the-sdgs-an-evidence-base-for-action>

Unfortunately, these concerns do not seem to have informed the adoption of the Sustainable Development Goals (SDGs) in August 2015, which initially failed to explicitly acknowledge the relationship between SOGIE and development.¹⁹ After strong advocacy by global civil society actors and the United Nations Office of the High Commission on Human Rights

(OHCHR), SOGIE issues received some attention in the SDGs. The SDG Outcome Document 2015 states in paragraph 19 that the language of non-discrimination should be applicable to persons of “other status”. “Other status” reflects two resolutions passed by the UNHRC in 2009 – the first resolution stated that “other status” included sexual

Box 2: SDG commitments particularly applicable to the context of SOGIE concerns

SDG 1: End poverty in all its forms everywhere

SDG 3: Ensure healthy lives and promote well-being for all at all ages – particularly targets 3.3–3.5, 3.7, 3.8, 3.b and 3.c

SDG 4: Ensure inclusive and equitable quality education and promote learning opportunities for all

SDG 5: Achieve gender equality and empower all women and girls

SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all – particularly targets 8.3, 8.5–8.10

SDG 10: Reduce inequality within and among countries – particularly targets 10.1–10.4

SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable

SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels – particularly targets 16.1–16.3, 16.9, 16.10 and 16.b

Source: Sustainable Development Goals Knowledge Platform

orientation and the second resolution extended this to include gender identity.²⁰ Based on this inclusion, a number of SDGs and respective sub-topics become applicable to the context of SOGIE (See Box 2 for a brief summary).²¹

2.1.2 SOGIE rights across the Asia region

At the regional level, men who have sex with men and transwomen communities face a crossroads in terms of the socio-economic, health and legal environment. In May 2009, in response to the Yogyakarta Additional Recommendations,²² the Asia Pacific Forum (APF) of National Human Rights Institutions (NHRI) facilitated a workshop of member commissions to discuss their role in promoting the implementation of the Yogyakarta Principles.²³ The APF recommended practical ways in which the NHRIs could use their functions and powers to better protect and promote the rights of people of diverse SOGIE. The workshop resulted in the Advisory Council of Jurists (ACJ) of APF issuing a comprehensive set of recommendations in line with the mandate of NHRIs, which have an important function in the protection and promotion of human rights. These recommendations related to the capacity-building of NHRIs; research and documentation in the area of human rights violations around SOGIE and their impact on

the lives of LGBTI people; dialogue and awareness-generation on SOGIE involving key institutions and stakeholders; and advocacy for legal reform.²⁴

In 2010, attention towards SOGIE concerns at the regional level grew when the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) passed a regional resolution to situate universal access to HIV prevention, care, support and treatment services in the context of human rights, and undertake measures to address stigma and discrimination, as well as policy and legal barriers to effective HIV responses, in particular with regard to key affected populations.

In 2011, UNESCAP passed another resolution for an Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS made in 2006. It called upon its members and associate members to further intensify the full range of actions to reach the unmet goals and targets under these commitments through strategic plans, operational partnerships at national and community levels, legal reviews and high-impact HIV interventions for key populations – the key target in question being 80 percent coverage for key affected populations towards the goal of universal access.²⁵

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- 20 Sustainable Development Knowledge Platform. (2015). *Transforming Our World: The 2030 Agenda for Sustainable Development*, United Nations. Available at: <https://sustainabledevelopment.un.org/post2015/transformingourworld>
- 21 Ibid.
- 22 Asia Pacific Forum of National Human Rights Institutions (2009). *Conclusions of the Workshop on the Role of National Human Rights Institutions in the Promotion and Implementation of the Yogyakarta Principles*. Asia Pacific Forum of National Human Rights Institutions. Available at: <https://www.outrightinternational.org/sites/default/files/316-1.pdf>.
- 23 The Yogyakarta Principles plus 10 (YP+10) were adopted on 10 November 2017 to supplement the Yogyakarta Principles. The YP+10 document emerged from the intersection of developments in international human rights law with the emerging understanding of violations suffered by persons on the grounds of sexual orientation and gender identity and the recognition of the distinct and intersectional grounds of gender expression and sex characteristics. Available at: <https://yogyakartaprinciples.org/>
- 24 UNDP, IDLO (2013). *Regional Report: The Capacity of National Human Rights Institutions to Address Human Rights in Relation to Sexual Orientation, Gender Identity and HIV*. Bangkok, UNDP.
- 25 UNDP, SAARCLAW (2014). *South Asia Regional Advocacy Framework and Resource Guide: HIV, Human Rights and Sexual Orientation and Gender Identity*, UNDP.

- 26 Mago, A. (2012). *South Asia Roundtable Dialogue: Legal and Policy Barriers to the HIV Response*, IDLO.
- 27 UNDP, APF (2016). *Promoting and Protecting Human Rights in relation to Sexual Orientation, Gender Identity and Sex Characteristics: A Manual for National Human Rights Institutions*; UNDP, APTN (2017), *Legal Gender Recognition: A Multi-Country Legal and Policy Review in Asia*.
- 28 Ibid.
- 29 However, not all hijras and other transgender persons seek “third gender” status, but instead seek legal recognition of their perceived authentic gender (within the gender binary).
- 30 Transgenders Officially a ‘Third Gender’ in Bangladesh (2013). *Firstpost*, 14 November. Available at: <http://www.firstpost.com/world/transgenders-officially-a-third-gender-in-bangladesh-1229221.html>
- 31 In 2016, JAMAKON together with Bandhu Social Welfare Society called for the immediate enactment and implementation of the draft legislation. See: Bandhu Social Welfare Society (2017). *Consultation Meeting on Anti-Discriminatory Law*; UNDP and APTN (2017). *Legal Gender Recognition: A Multi-Country Legal and Policy Review in Asia*.
- 32 Karim, H. (2017). How effective will the anti-discrimination law be? *The Daily Star*, 20 October. Available at: <https://www.thedailystar.net/star-weekend/human-rights/how-effective-will-the-anti-discrimination-law-be-1478878>

Further, in November 2011, UNDP, the International Law Development Organization (IDLO) and SAARCLAW partnered with the World Bank and UNAIDS to co-host the South Asian Roundtable Dialogue: Legal and Policy Barriers to the HIV Response (South Asian Roundtable). The South Asian Roundtable brought together community leaders and advocates, representatives of the judiciary, human rights institutions, parliamentarians, government officials, lawyers and law students to address HIV and key affected populations. The South Asian Roundtable stimulated participants to undertake initiatives designed to strengthen the rights-based response to HIV in their countries.²⁶

2.1.3 Progress and gaps toward SOGIE rights across the seven countries

Across the seven countries included in this study, progress towards the fulfilment of SOGIE human rights is uneven. Much of this progress has been made in the past few years, from 2012 to 2016. Box 4 provides a snapshot by country of the existing laws and policies related to SOGIE concerns, including laws related to criminalization, sex work and HIV. This is followed by a summary of progress specifically related to laws and policies on SOGIE in each country.

Afghanistan: Recognition of SOGIE-related concerns remains underprioritized in Afghanistan. Article 427 of the Afghanistan Penal

Code criminalizes same-sex sexual activity as well as sex work.

Bangladesh: The National Human Rights Commission of Bangladesh (JAMAKON) has engaged with LGBT communities (more so with transwomen), but mainly from a public health perspective of vulnerability to HIV. JAMAKON has established a thematic committee focused on human rights issues faced by excluded minorities, specifically including *hijras*.²⁷ The committee monitors and reports, contributes to policy dialogues, and provides feedback on draft laws and strategic guidance to JAMAKON.²⁸ In November 2013, the Bangladesh government recognized *hijras* as a separate gender.²⁹ Yet, the same year, Parliament refused to consider the United Nations Human Rights Commission recommendations to decriminalize same-sex sexual relations.³⁰ Despite state recognition of *hijras*, they continue to face discrimination in many ways.

In 2014, the Law Commission drafted an Anti-Discrimination Law, which included a person’s status as *hijra* as one of the possible grounds of discrimination. The law has yet to be enacted though JAMAKON has continually advocated for its passage.³¹ If the law is passed, it is a first in Bangladesh’s history and will criminalize discrimination; however, it was reported in late 2017 that the process to pass the law “hasn’t even begun”.³²

Table 1: Snapshot of country contexts with regard to SOGIE concerns

Country	Explicit constitutional recognition	Criminalization of same-sex sexual relations	Transgender rights legal recognition	Laws against sex work	HIV legislation
Afghanistan	None	Yes, Article 427 of Afghanistan Penal Code	None	Article 427 Afghanistan Penal Code	None, but national HIV response covers MHRB
Bangladesh	None, though specific articles could be supportive	Yes, Section 377 Bangladesh Penal Code	<i>Hijras</i> received recognition as third gender in 2013	SITA 1933 and OWC Act 1995 – sex work per se is not criminal but associated practices are	None, but national HIV response covers MSM and <i>hijras</i>
Bhutan	None	Yes, Sections 213–214* Bhutan Penal Code	None	Criminalized under Penal Code 2004	None, but national HIV response covers MSM
India	None, but specific articles are seen to be supportive	Yes, Section 377 Indian Penal Code (read down by Delhi High Court in 2009, reinstated by Supreme Court in 2013)	Recognition via Supreme Court verdict in 2014; draft bill tabled in Parliament in 2016; welfare boards set up in 5 states	ITPA 1986 – sex work per se is not criminal but associated practices are	National legislation drafted but not tabled in Parliament; national HIV response covers MSM, transwomen
Nepal	Yes, protection for equal rights enshrined in Constitution since 2015	Decriminalised by Supreme Court since 2007	Third (or other) gender recognized	Penal Code 119–120: Sex work per se is not criminal but associated practices are	None, but national HIV response covers MSM, transwomen
Pakistan	None, negative influence of religious law, but specific articles could be supportive	Yes, Section 377 Pakistan Penal Code	Supreme Court granted several rights from 2009–12 Transgender Persons (Protection of Rights) Act passed by Senate	Sections 371A, 371B criminalize sex work and related activities	Only Sindh province has legislation; national HIV response covers MSM, transwomen
Sri Lanka	None	Yes, Sections 365, 365A and 399 Sri Lanka Penal Code	Recognition via MOH circular to health and education departments	Sex work per se is not criminal but associated practices are – this is reflected in terms of Vagrants and Brothels Ordinances	Yes, HIV discrimination prohibited in 2016; national HIV response covers MSM

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- 33 Lawyers Collective (2016). Supreme Court Recognizes the Right to Determine and Express One's Gender; Grants Legal Status to 'Third Gender'.
- 34 Lawyers Collective (2016). Supreme Court Sets Aside the High Court Decision on Anti-Sodomy Law: Huge Setback for LGBT Rights, Activists Vow to Continue the Fight.
- 35 Supreme Court to review Section 377 which criminalises gay sex (2018). Times of India, 8 January. Available at: <https://timesofindia.indiatimes.com/india/supreme-court-to-review-article-377-which-criminalises-gay-sex/articleshow/62412768.cms>
- 36 The Rights of Transgender Persons Bill, (India) (2014) Bill No. 49 of 2014; UNDP, APTN (2017)
- 37 The Transgender Persons (Protection of Rights) Bill (India) (2016) Bill No. 210 of 2016; UNDP, APTN (2017).
- 38 All you need to know about the Transgender Persons Bill (2016). *The Hindu*, 30 November. Available at: <http://www.thehindu.com/news/national/all-you-need-to-know-about-the-transgender-persons-bill-2016/article21226710.ece>
- 39 Bill on transgender rights sent to Cabinet (2018). *Indian Express*, 18 March. Available at: <https://indianexpress.com/article/india/bill-on-transgender-rights-sent-to-cabinet-5102366/>
- 40 *Sunil Babu Pant and Others v. Nepal Government and Others* (Nepal) (2007), Writ. No. 917 of 2064 BS (2007).

Bhutan: Sections 213 and 214 of the Bhutan Penal Code criminalize same-sex sexual activity. Sex work is also criminalized under various sections of the Penal Code 2004.

India: The National Human Rights Commission of India engages with LGBT communities largely in the context of public health. Some state commissions of the National Human Rights Commission of India did intervene in matters of the right to vote, discrimination in employment, and illegal detention and police abuse faced by transwomen. In April 2014, the Supreme Court of India followed the suit of neighbour, Pakistan, when it passed a landmark verdict on recognizing transgender identities and their citizenship rights (the NALSA judgment).³³ In July 2009, the Delhi High Court held the application of Section 377 of the Indian Penal Code, which criminalized “carnal intercourse against the order of nature” between consenting adults, to be unconstitutional. This decision was reversed in December 2013, when the Supreme Court held that decriminalization of LGBT people should be part of the legislature’s remit.³⁴ In January 2018, however, the Supreme Court agreed to reconsider its verdict from 2013 and review Section 377 in light of the fundamental right to privacy.³⁵

In 2015, the Upper House of Parliament (Rajya Sabha) passed a private member’s Rights of Transgender Persons Bill, which was

in line with the NALSA judgment.³⁶ However in 2016, the government introduced a different version of a Transgender Persons (Protection of Rights) Bill, which contained problematic definitions of the term ‘transgender’.³⁷ The bill has been subject to criticism from the community.³⁸ This bill is currently under consideration, but has not yet been passed. The transgender protection bill has since been revised based on recommendations from the Parliamentary Standing Committee. The Social Justice ministry has sent a bill on transgender rights to the Cabinet after finalizing nine amendments, including those on the definition of the term ‘transgender’, keeping with the recommendations of a parliamentary panel.³⁹

Nepal: In 2007, the Supreme Court of Nepal formally recognized the rights of sexual and gender minority groups. As part of this ruling, the Court decriminalized homosexuality, noted that the fundamental rights to equality and non-discrimination applied to all citizens, and ordered that identity cards with a third gender be issued.⁴⁰ The Muluki Ain (civil and criminal code of Nepal) was updated in 2017, but the official English translation has not been released. The last proposed set of amendments in 2015 did not reflect the 2007 judgment, and it was uncertain if this last version that has been passed would reflect them either. A 2013 IDLO assessment of NHRI found that the Nepali NHRI had been

the most proactive in establishing steps toward national protection and anti-discrimination policies for sexual and gender minority groups.⁴¹ In particular, the National Human Rights Commission Nepal created an LGBT focal point within the institution and put in place an institutional relationship with the country's national LGBT network.

On 16 September 2015, Nepal continued its progressive tradition of LGBT inclusion through the adoption of a new Constitution that provided explicit protections for LGBT people from discrimination, violence and abuse.⁴² With this move, Nepal joined only a handful of countries, including Ecuador and South Africa, which have enshrined equal rights protections for LGBT people in their national constitutions.⁴³ In 2017, the Supreme Court ruled that the Nepal government must develop a policy to enable transgender people to change their name.⁴⁴

Pakistan: In 2018, the Transgender Persons (Protection of Rights) Act was passed by Pakistan's Senate and Parliament but is yet to be signed into law by the country's president. The act allows people to choose their gender and to have that identity recognized on official documents, including national IDs, passports and driver's licences. The bill prohibits discrimination in schools, at work, on public modes of transit and while receiving medical care. The measure also states that transgender people

cannot be deprived of the right to vote or run for office. It lays out their rights to inheritance, in accordance with their chosen gender. And it obligates the government to establish "Protection Centers and Safe Houses" — along with separate prisons, jails or places of confinement.⁴⁵

The Pakistan National Commission for Human Rights is still at the early stages of engagement on SOGIE issues. However, between 2009 and 2012, the Supreme Court of Pakistan granted a number of rights and privileges to *khwaja siras* in a series of rulings, recognizing *khwaja sira* as a distinct sex/gender in addition to male and female.⁴⁶ The National Human Rights Commission's Sindh chapter is currently drafting a *khwaja sira* protection bill to be introduced in the Sindh Provincial Assembly.

Sri Lanka: The Human Rights Commission of Sri Lanka is similar to Pakistan, in that it is in the early stages of engagement on SOGIE issues. Notably, the Commission intervened on a March 2015 complaint from a transgender person resulting in the Ministry of Health issuing a circular to health services and education institutions about issuing gender recognition certificates to transgender people.⁴⁷ At the end of April 2016, the Supreme Court of Sri Lanka made a landmark decision prohibiting HIV-based discrimination, which stands to benefit all of those affected, including men who have sex with men and transwomen.⁴⁸

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- 41 UNDP, IDLO (2013). *Regional Report: The Capacity of National Human Rights Institutions to Address Human Rights in Relation to Sexual Orientation, Gender Identity and HIV*, Bangkok, UNDP.
- 42 Article 12 [Citizenship Based on Descent with Gender Identity], Article 18 [Right to Equality] and Article 42 [Right to Social Justice] of the Constitution of Nepal
- 43 Human Rights Campaign (2015). In a Historic Step, Nepal Ratifies New Constitution That Includes LGBT Protections. Available at: <http://www.hrc.org/blog/in-a-historic-step-nepal-ratifies-new-constitution-that-includes-lgbt-protect> (accessed 4 June 2016)
- 44 UNDP and APTN (2017).
- 45 Pakistan Passed Historic Transgender Rights Bill (2018). NPR, 9 May. Available at: <https://www.npr.org/sections/thetwo-way/2018/05/09/609700652/pakistan-passes-historic-transgender-rights-bill>
- 46 Khan F.A. (2016). *Khwaja Sira Activism – The Politics of Gender Ambiguity in Pakistan*, *Transgender Studies Quarterly*, Volume 3, No. 1–2, Duke University Press.
- 47 Ministry of Health (Sri Lanka) (2016). General Circular No: 01-34/2016 on Issuing of Gender Recognition Certificate for Transgender Community (16 June 2016); The Registrar-General (Sri Lanka) (2016). Circular No 06/2016 [28 June 2016].
- 48 UNAIDS (2016). Sri Lanka's Supreme Court Makes Landmark Decision Prohibiting HIV Discrimination, 4 June 2016. Available at: http://www.unaids.org/en/resources/presscentre/featurestories/2016/may/20160502_Srilanka_nodiscrimination.

- 49 See, generally, Penal Code Section 377 in Bangladesh, India and Pakistan; Section 427 in Afghanistan, Section 213 in Bhutan and Sections 365 and 365A in Sri Lanka.
- 50 Govt. agrees to remove 'eunuch' from Police Act (2016). *Times of India*, 13 January. Available at: http://timesofindia.indiatimes.com/articleshow/50556225.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst
- 51 Sarkar, A. and Nath, P. (2013). Preparing for Section 377 Verdict, 'Varta', December. Available at: <http://varta2013.blogspot.in/2013/12/preparing-for-section-377-verdict.html>
- 52 People's Union for Civil Liberties (2003). *Human Rights Violations Against the Transgender Community: A PUCL Report. A study of Kothi and Hijra Sex Workers in Bangalore*.
- 53 Health Issues India (2013). Supreme Court Verdict on IPC Section 377 Impedes Fight Against HIV/AIDS. Available at: <http://www.healthissuesindia.com/2013/12/17/supreme-court-verdict-ipc-section-377-impedes-fight-hiv aids/>
- 54 National AIDS Control Organisation, India (2017). HIV/AIDS Act 2017. Available at: <http://naco.gov.in/hiv aids-act-2017>
- 55 UNAIDS (2016). Sri Lanka's Supreme Court Makes Landmark Decision Prohibiting HIV Discrimination. Available at: http://www.unaids.org/en/resources/presscentre/featurestories/2016/may/20160502_Srilanka_nodiscrimination.

The limits of legal and policy-related protections: Despite the progress described above, there remain large gaps in constitutional, legal and policy frameworks across the region. Discriminatory and contradictory laws that criminalize or exclude LGBT people continue to remain as part of the legal and social environment in South Asia. Sections of penal codes throughout the region continue to be used to persecute, if not prosecute, LGBT people for consensual same-sex conduct.⁴⁹ In contrast, recent legislative processes in South Asia have largely focus on legal gender recognition and citizenship rights for transwomen, and to a limited extent, transmen. Other laws around sex work, vagrancy and public nuisance also exist that allow the police to carry out arbitrary arrests and commit unjustified violence against LGBT people, particularly transwomen (including transgender sex workers). One example in the Indian context is Section 36A of the Karnataka Police Act, 1963 which was introduced in 2011 to control the "objectionable activities of eunuchs". Fortunately, after concerted advocacy and campaign, the word "eunuch" was dropped from the law in 2016, but LGBT activists feel that the entire section should go.⁵⁰

Obscenity laws like Sections 292 to 294 of the Indian Penal Code⁵¹ (and similar counterparts in the Pakistan Penal Code) continue to restrict freedom of speech and expression,⁵² making NGOs working on HIV and

other sexual health concerns of LGBTI people vulnerable to punitive action, including charges of abetment in relation to Section 377.⁵³ The Indian Supreme Court's reversal on Section 377 is similarly believed to have caused a setback to the national HIV response by recriminalizing men who have sex with men and transwomen and hampering their ability to access health care services. On the other hand, the Indian HIV/AIDS Act 2017 and its rules provide protections for NGOs and outreach staff providing HIV prevention messages and commodities.⁵⁴

In fact, other than Sri Lanka, few countries in South Asian have legal safeguards against HIV-related discrimination. Sri Lanka's courts have ruled to recognize the right to non-discrimination in specific contexts, including schools; and the national HIV law was passed by the Parliament.⁵⁵

In addition to a lack of protection laws, discriminatory laws significantly impede the realization of constitutional, legal or policy gains around SOGIE issues. Often, governments fail to act on court verdicts by enacting legislation which would clearly designate the actions to be taken by government departments, including service providers. In India, no law has been enacted to reflect the 2014 Supreme Court verdict on transgender identities and rights. In 2015, the Ministry of Social Justice and Empowerment prepared the

Transgender Rights Bill, which was tabled in August 2016. However, LGBT activists have criticized the draft bill for not honouring the court's directive on a mechanism for self-identification and instead, over-emphasizing "government certification of identities". Additionally, activists have criticized the bill for failing to address the issues of violence and employment in a sensitive and comprehensive manner.⁵⁶

Transgender rights have also received attention in other countries in recent years. However, a significant gap remains throughout the region (including Nepal) with regard to easily accessible protocols for safe and inexpensive feminization, and masculinization procedures (including gender-affirming surgery). Despite progress resulting from the legal recognition of the 'third gender', most other rights for LGBTI people are not recognized by law, such as same-sex relationships, alternative family structures, adoption rights for same-sex couples and transgender individuals, and equal property rights. Moreover, laws against sexual assault fail to protect transgender victims by remaining gender-specific and failing to recognize that a victim may be transgender⁵⁷ (let alone male) in contravention of recent judicial rulings on transgender rights.

