Not to Stigmatize But to Humanize Sexual Lives of the Transgender (*Hijra*) in Bangladesh: Condom Chat in the AIDS Era

Sharful Islam Khan
Mohammed Iftekher Hussain
Gorkey Gourab
Shaila Parveen
Mahbubul Islam Bhuiyan
Joya Sikder

ABSTRACT. Despite condom interventions since year 2000 with the transgender (*hijra*) population, condom use remains low. Consequently, *hijra* suffer from higher rates of active syphilis, putting them under threat of HIV transmission. In an ethnographic study, 50 in-depth interviews with diverse groups of *hijra* along with 20 key-informants interviews with various stakeholders, and 13 focus group discussions (FGDs) were conducted with comprehensive field observations. Findings indicate that most *hijra* understand the importance of condoms, but none use condoms consistently. Complex underlying reasons positioned beyond the individual's cognitive domain include: low self-confidence; economic hardships for mere survival; multiple transient partners; sexual desire, preferences, and eroticisms concerning anal sex; stigma associated with purchasing condoms; poor quality and interrupted supply of condoms and lubricants; limitation of fear-producing messages in favor of condoms; inadequate professional skills and motivational impetus of the outreach staff for condom promotion, and incompetent management with inadequate understanding about the dynamics of condom use. Imposing condoms by disregarding socio-cultural and socio-economic scripts of sexual relationships and eroticism of *hijra*-sexuality have challenged the effectiveness of current condom interventions. Interventions should not mechanize the process, rather they may humanize and eroticize sexual lives of the *hijra*. A paradigm shift is required where condoms enhance the dignity and quality of sexual lives of the *hijra* beyond the framework of disgrace, disease, and death.

KEYWORDS. *Hijra*, sexual health, condom, HIV and AIDS, Bangladesh

---

Sharful Islam Khan, MBBS, MA, PhD, Mohammed Iftekher Hussain, MSS, Gorkey Gourab, MSS, Shaila Parveen, MSS, and Mahbubul Islam Bhuiyan, MSS, are all at the Social and Behavioral Sciences Unit, Public Health Sciences Division, ICDDR, B, Dhaka, Bangladesh. Joya Sikder is the Secretary, Badhan Hijra Sangha, a community-based organization in Kuril, Dhaka.

Address correspondence to: Sharful Islam Khan, MBBS, MA, PhD, Social and Behavioral Sciences Unit, Public Health Sciences Division, ICDDR, B, Dhaka, Bangladesh (E-mail: sharful@icddr.org).

This article is based on data of a project conducted at ICDDR, B with research grants (GR # 00367) from Department for International Development (DFID). The authors thank the Social and Behavioural Sciences Unit (SBSU) of the Public Health Sciences Division for its support for the project. All project staff members are to be thanked for their hard work. The authors also are grateful to Dr. Alejandro Cravioto (Executive Director), Dr. Tasnim Azim (HIV Program Head), and Dr. Abbas Bhuiya (Head of SBSU) for their encouraging and very supportive role throughout the project period. Without their support, it would simply not have been possible to implement this kind of project on stigmatized people in the context of Bangladesh. Finally, the authors express their gratefulness to the members of the *hijra* community who provided their valuable time and shared intimate issues of their lives.

Journal of LGBT Health Research, Vol. 4(2–3) 2008
Copyright © Taylor & Francis Group, LLC
doi: 10.1080/15574090902949473

Transgender people are traditionally known as *hijra* in Bangladesh. They have existed in the Indian subcontinent with a history of more than several hundred years (Nanda, 1990; Reddy, 2003). The *hijra* do not conform to conventional notions of male or female gender, but combines or moves between the two (Khan et al., in press). The national behavioral and serological surveillance in Bangladesh has demonstrated that *hijra* are vulnerable to sexually transmitted infections (STIs) including HIV because of involvement in selling unprotected sex to multiple clients. In the fifth round of surveillance (Government of People's Republic of Bangladesh [GoB], 2007), the *hijra* in Dhaka had the highest recorded rate of active syphilis (10.4%) among other most at-risk populations. The Behavioral Surveillance Survey (BSS) of 2006–2007 indicates that *hijra* in Dhaka entertained, on average, 14.7 new and 14.5 regular clients in a week. Consistent condom use in the week was only 1.2%. Around 28% *hijra* reported having unprotected group sex in the last month and 28% reported being beaten or raped in the last year (GoB, 2009).

Little is known about condom use by transgender people throughout the world. Bangladesh, like many other countries of South Asia, is no exception in this aspect. We found no relevant literature on condom use among the *hijra* in Bangladesh. A few articles discussed socio-cultural aspects of *hijra* (Mazumder & Basu, 1997; Sarkar, 2001); none focused on risk behaviors. Few quantitative studies and surveillance studies addressed sexual behaviors of *hijra* (GoB, 2004, 2005, 2009). Studies on safer sexual behaviors conducted in India and in other countries did not include *hijra*. Thus, this research is significant due to paucity of information in Bangladesh and elsewhere in South Asia on safer sex practices of the *hijra* in the era of AIDS.

Because of limited understanding about condom using behavior, the current model of condom promotion for the *hijra* has been borrowed from the existing model of condom interventions, particularly operating for males having sex with males in Bangladesh. Not only in *hijra*, but among all known most at risk populations in Bangladesh, the consistent use of condoms has been frustratingly low. This has questioned the current model of condom promotion and called for strengthening of the model. Thus, the focus of this article is to provide comprehensive understanding of the complexities of condom using behaviors and dynamics of condom interventions for the *hijra* in Bangladesh. We expect the findings will assist donor, policy planners, and program managers in revisiting condom interventions in Bangladesh and elsewhere in South Asia.

SETTING THE CONTEXT

Most of the *hijra* in Bangladesh are biologically males who find their inner psyche more similar to that of women, and their gender roles resemble those of females. They often claim that their female mind has been trapped in male biology (Dowsett, Grierson, & McNally, 2006; Khan, Parveen, S., Hussain, M. I., Bhuiyan, M. I., & Gourab, 2007; Nanda, 1990, 2000). Therefore, they are uncomfortable being identified as traditional males or females, but seek a separate category often claimed as a '*third gender*' by many cross-cultural scholars (Herdt, 1993; Nanda, 2000; Reddy, 2003). However, in hetero-normative bi-gendered society of Bangladesh, there is no social, religious, or political space for people having any gender orientation beyond the male–female dichotomy. Conservative and phobic attitudes towards sexualities and gender diversities have contributed to ignoring people who do not align with obligatory heterosexuality or with male–female gender dimensions.

In the context of such sex–gender disparities, we attempted to understand condom-using behaviors of the *hijra*. We applied the framework of social constructionism (Gagon & Parker, 1995; Gagnon & Simon, 1973; Laumann & Gagnon, 1995; Vance, 1999) to understand the complex dynamics of condom use and nonuse of people who live with alternate gender orientations. A social constructionist approach allows examination of socio-cultural, socio-economic, and political influences on the construction of people's sexuality at various times and places (Parker, 2001). Sexual behaviors such as condom use acquire meanings within socio-cultural and economic contexts. Condom use is not

static; rather, it may actively evolve in the changing social and cultural context of society and the country within the realm of gender segregated roles and relations in most patriarchal societies (Parker, Barbosa, & Aggleton, 2000; Thompson & Pleck, 1995). For this reason, the postmodern social constructionists draw attention to the holistic view of sexuality, realizing the complex interplay of historical, social, and cultural factors that underlie human sexuality (Gagnon & Parker, 1995; Weeks, 1995). Although Vance (1999) warns that social constructionism has various meanings for different researchers when they look at sexuality, the ultimate notion opposes essentialism. The social constructionist theory denotes that sexual behaviors have diverse socio-cultural significance and consequence with subjective meanings specific to local cultural contexts.

The *hijra* in Bangladesh can be classified into three categories (Khan et al., 2007), including *badhai hijra,* sex worker *hijra* and those involved in both *badhai* and sex trade. The *badhai hijra* live a traditional life. This includes collecting money through blessing newborn babies (*bachcha nachano*) and/or from markets (*bazar tola*). They wear feminine outfits (*shari-churi*) and claim that they do not have sexual organs or power, and, therefore, are incapable of having sex or conceiving children. They raise this issue to justify earning through traditional ways. The *badhai hijra* generally do not sell sex. To them, a *hijra*'s involvement in the sex trade is a matter of shame, as it destroys the image of asexuality and, thereby, fails to draw attention to the people *bachcha nachano* and *bazar tola.* Nonetheless, sexual relations exist. Such sexual involvement is grounded in affair-based relations. Lovers are called *parik*. Many have more than one *parik*. Compared to other categories, the *badhai hijra* are more powerful in the *hijra*-hierarchy system. The second variety is a sex worker *hijra.* For convenience of expression, we call them *hijra* sex workers (HSWs) in this article. Their clothing styles may be masculine or feminine. They sell sex and do not follow traditional ways of earning incomes. Sometimes, at the cruising spot or contact place, they introduce themselves as female sex workers to sell sex. In addition, most maintain male partners, sometimes more than one partner at the same time. Condom promotional activities among the *hijra* in Bangladesh were first launched with this group. More *hijra* are now getting involved in this profession. The third variety is a combination of both *badhai* and sex work. Many *hijra* are involved in both *badhai* and sex trade. During the day, they collect money through *badhai*, and they sell sex at night. Most wear feminine outfits. Like other groups, they are involved with one or more *parik* and maintain networking with influential *badhai hijra guru* to keep their earnings safe.

RESEARCH METHODOLOGY

An ethnographic phenomenological study (Denzin, 1997; Lopez & Wills, 2004) was undertaken to explore *hijra* culture with particular attention to sexuality construction and sexual culture with the *hijra* in Dhaka City. Members of the *hijra* community were recruited and trained as researchers. They were directly involved in identifying problems related to use of condoms, gathering information on the meanings of condoms use, and also participating in interpretation of the findings.

Through ethnography, tales of the field were explored to gain multiple and intersubjective interpretations and perspectives of *hijra* culture (Van Mannen, 1988). Various methods of qualitative data collection were blended to answer the research questions. Fifty in-depth interviews and 20 key-informant interviews with diverse groups of *hijra* were conducted. We purposively included all three categories of *hijra* described earlier to maximize the known diversity of *hijra*. Among the key-informants, we interviewed service providers, influential *hijra* guru and organizational leaders and staff members of the *hijra* community-based organizations (CBOs) and some well-known and self-identified *parik* (male lovers of the *hijra*). In addition, 13 focus group discussions (FGDs) with members of the *hijra* community and key-informants, and 40 issue-based informal focused interviews were conducted with the *hijra* and related non-*hijra* individuals who know *hijra* issues from their working relationships with the *hijra* community. Concept mapping exercises

with *hijra* were also applied to understand barriers to use condoms.