2.2 SOGIE-based violence

2.2.1 Gender-based violence and SOGIE-based violence

There is some confusion over how to define violence experienced by sexual and gender minority groups. Gender-based violence has been traditionally understood as physical, sexual, psychological, emotional, economic and other forms of violence experienced by women, most often at the hands of men. OHCHR's Committee on the Elimination of Discrimination Against Women states that gender-based violence is "violence that is directed against a woman because she is a woman or that affects women disproportionately."⁵⁸ Therefore, in this definition, 'gender-based violence' refers to the violence caused due to unequal power relations between women and heterosexual men, assuming that men and women engage in heterosexual relationships, and violence happens within the context of these unequal, heterosexual power dynamics.

However, gender-based violence can also refer to violence experienced by people belonging to other gender identities, such as transgender or non-binary gender people, or people who engage in same-sex activities. These people can experience gender-based violence due to their gender identity and/or expression, or their sexual behaviours. The experiences of violence among sexual and

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- 56 Orinam (2015). Telangana Hijra Intersex Transgender Samithi Responds to MSJE Transgender Rights Bill. Available at: <http://orinam.net/telangana-samithi-response-msje-trans-rights-bill/>
- 57 Only post-operative transgender women are covered by the sexual assault laws, but not other transwomen.
- 58 Available at: <http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/VAW.aspx>

- 59 Hagan, J. (2016). Sexual orientation and gender identity as part of the Women, Peace and Security Project. Available at: <http://blogs.lse.ac.uk/wps/2017/01/10/sexual-orientation-and-gender-identity-as-part-of-the-wps-project/>.
- 60 Council of Europe. (2007). Chapter 2: Gender-based Violence. *Gender Matters: A manual on addressing gender-based violence affecting young people*. Available at: http://www.eycb.coe.int/gendermatters/chapter_2/1.html
- 61 Miedema et al. (2017).
- 62 Logie et al. (2012). Adapting the minority stress model: Associations between gender non-conformity stigma, HIV-related stigma and depression among men who have sex with men in South India. *Social Science & Medicine*, 74, pp. 1261–1268.
- 63 Khan et al. (2005). Men who have sex with men's sexual relations with women in Bangladesh. *Culture, Health & Sexuality*, 7(2), pp. 59–169.
- 64 Carroll, A. and Mendos, L.R. (2017). *State-sanctioned Homophobia* (12th ed.). Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association.
- 65 Miedema et al. (2017).
- 66 Shaw, S.Y. et al. (2012). Factors associated with sexual violence against men who have sex with men and transgendered individuals in Karnataka, India. *PLOS One*, 7(3), p. e31705.
- 67 Chakrapani, V., Newman, P.A., Shunmugam, M., McLuckie, A. and Melwin, F. (2007). Structural violence against Kothi-identified men who have sex with men in Chennai, India: a qualitative investigation. *AIDS Education and Prevention*, 19(4), pp. 346.

gender minorities suggest that a broader definition of gender-based violence is needed to include a more diverse range of experiences.⁵⁹

Some definitions of gender-based violence now include acts of violence committed by either a man or a woman against a man or a woman “with the purpose of maintaining social power for (heterosexual) men.”⁶⁰ For example, the violence faced by men who have sex with men and transwomen often find their roots in homophobia (or the fear of homosexuality) and transphobia (or the fear of non-binary gender identities). In these cases, violence committed against sexual or gender minority groups reflect power inequalities between the perpetrator and the victim based on gender and sexual identity.

This report uses the term ‘sexual orientation, gender identity and expression (SOGIE)-based violence’ to discuss experiences of violence by people and communities who are not often considered under the umbrella of gender-based violence. For the purpose of this study, SOGIE-based violence refers to all kinds of acts of violence that are related to (a) the social status of one’s gender identity; (b) not conforming to socially accepted gender roles, and (c) non-binary gender identities.

2.2.2 Experiences of discrimination, abuse and violence

Studies document extensive SOGIE-based violence faced by men who have sex with men and transwomen in South Asia, and beyond. The UN Multi-country Study on Men and Violence in Asia and the Pacific found that sexual minority men were more likely to experience multiple forms of lifetime adversity compared to heterosexual men.⁶¹ Several studies across South Asia have documented gross human rights violations against those from sexual and gender minority groups, including stigma and discrimination related to gender identity, sexual orientation or HIV status,⁶² pressure to marry a woman,⁶³ legal prosecution,⁶⁴ homophobic bullying and abuse,⁶⁵ sexual violence,⁶⁶ and rejection, violence and isolation from family and community.⁶⁷ Perpetrators range from institutions such as hospitals, police and workplaces to family members and intimate partners.

Further, not all men who have sex with men experience violence uniformly. The forms, prevalence and perpetrators of violence may differ within various subgroups or identities of men who have sex with men and transwomen. For example, hijras in some South Asian countries, considered a ‘third gender’ and who are mostly transgender women, hold marginal cultural recognition; however, they continue to face

extreme discrimination and abuse in society.^{68, 69}

A study conducted with self-identified men who have sex with men in Chennai, India, showed that those individuals who identified as kothis, or who were “effeminate”, faced greater violence from police.⁷⁰ A study conducted in Bangladesh and Papua New Guinea found that men who have sex with men face multiple forms of violence, including higher levels of violence against men engaged in sex work and those with effeminate gender expressions from family and partners.⁷¹

2.2.3 Factors driving SOGIE-based violence

Many factors contribute to the high rates of SOGIE-based violence experienced by men who have sex with men and transwomen. Across the region, homosexuality and transgender identities are considered abnormal, pathological or deviant and in these widely held beliefs are often sanctioned by religious institutions. Across the region, religious intolerance appears to strengthen legally sanctioned violence and hate speech against sexual and gender minorities.

However, there are also examples of more tolerant approaches. In Pakistan, a group of 50 clerics from Lahore issued a fatwa (religious decree) in June 2016 that while non-binding, supported transgender

marriage and inheritance rights, and condemned violence against transgender persons. The fatwa was specific about marriage provisions, noting that marriage would be permissible only between two partners if one showed bodily signs of maleness and one showed bodily signs of femaleness. Some activists in Pakistan cautiously welcomed the decree while urging that social attitudes still need to change.⁷² Overall, social norms that pathologize and stigmatize homosexuality and transgenderism are the underlying root cause of SOGIE-based violence.

In Bangladesh, a high court banned fatwas in 2001 but the order was stayed. The Supreme Court finally lifted the ban in 2011 but said they cannot be enforced. Effectively, this means that clerics cannot punish people with a fatwa, and fatwas cannot be issued that contradict the existing laws of a country.⁷³ In this way, fatwas cannot be used in Bangladesh to persecute sexual and gender minorities.

Social expectations around men’s role in society, and the heterosexual framework of sexual relations, also drive SOGIE-based violence. Across South Asia, men are expected to be husbands and fathers, and continue the patrilineal line. A study in Bangladesh found that men who have sex with men were often forced to married women, against their desires, due to pressure from family and community.⁷⁴

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- 68 Jayadeva, C. (2017). Understanding the mental health of the Hijra women of India. *American Journal of Psychiatry*, 12(5), pp. 7–9.
- 69 Historical records of transgender communities in South Asia show that they did hold social status, derived from their performance of traditional and cultural rituals such as blessings at weddings and birthdays, or tales of transwomen in religious mythology. This includes only transgender women, known as Hijra in many South Asian countries, and does not extend to transmen.
- 70 Chakrapani, V., Newman, P.A., Shunmugam, M., McLuckie, A. and Melwin, F. (2007).
- 71 FHI 360 (2013). *Exploring gender-based violence among men who have sex with men, male sex worker and transgender communities in Bangladesh and Papua New Guinea*. Available at: http://www.fhi360.org/sites/default/files/media/documents/GBV%20Study%20report_Final.pdf.
- 72 BBC (2016). Pakistan’s Transgender Community Cautiously Welcomes Marriage Fatwa, 28 June 2016. Available at: <http://www.bbc.com/news/world-asia-36648141>.
- 73 Bangladesh lifts fatwa ban but forbids enforcement (2011). *BBC*, 12 May. Available at: <https://www.bbc.com/news/world-south-asia-13379016>
- 74 Khan et al. (2005). Men who have sex with men’s sexual relations with women in Bangladesh. *Culture, Health & Sexuality*, 7(2), pp. 159–169.

- 75 Fulu et al. (2013). Why do some men use violence against women and how can we prevent it? Quantitative findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific. UNDP, UNFPA, UN Women and UN Volunteers: Bangkok.
- 76 Chakrapani, V., Newman, P.A., Shunmugam, M., McLuckie, A. and Melwin, F. (2007).
- 77 Logie et al. (2012). Adapting the minority stress model: Associations between gender non-conformity stigma, HIV-related stigma and depression among men who have sex with men in South India. *Social Science & Medicine*, 74, pp. 1261–1268.
- 78 UNAIDS (2017). UNAIDS Data 2017. Available at: http://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf; Beyrer, C. et al. (2012). Global epidemiology of HIV infection in men who have sex with men. *Lancet*, 380, pp. 367–77.
- 79 UNAIDS (2016). Global AIDS Update 2016. Available at: http://www.who.int/hiv/pub/arv/global-AIDS-update-2016_en.pdf?ua=1
- 80 Beyrer, C. et al. (2012).
- 81 International AIDS Society (2014). Key Affected Populations – Men Who Have Sex with Men – Factsheet, March 2014.

Furthermore, across the region, there is a prevailing belief that “to be a man” means to be tough,⁷⁵ and must demonstrate signs of maleness (e.g., toughness, aggression and masculine behaviours). Men who fail to demonstrate socially sanctioned types of masculinity may face violence as a consequence.⁷⁶

Finally, socio-demographic factors such as geographical context, caste, class, religion, race and disability may also contribute to risk of violence faced by men who have sex with men and transwomen. However, less is known about these factors. One study shows that urban men who have sex with men reported that they had more social support, which reduced the effect of experiences of stigma on their mental health.⁷⁷ Differences between urban and rural experiences of SOGIE-based violence, along with other key socio-demographic variables, warrant greater attention in future research.

2.3 HIV prevalence

Globally, men who have sex with men bear a disproportionate burden of HIV compared to the general population.⁷⁸ In Asia and the Pacific, the distribution of new HIV infections among men who have sex with men was 18 percent.⁷⁹ In 2010, the regional prevalence of HIV among men who have sex with men was 14.7 percent compared to close to 1 percent in the general population.⁸⁰ In South Asia more specifically, HIV prevalence

among men who have sex with men was approximately 15 percent (between 2007 and 2011).⁸¹ Data from Bangladesh, India, Nepal, Pakistan and Sri Lanka show that men who have sex with men have higher HIV prevalence compared to the general population.⁸² While HIV prevalence among men who have sex with men has not been estimated across all South Asian countries, it is likely to be higher than in the general population in all countries across the region.⁸³

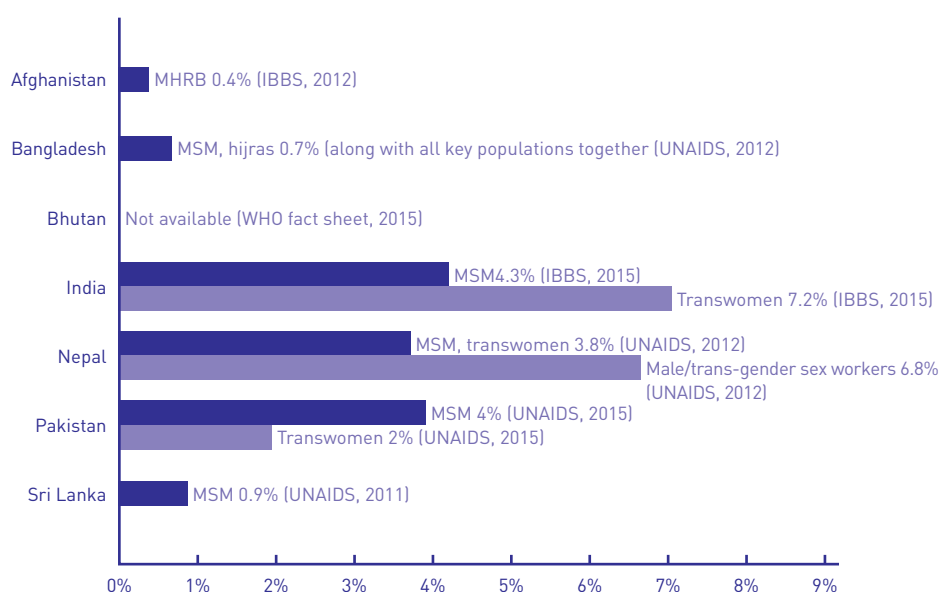
Transwomen are likely to show higher rates of HIV prevalence compared to men who have sex with men or the general population. Comparable regional data is still difficult to obtain, as transwomen are often subsumed under the category of men who have sex with men, rather than having a disaggregated category of their own. Global studies find that transwomen are significantly more likely to acquire HIV compared to adult males and females who are not transgender (up to 50 times more likely according to one study).⁸⁴ In 2016, the overall HIV prevalence in India was 0.3 percent compared to 4.3 percent and 7.2 percent among men who have sex with men and transgender people (including *hijras*) respectively.⁸⁵ Previous studies show higher prevalence. A 2015 study conducted among men who have sex with men across 12 cities in India found a 7 percent prevalence rate.⁸⁶ A 2012 study in major Indian cities found a 25 percent prevalence rate among transwomen (including *hijras*).⁸⁷

Despite nearly two decades of efforts to prevent and respond to HIV, men who have sex with men and transwomen are still often not covered by HIV interventions, yet, risky sexual behaviours contribute to the high burden of HIV prevalence within these communities.⁸⁸ In 2016, condom use among men who have sex with men was 45.8 percent in Bangladesh, 86 percent in Nepal, 22.4 percent in Pakistan and 47.1 percent in Sri Lanka.⁸⁹ High rates of sexual violence also drive HIV prevalence rates. A study in South India found that among men who have sex with men and transwomen, HIV prevalence was 20 percent among those who

reported experiencing sexual violence compared to 12 percent among those who did not report it.⁹⁰

Public health experts, policymakers, donors and governments increasingly recognize that men who have sex with men and transwomen in South Asia are important risk groups in the HIV epidemic. Yet the psychosocial and sociocultural issues specific to men who have sex with men and transwomen require more research. While more is specifically understood about prevalence patterns, less is known about the connections between HIV prevalence and SOGIE-based violence.

Figure 2: HIV prevalence among MSM and transgender people



- 82 UNDP (2012). Country Snapshots: Bangladesh, India, Nepal, Pakistan and Sri Lanka. Available at: <http://asia-pacific.undp.org/practices/hiv aids/>; UNAIDS (2017). UNAIDS Data 2017; and National AIDS Control Programme of Afghanistan and Johns Hopkins University (2012). *Integrated Behavioural and Biological Surveillance in Afghanistan*. Kabul, Afghanistan.
- 83 Van Griensven, F., de Lind van Wijngaarden, J.W. (2010). A review of the epidemiology of HIV infection and prevention responses among men who have sex with men in Asia. *AIDS* 24 Suppl 3, pp. S30–40. See also, Ministry of Health and Population (2015). *Nepal Country Progress Report on HIV/AIDS Response 2014*.
- 84 UNAIDS (2013). *HIV in Asia and the Pacific – UNAIDS Report 2013*. Available at: http://www.unaids.org/sites/default/files/media_asset/2013_HIV-Asia-Pacific_en_0.pdf
- 85 According to UNAIDS, urban areas have higher HIV prevalence than rural areas. UN Habitat and UNAIDS (2015). *Ending the AIDS epidemic: the advantage of cities*. United Nations Human Settlements Programme. Nairobi; UNAIDS (2017).
- 86 Solomon, S.S. et al. (2015). High HIV prevalence and incidence among MSM across 12 cities in India. *AIDS*. 29(6), pp. 723–31
- 87 UNAIDS (2017). *UNAIDS Data 2017*.
- 88 UNAIDS (2013). *HIV in Asia and the Pacific – UNAIDS Report 2013*.
- 89 UNAIDS (2017). *UNAIDS Data 2017*.
- 90 Shaw et al. (2012). Factors associated with sexual violence against men who have sex with men and transgendered individuals in Karnataka, India. *PLoS One*, 7(3), p. e31705.

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- 91 Miedema et al. (2017).
- 92 Sivasubramanian et al. (2011). Suicidality, clinical depression, and anxiety disorders are highly prevalent in men who have sex with men in Mumbai, India: Findings from a community-recruited sample. *Psychology, Health & Medicine*, 16(4), pp. 450–462.
- 93 Logie et al. (2012). Adapting the minority stress model: Associations between gender non-conformity stigma, HIV-related stigma and depression among men who have sex with men in South India. *Social Science & Medicine*, 74, pp. 1261–1268.
- 94 Reisner et al. (2016). Global health burden and needs of transgender populations: A review. *Lancet*, 388, pp. 412–36.
- 95 Jayadeva, C. (2017). Understanding the mental health of the Hijra women of India. *American Journal of Psychiatry*, 12(5), pp. 7–9.
- 96 Kalra, G. and Shah, N. (2013). The cultural, psychiatric and sexuality aspects of Hijras in India. *International Journal of Transgenderism*, 14, pp. 171–181.

2.4 Mental health among sexual and gender minorities

Men who have sex with men in South Asia report high rates of mental health problems. The *UN Multi-country Study on Men and Violence* found that in sites across Cambodia, China, Indonesia, Papua New Guinea and Sri Lanka, sexual minority men were more likely to report depression symptoms compared to non-sexual minority men.⁹¹ In one survey among men who have sex with men in India, 45 percent of the participants had thought about or attempted suicide, 29 percent reported major depression and 24 percent reported anxiety-related disorders.⁹² In South India, depression was higher among men who have sex with men living in rural areas compared to those living in urban areas, which suggests that the cultural environment plays an important role in the experiences of depression among this group.⁹³

Although, the highest proportion of global research on health issues facing transgender populations focuses on mental health, there are few studies on mental health among transgender populations in South Asia.⁹⁴ Given their gender identity, transwomen may be more visible compared to men who have sex with men, and thus face unique challenges due to their gender identity (e.g. employment-related discrimination). As a result, their mental health

burden may be greater.⁹⁵ In some studies, almost half of *hijras* in India suffer from a range of mental health problems, including substance abuse and depression.⁹⁶ A study in Nepal found that 68.5 percent of transwomen reported heavy alcohol use.

2.5 Research gaps

Overall, most research among men who have sex with men and transwomen in South Asia focuses on HIV prevalence and associated risk factors. The specific links between SOGIE-based violence and its effects on mental health and HIV risk are less often explored. Further, research among men who have sex with men and transwomen in South Asia often fails to disaggregate the specific experiences of transwomen from the category of men who have sex with men, particularly in the context of mental health research. However, preliminary evidence suggests that this population faces specific risks that need to be taken into account. The present research aims to fill these gaps. This study uses an ecological approach to identify the environmental and structural factors that drive SOGIE-based violence, and how these experiences relate to mental health and HIV risk.

The study also fills data gaps for countries such as Bhutan and Sri Lanka, where evidence of SOGIE-based violence among men who have

sex with men and transwomen is sparse, and Afghanistan that lacks evidence of SOGIE-based violence among men with high-risk behaviour. This data will be critical for evidence-based policies and programmes to stop SOGIE-based violence before it starts, and develop effective HIV prevention strategies. The study's cross-country approach enables comparison of the connections between violence, mental health and HIV in culturally distinct contexts. Thus, patterns can be assessed whether they are similar across the region or culturally specific.

Most programmes that reach out to men who have sex with men and transwomen focus on prevention, treatment and awareness of HIV and sexually transmitted infections. Programmes addressing SOGIE-based violence and its impact on men who have sex with men and transwomen are much less common. Yet global evidence shows that SOGIE-based violence directly impacts HIV risk, and indirectly impacts HIV risk through mental health problems. Greater understanding of these pathways in the South Asia context are critical to inform HIV and violence prevention policies and programmes.



Chapter 3: Methodology

3.1 Conceptual framework

3.1.1 Gender- and SOGIE-based violence

As described in Section 2.2, gender-based violence can include violence against persons based on sexual orientation or gender identity and expression. The term used in this report to refer to this type of gender-based violence is SOGIE-based violence. SOGIE-based violence refers to all kinds of acts of violence that are related to (a) the social status of one’s gender identity; (b) not conforming to socially accepted gender roles, and (c) non-binary gender identities.

Like gender-based violence, SOGIE-based violence can take many forms (Figure 3). Physical violence refers to the intentional use of physical force against an individual with a motivation to harm, injure, disable or kill. Emotional or psychological violence is aggressive verbal or non-verbal communication that intends to harm someone emotionally or mentally, devalue their self-worth, or control their behaviours. Economic violence can include the threat of or actual withholding of money, or harming the financial well-being of a person. Sexual violence includes any forced or unwanted sexual activity including sexual assault and rape. These forms

Figure 3: Types of SOGIE-based violence



Physical violence

The intentional use of physical force against an individual with a motivation to harm, injure, disable or kill



Economic violence

The threat of or actual withholding of money, or harming the financial wellbeing of a person



Sexual violence

Attempted or completed forced or unwanted sexual activity



Emotional or psychological violence

Aggressive verbal or non-verbal communication that intends to harm someone emotionally or mentally, devalue their self-worth, or control their behaviours

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- 97 Heise, L. (1998). Violence against women: An integrated, ecological framework. *Violence against Women*, 4, pp. 262–290.
- 98 Fulu, E. and Miedema, S. (2015). Violence against women: Globalizing the integrated ecological model. *Violence against Women*, 21(12), pp. 1431–1455.
- 99 Bronfenbrenner, U. (2005). Ecological Systems Theory (1992). In Bronfenbrenner, U. (Ed.), *Making human beings human. Bioecological Perspectives on Human Development*. Thousand Oaks: Sage Publications Ltd, pp. 106–173.

of SOGIE-based violence can be perpetrated by anyone. For example, a police officer may blackmail a transwoman or take her earnings in exchange for not arresting her. An intimate partner may steal money from a man who have sex with men. This would also be conceptualized as economic violence. SOGIE-based violence occurs across the life course. As will be seen in the following chapters, men who have sex with men and transwomen in South Asia face considerable levels of SOGIE-based violence throughout their childhood, adolescence and adulthood.

3.1.2 A socio-ecological approach to understanding SOGIE-based violence

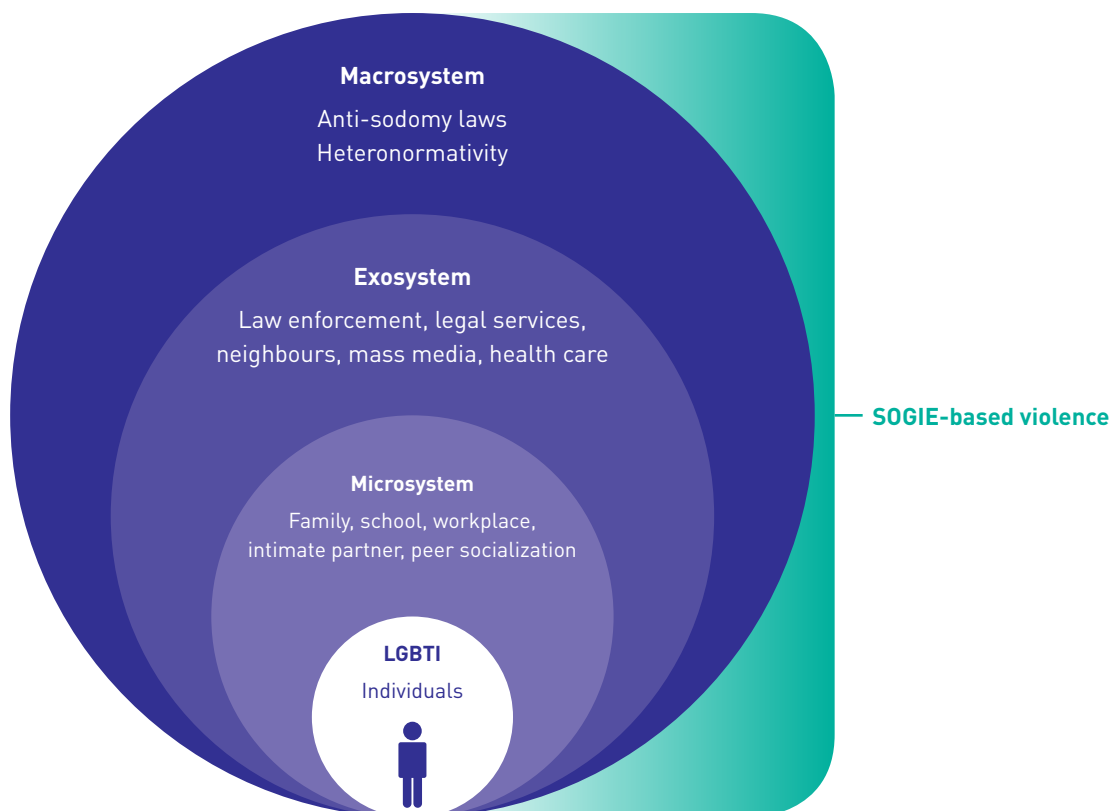
The socio-ecological approach provides a framework to understand the many factors that drive SOGIE-based violence, and how they intersect with one another. This model is widely used in the field of gender-based violence work, although it has largely been applied to the experiences of violence faced by women.^{97,98} This model uses a “person-environment perspective”⁹⁹ to situate the individual person within their social context (see Figure 4). The socio-ecological framework shows us how behaviours and outcomes are a joint function of the interaction between a person and their environment. The ecological paradigm allows for a more comprehensive approach to studying SOGIE-based

violence, including analysing its causes, forms and impact.

This approach guided the study team to conceptualize the various risks, vulnerabilities, violations and marginalization faced by men who have sex with men and transwomen at multiple levels. For example, at a macro-level, the existence of anti-sodomy laws contributes to an environment where men who have sex with men and transwomen cannot seek redress for SOGIE-based violence. Similarly, institutions in society, such as health care, law enforcement and mass media, often fail to treat or respond to the needs of men who have sex with men and transwomen. For example, past experiences of discrimination by a health care professional can affect whether or not they visit a health professional after an incident of sexual assault.

The model also considers how the more immediate environment affects experiences of SOGIE-based violence. Immediate environmental factors can include those related to families, schools, church or place of worship, peer groups and intimate partnerships. This model is further discussed in Chapter 7, as related to multiple factors – at different levels of the socio-ecological model – and how they interact across the life course to shape men who have sex with men’s and transwomen’s experiences of SOGIE-based violence, mental health and HIV risk.

Figure 4: Socio-ecological model



3.2 Study design

The study used qualitative research methods to capture in-depth information on perceptions and reports of SOGIE-based violence, and the connections between violence, mental health outcomes and HIV risk among transwomen and men who have sex with men in seven South Asian countries. Qualitative research is particularly well suited to this type of exploratory analysis. Qualitative research allows themes to emerge from the data. The voices, perspectives and narratives of participants thus determine what is significant and

important to the research topic, rather than predetermined parameters set by the external research team. This study specifically used focus group discussions and key informant interviews (KIIs).

3.2.1 Focus group discussions

The focus group discussions centred around case vignettes, or short stories that acted as case studies. Case vignettes are designed to prompt discussion among participants on a select topic by providing a story on which they can comment. As a research tool, case

100 Barter, C. and Renold, E. (1999). The use of vignettes in qualitative research. *Social Research Update*, 25.

vignettes help participants define their situation in their own terms while exploring the context along with other sensitive issues and allowing the gathering of data in a less threatening manner.¹⁰⁰ Case vignettes were first constructed based on major themes of the literature review. The case vignettes were then further vetted and modified based on discussions with experts on issues of sexual orientation and gender identity (See Appendix III and Appendix IV for the research tools). Case vignettes covered the following thematic areas: types of SOGIE-based violence, perpetrators, the impacts on physical and mental health, help-seeking options, mitigation of violence, health issues, recommendations for improving services, and strategies for decreasing violence. A total of 12 focus group discussions were conducted with men who have sex with men and 9 focus group discussions with transwomen across the 7 countries (See Appendix I for details).

3.2.2 Key informant interviews

In-depth interviews were used to collect data from the key informants who were stakeholders from the sectors of health, law and the community. They included representatives of community-based organizations that work with men who have sex with men and transwomen communities, community stakeholders from men who have sex with men and transwomen communities, health care

providers, lawyers and representatives from national HIV programmes, a total of 49 key informant interviews were conducted across the 7 countries (See Appendix I for details).

3.3 Sample, recruitment and data collection

3.3.1 Geographic scope

The study was conducted in 12 sites across 7 South Asian countries: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. Sites were selected based on feasibility and security, socio-economic and cultural characteristics, and site-specific HIV prevalence in order to capture variation in environmental, cultural and HIV-related conditions. The site selection was finalized in consultation with the Multi-country South Asia Global Fund HIV Programme's sub-recipients in each of the countries (See Appendix 1 for details).

3.3.2 Sample criteria and recruitment

Focus group discussions and key information interviews were conducted in all countries. The focus group discussions were conducted among two groups: self-identified transwomen (irrespective of whether they had had gender-affirming surgery) and men who reported sexual practices or behaviours with other men. The focus group

discussions in Afghanistan were with “men with high-risk behaviour”.¹⁰¹ Only individuals who were above 18 years of age¹⁰² and were willing to provide consent to participation in the study were recruited. Key informants included people who worked on SOGIE-related issues, particularly SOGIE-based violence. Focus group discussions were not conducted with transwomen in Afghanistan and Bhutan due to difficulties in reaching this group in the two countries.

Participants for both focus group discussions and key informant interviews were recruited using purposive sampling through local community-based organizations and HIV programmes. Participants for the focus group discussions were approached through sub-recipients of the Multi-Country South Asia Global Fund HIV Programme in each of the countries. The local offices of the sub-recipients identified and recruited the study participants through their project staff who were involved in community and peer outreach activities. Key informants were selected through consultations with UNDP and the local offices of the sub-recipients.

3.3.3 Interviewer training

The sub-recipients of the Multi-Country South Asia Global Fund HIV Programme assisted with identifying and hiring local interviewers to collect data in each country. Preference was given to interviewers

who were fluent in the local language, had prior experience of working with the study population, and had prior experience in conducting qualitative research. Interviewers were trained in a regional workshop for five days on different aspects of the study, including background knowledge on sex, sexuality, gender and violence; study design; focus group discussion facilitation skills-building; practising conducting interviews; ethics and safety; and review of protocols for data transcription, note-taking and data translation. The ethical and safety training section focused on how to administer verbal informed consent, maintaining confidentiality, and ethical practices around data management. During the training workshop with the local interviewers, the case vignettes were further adapted to each country context.

3.3.4 Data collection

Data collection took place between November 2015 and February 2016. Focus group discussions took place in designated “safe areas” across the seven study countries, which generally meant the drop-in centre of the community-based organizations in the relevant site. Interviews with key informants took place at their place of work or at a public place of mutual convenience. Focus group discussions and key informant interviews were audio-recorded and the research team took notes on the main themes of each interview.

101 However, for convenience, when discussing all focus group discussions or all participants, Afghanistan’s men with high-risk behaviour are included with the group “men who have sex with men”.

102 Though the study only recruited individuals of legal age who agreed to consent to participation, it should be noted that many critical issues for transgender people arise very early in life, often as young as age 5 when the sense of gender dissonance frequently becomes discernible.

A total of 21 focus group discussions were conducted (10 focus group discussions with men who have sex with men, 2 with men with high-risk behaviour in Afghanistan and 9 with transwomen). A total sample size of 100 men who have sex with men (or men with high-risk behaviour) and 77 transwomen were recruited and participated in the study (See Table 2 and 3). A total of 49 key informant interviews were conducted across the 7 study countries. Interviewed key informants included counsellors, doctors, lawyers, community leaders, representatives and staff from non-governmental and community-based organizations and leaders and officials from national HIV programmes across the seven countries (see Appendix I for a further disaggregation of the particulars of key informants by country). All interviews were audio-recorded.

3.3.5 Data analysis

Audio-recordings were transcribed in the local language and then translated. Translations were checked for accuracy by the original focus group discussion moderator and reviewed by ICRW data analysts for clarifications. ICRW data analysts blinded the data. Translated transcripts were coded based on an initial set of codes developed in reference to the study objectives. Data was analysed in English by ICRW data analysts.

Data for men who have sex with men and transwomen participants

was separately analysed to observe patterns unique to each population. After the first round of preliminary coding, data was further analysed to examine relationships across codes. The conceptual framework guided the coding process, so that the research team coded experiences, sources and sites of violence across all possible domains and levels, from the individual to the systemic. Memos were reviewed iteratively throughout data analysis to identify common themes across all study sites and across populations.

Multiple thematic areas that emerged out of the analysis were then further analysed to identify interconnections between themes. The interconnections between various themes were further verified by checking coding to validate interpretation of data. Furthermore, findings unique to countries and subgroups were identified. Families of codes that demonstrated relationships between various thematic areas were made to elaborate on the various emergent relationships among themes. Visual diagrams of families of codes were developed.

3.4 Ethics and safety measures

Given strong social, legal and religious sanctions against same-sex behaviours and non-confirming gender identities in the study countries, only verbal, informed consent was sought for participation.

Basic demographic information such as age, education and occupation was sought from the focus group discussion participants. However, no names, addresses or contact information were collected for any of the study participants. During the focus group discussions, participants were assigned numbers to facilitate discussion while they were cautioned to refrain from sharing the contents of the discussion elsewhere. While the focus group discussions were conducted in private spaces that were safe for the participants such as offices of community-based organizations, no staff members working at those community-based organizations were allowed to observe or participate in the focus group discussions. Notes and audiotapes from the discussions were stored in password-secured files that were accessible only to the study staff. The researchers aimed to not collect any identifiable information during data collection. As a further measure, transcripts were blinded and all potentially identifiable information was removed.

Members of APCOM South Asia Strategic Information Advisors (ASASIA) reviewed the protocol for this study. The ICRW Institutional Review Board (IRB) reviewed the study and provided ethical approval. Additional ethical reviews were conducted in each of the study countries. In countries where IRBs were not available or accessible, an independent expert panel reviewed

and approved study procedures related to recruitment, data storage, obtaining informed consent and ensuring confidentiality of data.¹⁰³

3.5 Strengths and limitations

This study had a number of strengths and limitations. A major strength of the study was the cross-country comparable nature of the data. The study collected critical information on SOGIE-based violence, and its connections with mental health and HIV risk in a number of underresearched countries (such as Afghanistan and Bhutan). Further, comparable methodology across sites allowed the assessment of similarities and differences across study sites. A second strength is the strong ethics and safety framework used for this study. Ethics and safety mechanisms are critical to ensure robust, ethical research on sensitive topics, including gender-based violence.¹⁰⁴ The emphasis on the protection of the participants' confidentiality, rights as research subjects, and compliance to ethical standards all contributed to the collection of high-quality, ethical data.

Finally, the study used qualitative methodology which is well-suited to research topics and settings where little is already known. The exploratory nature of data collection and analysis means that the findings directly reflect the voices and

103 A detailed description of the study ethical review procedures, names of the review boards and affiliations of experts across the study countries is located in Appendix II.

104 WHO (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women*. Geneva: WHO.

105 Outright Action International (2014). *Violence through the Lens of Lesbians, Bisexual Women and Trans People in Asia*. New York.

experiences of men who have sex with men and transwomen around SOGIE-based violence, mental health and HIV risk in these countries. The use of ‘case vignettes’ to facilitate discussion allowed the exploration of the breadth of experiences of SOGIE-based violence through the use of a third-person story. This prevented a sense of “coercing” participants to reveal personal information. This method yielded rich information on the perspectives, opinions and observations of participants, their networks, contexts regarding experiences of violence, and help-seeking behaviours.

The study also had limitations. Although qualitative data is important as a tool to explore a topic not accurately known until now, it is not possible to ‘count’ individual responses to represent the occurrence of an experience or event. Further, the use of a qualitative research design limited the generalizability of the findings. While this research attempts to unearth experiences of SOGIE-based violence, its consequences and far-reaching implications for HIV vulnerability, the interpretation of participant narratives is not clear-cut and is not generalizable to entire country contexts. There could be alternative explanations that this research did not identify.

In the future, mixed-method approaches, with greater geographic scope, are needed. The study data collection sites were chosen

purposively and do not capture the complete regional diversity and cultural variation around SOGIE-based issues. For example, in India, data was collected in a high-HIV-prevalence and a low-HIV-prevalence state from West and Central India. However, the cultural environment can vary from state to state, or region to region. This variation impacts the experiences of men who have sex with men and transwomen. Given the lack of evidence on SOGIE-based violence to date, this type of in-depth, exploratory qualitative data collection, despite these limitations, is a necessary first step to map experiences related to violence among this population, and connections with mental health outcomes and HIV risk.

A further limitation regards the study population. The present study sample did not include transmen, thus preventing a better understanding of discrimination and rights violation faced by transgender people as a whole. A study in the Asia region¹⁰⁵ has documented experiences of transmen and alludes to a different set of experiences and challenges faced by them, which were not covered in this research. The study also recruited only those participants that were reached by community-based organizations and HIV programmes. Though this approach enabled the study team to reach a hard-to-reach population, men who have sex with men and transwomen who fell outside the service net of

community-based organizations and HIV programmes are not adequately represented in the study and such individuals could represent a different population and have different kinds of vulnerabilities to violence and HIV.

Further, this research did not explore the experiences of transwomen in seeking gender-affirming surgeries and other forms of feminization procedures. This is an important event in the lives of many transwomen and presents several opportunities to study structural barriers and experiences in help-seeking and interaction with health care providers. An in-depth study could look at this issue. Factors such as the availability of transition-related services at affordable prices and the availability of trained mental health and health professionals in the journey of transition are much needed areas for further research.

Finally, this research has not explored the specific experiences of lesbians and bisexual individuals and their unique needs, experiences of SOGIE-based violence and help-seeking. Although a number of the participants could be bisexual or engage in bisexual sexual behaviour, they were included within the wider umbrella of men who have sex with men and/or transwomen and thus their specific needs and challenges were not specifically analysed in this study. Further research is needed to understand the vulnerabilities of bisexual people as they represent a

different population with a unique set of experiences and challenges. Understanding these would certainly aid in extending the reach of HIV programmes and decrease risk of HIV transmission.

A final limitation was the little evidence collected on intimate partner violence. Although issues of intimate partner violence and experiences of married men who have sex with men and transwomen surfaced in this research, the study did not explicitly focus on these areas of risk. These issues need more in-depth understanding for better articulating their impact on exposure to HIV risk and the needs of female and other same-sex partners and gaps in services with regards to addressing health and mental health needs.

3.6 Sample demographics

Study participants across all the seven countries and study sites represented varied backgrounds, educational qualifications and occupations (Table 2). Among the participants who were men who have sex with men, the majority were young adults, with a reported average age ranging from 24 years in Nepal to 31 years in Bangladesh. There was a broad range of educational attainment among participants. Among men with high-risk behaviour¹⁰⁶ in Afghanistan, the average level of completed education was 7.4 years. Comparatively, among men who have sex with

106 'Men with high-risk behaviour', or 'MHRB', is the term used to refer to men who have sex with men in the context of Afghanistan.

Table 2: Participant profile: MSM and MHRB

Study sites	Mean age, years (range)	Education	Justification for site selection
Afghanistan (n=15)	28.7 (19–40)	7.4 years (0–12 years)	Unemployed (5) Cook in a hotel (2) Dancing in parties (4) Casual labourer (4)
Bangladesh (n=18)	31.6 (19–45)	12.6 years (10–17 years)	Working in full-time employment (3) Working in a NGO (2) Casual labour (4) Hotel boy (4) Mechanic (1) Currently unemployed (2) Sex work (2)
Bhutan (n=7)	26.8 (19–35)	13 years (11–15 years)	University students (2) Coordinator in a NGO (1) Government employee (1) Out-of-school youth (2) Currently unemployed (1)
India (n=18)	27.2 (19–50)	10.2 years (0–15 years of education)	House help (1) Agricultural work (2) Full-time employed (3) Cook (3) Vegetable vendor (3) Small shop owner (2) Beautician (2) Tailor (1) Dance teacher (1)
Nepal (n=16)	24.8 (18–32)	10.5 years (7–15 years)	Unemployed (4) Mechanic (1) Farmer (4) Service (2) Student (3) Lab technician (1) Casual labour (1)
Pakistan (n=17)	25.4 (18–38)	8.7 years (0–15 years of education)	Casual labour (3) Driver (2) Teacher (1) Hotel staff (3) NGO worker (1) Unemployed (4) Student (3)
Sri Lanka (n=9)	26.7 (19–35)	12.2 years (9–17 years)	Student (2) Self-employed (1) Full-time employment (1) Currently unemployed (1) Accountant (1)

Note: data for employment was not available for 3 participants

men in Bhutan, the average level of completed education was 13 years. Similarly, participants across the study sites were engaged in various occupations, ranging from having full-time employment (n=17), to being casual labourers (n=12), dancers (n=5), or self-employed (n=13) as vendors, tailors, or beauticians running small businesses.

The sample demographics among transwomen were similar to the sample of men who have sex


with men, except with regards to occupation (Table 3). The average age of transwomen ranged from 24 in Pakistan to 35 in Bangladesh. Country average levels of educational attainment ranged from 8.3 years in Bangladesh to 12.7 years in India. Across all countries, 29 transwomen reported engaging in sex work for their livelihood. Eleven transwomen participants reported that they were unemployed. The remainder reported a range of occupations, from self-employment to office work.

Table 3: Participant profile: Transwomen

Study sites	Mean age, years (range)	Education	Justification for site selection
Bangladesh (n=19)	35.4 (20-38)	8.3 years (0-9 years)	Currently unemployed (5) Sex work (10) Beautician (1) Office assistant (2) Helper (1)
India (n=16)	29.2 (18-30)	12.7 years (0-17 years)	Chhalla Mangti (7) Badhai (7) Sex work (5) Office helper (1) Videography (1) Farmer (1) Unemployed (1)
Nepal (n=17)	28.6 (19-30)	10.5 years (6-15 years)	Beautician (2) Self-employed (4) Sex work (5) Currently unemployed (2) Office assistant (1)
Pakistan (n=16)	24.3 (18-30)	8.4 years (0-10 years)	Sex work (7) Office assistant (2) Beautician (3) Dancer (1) Currently unemployed (3)
Sri Lanka (n=9)	27.4 (20-28)	10.7 years (5-15 years)	Beautician (1) Full-time employment (2) Working in hotels, spas, massage parlours (4) Sex work (2)

*Note: participants reported more than one source of income

Occupation details for 3 participants not available



Chapter 4: SOGIE-based violence: Forms, impact and coping

4.1 Types of SOGIE-based violence

Participants discussed a wide range of violent experiences faced by men who have sex with men and transwomen across all seven countries. Table 4 breaks down how often different forms of violence were discussed in each of the focus group discussions. Although data presented in Table 4 is not representative of all the forms of violence reported by the participants, it illustrates the varied forms and intensity with which men who have sex with men and transwomen experience violence, and how certain forms of violence are experienced differently across contexts. The frequency with which different types of violence were discussed in focus group discussions reflects the pervasiveness of that type of violence as a known experience within the community. The subtypes of violence are specifically derived from the participant narratives themselves, thus giving voice to their interpretations of violence facing their communities.