Unstructured guidelines for interview and discussion sessions were utilized at the initial stage of data collection. With ongoing analysis and emerging understanding, semistructured guideline was prepared to capture issues more systematically for better comparison across informants. All interviews and FGDs were tape-recorded with participants' verbal and understood consent. Interviews were transcribed and entered into word files for further analysis through atlas-ti qualitative data analysis software. Transcripts were thoroughly and repeatedly reviewed for comments related to barriers to condom use. Data analysis was completed through a participatory approach with few members of the *hijra* community. Both manual and computerized data analysis processes were performed together within the thematic and contextualized analytical framework. The project was ethically approved by the independent Ethical Review Committee of International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B). The *hijra* who participated in the study, if reported suffering from sign/symptoms of STIs, were referred to health facilities and given free treatment organized by the project. They were also reimbursed their local travel cost related to participation in the study. Besides this, no other cash incentives were provided to them.

Fifty percent of interviewed *hijra* ($n = 50$) belonged to the age group between 18–25 years, 28% were between 26–30 years, and 12% were above 36 years of age. About a quarter (28%) had no institutional education; 30% had completed primary (1–5 years), and 36% completed secondary (6–10 years) level of education. Only 4% completed more than 10 years formal education. Thirty-six percent of *hijra* reported being involved exclusively in traditional occupations *bachcha nachano* and *bazar tola*; 30% reported only being involved in selling sex, and 18% were involved in both. In addition, 16% reported work in other occupations, such as non-governmental organization (NGO)/CBO workers, night-guards, dancers, chefs, and barbers. Most of the informants were Muslims, and Bengali as a mother tongue was used as medium of language in interview/discussion sessions. However, in many cases, some of the commonly used terms used by the *hijra* as part of their *ulti* dialect were collected and reported in this study.

RESULTS

It is widely know that the decision to use condoms is generally influenced by men who penetrate either females, males, or *hijra*. Thus, barriers to the use of condoms can mainly be described by men. Therefore, listening to women (or any receptive partners) to understand condom use dynamics is criticized because of limitations in realizing real barriers to use condoms. This study is no exception, as we also primarily interviewed the *hijra* who perform receptive sexual roles. Nevertheless, we noted that *hijra*, in their sexual relations with male partners, unlike other sexual cultures, decide regarding condom use. Therefore, it is crucial to listen to the ideas and opinion of the *hijra* on condom use.

The majority of study informants knew about STIs, HIV, and AIDS, and the protective quality of condoms. Most reported being involved in unprotected sexual acts with paid and unpaid sexual partners. Among the paid partners, general male clients are called *panthi* (men who penetrate) and some special male partners are named *parik* (lovers of the *hijra*). Complex underlying reasons for the low or nonuse of condoms exist in the contexts of these peoples' lives. Findings are divided into two broader categories: structural factors and individual factors. Some factors are identified for having more interactions at individual levels, but are also socially constructed. Underlying reasons for not using condoms based on these two categories are described in the following.

Structural Factors

Some barriers exist at the structural level of the intervention, where the role of the individuals is nominal. Contextual matters, often overlooked in condom dialogue, have enormous influences on the quality of condom promotion interventions. The following sections highlights some of these issues.

Economics of condom use: The context of sex trade. Many *hijra* live in extreme poverty. We

saw some homeless *hijra* who passed their days on roads, searched for clients at night, and came to the Drop In Center (DIC) in the morning to sleep. Many *hijra* reported being excluded from their family and some even had to leave their home. We met some *hijra* who have relations with their family members, but the basis of these relations was economic. For example, the HSWs support their families financially. The HSWs stated that they joined the sex trade to fight poverty. Those involved in traditional *hijra giri* have no choice but to join the sex trade to earn for mere survival.

> Earnings from *badhai* are so little. Two *taka* from shopkeepers . . . How more can we earn this way? I have to survive, and I have to take care of my family. I can earn comparatively more here (from selling sex). So, I choose this occupation.

In the sex trade, nothing but financial factors demonstrate critical roles in determining the use or nonuse of condoms. Sex trade, currently dominated by male and female sex workers, has become a competitive business for an HSW. All kinds of sex workers are available in the same venue, offering competitive options of commercial bodies for sale. Clients pay money to buy the body of a sex worker, male, female, or *hijra*, and, thus, sex workers as commodities make them attractive to be sold.

An HSW can only ensure earning when she can make a successful contact and contract with a client. During or after contract, condoms may come as an issue of argument. In most instances, clients refuse condoms. When the clients show reluctance to use condoms, the HSWs have three specific possibilities: (a) they can refuse to have sex with that client; (b) they can make more efforts in negotiating with clients for condoms, and (c) they can immediately agree to noncondom sex to retain the clients. Because of competition and high chance of losing the client, most commonly, the HSWs choose the last option. The issue of income cannot be overruled by putting condoms in between.

The number of clients is directly related to the amount of income an HSW can make. Therefore, no HSW rejects clients; rather, they reject condoms. On the sex trading venue, a single client finds many HSWs waiting for clients. Therefore, an HSW cannot take any risk by raising the issue of condoms. In situations when clients are limited, they specifically inform their clients about their unwillingness to use condoms. When the *hijra* get more clients, they find condom usage is a time-consuming event for many reasons. For example, time is required to convince clients in favor of condoms, and then helping clients to wear condoms takes additional time, and, moreover, condoms often delay ejaculation. The HSWs do not want to spend more time for a single customer. Rather, they want to maximize their earning through the best use of time by expecting quick ejaculation of their clients.