Participants discussed various forms of physical violence faced by men who have sex with men and transwomen, ranging from being hit, slapped and thrown out of running buses to being assaulted by weapons. The most commonly discussed forms of violence for both men who have sex with men and transwomen were sexual harassment in college, blackmail and/or extortion, violence

in public places, sexual assault by a sexual partner, and sexual harassment in the workplace. Each of these forms of violence was discussed in over half of all focus group discussions.

Some differences in discussions were seen between the two groups. Transwomen tended to discuss sexual harassment in the workplace more often than men who have sex with men (in 8 out of 9 of the focus group discussions). Transwomen also discussed extortion or blackmail as a problem facing the community (in all 9 focus group discussions). Sexual assault by a sexual partner was more commonly discussed by transwomen (in 8 out of 9 focus group discussions) compared to men who have sex with men (in 7 out of 12 focus group discussions).

Another significant result of the focus group discussions was the variation of violence discussed by both men who have sex with men and transwomen. The most common forms of sexual violence discussed by participants included assaults, staking and rape, and gang rape. The most common forms of verbal abuse discussed included name calling and abusive language directed at sexual and gender minorities. These types of violence were mentioned in all of the focus group discussions. Respondents reported various types of emotional violence included humiliation, ridicule and mockery in front of others or in public places.

Table 4: Forms of SOGIE-based violence mentioned in focus group discussions

Type of violence	Subtypes of violence	Afghanistan	Bangladesh	Bhutan	India	Nepal	Pakistan	Sri Lanka	Total number of FGDs in which type of violence is mentioned
 Physical violence	Assault with a weapon	▼	▲				▼▲		(4/21)
	Forceful eviction from home	▼▼	▼▲		▲		▼▲▲	▼▲	(10/21)
	Honour killing	▼							(1/21)
	Violence in public spaces such as at bus stands and railway stations.	▼▼	▼▼▲▲		▼▲▲	▼▲▲	▼▲▲	▼▲	(17/21)
 Sexual violence	Sexual assault in police custody	▼	▼▲		▲		▲	▲	(6/21)
	Sexual assault by sexual partner (including gang rape)	▼▼	▼▲	▼	▼▲▲	▼▲	▼▲▲	▲▲	(15/21)
	Sexual harassment in school/college	▼▼	▼▼▲▲	▼	▼▼▲▲	▼▼▲▲	▼▼▲▲	▼▲	(21/21)
	Sexual harassment at workplace	▼▼	▼▲▲		▼▲	▼▲▲	▼▲▲	▲	(14/21)
 Emotional violence	Blackmail/extortion	▼▼	▼▼▲▲		▼▲▲	▼▲▲	▼▼▲▲	▼▲	(18/21)
	Online harassment			▼				▼	(2/21)
	Forceful attempts at conversion therapy		▲		▼	▼	▲	▼▲	(6/21)

Notes: 21 FGDs (12 MSM and 9 transwomen); ▼ = MSM FGD; ▲ = Transwomen FGD.

Country-specific patterns emerged from the focus group discussions. The frequency with which different types of violence were discussed in focus group discussions varied across countries. Participants in Bhutan reported the fewest forms of SOGIE-based violence in their communities (a total of three forms of violence across the focus group discussions). Comparatively, participants in Pakistan reported the most forms of SOGIE-based violence (a total of 23 different forms of violence across the focus group discussions). Given the minimal visibility around sexual and gender minorities in Bhutan, and limited community outreach, these results are likely a result of underreporting due to limited knowledge of community-level issues. As a transwoman activist who served as a key informant in Bhutan noted, key national issues include the lack of “information” and “visibility” of “transgender”, which acts as a barrier in reaching out and organizing the transgender community. “Our biggest challenge is that they (community members) are not willing to associate even when we know that they are men who have sex with men or transgender.”

In a similar vein, men who have sex with men and transwomen communities across countries appeared to face different types of concurrent violence. In Afghanistan, focus group discussions with men of high-risk behaviour referenced a total of 15 different forms of violence

known to impact the community. Comparatively, in other countries with a high frequency of different types of violence, the violence tended to affect transwomen more so than men who have sex with men. For example, in Pakistan, as noted above, participants discussed a total of 23 different types of violence affecting their communities. However, only 9 of these were discussed in focus group discussions with men who have sex with men, compared to 23 different types of violence that faced transwomen. These regional patterns suggest that risk of SOGIE-based violence varies between transwomen and men who have sex with men and across countries. Transwomen may face more types of violence in some countries compared to men who have sex with men, and men who have sex with men face different types and risks of violence across cultural contexts. Awareness of what types of SOGIE-based violence face their communities appears to be contingent on the level of community organization among men who have sex with men and transwomen in a given context.

Participants reported that the perpetrators of violence were overwhelmingly, but not exclusively, male, and included: fathers, mothers, siblings (particularly brothers), classmates and work colleagues.

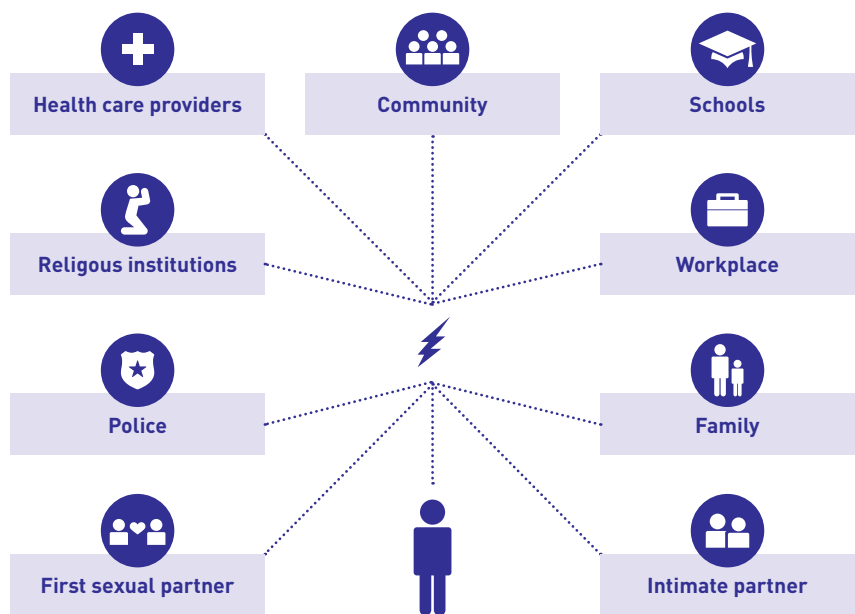
4.2 Sources of SOGIE-based violence

Participants report that their communities face SOGIE-based violence across multiple domains of their lives. Figure 5 breaks out the main sources of SOGIE-based violence and discrimination discussed in this study: legal and law-related discrimination and violence; barriers to education; violence within religious spaces; health-care-related abuse; employment discrimination and harassment; and violence by the community. The following section discusses each of these in turn.

4.2.1 Police

The forms of violence reported by participants faced at the hands of police and other people who have been arrested ranged from arrest to humiliation and harassment. A participant in a focus group discussion in Afghanistan recounted an incident in their community, “One day, one of our friends was arrested by the police along the street. The police asked our friend to dance in front of all the people and said that only if you do this, we will let you go. So, finally, he danced ... the police instead of helping us, made fun of

Figure 5 – Sources of SOGIE-based discrimination based on focus group discussions in Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka



us.” In Sri Lanka, men who have sex with men reported that police act as decoys to identify men who have sex with men. “Sometimes when the police catch gay people, they also pose as gay and make advances towards other men. If a man reciprocates, they alert other police staff on duty and then arrest and harass the person in all possible manners.” In Pakistan, participants reported that police have tacit understandings with local gangs or hooligans to ignore incidents of violence against men who have sex with men. “In the area I live in, at around midnight, no boy can roam around. Whoever does so, no matter how young or beautiful, gets kidnapped. Hooligans take them, rob them and more often than not, the police are in connivance with them. They do not do anything to rescue or protect them. Help, if any, comes from the Department of Rangers.”¹⁰⁷

Only in Nepal did study participants report recent reductions in violence committed by the police. An advocate from Nepal stated, “Compared to earlier times, police perceptions and behaviour towards the LGBTI community has changed a lot. I do not mean discrimination does not take place at all, but it has definitely reduced significantly. Earlier, they just used to pick [people] from the streets and put them in custody, harassing them verbally and physically. Recently, two transwomen were convicted with a false theft case. We fought their case and won it, but they

still had to go through a lot of pain and suffering besides having to stay in custody for 21 days.”

Overall, across the countries, police officers were a major source of SOGIE-based violence. The violence perpetrated by law enforcement officers (among others) signals the harm that comes from national legislation that discriminates against or fails to protect minority groups. When sexual and gender minority groups are considered unprotected by the law, violence against them can be perpetrated with impunity and is often done so by those responsible for upholding justice. Further, the institutional culture of impunity for police perpetrators of SOGIE-based violence can enable other institutional settings to perpetrate violence with impunity.

4.2.2 Religious institutions

Religious leaders and institutions were listed as a major source of SOGIE-based violence among participants in Afghanistan, Bangladesh and Pakistan. For example, in Afghanistan, participants discussed ‘honour killings’ as a religiously sanctioned punishment for engaging in same-sex behaviour. Participants feared losing their right to visit the mosque if their sexual orientation, gender identity and/or gender expression were revealed. Participants in Afghanistan also reported that religious leaders had ordered entire families to leave their

107 The Rangers are a paramilitary force in some provinces of Pakistan.

108 On 6 July 2018, the Indian Psychiatric Society (IPS), the country's largest body of psychiatrists, psychologists and psychiatric social workers released a 'Position statement on homosexuality', stating that homosexuality is not a psychiatric disorder. See: <https://www.ndtv.com/india-news/homosexuality-not-a-disorder-says-indian-psychiatric-society-1880806>

village or community upon learning that one family member engaged in same-sex relations. Several key informants in Afghanistan, Bangladesh and Pakistan also spoke of the role of religious sanctions against same-sex behaviour, stating that religiously sanctioned bans on homosexuality were used to legitimize actions against same-sex behaviours. The power of religious leaders on this topic was described as a major barrier to any legal reforms. As focus group discussion participants in India noted, "Religious leaders claim that sex of this kind doesn't exist. They say, 'No two men can love each other, nor can they marry and therefore these are all symptoms of madness!'" By disapproving of homosexuality, religious leaders delegitimize the social status of sexual and gender minorities.

4.2.3 Health care providers

No participant from the 21 focus group discussions reported a positive experience from health care providers, except those provided by community-based organizations or civil society organizations. In Bangladesh, India, Nepal and Pakistan, participants unanimously reported that they, and those in their communities, sought help for their health problems (particularly, sexual health problems) from community-based organizations, and in countries like Afghanistan, Bhutan and Sri Lanka, they accessed civil

society organization-based HIV and health services as they found health providers and counsellors in these facilities to be more accepting and friendly.

Though outright denial of services was not reported significantly, focus group discussions and key informants across countries reported several other barriers to men who have sex with men and transwomen accessing health care services. According to a key informant in India, ignorance of issues of gender and sexuality, and lack of training on the topic lie at the heart of insensitive health care. The key informant noted that although homosexuality was no longer officially pathologized in India¹⁰⁸, counselling is still given to change one's sexual orientation. In India, the medical curriculum itself is outdated in terms of information on gender and sexuality, with many students still using references that pathologize non-normative genders and sexualities.

Apart from lack of understanding on SOGIE issues and anticipated stigma from health care providers, participants reported several instances of harassment faced at the hands of health care providers. These instances were reported more by transwomen than men who have sex with men. Among transwomen, 7 of 9 focus group discussions discussed facing harassment by health providers, whereas only 4 out of 12 focus group discussions

among men who have sex with men described such experiences. Transwomen reported acts of sexual harassment ranging from undue and inappropriate enquiries about their sexual behaviour to cases of sexual assault. For example, a transwoman participant in India reported how transwomen experienced instances where the HIV counsellor and doctor repeatedly asked them to describe in detail each sexual act with their partner/s even after providing them with all information that was needed to carry out a test. A transwoman in Pakistan reported being sexually harassed by her dentist:

“I had pain in my teeth, so I went to a particular hospital. I told the doctor about my symptoms and he realized what I am and he started harassing me sexually.”

Several participants reported instances of breach of trust by a health care provider including discrimination based on their sexual behaviour and involuntary disclosure of their sexual orientation. In Sri Lanka, a transwoman said, “Health facilities do not maintain confidentiality about their transgender clients. For instance, if a transgender person has to undergo surgery because of an accident, the entire hospital will come to know that the client is a transgender person and

the information may even be leaked out to the media.”

Consequently, participants admitted a general reluctance to seek medical services, particularly in instances of rape and where they feared being “outed” by the health provider. As shared by a participant of a focus group discussion of men who have sex with men in Nepal, in response to the case vignette on sexual assault, “[the vignette character] cannot go to the hospital for treatment because again lots of questions regarding his sexual orientation will be raised for anal injuries and he will be harassed in the hospital too.”

It was reported in Bangladesh that a key issue is a lack of guidelines for medical practitioners to engage with members of the *hijra* community. Therefore, medical examinations are often performed in a degrading way. If *hijras* are not officially identified, they are prevented from accessing government facilities specially meant for them.¹⁰⁹

Finally, participants discussed subtle forms of service denial like deliberate delays in providing services. A health care provider in India said, “Stigma in health care settings is not gone (in both private and government sectors), but is much subtler now. Instead of outright denial, doctors defer treatment.” Similarly, men who have sex with men in a focus group discussion in India complained, “Even today when we go to a doctor, even

109 As reported from stakeholder interviews for the development of this report and the UNDP, APTN (2017), *Legal Gender Recognition: A Multi-Country Legal and Policy Review in Asia*.

when we voluntarily go for an HIV test with full information and knowledge, we are asked why we want to get tested. Rather than doing the test, they keep asking why we want to get tested.”

The range of discrimination, harassment and abuse faced by men who have sex with men and transwomen in health care settings has critical implications for HIV risk. When health care providers fail to treat clients with respect and adequate care, or in worst case scenarios, abuse clients, this can create community-level distrust of the institution. Health care settings can be a critical source of life-saving interventions or a venue for prevention efforts. When men who have sex with men and transwomen face discrimination, and subsequently do not access these resources, they can suffer harmful health consequences as a result.

4.2.4 Community

The immediate community served as another source of SOGIE-based violence, according to study participants. Major forms of violence included harassment in public spaces and on public transportation and difficulty renting homes. These sources of SOGIE-based violence were more commonly discussed by transwomen, whose gender identity is more visible in public spaces compared to men who have sex with men.

Public harassment on buses and in public spaces. Focus group discussion participants in several discussions cited instances of harassment in public spaces including the use of public services such as buses. Participants from Bangladesh, India, Nepal and Pakistan reported various forms of harassment while using public transport, including being thrown out of buses, drivers refusing to stop buses for them, being verbally abused and being handed over to the police just for travelling in a crowded local train or bus. A transwoman participant in Bangladesh made this telling comment: “If I go in a bus here in [site], I often see that the moment I sit, at least two or three people will get down from the bus. The bus conductor will use very foul language with me even if I don’t have change.” While public transport is just one of the sites of violence, transwomen sometimes use public space as their ‘workspaces’ for carrying out activities like seeking-alms for a living or dancing on occasions of childbirth or marriage. In particular, transwomen in Bangladesh, India and Pakistan reported facing humiliation at traffic signals or when approaching a family to dance for their newborn baby.

Housing discrimination. Transwomen participants from Bangladesh and India noted discriminatory experiences when renting accommodation. A transwoman in Bangladesh shared, “We cannot find a rented house, landlords make us pay extra rent and evict us without notice

suddenly when we come from home. Where should we go then? Sleep at bus stations?” Another transwoman in India shared her difficulties in renting a house,

“If we want to rent a room, nobody [rents one] to us, even if we are ready to pay the full rent and conform to all their conditions. Don't *kinnars* have the right to live? Are we ghosts who will gobble others up?”

These instances of violence within the community signal the conditions of discrimination, abuse and harm under which many sexual and gender minority groups live.

4.2.5 School

School and educational settings as sources of SOGIE-based discrimination differed between transwomen and men who have sex with men in this study. For transwomen, a critical aspect of education-related SOGIE-based violence was the lack of legal status and name change formalities as a barrier to greater education and opportunities in their communities. For some men who have sex with men as well as transwomen, schools were also a site where SOGIE-based violence occurred, often early in the life course.

Legal status and barriers to education. Transwomen faced considerable difficulty accessing greater educational opportunities due to barriers related to their legal status and the lack of educational quotas for transgender people. For example, a transwoman in Nepal (in a focus group discussion) commented on policy gaps: “We can do anything, because some of us are educated. If we get an opportunity, we can excel. There are quotas for females and others, but not for transwomen. We have the capacity and the necessary documents, but we cannot move forward because there are only quotas for females and males.” Another transwoman participant in India expressed her difficulties in enrolling at a local university,

“I went to complete graduation. I have passed my class 12 with good marks, but when I went to seek admission for a BA after a few years, university staff would not even look at my application form. They said, the name on the class 12 passing certificate is that of a man, but in your form, you are insisting on using a different name.”

110 UNESCO (2016). *OUT IN THE OPEN: Education Sector Responses to Violence Based on Sexual Orientation and Gender Identity/Expression*. France, UNESCO. Available at: <http://unesdoc.unesco.org/images/0024/002447/244756e.pdf>

111 Term from a focus group discussion in Nepal. Kanya-kanya is a make-believe game played by girls using dolls. They pretend to enact feminine gender roles like cooking as a part of this pretend play.

Structural problems like not being able to change names on certificates and other documents continue to act as barriers to accessing education, despite countries like Bangladesh, India, Nepal and Pakistan recognizing the 'third gender'. A key informant activist from Bangladesh highlighted the gaps and problems with these new policies: "A separate column as third gender has been created in the passport form ... where *hijras* can fit ... but who will fit under this third column? There is no clarification of that. If a *hijra* wants to fit there, the authority wants several papers. But the authorities who are supposed to provide those papers do not know [about it]." The activist went on to describe an incident in which a *hijra* friend had undergone gender-affirmation surgeries and then attempted to change her legal gender in order to apply for a job. She found a considerable lack of coordination between government ministries, and a lack of clarity among stakeholders around what qualifications were required for *hijras* to be recognized legally. In these cases, even when legal recognition is a possibility, it can be difficult to put into practice.

School-based bullying and harassment. This study confirms previous research that shows schools as a major source of SOGIE-based violence in Asia.¹¹⁰ Study participants across all sites spoke about violence faced in schools and colleges at the hands of their peers and teachers. Classmates ridiculed transwomen

because of their gender behaviours, such as their preference to play with female classmates, to play with dolls or to play '*kanya-kanya*'¹¹¹ with other girls in school. Teachers, in addition to students, bullied and sexually harassed participants. A man who has sex with men in Pakistan described experiencing sexual abuse by a teacher as a child, "One of the teachers in the school I attended loved me and made me sit in his lap. I didn't know what was happening with me. I only knew that he was a teacher and he liked me. But how would I have known what he was doing while loving me?"

At a school level, the absence of a redress mechanism for pressure, criticism, bullying and sexual violence in schools and colleges by faculty, students and other staff resulted in additional trauma for students. As a respondent in a focus group discussion in Afghanistan of men with high-risk behaviour described evocatively, "We are not accepted in school. They have special hate for us. No one accepts us. There is no one to listen to our problems ... and if the family knows that their son is like this, there will be no place for him in that family." School policies that do not provide options for gender-neutral bathrooms further marginalize transwomen students. A transwoman in Nepal stated, "We can't take a piss at school, we just hold it. We cannot go inside a ladies' or a men's restroom."

In Bangladesh, India and Nepal, transwomen discussed continued difficulties in accessing college or university-level education despite embracing female attire and taking hormones. As summed up by a transwoman in Nepal,

“I joined the community-based organization and they encouraged me to continue education. I started to dress like a girl and I also started taking hormones. When I started college, I used to dress as a man, I am identified as male on a certificate, but later on, I started to go to college in a female getup, with makeup and long hair, then other students started staring at me. Even teachers started to look at me differently. Students from other classes used to call me *chakka* and *hijra*, so I had to leave college.”

It is notable that bullying and discrimination against men who have sex with men and transwomen in educational settings were related to femininity. Participants observed that harassment and violence in schools were largely due to ‘effeminate’ behaviour. Outward feminine gender

expression seems to be an important marker for experiencing violence, particularly in childhood and adolescence.

The spectrum of violence within the educational system, alongside barriers to accessing the education system, was a major source of SOGIE-based violence discussed by participants. These formative experiences have long-term impacts. Lack of education or poor scholastic performance can later inhibit men who have sex with men’s and transwomen’s ability to gain employment related to training or education.