We met some HSWs who perceived themselves as more beautiful and attractive than others. They claimed to be rigidly asking the clients for condoms. At some point of discussion, they acknowledged that because of their physical attractiveness, they knew that clients would not simply leave them because of condoms. Rather, they intentionally forced the clients to use condoms and created a situation where the clients finally agreed to pay some additional money for not using condoms. Therefore, asking and becoming rigid on condoms was used as a technique to earn more money. Not only the attractive HSWs, but many others also reported similar bargaining techniques who reported to be convinced by the NGO peer-educators. They argued that asking for condoms does not mean finally refusing clients, particularly if any client wants to pay more, so why become so rigid about condoms?

> At first, I ask him (client) whether he would use condom or not. If he wants to do it without condom, I just drive him away. Moments later I start thinking, "What have I done! If I had sex for 20 taka I would become benefited." Then I call him again and tell, "Give me 30 taka, I will have sex without condom." Thus, I have sex for 30 taka. Ten taka more . . . isn't it better than losing a client?

We met a few HSW who claimed that, without condoms, they would not have sex even were

they offered a thousand taka per sex act. After exploring deeper, we found that these HSWs were closely involved with NGO interventions. From a professional point of view, they always try to maintain their condom-aware image. They try to establish that they have adequate knowledge on HIV and AIDS, and they are motivated. Needless to say, many of them belong to the groups of *hijra* who participate in seminars, processions, or AIDS awareness programs. They are frequently shown in front of the donors so that the success of the interventions can be displayed. However, with subsequent mental space and considerable rapport, they admitted that if an extra amount was offered, the knowledge on HIV transmission and safer sex could not win. Because of the hard-core poverty in most of the HSWs' lives, they have less drives to negotiate for condoms. These HSWs depend on the CBOs for the supply of condoms and lubricants. If condoms and lubricants are unavailable in a venue for a single day, many HSWs will have unprotected sex. Therefore, supply of condoms is essential in the *hijra* sex trade.

Interrupted supply of condoms: Huge impacts on condom using habit. Most HSWs depend on the intervention programs. In greater society, the *hijra* are perceived as intersexed or impotent individuals who do not have well developed genitals either of males or of females. Therefore, they are considered neither males nor females, and believed to have no sexual life. By acknowledging these social norms, many are involved in traditional *hijra giri*, which is based on the societal assumption of their asexual nature of life. Many HSWs are involved in traditional *hijra giri*, as well. Their involvement in sexual relations, commercial or non-commercial, may have endangered their 'asexual' image in greater society. They are condemned by their *hijra guru* (leader of the *hijra* community). Their income from *badhai* is also hampered. Ultimately, they are unable to openly seek condoms. Therefore, the *hijra* cannot buy condoms from any shop. They reported that buying condoms is impossible for them. Therefore, for both condoms and lubricants they have to depend on interventions. However, in many occasions, the supply of condoms gets interrupted because of noncontinuity of funds and other related problems. In that situation, HSWs simply stop using condoms. Once a HSW starts having unprotected sex, it becomes a huge problem for a peer-educator to convince a HSW for consistent use of condoms.

Condoms without lubricants: Rather discouraging. Generally, condoms and lubricants are distributed together. However, because of the higher price of lubricants, quite often the HSWs do not receive lubricants at regular basis. Moreover, there are lots of issues regarding the quality of the lubricants supplied to them. However, the crucial issue is the danger of promoting condoms without proper lubricants. The use of condoms without lubricant was reported painful for anal intercourse. Lubrication was described as essential for anal intercourse, particularly when condoms are used. Most of the *hijra* reported that if lubricants were not available, then they would have sex without condoms to avoid painful intercourse. The freely-supplied, less-lubricated condoms require additional lubrications. Therefore, condoms must be distributed with lubricants.

Demoralized soldiers and down-heartened targets: The winning dilemma! The role of outreach workers is very important as they work at community level. According to CBO leaders, due to many constraints, their performance does not seem to have reached a satisfactory level. For example, many peer-educators frequently become jobless because of short duration of the projects. After being away from the jobs, many of them do not communicate with the NGO/CBO. Many claimed that the salary they receive from the organizations does not seem enough for a healthy living. They do not even get adequate amount as transport cost for effective fieldwork. They cannot think of developing their professional careers as outreach workers. They are dissatisfied in many ways. There is no promotion or acknowledgement despite their hard work. Sincere effort is not valued; rather, nepotism works in many ways. These issues demoralize them. Many are alleged to be involved in the sex trade during their official working hour although that is not approved.

The outreach workers are given a target regarding condom sales. Therefore, every outreach worker has to concentrate on filling up quotas regarding condom sales. However, it is also difficult to sell condoms while different

policies exist between different interventions regarding condom distribution (free vs. subsidized). In such cases, to reach the target ascribed by the organization, many outreach workers distribute condoms free of cost and pay the amount from their own pockets. Otherwise, their jobs will be threatened. Thus, the CBO staff members whom we met during our fieldwork seemed demoralized and dissatisfied. They expressed various problems and issues of their unhappiness. Rather than gaining interest and commitment, they gradually lost their interest. They did not resign, as they would not get any other suitable job. Therefore, whatever they earned was considered useful and necessary for their survival. However, we noted their clear frustrations, which have tremendous impacts on the quality of their work.

On the other side, the populations targeted for intervention (i.e., members of the *hijra* community) live in extreme poverty, social deprivation, and exclusion, which has resulted in low self-esteem and frustrations. To most of the *hijra*, the importance of safer sex, STI, and HIV has little or no meaning. Many of them show reluctance if they are advised to come to DIC. Outreach workers often face noncooperation from them. Because *hijra* are involved in fighting for mere survival, they laugh when they are told to fight against AIDS. When they suffer from hunger, and are physically, mentally and sexually abused; when they are excluded from the social, cultural, economical, and political aspects of everyday life, the threat of AIDS becomes meaningless to them. Therefore, the fear model of HIV intervention seems inappropriate for the *hijra* community. The current condom promotion interventions have devalued the glory of *hijra* sexuality, their sexual desires and pleasure. Rather, condoms and lubricants are promoted in the disease and survival framework of popular public health dimension of AIDS prevention model. This model has further undermined the human potential of this social excluded population.