4.2.6 Workplace

Participants faced challenges, discrimination and harassment both in gaining employment as well as in keeping a job. Again, like SOGIE-based violence experienced in educational settings, violence experienced in the workplace varied between men who have sex with men and transwomen. Transwomen reported discrimination and harassment due to their (visible) gender identity. Among men who have sex with men, workplace harassment and violence were discussed often in reference to more feminine-presenting men.

In all nine focus group discussions with transwomen, participants discussed the lack of job opportunities and avenues for gainful

and remunerative employment, including issues related to masking themselves in order to find and keep a job. In terms of gaining employment, participants discussed various forms of harassment and discrimination faced by their communities. A transwoman participant in Sri Lanka said, “It is not uncommon for [transwomen] to be interviewed for a job and be posed degrading questions like, ‘What is your sex organ? Is it well grown? How long has it been? Are there any surgeries?’ So, by the time they leave the interview room, everyone in the office knows about their most private details.” A transwoman participant in Sri Lanka shared, “If I want to work in a proper office, I will have to dress like a man and not let anyone know about me.”

Employment-related discrimination was discussed in relation to driving transwomen into sex work. As one transwoman participant in Bangladesh stated, “When I went to Dhaka, I wanted to pull a rickshaw, but no one was ready to rent me a rickshaw, so I had to do sex work for the sake of survival.” Even those participants who found work in the area of their choice reported facing sexual harassment at the workplace and discrimination in paid wages. Some even faced sudden and unexplained termination of jobs. Following this, some participants resorted to sex work, dancing in bars or seeking charity and alms as a means of livelihood.

Discrimination in the workplace was also brought up in 8 out of 12 focus group discussions with men who have sex with men. Experiences of discrimination at workplaces faced by men who have sex with men were discussed in the context of feminine-presenting men who were often the targets of ridicule, gossip, and in some cases, sexual harassment by colleagues.

4.2.7 Family

The family emerged as a major source of early life adversity and trauma among men who have sex with men and transwomen across all seven countries. Both men who have sex with men and transwoman participants discussed that as children, they were expected to learn and follow expectations of what it meant to be a man in their communities. All focus group discussions suggested that the first experience of violence faced by men who have sex with men and transwomen was perpetrated by the family due to their transgression of these expectations. Multiple forms of violence – emotional/psychological, physical and financial – began to occur, particularly as men who have sex with men and transwomen shift away from “appropriate” appearance, dress, play, body language and choice of friends.

Both groups of participants in all seven countries reported a wide range in instances of discrimination and violence towards non-conforming children. These ranged from subtler

forms of discrimination, such as neglect in food distribution, to violence, including physical violence in the form of beating. A participant in focus group discussions for men who have sex with men in Pakistan said, “my father, brother, both would yell at me and sometimes beat me when they would find me playing with my sisters’ dolls.” In some cases, violence took on the form of neglect. A transwoman in Bangladesh reported, “when I was growing up ... my brother was given [the] head or larger piece of fish, or the chicken leg, but I was not given a big piece. I was underestimated”.

A particular form of violence enacted by families was the attempt to “cure” a non-conforming gender identity or sexual orientation through “quackery” or questionable medical practices or treatments. A participant in focus group discussions for men who have sex with men in India told the story of a friend, “He was educated ... when he tried to tell his mother about his feelings, his family took him for black magic to cure him. Then the pundit who does the *puja*, the *ojha*, suggested that the boy was possessed by a girl’s spirit and soon a story was made up that the spirit was that of a girl who had died recently in a village... and this boy was quite feminine in appearance and mannerisms.”

The larger community (including extended family, neighbours and family friends) were a source of pressure for families who faced

enquiries, complaints or taunts about children who did not conform to social expectations. This pressure sometimes triggered further family violence. A transwoman from Bangladesh said, “My father goes to mosque for his prayer. He [faces] complaints ... The people at the mosque say that I talk like a girl. Or I dance or sing like a girl. Again, my mother goes to the neighbour and her friends’ places in her pastimes. She is also reproached there. So, our parents scold us always for these reasons.” In Afghanistan, participants reported that families could even face eviction from the neighbourhood, which was the most extreme type of community pressure discussed in the study. Across the countries, family members could face loss of social standing and position due to non-conforming behaviour among children.

It is notable that participants remarked that “only effeminate” boys faced restrictions and sanctions against them. As in the education system, this signals that violence was a result of deviation from gender norms. When men who have sex with men did not appear effeminate, they did not necessarily face this abuse and harassment.

Another key form of pressure – which sometimes gave way to violence – was the pressure of conforming to social expectations by marrying. This pressure was discussed as a major issue in all 12

112 Some respondents noted that a first sexual encounter could also be with girls, but this issue was not explored in any detail in the study, suggesting that it might not be relevant or meaningful to the study population.

focus group discussions with men who have sex with men. It was not discussed in transwomen focus group discussions. As noted earlier, masculine-appearing men who have sex with men may not have faced harassment in schools or may not have been penalized by parents for their effeminate behaviour. However, they have to deal with the pressure to marry a woman. Attempts at forcibly marrying them off become the next recourse for the family to “set things right”. This is often accompanied with several other forms of violence including verbal abuse, gossip and community-based discrimination. As noted by a participant from Nepal from the focus group discussions for men who have sex with men, “We are forced to get married to a girl at a young age. Our parents and elders, on getting to know about our sexual orientation, want us to get married. They think we will correct our behaviour after marriage. They are convinced that if we do not get married, then our behaviour will get worse in the future.” A core dilemma that seems to characterize this life stage of men who have sex with men in particular is between forming intimate romantic relationships with same-sex partners and getting married to a woman. The coping strategies and consequences of this pressure are discussed in Chapters 5 and 6 respectively.

4.2.8 First sexual encounter

First sexual encounters with same-sex partners were often discussed as being forced or abusive in nature.¹¹² First same-sex sexual encounters tended to occur during adolescence, although participants in one focus group discussion in Bangladesh for men who have sex with men discussed the age as being as low as 8 years old. First sexual encounters were discussed as often taking place at home, giving participants no option to escape. Some encounters took place as a result of self-exploration of sexuality, where exploration led to the first encounter and in some instances, the first sexual encounter was a result of a sexual assault, followed by repeated sexual abuse accompanied by threats and blackmail.

Participants discussed the grey areas around sexual consent during first same-sex sexual encounters and the development of early sexuality. They spoke about how consent for acts such as hugging might progress to more sexual acts such as being penetrated, and that at the time, they did not know what to expect or how to say “no”. One participant in focus group discussions for men who have sex with men in Pakistan recounted, “I did not know that there is something like anal sex ... I just thought that I am enjoying the hugging ... just doing it for fun, but suddenly when anal sex happened, when he entered me, I felt sudden

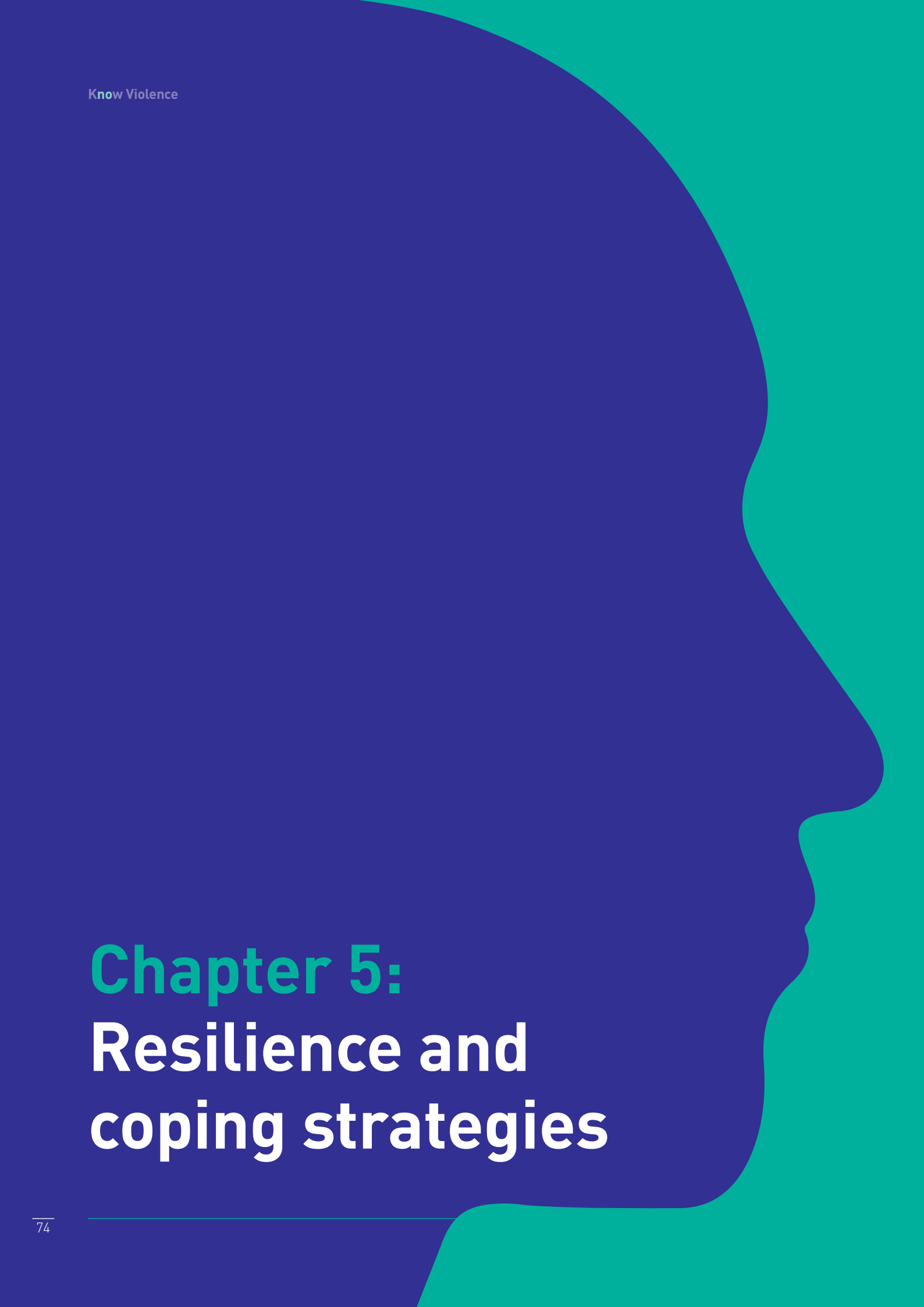
shock and pain and I pushed him back and told him I don't want to do this. I started crying and I ran away from that park". Across all the study countries, participants mentioned that the male person they had their first sexual encounter was an older person such as a cousin, uncle or acquaintance such as a neighbour, teacher, friends, classmates or other relatives. This was an observation common to both men who have sex with men and transwomen.

4.2.9 Intimate (male) partner

Although this study did not explicitly investigate intimate partner violence, 4 out of 12 focus group discussions with men who have sex with men and 7 out of 9 focus group discussions with transwomen talked about violence faced in intimate partnerships. There appeared to be a connection between the extent of family violence and the experiences of violence during intimate partnerships. Common forms of family violence (by parents, siblings and female spouses) such as physical, verbal and sexual violence, financial exploitation and controlling behaviour were also discussed in relation to intimate same-sex partnerships. Although transwomen did not report issues around pressure to marry, the pressure to maintain intimate partnerships at all costs was shared by both transwomen and men who have sex with men. One of the factors affecting intimate

relationships was the economic abuse faced in intimate relationships where study participants reported meeting financial demands of intimate partners. A transwoman focus group discussion participant in India said, "Among *hijras*, there is no such thing as love. It is all about begging and eating and taking care of the household. Even if we fall in love, then that person will be with us for one month or a maximum six months and after that, he shows his true colours, like drinking and taking money. If the *hijra* does not give the money, she faces torture by having her hands burned or being beaten up. In fact, most of us cannot reveal our feelings to anyone because if we share anything with anyone they will torture us even more."

Similarly, a transwomen focus group discussion participant in Nepal shared, "Whenever we see a handsome guy who talks to us, we start fantasizing about our life together with him and we request him to stay. There was a guy for whom I bought so many things like cell phone, bicycle and others. Then I knew that he also had relations with a girl. He got calls from her and used to lie that it was his mother. Then he took 50,000 rupees from me and ran away with his girl. I had no one to report to. I could not even say to anyone that he was my partner." A common expression is "*Kothis* support their *parikhs* for a lifetime and in return the *parikhs* leave them."



Chapter 5: Resilience and coping strategies

When faced with chronic violence, people tend to have strategies to resist and cope with the impact of that violence. These strategies can mitigate the short-, medium- and long-term effects. Coping strategies can be positive or harmful. In this study, men who have sex with men and transwomen discussed four major coping strategies: living a dual life, coming out, self-exclusion and leaving the community, and fostering resilience, including through building self-acceptance and fostering community networks.

5.1 Living a dual life

A major theme emerging from the data was the option of living a dual life. Men who have sex with men and transwomen tended to conform to dominant expectations of what it meant to be a man in their societies as a way to reduce their exposure to SOGIE-based violence. This included conforming to more ‘masculine’ personal attributes and/or marrying a woman. Participants indicated that men who have sex with men and transwomen often “gave in” to societal or family pressures by “acting straight” and dressing in a masculine way, cutting their hair short, changing their mannerisms and getting married. Participants who were men who have sex with men elaborated on various ways in which people in their community lived dual lives. They could pretend to have girlfriends, but maintain secret relations with

men. They could travel to other cities to act out their sexual orientation, while maintaining a heterosexual appearance back at home. Living a dual life, according to participants, was justified, given the alternative. They suggested that this ‘duality’ enabled them to acquire respect and status in society, while also seeking romantic and sexual fulfilment.

However, participants in focus group discussions in several countries observed that for men who have sex with men, the ability to fulfil the breadwinner’s role for the family superseded even the pressure to marry. Participants from these countries observed that as long as they provide financially for their family, they are perceived to be valuable, and the family does not pressure them as much to marry, even if they are effeminate.

5.2 Coming out

A second set of participants felt that marriage to a woman was not something they could live with as it would put extra pressure on them to maintain a relationship with their wives. They do not feel sexually attracted to women and feel that marriage would distance them from their male intimate partners. It would only add to their current issues instead of solving problems. As observed by a participant in Pakistan, “After you marry, they immediately want to know if you

have been intimate with the wife, when do we hear the 'good news' (about pregnancy)? If there has been no sexual intercourse with the wife, the woman is often blamed and everybody wants her to get tested. It can be dealt with by postponing the topic – by giving excuses, stating high expectations from the match.”

Participants in three focus group discussions with men who have sex with men in Bhutan, India and Nepal reported taking active steps to avoid marriage. Apparently, the most successful strategy was to disclose their sexual orientation to their parents and families. Disclosure of sexual orientation to family members, however, was easier said than done. Participants in focus group discussions for men who have sex with men in Nepal shared that they needed help in breaching the topic of marriage and their sexuality to their family members. A participant from Nepal said, “My mother kept asking me about my plans for marriage. I tried to tell her on several occasions that I am not interested in marriage, but she wouldn't listen. I decided to speak to the counsellor in [site]. She helped me in gaining confidence to tell my mother and offered help. Finally, I told my mother, and made her talk to the counsellor to understand. She is still sad, but has stopped asking about marriage.”

Mental health professional key informants in India and Nepal corroborated the need for counselling

support while dealing with pressure to marry a woman and the subsequent coming out process. Parents, they said, go through a mourning process as they lose the “image” of a son they had cherished, and the expectations they had built in terms of grandchildren. However, with support, some parents are willing to stand by the choices of their children. A psychologist in India said, “Parents in Asia raise their sons with long-term plans for their (sons’) lifetime. They have already thought about how their son’s future life will be, their grandchildren, their retirement and grandchildren being a major focus of retired life. When they realize that their son does not want to marry, all their dreams come crashing (down). With a lot of education and counselling, they accept that same-sex behaviour is natural, but they find it most difficult to come to terms with their lost cherished dreams. They then feel the challenge of what to tell their relatives, and what should they expect will happen to their son in his future, like, who will care for him once we are gone?” However, with the exception of India and Nepal, in no other study country did the participants mention counselling for their family members.

Of all the study countries, Bhutan was the only site where participants remarked that parents do not pressure them to marry to a great extent. They attributed this to the overall increasing age of marriage in Bhutan as a result of changing gender

norms and improved education levels. Focus group discussion participants in Bhutan also stated they find it easy to talk to their parents and make them understand their sexuality. Despite being unsure of the outcome of such conversation, they felt that parents would accept them. As summarized by a focus group discussion participant in Bhutan, “Parents would first ask why they don’t want to marry. They will try to persuade him that it is high time that he got married. The older family members would think that it is the obligation of their sons to get married. If the son tells their parent that he wanted to marry a boy and not a girl, then their parents would not believe it and it would be like giving their parents a surprise birthday party. But if their son explains to their parents, they would understand. But again, there is also the chance of going in the wrong way [*another way round depending upon the family*] in which he may get kicked out of the house or [they would] not talk to him [again].”

5.3 Self-exclusion and leaving the community

Another form of coping that emerged from the data was that of “self-exclusion” or withdrawal, particularly from the family unit or community. The family unit is an important social unit in South Asian societies. Individuals reflect one’s family, and honour and status are given to the individual and family accordingly within the community.

Participants revealed that when faced with situations of violence and discrimination due to their gender identity or sexuality, individuals tended to withdraw from those situations as a way to mitigate the violence. A common demonstration of self-exclusion across all seven countries was moving out and away from home, villages, towns or even the country. The explanation behind one’s decision to leave the family or home community varied. For example, transwomen in all focus group discussions listed the desire to live on their own terms, the desire to live as a woman and the need to be with other transwomen. Comparatively, men who have sex with men often moved away from their home communities to avoid marriage or to escape violence and eviction due to the disclosure of their sexual orientation. Notably, men who have sex with men did not report similar experiences with clans or established communities as a new home, unlike transwomen.

However, a consequence of this coping strategy was the loss of home-based economic opportunities and support networks. Men who have sex with men and transwomen discussed challenges when migrating to a new city or town. Given the impact of discrimination and violence on participants’ education levels, participants reported that finding regular employment was a major challenge. Of the 77 transwomen participants, only 7 held regular or

salaried employment while all other participants reported engaging in low paying, irregular jobs such as hotel staff, cooks, delivery personnel and running small shops. As described in Chapter 4, they faced sexual harassment at work, such as delayed wages, and harassment by co-workers and employers. Key informants corroborated this trend, and noted that feminine-presenting men who have sex with men and transwomen struggled more to find work opportunities. As expressed by a transwoman activist in Pakistan, “Nobody wants to give *murat* a job. You will not find a single *murat* working in an office job, and it’s only in community-based organizations that you will find men who have sex with men and transwomen doing jobs sitting in front of a computer.” Lack of job security may attenuate the potential positive effects of leaving home as a coping strategy.

Participants also revealed they withdrew or excluded themselves from social settings, such as avoiding family functions, withdrawing from socialization with peers in schools and colleges, and keeping themselves away from those they felt threatened by, in order to avoid facing violence.

5.4 Resilience

Participants discussed several positive coping mechanisms to enable them to thrive in adverse conditions, fight back, build individual and

community resilience, build alliances and celebrate their sexuality and gender identity.

5.4.1 Self-acceptance and coming out

Participants discussed ‘self-acceptance’ as a strategy that enabled them to build resilience. At the individual level, participants reported that ‘coming out’ or disclosure to friends and family was adopted as a strategy irrespective of the outcome of such disclosure. Participants reported that when voluntary, the disclosure was received not with violence but with curiosity, particularly from heterosexual friends who then stood by them and provided support. Participants in focus group discussions for men who have sex with men in Bhutan, India and Nepal reported that the support of an organization, community or friends was crucial during the disclosure to family members in the context of marriage. Participants noted that when they identified others like themselves and could associate themselves with “a community”, it provided a sense of belonging.

5.4.2 Fostering community networks

The extent to which community bonding facilitated self-acceptance varied depending on the level of community mobilization in a country. In some contexts, like Afghanistan,

Bhutan and Pakistan, community-based organizations facilitated community bonding through their drop-in centres, by delivering health and outreach services and facilitating individuals to reach out to each other through social media, particularly where congregating was considered unsafe. Focus group discussion participants in Afghanistan and Bhutan discussed the lack of “visible” networks, and therefore visits to civil society organizations for services provided the only opportunity for them to talk about their issues with others like them. Participants in Bhutan suggested that they had few friends in the community and most ‘cruising’ took place online and through social media. A participant from Afghanistan said, “I know there are others like me who are into the same work, but I cannot meet them. I only have my few friends. Most of us talk to each other on mobile phones.” Coming together in a group could create safety and security issues. A key informant from Afghanistan reported that civil society organizations that reach out to men with high-risk behaviour face challenges in delivering services and have to be careful in allowing large groups of men to be seen together. At the same time, when visits to civil society organizations were possible, they provided an opportunity for men to make friends in person and share experiences.

Comparatively, in countries like Bangladesh, India, Nepal, Pakistan and Sri Lanka, participants reported

being part of networks that spread beyond services provided by community-based organizations to networks of friends and communities who helped participants overcome difficult situations or crises. These networks formed a kind of emotional support, ensuring guidance from peers, in addition to material support such as shelter and sometimes, financial resources.

Transwomen participants from countries like Bangladesh, India and Pakistan stated that the support of the community was their biggest resource and instrument of coping. Often, transwomen discussed leaving home and joining the “family of [their] choice”, in order to fully embrace their identities. When transwomen migrated to cities, they often joined transwomen communities. Participants from Bangladesh, India and Pakistan reported that the transwoman community ensured their basic needs were met, and helped them to find employment opportunities, often sex work and begging. Although these occupations, especially sex work, further exposed transwomen to violence, in some instances transwomen participants discussed their safety techniques. A major technique was to travel with other transwomen in small groups. Many transwomen, especially in Bangladesh and India, reported that community-based organizations and their transwoman leader intervened in crises and advocated for them with police with success.