Inadequate understanding and overall negligence on condom issue. When findings from surveillance reflect major concern about low use of condoms, when researchers keep saying consistent condom use yet alarmingly low, when donors are not satisfied with NGO/CBO performance, at that context, we have noted that the staff members of the CBOs are not serious about the issue of low use of condoms. Focus was on the distribution and record-keeping system for the condoms, but not, obviously, on actual use. The staff members feel that at the end-user level, because they cannot control the decision, they have nothing to do. Little thoughts seemed to have been given to understand the underlying reasons for nonuse, and, further, little emphasis was even given to address those reasons. The coordination among the field office and central office regarding availability of condoms in the field was not well-planned and managed.

Literacy matters. There are misconceptions about HIV and AIDS among the HSWs. The following voices reflect this reality: "If someone is infected with AIDS, his skin will get stained." Or, "The symptoms of HIV are anal ulcers, oozing of pus, inflammation; purple on the whole body like chicken pox . . . and after having anal intercourse inflammation occurs." At the same time, although a few were a bit frightened about their irregular nature of condom use, most do not use condoms at all and do not feel any sort of anxiety. Their indifferent attitudes emerge from their level of understanding, as many perceive that if they have noncondom sex in few occasions, it would not create a huge problem. As a *hijra* stated, "I am not having sex without condoms regularly. I did this just for once or twice a month, and sometimes I use condoms. So I don't think it's risky . . . as I even not always, but mostly use condoms." Thus, some *hijra* perceive that regular users will not be affected by occasional nonuse. The research revealed that the message *hijra* got about condom use is either incomplete or not internalized properly due to their illiteracy and level of understanding. Even they could not read the textual behavior change materials delivered to them resulting utilization of the materials. This issue was also raised by the peer-educators and outreach staff of the CBOs. They mentioned:

> The literacy rate of the most *hijra* is very low; they do not listen to us; they do not understand what we say; it is very difficult to break their beliefs; they are very rigid in their mentality. We are not literate as

> well. It is difficult for us to change their behaviors.

It is important to notice the frustration of a peer-educator who is not that educated and suffers from low self-esteem. In fact, working for a population who are not literate has to be well-designed and planned. This is difficult for inadequately literate peer-educators to teach a similar background population. These issues have to be critically analyzed.

When venue becomes a barrier! The sex trading venues are generally parks, stations, transport stations, and other open public venues. The timing of sex cruising starts after sunset. Both the environmental context of the sex venues and timing of sex cruising are not supportive for use of condoms. There are threats of harassment of both HSWs and their clients by the *mastan* (hoodlums) and members of law enforcing agents, such as police. The HSWs reported that their clients always suffer from threats of being harassed physically, verbally, and monetarily by the *mastan*, and police moving around both contact and action venues. The clients who particularly look for HSWs suffer from more tensions of losing their social prestige if being caught with a HSW on the spot. Therefore, most of the clients, according to the report of the HSWs, want to leave the venue as soon as possible. Because condoms delay ejaculation, the clients do not like to use condoms in such open venues.

> I may take the attempt to put him [in] a condom. Client stays on speed and shouts, "Hurry up!" Sometimes we use parks for sexual intercourse. People frequently come and go. Some may recognize him. That's why they (clients) always want it to make it (intercourse) done quickly and leave as soon as possible. Therefore, a client does not give that much time, so that I can wear him condom.

Many peer-educators and CBO outreach workers reported inconvenience in condom promotion activities on the cruising sites. They reported that many HSWs do not want to listen to them in the cruising sites. When asked about this issue, many HSWs reported that they would really have no time to spend with the peer-educators at the business hour. Moreover, if the clients see them listening to AIDS workers, they are discoursed and do not prefer to talk to that HSW.

Venues like parks are generally unsafe. Snatching, thievery, conflict or even murders take place, which makes the venue insecure both for the HSWs and their clients. This type of situation can last for few days, or even for few weeks, followed by harassments by police and *mastan*. However, as HSWs live through selling sex, they come to the venues in adverse situations. During such periods, they do not want to stay long at the venues. These situations increase the possibility of nonuse of condoms

> Sometimes customers' money or cell phone can be stolen. If it happens, the situation of the venue gets changed. The *hijra* and the clients both become terrified of harassment by mastan or by police. That is why they (HSWs) think, "Once we've come, we should finish it (intercourse) quickly." If [a] condom is used, sexual intercourses will be prolonged, which is not expected. We can be tortured. It is problematic to put on condoms. Not only ejaculation is delayed, it takes time to put on and to put off and dispose in correct place.

Violence and condom use: The divergence. On the venue, in many cases, police, *mastan*, or clients have sex with the *hijra* by applying physical force. Often *hijra* become the victim of forced sex without condoms. Incidents of sexual abuse were reported by many *hijra*, whether they were involved in the sex trade or not. The incidents of sexual abuses were reported to take place without condoms. The timing, context, or situations of forced sex do not support the use of condoms. Exercising their power, perpetrators of sexual abuses force them to participate in unsafe sex. Most often, the *hijra* reported that during forced sex, they could not bring up the issue of condoms, as the situation was beyond their control. The *hijra* wanted to get rid of the abusive situation; they did not have any mental and environmental arrangement to pursue for condoms. They, rather, were busy saving their anus from painful penetration. As condoms delays

ejaculation, they deliberately avoided the use of condoms. "If anyone wants to use condoms, I rather request not to use." Therefore, condoms are absent from the scenario where there is violence and sexual abuse. Violence and condoms cannot exist together.

Limited project period: Diminishes the morale of the project staff. The issue of non-continuation of funds for *hijra* intervention was raised by the management staff of the CBOs. Due to discontinuation of funding, the CBOs have no choice but to stop their interventions. Sometimes, even with funding, due to management-level crisis at a donor or management agency, an unwanted gap is created between the end of one phase and the beginning of a new phase. During this gap, because CBOs do not have any planning for their sustainability, they simply cannot carry out any intervention, even during the transition period. This is the phase when the CBOs become more concerned about their upcoming work. They start planning the work of the next phase. The CBOs have to a concentrate more on their administrative and financial work. We talked a Behavior Change Communication (BCC) and advocacy officer of a CBO about this matter. He said:

> CBO working on HIV/AIDS prevention programs should plan differently. Why the CBOs cannot continue their intervention, even for only few months, without any external fund[s]? The CBOs have no exit or sustainability plan. They only depend on external fund[s]. The concept of CBO is not like this.

According to their observation and experiences, sudden discontinuation of a program has long-term adverse effects on condom programs. For example, after a certain period of intervention, when the *hijra* gradually are becoming familiar with condoms, and are considering using condoms, the sudden absence of the field program "terribly discourages them to stick on condom use. Rather, they become angry and react on opposite way. They again return to noncondom sex." According to the field staff, "If a *hijra* returns to nonuse of condoms, then it might be extremely difficult to convince them again for protected sex." Many field staff described similar experiences and demanded that the CBOs should not begin interventions if they are not sure how long they can continue.

Social exclusions and condoms: The puzzle! All *hijra* informants of this study described their experiences of multifaceted forms of exclusions. They described pathetic stories of deprivations from basic life amenities. For example, the *hijra* are excluded socio-culturally (e.g., discrimination, humiliation, and deprivations at home; excluded from own home and school settings), politically (e.g., constrained access to service facilities including health and legal, deprivations from rights of the citizenship) and economically (e.g., deprivation from earning livelihood from mainstream occupations). The lives of the *hijra* unquestionably signify the fact that most deprivations in their lives are grounded in nonrecognition of the *hijra* as a separate gendered human being beyond male–female dichotomy. This has prevented the *hijra* from positioning in the greater society with human potential and dignity. For example, most *hijra* informants reported abuse at home and schools. Gradually they became isolated, and at some point were expelled from both home and schools. Many were abused in the workplace and lost jobs. They had no access to any social institutions such as health facilities or social and legal services, particularly if they identified as being *hijra.* Because of this extreme level of social exclusion, they suffer from very low level of self-worth and do not fear to be involved in risky sexual behaviors. A *hijra* thus said: "We are not considered human beings in the eye of the greater society. Whether we survive or not, who cares? We are so unfortunate, we better die! Now the NGOs care about condoms, not us!"

Individual Factors: Socially Constructed

We have identified some factors thought to be closely interrelated at individual level; nevertheless, these factors have socio-cultural, economic, and political meanings. The following sections highlight the fact that, although reflected in the individual, they are socially constructed and deconstructed at social level, moving beyond individual domain.

"Tasting sweets with polythene coating." Most of the interviewed *hijra* mentioned that condoms reduce pleasure. The meaning of pleasure is a complex phenomenon with diverse meanings. Most of the *hijra* perceive that penile–anal contact is the ultimate way of getting sexual pleasure. Their perceived way of getting *ashol moza* (real pleasure) is to have sex without any kind of barrier, i.e. condoms. On the same ground, even those who claimed that they do not have sex without condoms, mentioned from their past experience that sex without condoms is more pleasurable, compared to sex with condoms. The *hijra* perceive condoms as barriers to the attainment of real sexual pleasure.

> I don't feel good while having sex with condoms. I feel discomfort inside my anus. With condoms, I don't feel *ashol moja*. Therefore, I prefer having sex without condoms. If a person (*panthi*/client) is aged or odd-looking, only then [will] I have sex with condoms.

Some *hijra* felt pain if condoms were used by their partners. Condoms are generally less lubricated, and during intercourse they experienced anal pain. Although sex is meant to enjoy, painful sex is impossible to accept. Because condoms lead to anal pain, the issue of sexual pleasure simply disappears.

> It's our backside (anus), understand? It's not women's vagina, it's not lubricated either. You know, you can't insert (penis) as huge as you want as you can do in case of vagina. Our anus is soft, the huge ones (penis) don't enter easily. It creates 'sharp' pain (*chinchinaya betha*) when condom is used.

Although the issue of sexual pleasure is complex, by using the following metaphor, the meaning of pleasure and the negative role of condoms were nicely described.

> Sex is so sweet, and you have to taste it "raw." If you eat sweets with a coating of polythene, can you really understand whether it was sweet or sour? Sex with condoms is like eating sweets with polythene coating [i.e., condoms]. Can you enjoy the taste; if not then why eating, why wasting time?

Condom clashes love relations. Most of the *hijra* strongly desire to develop and maintain love relations with their men, whom they call *parik.* Such love relations between a man and a *hijra* does not last long due to dominant and rigid hetero-normative sexual culture in Bangladesh. Despite knowing all uncertainties, most *hijra* were found yearning to continue such relations as long as possible. As such, they try their best to please their *parik* in all possible ways. They do not like to be involved in any activity that may raise suspicion and disputes with the *parik*. Accordingly, they always try to project their pure image of loving heart in front of the *parik*. In this context, use of a condom appears counterproductive to their perceived love, trust or reliability.