But sometimes, communities can be a source of violence alongside support. A transwoman in India described this experience: “If we listen to them (*gurus*), that is when they support us ... if we don’t listen to them, they beat us with a stick, chop off our hair ... make us bald ... after that, if we beg in the trains, the policemen also equally harass us...” However, transwomen still identify

with their communities even when they experience violence from their *gurus* or other community members. A transwoman participant in India noted, “*Kinnars* are my family ... *kinnars* are my parents, siblings and everything to me ... even if they beat me up, I don’t feel bad ... I earn and whatever money I get I give them and make them proud and make myself proud too.”

Figure 6: Coping strategies



Living a dual life

In order to conform to dominant social expectations to marry and have children, men who have sex with men and transwomen reported living a dual life – engaging in relationships with women, while also seeking romantic and sexual relations with men.



Coming out

Some men who have sex with men and transwomen took active steps to avoid marriage, and disclosed sexual orientation to parents and families in order to mitigate family pressure.




Self-exclusion and leaving the community

Withdrawal and self-exclusion from natal family and community was a strategy used by men who have sex with men and transwomen to avoid violence and discrimination based on gender identity and sexuality.



Self-acceptance

Men who have sex with men and transwomen described processes of self-acceptance, through the support of friends, family and community bonding. Self-acceptance facilitated their ability to build alliances and celebrate their sexuality and gender identity.



Chapter 6: SOGIE-based violence, HIV and mental health

6.1 SOGIE-based violence and mental health

Lifetime exposure to violence and discrimination, including social exclusion and marginalization, negatively impacts on the mental health and well-being of men who have sex with men and transwomen. According to the data, their psychological issues ranged from poor self-esteem and self-doubt to suicidal attempts and occurred due to the gradual build-up of stress, coupled with a lack of recourse, acceptance or support systems in face of discrimination or abuse.

6.1.1 Suicide

Participants discussed attempted suicide and suicide as a serious consequence of SOGIE-based violence. A participant from focus group discussions for men who have sex with men in India recounted a story about a peer whose family tried to use black magic to eliminate his same-sex attractions: “He finished his school and entered college. But the problem continued with him. He was compelled to go for a medical check-up though this was not a mental health problem. He attempted suicide twice, he even slashed his hands, but his family failed to understand him. Now he doesn’t stay with them and his family also doesn’t ask about him or try to look for him. Now he lives elsewhere and works in an NGO as a peer.”

Another focus group discussion participant in India said, “If a 13 or 14-year-old commits suicide, people say he was just a kid – he must have been playing when he put the noose around his neck and then got killed by accident, or that he must have been trying to imitate Shaktiman¹¹³ ... some people may say he failed in the fifth class and was in depression, but the reality of him being tortured and abused remains hidden [due to his sexual orientation or gender identity]. Family members, too, even if they want to, cannot be open about the real reason because of social shame ... If the real reason gets known, tongues will start wagging.”

6.1.2 Substance abuse

Both men who have sex with men and transwomen participants, particularly in Bangladesh and Pakistan, and men with high-risk behaviour in Afghanistan, reported using substances to cope with the emotional and psychological impacts of violence and discrimination. Particularly men with high-risk behaviour in Afghanistan mentioned using cannabis and injecting drugs whereas both men who have sex with men and transwomen participants in Pakistan reported using hashish and injecting drugs. Additionally, participants from Bangladesh reported misusing over-the-counter drugs like sleeping pills. Almost all transwomen focus group discussions in India, Nepal, Pakistan and Sri Lanka reported alcohol use to

113 A superhero character, akin to Superman, on an Indian television show in Hindi for children.

cope with mental stress, tension and feeling low. A transwoman in Pakistan reported, “Drugs are to control the mental stress, it slowly becomes a habit.” Transwomen participants from Bangladesh, India and Pakistan also reported being coaxed into drinking alcohol by an intimate partner.

6.1.3 Stress related to dual lives

As noted in Chapter 5, participants discussed leading dual lives – marrying women and continuing secret same-sex relations – as a strategy to avoid discrimination and violence related to their gender identity or sexuality. However, participants also note that living a dual life impacts the mental health of married men who have sex with men. Participants reported that married men who have sex with men resorted to alcoholism to deal with the stress of demands from marriage and maintaining a relationship with the same-sex partner. Men who have sex with men also felt constant anxiety and fear around being found out by their families. One participant in Sri Lanka said, “One person might control himself and go for a marriage. After marriage, he secretly continues his desires the way he wants. He is too stressed. He has to pay attention to his wife or the family will complain and on the other hand if he can’t give time to his male partner, then that is also bad. Plus, there is tension of people finding out at home. Anyone can easily lose their mind.”

6.2 SOGIE-based violence and HIV risk

Participants described a number of situations in which SOGIE-based violence led to greater HIV risk. Three major themes that emerged were (1) SOGIE-based violence and discrimination driving men who have sex with men and transwomen into sex work and risky sexual situations with clients and police; (2) barriers to health care in cases of sexual assault; and (3) the processes of finding sexual partners in contexts where same-sex activities were illegal or socially unacceptable.

6.2.1 Violence during transactional sex and HIV risk

The violence that men who have sex with men and transwomen faced from families and communities often forced them to leave home. With little educational or employment opportunity (see Chapter 4), participants discussed how men who have sex with men and transwomen might transition into transactional sex work. For transwomen, the transition could lead them to the care of a guru or mentor in the transwomen community. Transwomen also saw this transition as a shift into sex work as well as earning money by dancing at parties, religious occasions and seeking alms as means to earn a living. Transwomen gurus often encouraged and supported these means of earning. For men who

have sex with men, the transition was less about organized sex work through a guru, and more about transactional sex as a dancer, or providing transactional sex in cruising spots. However, participants perceived sex work as a high HIV risk activity. A transwoman in Pakistan noted, “Some people say that they ran away from home, entered in *guru-chela* (leader-disciple) system and got freedom. I think the *guru-chela* system is itself a jail in that you have to follow various restrictions and not every *guru* is one who takes care of you. There are many who ruin your life and at the same time, many who are good for you. They force them into sex or to beg and torture them. You come to a *guru* with a thought in mind that she will be a support for you, but she ends up forcing you to become a paid sex worker to make money off of it. So, rather than having a good future, you end up having sexually transmitted diseases.”

Participants noted that engaging in sex work and having sex with unknown partners were fraught with many dangers like blackmail, extortion and gang rape, particularly by clients and police. A transwoman in Bangladesh said, “I do sex work ... so there are some boys who while negotiating sex, say that they will give 500, 250 whatever ... one person takes us there, five, six people come ... they come in a gang under the influence of alcohol ... if we say no, they force themselves, they tear our clothes ... beat us ... some people have sex and

give money too and drop us home ... and some just take money ...” In circumstances like these, men who have sex with men and transwomen face HIV risk through the lack of or inability to negotiate condom use, as well as increased HIV transmission risk through open wounds, tears and abrasions.

Participants did describe creating strategies to protect themselves from violence. These strategies included keeping the *hijra guru* informed about their whereabouts while engaging in sex work, accompanying clients only to known places, working in pairs within a specified geographical area and marking safer spaces for engaging in sex work. Yet, as described in Section 4.2.1, the impunity with which perpetrators operate gives men who have sex with men and transwomen little recourse to justice, in cases of assault and violence.

When asked about help-seeking after a sexual assault, participants reported that they turned to friends as the first line of support. When asked about seeking formal help, both men who have sex with men and transwomen participants said they sought help from police, but faced further discrimination and violence. One transwoman participant in India shared, “Even if we go to complain to the police, for example, there is a kinnar who is alone and seeks help from the police ... the person who has attacked them will give some money

to the police and he will be freed ... instead, the *kinnar* will be put in the lockup and whichever police is there on the night shift will have sex with the *kinnar*.”

6.2.2 Discrimination by health care providers

Section 4.2.3. describes the violence experienced by men who have sex with men and transwomen by health care systems. This discrimination can compound the HIV risk that occurs in instances of sexual assault. In addition to reporting instances of sexual assaults, participants had physical injuries, which needed immediate medical attention. Participants’ experiences in seeking health services in the event of sexual assaults varied. All participants reported going to clinics for sexually transmitted infections first for treatment given the likelihood of doctors being more sensitized at these clinics. However, if these services were unavailable, they described feeling more anxious about seeking treatment from other health care providers, as they often face humiliation and discrimination at other facilities. For example, participants in Afghanistan and Bhutan reported that at government clinics, they did not disclose their sexual behaviour and felt that they had no alternative, but to tolerate the pain. Participants in Sri Lanka were concerned that doctors might fail to maintain confidentiality and

expressed fear that the media might report and sensationalize their rape cases.

Stigma and discrimination by health care providers can also exacerbate general HIV risk, outside of direct instances of sexual assault. Anticipated stigma led to low levels of health care usage, which could lead to mistreatment, delayed treatment or lack of treatment for sexual health issues. A health professional in Bhutan said, “Access to health is guaranteed but people are afraid to go. They have equal access to education and health facilities like any other. We see cases of anal warts coming mostly from the monastic bodies. Even discharge from their genitals. But nobody is being denied any health services. Firstly, they come during the late stages of any symptoms. For example, if there is urethral discharge from their genital areas, they will come only during late stages, because of the fear of stigmatization from health workers. So, the treatment becomes difficult. If they come with problems in the anal region due to anal sex, most of them are hesitant to tell us that they had anal sex rather than normal vaginal intercourse.”

In Afghanistan, Bhutan and Sri Lanka, participants underscored that health care systems may not be sensitized to SOGIE issues and were either largely unaware of or unwilling to acknowledge the existence of sexual and gender minorities. For example,

a participant in Bhutan said, “There is an absence of organizations and services where help can be sought. Most agencies, services, and counsellors do not even know about the existence of men who have sex with men or are not sensitive to their needs. Mental health departments in hospitals, rehabilitation centres and other agencies are not sensitized to their issues.”

For participants of the focus group discussions, this lack of acknowledgement of SOGIE issues is reflected in the lack of sensitive health services. For example, across all focus group discussions in Afghanistan, participants expressed a sense of helplessness with regard to seeking health care, especially for their sexual health. Participants reported that only two male health clinics existed in the country where they could talk to health providers and counsellors about their health and mental health issues and feel safe in doing so.

Very often, participants of focus group discussions in these study sites reported either not seeking health services or not fully revealing their sexual history at health services due to the fear of discrimination, humiliation or being outed. As shared by a participant in Bhutan, “Medical services are readily available, but people do not go because they hesitate. There is no restriction based on gender, but they will not have the courage to say that they had anal

sex. Many times, the doctor does not even ask for patient history. So, it is neither the fault of the service institution nor that of the individuals.” Discrimination or lack of training by health care professionals, coupled with the hesitation of men who have sex with men and transwomen to access health care settings, contribute to inadequate prevention of sexually transmitted infections and HIV, care, support and treatment. While discrimination by health care providers is a serious concern, advocacy efforts by community-based organizations in countries like Bangladesh, India and Nepal helped to offset some of this discriminatory behaviour.

Participants emphasized the impact of community-based organizations on the lives of men who have sex with men and transwomen, speaking at length about their efforts concerning sensitization and advocacy over the years that have resulted in building alliances with friendly health providers, lawyers and even police. A community-based organization leader in India shared his experiences saying, “We initially met at a support group. But we realized that there were many like us and we needed to reach out. With HIV knocking at our door, it became imperative to have health providers on our side who understood issues of the community. We were lucky to forge friendships with fantastic doctors who sent their students for internships at our organization, and to date, we have

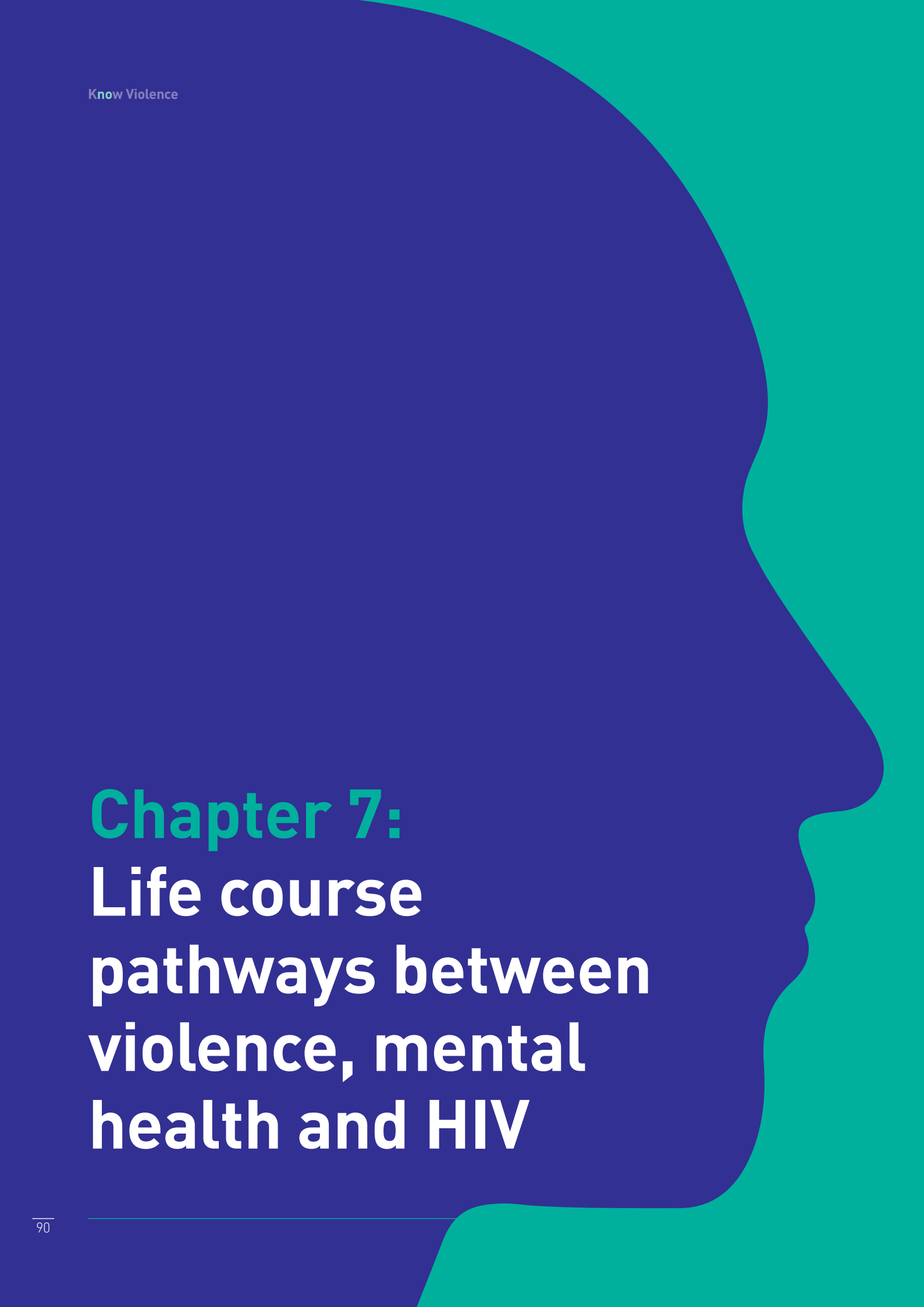
health clinics that are very friendly.” Community leaders in Bangladesh, India and Nepal shared experiences of working with the police and legal system to help community members in situations of crises that included initiating dialogue and sensitization of police and lawyers to ensure friendly services.

6.2.3 Risky situations and evolving networks

In countries like Bhutan and Sri Lanka, the participants in focus group discussions for men who have sex with men spoke about the changing nature of social and sexual networking through the use of social media and the perils involved in identifying sexual partner, given the highly stigmatizing social environment. Men who have sex with men in Bhutan said, “Social media networking sites are a source of emotional support and finding friends and sexual partners ... but sexual partners found over these sites, especially older ones, may be exploitative. They may promise to teach the basics of sex, but refuse to use condoms.” Transwomen in Sri Lanka agreed, “It’s not safe finding partners via Facebook, because there are so many fake accounts floating around. Assume we find a person. Here, they might decide to meet up alone and yet, come along with a group of around four or five people leading to the highly risky situation of sexual abuse. Other than that,

they can take photos and post it on Facebook and trap us. Once they get to know us and our real identity, they can spill the beans on us in our homes, or sneak to the police saying we are sex workers. They can spread (the news) all over causing devastation in our lives. Sometimes, it can cause legal problems for us, and at the same time, threaten to destroy our professional life by coming to our work. Further, the lack of ability to negotiate safety and locations where little to no help was available heightens the risk of unsafe sex.”

Among men who have sex with men and transwomen participants who discussed intimate partnerships, they noted that although failure to use condoms increases the risk of HIV, negotiating condom use in a same-sex relationship could be a challenge. As a participant in focus group discussions for men who have sex with men in India said, “We are unable to negotiate condom use because of lack of pleasure and to be able to retain the partner’s trust, which places the individual at risk of getting infected.”

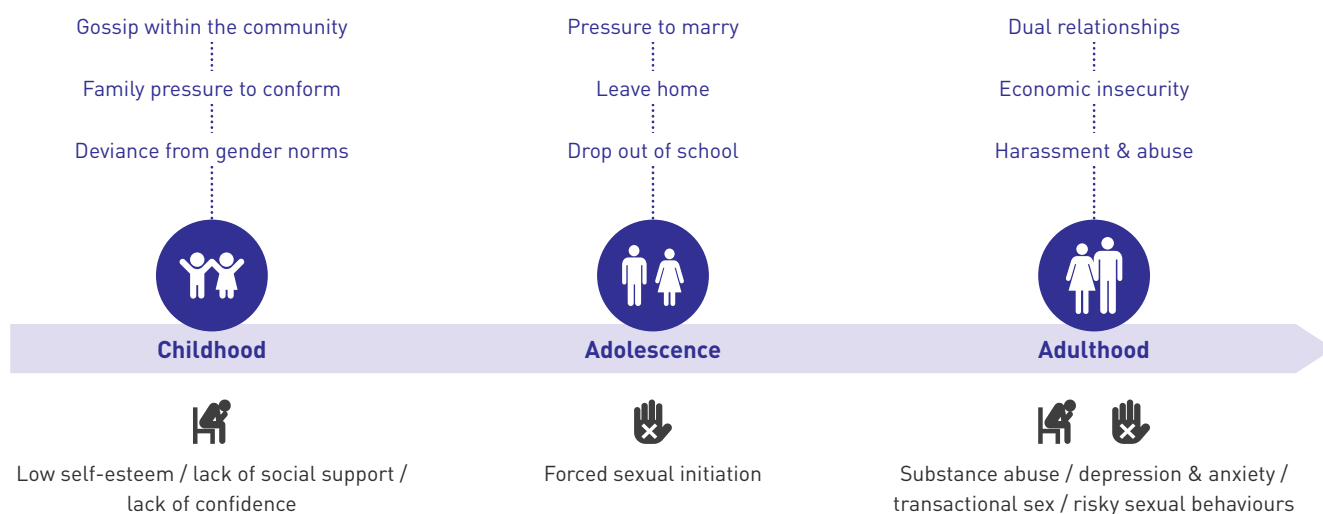


Chapter 7: **Life course pathways between violence, mental health and HIV**

In all of the countries covered in this study, the perception that men who have sex with men and transwomen transgress the dominant social paradigm that privileges heterosexual cisgender men within society appears to be the fundamental cause of the various forms of violence. Participants discussed the considerable impact of this violence on mental health and HIV risk among men who have sex with men and transwomen. The connections are complex and qualitative data lends itself to an exploratory approach to these connections. This chapter maps links between violence at the individual, family, community and society levels with mental health and HIV risk faced by men who have sex with men and transwomen in the seven countries. Figure 7 integrates results from Chapters 4, 5 and 6 into

a single life course model of how multiple sources of violence and discrimination can have complex and harmful consequences for mental health and HIV risk within the study populations. The life cycle approach demonstrates the long-term consequences of early adolescent and youth experiences on the life trajectories of men who have sex with men and transwomen, and how constant exposure to violence and trauma can lead to heightened vulnerability to HIV risk and mental health problems throughout adulthood. The pathways in Figure 7 are by no means exhaustive; however, they bring forth the major themes that emerged from participant discussions. This section highlights particular sections of Figure 7 for further discussion.

Figure 7: Connections between SOGIE-based violence, HIV and mental health across the life course



7.1 Power and status in society

A major trend across the countries was the loss of power or status across the life course due to one's gender identity or sexuality. Often, teasing, bullying, harassment and stigma against men who have sex with men and transwomen as children would lead to lower access to resources, such as education or occupational training. Leaving the family or community might further exacerbate economic insecurity. Not being able to get good jobs, men who have sex with men and transwomen might face further loss of status in society. Combined with continued discrimination, harassment and abuse as adults, these experiences contributed to experiences of mental health problems (notably depression and substance abuse) and HIV risk behaviours and settings. In instances when men who have sex with men or transwomen were able to provide for their families economically, they retained a level of status in their families, despite their sexual or gender identity. This trend demonstrates the powerful impact of social norms around masculinity – what men should do, how they should act, who they should marry and love and who they should have sex with. When men who have sex with men and transwomen deviate from these norms, they experience violence, stigma and discrimination across the life course, which can lead to a loss of power and status in society.

Thus, across Figure 7, we see that the presence of social norms against sexual and gender minorities provide a backdrop for men who have sex with men's and transwomen's experiences of SOGIE-based violence.