> With him, I have sex without condoms. . . . I do this as he prefers so; he has assured me that he does not go anywhere else for sex. Sometime I believe him; sometimes I feel he may not [be] telling the truth. But if I suspect him and want to use condoms, then he may think that I do not love him, and you know that I love him and I will try my best to keep him with me as long as possible.

The sense of love, faith, and relationship is very strong among the *hijra*. They perceive that their roles are like thosee of women and wives, and they want to be loving wife of their *parik*. A *hijra* thus stated:

> If you are married, can your wife suspect even you do *akam-kukam* (dirty deeds; having sex with others)? No, she won't. You just get back home from Dhaka once a week or a month. You have sex with your wife. It means you have sex with your wife and with others like me. Can she suspect anything? In that case, if you use condoms in sexual intercourse with your wife, your loved one, she must suspect you. Likewise, our *parik* suspect us if we request them to

> use condoms. If we use condoms, they begin accusing us of having sexual relations with others. I don't want to lose my *parik*. In order to avoid his suspicion, I never even ask for condoms, rather if he wants to use, I refuse; I say that, "Why condoms, we are in love, we do not have sex with anyone else, then where is the problem?" I want to show him that I am "pure" and I do not have sex with any other male[s] beside him. I know that none of us are "pure;" I have sex with other males, and I guess he may do the same, but at the end of the day, the ultimate truth is we are in love, and I want to continue this relations.

Apart from the notions of purity, condoms generate suspicion regarding their occupational identity. Most often the *hijra* are believed to be involved in *badhai* occupation, which involves collecting money through blessing the newborn babies (*bachcha nachano*) and/or from markets (*bazar tola*). However, many are involved in selling sex, which they keep in extreme secret, particularly from the *parik*. Emphasizing the use of condoms endorses the suspicion of a *hijra*'s involvement in selling sex; most *hijra* even keep silent regarding any discussions on condoms with their partners.

One of the key informants (sex worker by profession and involved with a CBO) stated that many HSWs now, because of HIV interventions, use condoms with their clients. However, with the *parik,* none of them use condoms. If they are advised to use condoms with the *parik,* they straightly refuse it. Their argument is very straightforward, "Why should I use condoms with my husband?"

Condoms are antagonistic to 'fresh' image. A successful attempt of motivating a client ensures earning, whereas losing clients means a survival threat. If an HSW asked for condoms, most of the clients expressed their suspicion about the presence of STI in that particular HSW. Several HSWs mentioned that clients generally get nervous and do not show interest if a HSW gives more emphasis to condoms. As one HSW stated, this kind of rumor of STI spreads rapidly, and clients avoid those HSWs. As a result, at the venue, many *hijra* kept silent about condom use to indicate their disease-free status in front of the clients. When they open-up the packet of condoms, the customers express their complaint telling, "I don't have *jouno rog* (STI). Then you must be infected." Or they say, "Hey! You're telling me to use condoms! Are you infected (with STIs)? Well then, I won't have sex with you."

The HSWs reported that such suspicion regarding STIs also make clients scared about losing their sexual power. This, in turn, drives the clients away from a HSW who offers condoms to clients.

> They [clients] come to me, because they like me, and I have sex, as I like it too. If I raise that topic [regarding condom use], they would suspect that I'm a suffering from *jouno rog* [STI). And if I raise issues on vulnerability to HIV, he [customer] might just lose their *jouno shakti* [sex power]. He'd lose his [sexual] interest on me and say, "Really? Is it true that sexual exposure without condoms cause AIDS? Then I might lose my sex power!" If I lose him, he won't come back to me again. He might think that AIDS can be transmitted from us (the *hijra*).

Clients' rights to say 'no' to condoms. The HSWs, themselves, perceive that clients have the right to have sex without condoms, as they have money to enjoy sex. Although we did not talk to the clients directly, so we are not sure about their direct perspectives, the voices of *hijra* reinforced that the clients also think in similar ways of showing and establishing their rights to enjoy sex, if needed without condoms.

In most cases, the HSWs take money from clients just after the negotiation and before the sex act. In many cases, the issue of a condom was not raised at the time of negotiation. Some of the HSWs intentionally keep silent and assure the clients first with a secret desire in mind that they will raise about condoms before the sex act begins, as at that point a client cannot leave as money has been paid. However, in most cases, this technique does not work, rather, it creates a tense relationship with the clients. In some cases, the clients physically abuse the HSWs

for raising the issue of condoms. According to the perception of HSWs, because the clients pay money for having sexual enjoyment, they have the right to perform sex in their preferred ways, which include without condoms. Most of the HSWs reported that the clients would get annoyed if they [HSWs] talked about condoms. Some start alleging by telling, "Why won't you have sex without condoms? Hurry up. You have taken money earlier." A HSW explained this situation, "the clients get angry and keep telling, 'I have come and paid you to get pleasure (*moza lowa*). What pleasure will I get with this condom?"'

"Why condoms, infection can be identified externally." Many HSWs reported keeping their wary eyes on the clients to guess their intention, economical condition, attitudes, and so on. Thus, they construct a sort of primary idea about clients' health conditions. They visually inspect clients' appearance, dress, or, finally, penis to be assured of their sexual disease condition. Some perceive that if the client has an infection or *chulkani* (scabies), it can be seen from outside when the light is available, and if it is dark they can feel it through touching a client's penis. Accordingly, if some HSWs suspect that clients may have infections, they use condoms, otherwise, "why one has to use condom when pregnancy is not the matter of concern?"