7.2 Family context

Early life experiences of discrimination by family members were discussed as being key sources of SOGIE-based violence that led to considerable emotional distress and framed the life course trajectory of stigma, discrimination and adversity. A transwoman from India recalled, "I had left home, but I went back home because I was missing my parents and my siblings ... my hair was long ... so, my father and uncle together chopped my hair ... they said, 'Why are you like this?' ... they took me to the hospital and gave me shots ... they took me everywhere ... I thought it would be better that I die than suffering here." However, other men who have sex with men and transwomen discussed situations where they or those in the community received family support, although it was attenuated by perceived condemnation from the community. Where families are tolerant of a gender non-conforming family member, the societal pressure to conform and stigma places the family in a difficult situation: either reject their child or risk losing social standing and position. A participant from focus group discussions for men

who have sex with men in Pakistan explained, “The family usually is fine with us, but they are too afraid to support us openly. Other relatives and neighbours don’t leave them alone. They want to know everything.”

A mental health practitioner in India further corroborated the pressure faced by family from community and extended family stating, “There are supportive families as well, because there is no absolute support or absolute absence of support ... In my experience, I have seen supportive families. Many a time, the mother is accepting, the father is not, something like that. Later on, there is partial acceptance: ‘Okay, fine, you do this but please do not dishonour us’ or ‘please do not bring your friends to our home.’” Conditional acceptance by family members highlights the challenges that supportive families might face while supporting their children. This further demonstrates the influence of community and social-level factors on the interactions between men who have sex with men and transwomen and their families.

7.3 Trajectories into a dual life, or not

Discrimination, violence and harassment from family and community, alongside the pressure to marry and fulfil social expectations, often drove men who have sex with men¹¹⁴ into considering, and possibly

entering heterosexual marriages. Across the region, many sexual minority men do enter heterosexual marriages. The UN Multi-country Study on Men and Violence in Asia-Pacific found no significant difference between sexual minority men and heterosexual men of whether they had ever been married or cohabited with a woman.¹¹⁵ While on the one hand, marrying women enables men to adapt to the social context, as we saw in Chapters 5 and 6, it can also lead to stress and fear of exposure. The practice also has implications for HIV risk for both men who have sex with men, their same-sex partners, and their female partners.

Dual lives can lead to concurrent sexual partners. Among the participants, there were differences in how they viewed concurrent sexual partners, or engaged in sexual relations with both a wife and a male same-sex partner(s). This perception was shaped by their internalization of social norms. In Pakistan, participants felt, “When in Rome, you have to be a Roman” and that once marriage takes place, family members leave them alone and they can lead a double life. In Afghanistan, a participant who identifies as a man with high-risk behaviour felt, “We should fulfil family duties and be good with all people and leave bad behaviour behind.” In the context of Afghanistan, key informants agreed with this justification of marriage, stating that “homosexuality is a sin in the eyes

114 No transwomen in the study discussed marriage to women.

115 Miedema et al. (2017).

116 Potentially a reference to the fact that women in most parts of South Asia are expected to compromise and uphold the institution of marriage much more than men.

117 Choi et al. (2008). Social discrimination, concurrent sexual partnerships, and HIV risk among men who have sex with men in Shanghai, China. *AIDS Behavior* 12, pp. S71–S77.

of the religion and marriages are a must, as these are expected things for a man to do.” Key informants alluded to the larger social, religious and cultural contexts of countries such as Afghanistan, where there are no existing role models for men with high-risk behaviour and homosexuality is strongly condemned with harsh penalties for deviance (as documented in the previous chapters).

Some men who have sex with men faced this challenge more than others. A focus group discussion participant in Pakistan said, “Masculine or male-presenting men who have sex with men face greater pressure to get married as they do not express their sexuality outwardly. They are, however, believed to be better able to work out the marriage compared to effeminate men who have sex with men, in whose case the onus to make the marriage work falls more on the wives.”¹¹⁶ In such environments, the internalization of social norms around “appropriate” behaviour may thus lead to marriage with women.

When marriage with women takes place alongside sex outside the marriage with same-sex partners, the connections can be traced between the broader social context, the individual sexual behaviours, and the risk of both mental health issues and HIV. Participants in previous chapters describe the increased chances that dual lives lead men to drink to cope

with stress, and live in fear of others finding out about their extramarital same-sex practices. A participant in focus group discussions for men who have sex with men in Sri Lanka said, “They might control themselves and get married but after marriage, they secretly continue with fulfilling their desires. If they are caught, they risk losing their family life and respect in society. There are some friends who have left their home and country due to such situations.” Studies show that having multiple concurrent sexual partners is linked to overall higher HIV transmission risk.¹¹⁷ Further, condom use with female partners is likely to be low, thus increasing risk of HIV transmission to women. Married men who have sex with men face additional pressure to have children. This results in a lack of condom use, which can place their female partners at greater risk of HIV exposure. While this linkage has not been directly reported in the data, it is an interpretation drawn from the narratives.

7.4 Mental health problems, substance abuse and unprotected sex

A final key area of connection between SOGIE-based violence, mental health and HIV was the impact of mental health problems, stemming from discrimination, on risky sexual practices. As a man with high-risk behaviour in Afghanistan noted, “Most of our men who have

sex with men suffer from mental health problems. They talk and laugh with themselves because of all these pressures and bad reactions. Some of us have left our families and live alone.” This isolation, alongside a lifetime of stigma and discrimination can lead to risky sexual behaviours. As a participant from focus group discussions for men who have sex with men in Pakistan said, “In a depressed state of mind, the individual indulges in sex with multiple sexual partners, even while telling themselves that they are not gay. Often there is a lack of safe space to have sex, leading to indiscriminate sexual encounters at different places where the use of a condom too may be rare.” Participants in Bhutan corroborated this statement, “People have anger issues, leading to their taking up substance use as a result of depression to neutralize pain, and indulge in unprotected sex.” This pattern also appeared among focus group discussions with transwomen. A transwoman in Pakistan noted, “Use of substances like alcohol, drugs, cigarettes and sleeping pills to reduce stress is common among transwomen in Pakistan.” The mental health consequences of a lifetime of SOGIE-based violence – across multiple domains – can thus lead to the uptake of risky sexual behaviours as a coping strategy. Combined with the low levels of health care use described in Chapters 4 and 6, these links put men who have sex with men and transwomen at increased risk of HIV transmission.

Chapter 8: Recommendations

Transwomen and men who have sex with men face multiple forms of SOGIE-based violence across Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka. The results of this study demonstrate how SOGIE-based violence is linked to mental health issues and HIV vulnerability among the study


population. This section provides recommendations for multiple actors and institutions across different levels of society, to address the experiences of violence across the life courses of members of these groups, and the long-term effects on mental health and HIV.



What can a policymaker do?

Recommendation	Evidence
<p>Repeal laws criminalizing same-sex behaviour</p>	<p>Legal discrimination towards those who engage in same-sex behaviour creates an environment of impunity for those who are discriminatory and encourages the belief that men who have sex with men and transwomen are not equal citizens. This leads to increased violence and mental health problems. Enforcement of these laws can reduce the use of health care facilities and support networks.</p>
<p>Provide legal gender recognition of third gender and transgender people</p>	<p>Lack of gender recognition hinders the ability of transwomen to seek higher education. Lack of education and the formal recognition of gender identity can be a barrier to stable work and the ability to make a living wage.</p>
<p>Include sexual and gender minorities in laws and policies to criminalize gender-based violence</p>	<p>Men who have sex with men and transwomen face high levels of SOGIE-based violence, partly due to impunity and a lack of legal mandate against these types of violence. Amendment of laws to criminalize rape, sexual assault and domestic violence against sexual and gender minorities is an important step toward reducing violence and shifting norms that normalize or condone SOGIE-based violence.</p>

<p>Pass anti-discrimination policies across industries</p>	<p>Protection against violence is not enough, when countries fail to also protect the broader rights of sexual and gender minorities to live free from discrimination. Anti-discrimination laws for the workplace, housing and health care settings can help to reduce direct and indirect discrimination and abuse that men who have sex with men and transwomen experience, and mitigate the long-term effects of abuse.</p>
<p>Ratify the ILO Discrimination (Employment and Occupation) Convention 1985 (No. 111)</p>	<p>Specific to the workplace, policy-makers in countries that have yet to ratify the ILO employment and occupation discrimination convention should advocate for its ratification in accordance with international legal and treaty standards.</p>
<p>Prohibit conversion therapy</p>	<p>Conversion therapy has harmful and long-term effects on the mental health and well-being of those who undergo this “treatment” and constitutes a form of abuse against sexual and gender minorities.</p>
<p>Establish budget allocations to design and implement inclusive systems</p>	<p>Funding is needed to build inclusive and supportive policies across multiple domains, including education, labour and health care. The allocation of resources to the development of these policies demonstrates a practical commitment to ending SOGIE-based violence.</p>

 What can the health care system do?

Recommendation	Evidence
Establish formal training and sensitization mechanisms in the curricula of medical and health care professionals (including doctors, nurses, mental health professionals and social workers)	Men who have sex with men and transwomen face considerable discrimination from health care providers. This discrimination and abuse stem, in part, from lack of knowledge or awareness of the specific health needs facing these groups. With sensitization and education around sexual orientation and gender identity issues mainstreamed into curricula, more health care professionals will be formally trained to respond adequately and appropriately to the health needs of men who have sex with men and transwomen.
Sensitize health care providers around SOGIE health issues	Ongoing professional training and education can help to sensitize health care providers to SOGIE-related health concerns, and make them aware of biases, stigma and negative perceptions they may hold that negatively impact the quality of care for sexual and gender minorities. ¹¹⁸
Integrate the rights of sexual and gender minority patients into professional codes of ethics	Professional associations for medical and health care professionals have codes of ethics that guide behaviour. Revisions to codes of ethics to formally declare the rights of sexual and gender minorities can drive normative change in the health care system around SOGIE rights and well-being.
Create supportive health care environments	A key barrier to health care access among the study population was the perception of stigma and abuse they would experience by health care providers. By demonstrating a visual understanding of SOGIE-issues (e.g., posters about population-specific health care issues), health care settings can demonstrate their commitment to improving the health of all, including sexual and gender minorities.

118 The Time Has Come package is a good example of training and sensitization material. UNDP and WHO (2013). *The Time Has Come: Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific*. Bangkok, UNDP. Available at: http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/the-time-has-come/

119 UNESCO provides specific education policy guidelines for the inclusion of SOGIE groups, for reference, see UNESCO (2016). *OUT IN THE OPEN: Education Sector Responses to Violence Based on Sexual Orientation and Gender Identity/Expression*. France, UNESCO. Available at: <http://unesdoc.unesco.org/images/0024/002447/244756e.pdf>

Develop networks of community-based organizations and civil society organizations with the health care system

Community-based organizations and civil society organizations are often the first stop for men who have sex with men and transwomen when they seek health care. Direct connections with health care institutions can facilitate the provision of health care to these hard-to-reach populations.

Declassify homosexuality and gender identity disorders

The declassification of homosexuality and gender identity disorders from psychiatric diagnostic manuals can help to reframe the understanding of men who have sex with men and transgender people as normal and healthy, as opposed to deviant and pathological.



What can the educational system do?

Recommendation	Evidence
Develop educational policies that prohibit SOGIE-based violence and discrimination in schools	Participants of the study discussed schools as a key place where they suffered SOGIE-based violence during childhood and adolescence. This violence often contributed to high drop-out rates. Creating a safe space in schools can reduce violence during key development stages and increase the educational attainment of sexual and gender minorities. ¹¹⁹
Build the capacity of teachers, faculty, staff and administrators to respond to and prevent SOGIE-based violence	Teachers, faculty, staff and administrators are often the first to hear of incidences of SOGIE-based violence. These actors play a key role in the frontline response to incidences of violence, to reduce impunity and implement anti-discrimination school policies. Ensuring that schools have adequate information for referrals for further intervention, and friendly service providers will also help to mitigate the effects of school bullying and harassment.

<p>Establish policies and procedures to protect and promote the rights of sexual and gender minorities in admissions and testing</p>	<p>Many study participants discussed barriers to higher education as a consequence of discrimination and stigma against sexual and gender minorities. Implementation of formal policies and procedures to protect the rights of these populations can reduce barriers to educational attainment.</p>
<p>Integrate sexual orientation and gender identity topics in school curricula</p>	<p>Integrating the histories, cultures, experiences and needs of sexual and gender minority groups in school curricula can help to reduce stigma and increase acceptance of these groups, as well as provide role models for students.</p>

 **What can industries and workplaces do?**

Recommendation	Evidence
<p>Implement inclusive policies and practices in the workplace</p>	<p>The lack of recognition of a person’s gender identity and sexual orientation can contribute to a sense of hostility and discrimination in the workplace. Conversely, validation of a person’s gender identity and sexual orientation through formal policies and practices can create a supportive environment for gender and sexual minority groups. Examples include gender-neutral toilets, dress codes that do not impose specific gender identities on employees, and appropriate leave policies for HIV-positive employees.</p>
<p>Develop and implement response mechanisms against discrimination in the public and private sector</p>	<p>Public and private sector workplaces can help to foster an inclusive and safe workplace environment for sexual and gender minorities by taking active steps to implement responses to incidents of discrimination or stigma.</p>

120 Garcia-Moreno et al. (2015). The health-systems response to violence against women. *Lancet*, 385, pp. 1567–79.



What can gender-based violence and sexual reproductive health programme teams do?

Recommendation	Evidence
<p>Promote definitions of gender-based violence that include gender and sexual minorities</p>	<p>Gender and sexual minorities face high levels of discrimination, harassment and abuse. At the root of this violence are gender inequalities and heterosexism. A broader framework of gender-based violence can facilitate greater attention to the experiences of these groups, and highlight the interlinkages between cisgender women’s experiences of violence and those of sexual minority women and trans and sexual minority men.</p>
<p>Sensitize gender-based violence and sexual reproductive health practitioners to the overlap between gender-based violence and SOGIE-based violence</p>	<p>Gender-based violence and SOGIE-related issues remain largely separate from each other in development work. However, there are considerable overlaps and commonalities between these forms of violence. Greater conceptual awareness can lead to more nuanced interventions that are attuned to the overlapping experiences of multiple groups.</p>
<p>Build gender-based violence response services specifically tailored to sexual and gender minorities</p>	<p>A systems-wide response to violence against women is considered a gold standard of health care response.¹²⁰ A parallel multisectoral response to SOGIE-based violence needs to be put in place, in order to develop appropriate health systems responses to violence experienced by sexual and gender minorities. Gender-based violence programmes can help to advocate and begin planning for this type of systemic change in health care delivery.</p>

<p>Include sexual and gender minority groups in gender-based violence prevention and response programmes</p>	<p>Programmes to prevent gender-based violence – such as gender equality training in schools and programmes to transform harmful forms of masculinity – can integrate sexual and gender minorities to provide more comprehensive coverage, make programmes relevant to a broader group of participants, and prevent overlapping forms of gender-based violence.</p>
<p>Link gender-based violence prevention work with HIV prevention interventions</p>	<p>The evidence presented in this study demonstrates the impact of violence on HIV vulnerability. Greater integration and collaboration between agencies and organizations working on gender-based violence prevention and HIV prevention can help to respond to the specific risk factors facing sexual and gender minority groups.</p>
<p>Conduct formative research on the specific gender-based violence and reproductive health concerns of sexual and gender minorities</p>	<p>More evidence on the specific forms of violence faced by sexual and gender minorities is needed to ensure that programmes to respond and prevent gender-based violence integrate and are aware of intersectional types of violence. Specific research is needed on the reproductive and sexual health issues facing sexual and gender minorities.</p>
<p>Counselling and support services for families</p>	<p>Participants noted the effects of their sexual orientation or gender identity on their families, and family expectations. In places where family counselling was available, this served as a bridge between the individual and their families. Gender-based violence prevention and response efforts can target greater awareness and mentorship of families, to build supportive home environments for men who have sex with men and transwomen in early childhood and adolescence.¹²¹</p>

121 Groups like the Parents and Friends of Lesbians and Gays (PFLAG) that are based in countries like the United States of America and have also been established in Asian countries like China and Vietnam are important support groups for providing support and education to families of men who have sex with men. Of the seven South Asian countries in this research, India is the only country that has initiated such a support group for parents. The value of this support group is best highlighted by one of the family members who runs this support group who said, “Many parents who attend our meetings feel that they are not alone and that their children are not the only ones. We often discuss how we all confront questions from extended family and neighbours on things like ‘Why is your son not getting married?’ or ‘Your son seems to have very special friends’ ... such sharing goes a long way in building the confidence of family members.”

122 See UNDP (2015). *The Right(s) Evidence – Sex work, violence and HIV in Asia: A Multi-Country Qualitative Study* for further recommendations specific to sex workers.



What can an HIV prevention programme team do?

Recommendation	Evidence
Synchronize programme intervention design with gender-based violence experts	SOGIE-based violence has considerable impact on HIV vulnerability. Integrating gender-based violence experts and programme staff into HIV programmes can help to mainstream gender-based violence frameworks and response and prevention strategies into ongoing HIV programming.
Conduct capacity and needs assessments with staff and partners	Identify key gaps in knowledge around links between SOGIE-based violence and HIV among programme staff and partners and build capacity development materials to increase awareness.
Work with police officers and law enforcement to reduce SOGIE-based violence and improve formal responses	Study participants described violence by police and law enforcement officers. In addition, they did not have confidence that police officers would respond appropriately to their experiences of violence. This was particularly pronounced for sex worker communities. Increased education and sensitization, and building collaboration with police stations and law enforcement departments can create an environment in which violence is not perpetrated with impunity. ¹²²
Support community-based organizations and civil society organizations, a and build networks	For many men who have sex with men and transwomen, community-based organizations and civil society organizations provide critical health services and community support. Community-based organizations and civil society organizations also serve as key advocates for the rights of men who have sex with men and transwomen, and build alliances with stakeholders such as doctors, mental health professionals, lawyers and police officers. These services are important to mitigate the effects of SOGIE-based violence. More networking and collaborations across the region can facilitate cross-national learning and build a collaborative movement to promote SOGIE rights and well-being.



What can researchers do?

Recommendation	Evidence
Conduct research on links between SOGIE-based violence, HIV and mental health	More evidence is needed on country-specific patterns of interlinkages between SOGIE-based violence, HIV vulnerability and mental health and other health outcomes
Conduct research among sexual minority women	Sexual minority women face a unique combination of gender-based violence due to their status as women (at some period of the life course) and SOGIE-based violence due to their sexual orientation or gender identity. These experiences warrant further research, as little is known about this population in the Asia-Pacific region.

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Appendices

Appendix I: Rationale for site selection at each study site

Country	Number of sites for Focus Groups Discussions (FGDs) and Key Information Interviews (KIIs)	FGDs and KIIs per site	Justification for site selection
Afghanistan	Kabul	2 FGDs with men with high-risk behaviour 5 KIIs (2 officials from the National AIDS Program, 1 head of a CBO, 1 medical doctor at a CBO and 1 counsellor)	Recruitment was feasible in Kabul.
Bangladesh	Dhaka and Sylhet	4 FGDs, 2 per site 9 KIIs (3 heads of CBOs/activists, 1 lawyer, 3 counsellors and 2 doctors)	Dhaka has the oldest CBO and reaches a diverse population. Sylhet is Hindu-dominated and offered diverse data.
Bhutan	Thimphu	1 FGD per site (MSM) 5 KIIs (1 NACP official, 1 Health Ministry official, 2 community activists and 1 doctor)	Recruitment of men who have sex with men was feasible only in the capital city.
India	Maharashtra and Chhattisgarh	4 FGDs, 2 per site 9 KIIs (2 lawyers, 2 transgender community leaders, 2 counsellors, 1 doctor and 2 MSM community activists)	Maharashtra and Chhattisgarh were selected as there is little information on the situation of violence faced by men who have sex with men in these states. States were selected to represent a mix of high and low HIV prevalence states. Maharashtra is a high prevalence state with good penetration of HIV programmes and men who have sex with men and transwomen have relatively more access to resources, whereas a low prevalence state like Chhattisgarh has very little information available to men who have sex with men and transwomen as the HIV programmes are new and men who have sex with men and transwomen are likely to have less access to services. Thus, a diversity in responses can be expected.

Appendix I: Rationale for site selection at each study site

Country	Number of sites for Focus Groups Discussions (FGDs) and Key Information Interviews (KIIs)	FGDs and KIIs per site	Justification for site selection
Nepal	Kathmandu and Virat Nagar	4 FGDs (2 FGDs in Virat Nagar and 2 FGDs in Kathmandu) 8 KIIs (2 counsellors, 1 transgender community activist, 2 CBO heads, 1 lawyer and 2 National HIV Program officials)	Sites were chosen to represent different regions and capture data from varied subgroups of men who have sex with men and transwomen.
Pakistan	2 sites – Lahore and Karachi	4 FGDs – 2 FGDs per site 5 KIIs (1 counsellor, 1 MSM community activist, 2 heads of CBO/activists and 1 transgender community activist)	Lahore and Karachi have operational programme sites and are relatively safer than alternative sites in North-western Pakistan.
Sri Lanka	1 site –Colombo	2 FGDs in Colombo 8 KIIs (2 transgender activists, 1 National HIV Programme official, 1 NGO head and 4 MSM community activists)	Most participants lived in Colombo.

Appendix II: Ethical review procedures across study countries

Country	Ethical review process	Name of the approval body / Organization / Affiliations of expert committee
Afghanistan	Institutional Review Board	Ministry of Public Health, Afghanistan
Bangladesh	Expert Committee	ICDDRDB (in voluntary capacity) Responsive to Integrated Development Services (RIDS) Asia Pacific Network of Sex Workers (APNSW)
Bhutan	Research Ethics Board	Ministry of Health, Bhutan
India	Institutional Review Board	ICRW, Institutional Review Board, Washington DC Sigma-IRB, India
Nepal	Expert Committee	Climate Change Hazards Project supported by World Bank Independent consultant
Pakistan	Expert Committee	London School of Hygiene and Tropical Medicine Rozaan Independent Consultant
Sri Lanka	Expert Committee	Women and Media Collective University of Colombo <i>Samutthana</i> : The King's College London Resource Centre for Trauma, Displacement and Mental Health

Appendix III: Focus group discussion guidelines for men who have sex with men

Instructions to the Facilitator:

A field guide is a guidance document. Though efforts should be made to follow the guide, skilled facilitators may change the sequencing of questions as per the flow of the discussion. Each of the topic areas should be covered during the discussion. The questions indicated are just examples. This is the type of information we are interested in, but how the question is asked will depend entirely on how the discussion is going. You are requested to use these pointers only as a guide to start off a discussion. Please allow your group to discuss; listen to them carefully. Make them feel that their opinions are very important to you and to the project. If you think that the discussion is getting unfocused, please do not cut them off rudely. Use your moderation skills to get back to the issue. The questions are not meant to limit the discussion, but rather to keep it on track.

Remember there are no right or wrong answers!

Begin the discussion by explaining the study, its goal and objectives, and how the current discussion fits into the overall goal. Reiterate that the discussion is confidential.

No names are to be used by the respondents while sharing any experiences. Encourage respondents to share observations, concerns and opinions about their community rather than personal experiences. The focus group discussion should be conducted by at least two people. There should be a moderator and a note-taker. Please ensure that everybody gets a chance to speak. The discussion should be held with the consent of each participant in the group.

Note to facilitator: Speak about the background of the study and confidentiality; reiterate the need to maintain confidentiality about what gets shared in the group. Take a five-minute break after each vignette. Make sure that refreshments are served during the focus group discussion.

GUIDELINES

Today, we will be discussing issues around the lives of men who have sex with men in your country. We do not expect you to share any kind of personal information but you can speak about ideas of the community in general.

Let's begin. I will read out a vignette, a small story of an individual. Please listen to the story carefully. I will then ask you questions about the story that will help us understand issues faced by men who have sex with men in your country.

Vignette 1

Anil is an 18-year-old boy. Anil's friends have girlfriends; they talk about girls in a sexual way and fantasize about them. Anil does not enjoy such talks and cannot participate in them. He too has girls as friends but does not feel attracted towards them like his friends do. On the contrary, Anil notices that when he sees some men he feels sexual attraction towards them. Anil remembers having similar feelings since he was 12 years old. He feels there is something different in him and he is the only person who has such feelings. Even the other boys have noticed that he is not like them in many ways.

What do you think happens to boys like Anil in our society?

Probes:

- What reactions do they face from family, school, religious leaders and society in general? How do they deal with them?
- What is the effect (physical and emotional) of these reactions on Anil?
- How do people like Anil cope with being "different" – how do they deal with negative reactions from others?

Could you describe the social life of Anil?

Probes:

- Who does he make friends with? (check for loneliness/isolation/feelings of alienation)
- How does he express his sexual feelings towards other men?
- Does he find friends who don't react negatively to him?

What are some of the places and organizations that Anil can go to for help (*The facilitator should list suggestions*)?

Now, moving on, let us think about Anil further:

Could you describe the typical situations in which Anil is likely to have his first sexual encounter?

Who would the first sexual encounter likely to be with? A boy or girl?

Either? (*The facilitator should let the group share their responses before asking the next probe*)

- Is this encounter with someone older or with boys or girls of same age?
- What type of sexual activities might they be?

How likely is this first sexual encounter to be at a boy's own will? (*The facilitator can ask this as a percentage*)

Is he likely to be forced to have sex by others? By whom?

What are the likely places where Anil is likely to meet other male sexual partners and have sex? What are examples of some places?

What are the circumstances in which sex happens between two men?

Which of these situations may compel men who have sex with men to engage in activities that harm their lives? (e.g., high-risk sexual behaviours or being forced into sex work as a vocation) (Explore differences if any as per the identity of young men)

Probe:

- Lack of safe space and privacy
- Lack of access to condoms
- Physical environs like bushes/ jungles/abandoned buildings

Are there any sources of help available in the community for young men like him?

Does Anil's same-sex sexual orientation get revealed to his family and friends? How?

Probe:

- Is the disclosure voluntary or involuntary (probe for both)?
- What are the typical reactions in case of disclosure: how do family, friends react?

What help do you think people like Anil need? How can he be helped? (*Facilitator should list strategies and ask the group to prioritize the three most important*)

Do you think Anil can approach someone or some organization for help? (*Facilitator should note down the services listed*)

Now, let's read the second story and continue the discussion. Please feel free to ask for any clarifications.

Vignette 2

Akash is 30 years old, and works hard to support his parents. His family is happy with him and feels that he is a responsible son. They expect that he should get married to a woman. Akash's family has a lot of expectations from him and force him to consider marriage proposals. On several occasions, Akash has tried to escape marriage by giving various reasons, but in vain. Akash is well aware of his attraction to other men and in fact has a regular male partner who lives in the same community. Akash feels that he should run away from home to escape marriage on one hand, but also feels that he has to fulfil his duties towards his parents on the other. He is wary of leading a double life and lives in constant fear of being "found out". He is contemplating leaving his hometown to go to some other place ... but is unable to decide

Do such situations occur with people in your country too? How different are these situations than the one described above?

How does the family respond in situations like the one just discussed? *(Explore physical, sexual, emotional, economic violence)*

How do people in the neighbourhood treat people like Akash? How do families treat family members like Akash? *(Explore physical, sexual, emotional, economic violence)*

- Do you think these reactions are different for young men who are effeminate and those who are not effeminate? How? Why?
- What is the effect of these reactions on the physical and mental health of the man? Is the effect different for effeminate and masculine men, older men who have sex with men, younger men who have sex with men?
- How do men who have sex with men deal with these reactions?
 - What strategies do they use to protect themselves?
 - Do they use any strategies that harm them? e.g. risky sexual behaviours, substance use, sex work.

Do people like Akash leave their village and migrate to other places?

What would you advise Akash to do in this situation?

- Are there any services Akash can seek? *(List services mentioned)*. If he lived in your community, where could he go for services?
- What kind of experience would Akash have with various health providers *(counsellors, lawyers)*?

What kinds of services are needed for men like Akash? *(Facilitator should list strategies and ask the group to prioritize the three most important)*

Vignette 3

Ramesh, 25, is sexually attracted to other men. He used to have sex with his friends in his neighbourhood. Over a period of time, he started meeting men from outside his neighbourhood and got to know about places where men can find other men for sex.

Ramesh frequently visits cruising sites while returning from work. One such evening while returning from work, he visits the public cruising site and finds an attractive man. They interact with each other and agree to go to a park nearby to have sex. In the midst of having sex in the park, they are surrounded by men who catch hold of Ramesh and beat him and take away his valuables and money. One of them also forces Ramesh to have sex with him. While this is happening, the other man runs away from the situation.

Are you familiar with similar scenarios in your context? Could you describe a few?

What are the different forms of violence that happen to men who have sex with men in your community?

- Probe for physical, sexual, verbal and mental forms of violence

Who are the different people who commit violence on men who have sex with men?

- Probe: policemen, local goons, family, partner, friends

Which types of subgroups of men who have sex with men are more likely to face violence?

- Probe: Effeminate versus masculine men, people with strong social networks versus weak social networks, old versus young men, sex workers

What are the impacts of violence on sexual health?

- Would condoms be used when sexual abuse takes place?
- Physical problems such as anal tearing, bleeding and uncomfortable sex acts
- Gang rape

In case of unprotected sexual violence, are there places where Ramesh can go and seek medical help?

- Probe: medical check-ups, post-exposure prophylaxis.

How do you think Ramesh will be treated by health providers?

What are the impacts of violence on mental health?

- Probes: Trauma, depression, suicidal ideation.

What do people like Ramesh do when they are faced with such kinds of problems?

- Probe: Do they seek help or refuse to seek help from others?

How do you think Ramesh will be treated by a counsellor? Are there friendly counsellors?

How likely is Ramesh to go to the police with his complaint? If he goes, how would he be treated by the police?

Do people in situations like Ramesh seek legal aid? What are their experiences in seeking legal aid?

Are there any organizations that Ramesh can approach with this problem to seek help?

- Probe: Mental health counselling, legal counselling.

Are there any other local informal groups that can help Ramesh in dealing with this crisis situation?

What else do you think needs to be done to reduce the rates of violence against men who have sex with men?

- Probe: Advocacy and sensitization programmes?

Thank you for an enriching discussion. Is there anything that you would like to add?

Note: Names used in the vignettes were changed according to various study sites.

Appendix IV: Focus group discussion guidelines for transwomen

Instructions to the Facilitator:

A field guide is a guidance document. Though efforts should be made to follow the guide, skilled facilitators may change the sequencing of questions as per the flow of the discussion. Each of the topic areas should be covered during the discussion. The questions indicated are just examples. This is the type of information we are interested in, but how the question is asked will depend entirely on how the discussion is going. You are requested to use these pointers only as a guide to start off a discussion. Please allow your group to discuss; listen to them carefully. Make them feel that their opinions are very important to you and to the project. If you think that the discussion is getting unfocused, please do not cut them off rudely. Use your moderation skills to get back to the issue. The questions are not meant to limit the discussion, but rather to keep it on track.

Remember there are no right or wrong answers!

Begin the discussion by explaining the study, its goal and objectives, and how the current discussion fits into the overall goal. Reiterate that the discussion is confidential. No names are to be used by the

respondents while sharing any experiences. Encourage respondents to share observations, concerns and opinions about their community rather than personal experiences. The focus group discussion should be conducted by at least two people. There should be a moderator and a note-taker. Please ensure that everybody gets a chance to speak. The discussion should be held with the consent of each participant in the group.

Note to facilitator: Speak about the background of the study and confidentiality; reiterate the need to maintain confidentiality about what gets shared in the group. Take a five-minute break after each vignette. Make sure that refreshments are served during the focus group discussion.

GUIDELINES

Today, we will be discussing issues around the lives of transwomen in your country. We do not expect you to share any kind of personal information but you can speak about ideas of the community in general.

Let us begin. I will read out a vignette, a small story about an individual. Please listen to the story carefully. I will then ask you a few questions about the story that will help us understand issues faced by the transgender community in your country.

Vignette 1

Manju, age 35, has since childhood felt that she is a woman trapped in a man's body. From childhood, she used to wear female dress and behave like a female. Her parents and siblings always scolded her to change her behaviour. One day, she was caught wearing her sister's dress and ornaments. Her parents took her to different places to change her behaviour. Manju was distressed and eventually decided to run away from home. She moved to another city and found people who were like her and started staying with them. She liked staying with these people as she could live as a woman; however, she had to beg and engage in sex work to make enough money to survive.

How do you think people like Manju are treated in society?

What would have been Manju's feeling when she realized that she was a woman trapped in a man's body?

- Probe about confusion, acceptance, other feelings

What could be the reasons that Manju was not accepted by her parents and siblings?

- Probe about gender roles, shame for family, societal reasons

What do you think are the different places that her parents might have taken her to change her behaviour?

- Probe: quacks, religious places, psychiatrists

What do you think about her leaving home?

- Probe: Is it common and why do people prefer to leave their birthplaces and migrate to another location?

What might be the support systems available for Manju when she is in a different city?

- Probe: Peers from transgender/Hijra community, gharanas, dera, CBOs

What role does the transgender/Hijra community play in the lives of people like Manju?

- Probe: Shelter, source of livelihood, support for health seeking

What are the different livelihood options available for transwomen?

- Probe: Begging, sex work, dancing, working in NGO/CBOs

What are the problems faced by transwomen like Manju in these livelihoods?

- Probe: Violence across all the livelihood options; how do people react to a transwoman begging? Are transwomen involved in any religious rituals? How are they treated in these rituals like welcoming a newborn? What applies to your country?
- Probe: Where does sex work take place? Who are the clients? Are there regular partner/s? What problems arise during sex work: police interference, blackmail, extortion, rape, forced sex. What about condom usage?

What do you think about Manju's sex life? Do you think the difficulties and risks among transwomen are also related to their intimate relationships with other male partners and relationships between a transwoman and her giriya or panthi?

- Probe: Regular partners, type of relationship with intimate partners? Do they live with them or are they clients?
- Probe: Violence in intimate relationships with regular partners (extortion, blackmail, other forms of violence, etc.)

In general, what do you think about condom usage within the transgender community?

- Probe: Do transwomen use condoms all the time (on a scale of 1 to 10, how often do transwomen use condoms?
- Probe: Do transwomen use condoms with all sexual partners or only a few (check whether people use condoms with clients, casual partners and regular partners/intimate partners)?

How do people like Manju cope with the various challenges in their lives?

- Probe: On a scale of 1 to 10, how many people like Manju will use alcohol, tobacco or other substances? Any steps taken to reduce substance use?
- Probe: Support from community in dealing with adverse experiences
- Probe: Community rituals such as celebrations that foster a sense of "belonging"

What is the effect of her life experiences on Manju's mental health?

- Probe: Do some transwomen attempt suicide?
- Probe: What are other signs of tension and stress? How do they seek relief? Do they go to professional counsellors/mental health professionals? Experiences with mental health providers?

Vignette 2

Kiran is a 30-year-old transgender woman who lives in a small town with other members of the transgender community. Like many other friends in her community, Kiran begs and does sex work for a living. One day, Kiran was waiting at her usual spot on the highway to look for clients. Kiran was approached by a man who showed an interest in her. Kiran responded to him and expressed interest; however, as they got closer the man suddenly withdrew and began hitting Kiran and calling her bad names. He accused her of doing “dirty work” and threatened to take her to the police. He let go of Kiran only after taking all her money away and leaving her injured.

What do you think about the situation faced by Kiran? Do other transwomen face similar situations? Could you elaborate on some?

What do you think happened in this situation?

- Probe: Who are people like the male client in the story? What other things happen to people like Kiran in similar situations? What kind of violence could Kiran have faced?

What impact do you think this situation will have on Kiran?

- Probe: Physical, emotional, sexual health. Risk of exposure to HIV infection.

What kind of help does Kiran need in the situation described above?

- Probe: Psychosocial support, medical support, legal support, HIV testing, financial support, any other support?

What do you think Kiran or similar members of the community will do when faced with situations like the one described above and the other similar situations described by you?

- Probe: Who do they typically go to (community/friends/CBOs/police/doctors/lawyers)?
- Probe: What kind of experiences do they have with each kind of source (community/friends/CBOs/police/doctors/lawyers)?
- Probe: What kinds of services are needed to help people like Kiran?

What are some of the strategies that transwomen community members can use to protect themselves while doing sex work, or even begging, so as to avoid situations like Kiran faced?

- Probe: Strategies followed at an individual level, e.g. negotiating safety, developing friendships with gatekeepers at sex spots, going out in small groups/pairs, avoiding certain places, etc.
- Probe: Strategies followed at a community level, e.g. negotiating safety with gatekeepers at sex spots (paying a part of their earnings to gatekeepers, scouting

for “safe spaces”, building alliances with truck drivers, etc. Check for any innovative ideas.)

- Probe: Strategies followed by CBOs working for transgender communities (sensitization programmes with police, health providers, availability of friendly services etc.)

Where and who do transwomen go to get treatment for any illness (including HIV)? What are their general experiences?

How would you like to help people like Kiran?

- Probe: What do you think can be done to help transwomen? (*The facilitator should write down the strategies and ask participants to prioritize the three most important ones.*)

Let’s talk a bit about the experience of transwomen in health and other services in your society.

Is the social environment conducive or non-conducive for transwomen to get equal opportunities as compared to other people? How?

- Probe: What are the reasons for equality or inequality? Who are involved in fostering inequality?
- Probe: How does inequality impact the lives of transwomen?

Are transwomen able to access different public and health services?

- Probes: What are their experiences? How do they surmount difficulties in access?

- Probe: Who helps and who does not? What works and what does not?

What could be done to help transwomen access services? (*Facilitator should write down the strategies and ask participants to prioritize the three most important ones.*)

- Probe: What needs to happen? (Change law, sensitize society and service providers, etc.)

Thank you for an enriching discussion, is there anything that you would like to add?

Note: The names used in the vignettes were changed according to the various study sites.

Appendix V: Key Informant Interview guidelines

SOGIE-based violence against men who have sex with men and transwomen in South Asia

How many years have you been working on issues of HIV and sexual minorities?

Designation:

Qualifications:

As a service provider, who do you provide services to? Men who have sex with men only/ transwomen only/ both men who have sex with men and transwomen

Thank you for agreeing to participate in this discussion. To tell you briefly about this research study, we are undertaking a study entitled, *Know Violence: Exploring the links between violence, mental health and HIV risk among men who have sex with men and transwomen in South Asia*. Under this study, we are conducting research with men who have sex with men and transwomen to understand their experiences of SOGIE-based violence, causes, manifestations and consequences of violence and how violence makes men who have sex with men and transwomen vulnerable to HIV.

An important piece of this research is to understand how men who have

sex with men and transwomen participants cope with violence and what roles do various stakeholders play in mitigating violence and its effect. Also, we would like to know what various stakeholders feel about the situation of men who have sex with men and transwomen in your country. I would like to discuss with you briefly about various issues that affect the sexual minority communities in your country.

1. How would you describe the overall environment for men who have sex with men and transwomen in your country?

Probes:

- Social: family, general community norms around sexuality
- Religious: religious sanctions, any religious penalties/diktats etc.

2. How would you describe the overall legal context for men who have sex with men and transwomen in your country?

Probes:

- Legal status of same-sex behaviour, gender-affirmation surgery
- Activism against sodomy laws, etc.
- Hate crimes against sexual minority individuals

3. Thank you for discussing with me about the overall social and legal environment for men who have sex with men and transwomen. I would

like to know a little more about the communities of men who have sex with men and transwomen? Could you tell me what are the various ways in which sexual minorities in your country congregate to meet with each other to develop their sexual and social networks?

Probes:

- Public spaces
- Explore – networking using technology – like chat rooms, cell-phones
- Cruising spots like bars, parks, public spaces, etc.
- Use of drop-in centres in CBOs

4. How well are members of sexual minority groups accepted by their families?

Probes:

- Explore pressure for marriage
- Are effeminate men and transwomen treated differently than masculine men who have sex with men?
- How do men who have sex with men deal with family pressures?

5. What is the status of stigma and discrimination faced by men who have sex with men in your country?

Probe:

- School/educational settings
- Workplace
- Health care
- Other services

6. Does stigma and discrimination for transgender people differ from the situation you just mentioned and how?

7. In the face of stigma, discrimination and social isolation, where do sexual minority groups seek help and support?

Probe:

- CBOs/NGOs/government institutions?
- Community/informal networks

8. Let's talk a little more about health care, how easy or difficult do transwomen and men who have sex with men find it to access health care? What are some of their experiences?

Probe:

- Do these experiences differ between men who have sex with men and transwomen? Why?

9. Do transwomen and men who have sex with men face barriers in seeking redress for abuse, assault and crimes? Who helps them with such issues?

Probes:

- Legal redress in the case of violence or denial of rights
- Grievance against hate crimes
- Explore existence of friendly lawyers, police and religious leaders

10. In the context of HIV, what are the major HIV prevention needs of men who have sex with men and transwomen in your country? To what extent are the current HIV programmes able to address these needs?

11. In your opinion, what needs to be done differently to reduce the HIV-related risks and vulnerabilities of men who have sex with men and transwomen?

Probes:

- Advocacy needs
- Programme restructuring
- Making the larger social and legal context more conducive

12. It is documented that in several countries men who have sex with men and transwomen often face stigma while seeking various services like health, law enforcement etc. What are some barriers that various service providers face while providing services?

Probe:

- Knowledge gaps
- Need for training
- Lack of exposure
- Fear of legal and social ramifications
- Homophobia
- Existing laws that criminalize same-sex behaviours

13. Given that despite the hostile atmosphere, there are still friendly service providers like yourself that provide services to sexual and gender minorities, what strategies do you use to overcome some of the barriers that we just discussed?

Probes:

- Check how people interpret relevant laws
- Did people seek information to fill in their knowledge gaps about the community?
- How did they come to engage with the community?

14. As a friendly service provider, how do you negotiate with the larger society to improve the rights of men who have sex with men and transwomen individuals who seek your assistance? Could you give me examples from your work as to how you handled sensitive situations?

Probes:

- In the case of lawyers – explore situations where legal redress was achieved or attempted and what helped them to assist men who have sex with men and transwomen
- In the case of doctors – explore situations where giving health care required them to confront their own attitudes in associating themselves with certain CBOs or even being seen talking to transwomen and men who have sex with men by others

- In the case of police – explore situations when they negotiated safety for transwomen and men who have sex with men
- In the case of CBO leaders – explore situations in which they run programmes in an environment of fear.

15. Do others in your community, friends or family know that you provide friendly services to transwomen and men who have sex with men? Do people know that you interact with men who have sex with men and transwomen?

Probes:

- Check for disclosure and consequences of disclosure
- Check for fear or threats perceived by Key Informants in being openly associated with transwomen and men who have sex with men
- Explore instances of rejection, ridicule or stigma from others experienced by the Key Informant for providing services to men who have sex with men and transwomen

16. What could be done to make service providers more responsive to the needs of men who have sex with men and transwomen?

If you are interviewing CBO staff, only ask the following three questions:

- a.** Could you elaborate a bit on the role of the CBOs in the lives of

men who have sex with men and transwomen?

- b.** What are the challenges faced by CBOs in reaching out to sexual and gender minority groups?

Probes:

- Unwillingness of the groups to associate with the CBO
- Hostile social and legal environment

- c.** What do you think could be done to increase the participation of sexual and minority groups (men who have sex with men and transwomen) in CBO activities?

Thank you for an enriching discussion. Is there anything that you would like to add?



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