> A good looking man does not suffer from any illnesses. A healthy man will have a uniform penis . . . from beginning to end his penis is, won't be thick and thin. He won't have any problem and his attitudes won't be worse. I can understand who's addicted (drug user) and who's not. If I'm convinced, I have sex with these clients without condoms.

Therefore, it is believed that signs and symptoms of STI can be seen externally. Based on inspection, the use or nonuse of condom is determined by many 'smart' HSWs. Not only by inspecting physically, infections can be suspected from social class as well. For example, a HSW stated:

> If I realize his family background and economic condition is good or if he is a college student, then no tension of disease, generally such clients including the college boys do not have sex with multiple sex workers. So, if I have sex without condoms, no chance of getting infected!

DISCUSSIONS AND POLICY DIMENSIONS

> When I began work in 2003, I thought *hijra* would use condom some day in future, as a response to our intensive counseling. But standing now in 2007, I see the rate of condom use is still very low. Actually none of them use condoms regularly. They actually do not care for their life, why [worry] about condoms? Constant familial and social negligence and abuses make them frustrated towards life. (A *hijra* outreach staff working since year 2000)

After working many years on an outreach staff, the previous statement reflects multiple realities of the lives of *hijra*, and also has contextualized the meanings of nonuse of condoms. Low self-esteem induced by stigma and social exclusion is a key factor that plays a vital role in the decision regarding condom use. Frustration generates mental and social exclusion and isolation. Life seems meaningless, not precious, and thus the outlook of *hijra* towards life is pessimistic. Therefore, the fear model as a means to encourage the *hijra* using condoms is not working properly. The economic hardships, along with discriminations and violations of their human and sexual rights, are major discouraging factors against condoms. For this reason, despite nonstop effort to promote condoms, the *hijra* are less likely to pay attention to intervention messages. Thus, the conventional fear-producing messages on STI/HIV are questioned.

In the era of HIV and AIDS, most interventions with the *hijra* in Bangladesh are targeted to prevent HIV in a mechanistic manner (Khan et al., 2007). We have noted that various factors related to interventions have negatively influenced to promote condoms effectively. These factors include inadequate professional skills of the CBO outreach staff (e.g., low literacy and

inadequate training of the field-force), inefficient management of the CBOs, design errors of interventions in terms of interrupted supply of condoms and lubricants, interrupted flow of funds, demoralization of staff due to low salary and conveyance bills for the outreach staff, and job uncertainties due to brief period of the project. Although we have not evaluated current interventions and the efficiency of the approaches, the voices of the informants and key-informants repeatedly enforced that intervention, as a whole, is not working properly for the *hijra* community. Therefore, we recommend that a thorough evaluation study is urgently needed to identify the loopholes and the possible solutions to make condom-interventions effective for the *hijra* community.

There is no safe socio-political space where a *hijra* can live a life of a human being with dignity (Khan et al., in press; Khan et al., 2007). The access to social, cultural, political, legal, and health services is extremely restricted in the lives of the *hijra*. Current interventions primarily promote condoms and lubricants, and mainly provide treatment for STIs. They do not provide any social and legal services to the *hijra* in terms of establishing their citizenship as a gendered human being within a human rights framework. Due to constrained participation in family, social, and public spheres, and because of their extremely limited access to information and health care services, they are delayed in seeking care for STIs, having low knowledge on prevention of HIV and not-using condoms and suffering more from STIs (Khan et al., in press).

Members of the *hijra* community often claimed that mainstream society does not understand *hijra* culture, their gender and sexualities. Dimensions of social exclusion in *hijra* lives have never received attention in the development sector. The *hijra* are harassed due to supposedly inappropriate gender and sexual roles, a violation of human rights (UNAIDS, 2006). All forms of violence and harassments against sexual minorities compel them to pursue risky lifestyles conducive to HIV transmission (Anyamele, Lwabaayi, Nguyen, & Binswanger, 2005). This has been the case for the *hijra* in Bangladesh. Pain and pleasure of the lives of the *hijra* and the violation of human and sexual rights are overlooked in the traditional HIV interventions (Khan et al., 2007). The *hijra* become frustrated, find them useless for society, and often are encouraged to pursue risky lifestyles, including unprotected sex. This pathway was named *instrumental*, linking social exclusion and health sufferings (Popay et al., 2008). The multifold of social exclusions revealed in the lives of *hijra* are extreme examples befitting to the framework of multidimensional social exclusion proposed by many scholars (Beall & Piron, 2005). This has posed further challenges for designing successful interventions for the promotion of condoms with *hijra* who live on the extreme margin of life.

When the CBOs are trying to prevent HIV infections, the *hijra* populations want social, economical, and legal protection. Thus, it is important to understand the socio-cultural and socio-economic aspects of discriminations and deprivations in the lives of the *hijra* to protect this marginalized community. Because of social exclusion and deprivations, their self-esteem and human dignity have been diminished, which has erased their belongingness to the society. Condoms have potential to protect from HIV infections, but have no capacity to uphold their human potential and economic survival. By disregarding socio-cultural and socio-economic scripts of sexual relationships and gender dimensions, imposing HIV intervention under the banner of condom and lubricant promotion, and STI services are mechanistic and deceptive frameworks of intervention, through which the *hijra* do not see any tangible benefits.

Condom promotion needs to move beyond disease and death. Most countries, with conservative and homophobic attitudes towards sexualities and gender diversities, have ignored the people who do not align with obligatory heterosexuality and/or with male–female gender alliance. We (the Professionals working in the development sector) need to work with the members of the mainstream society, particularly with the policy planners, civil society, and gatekeepers regarding legal and policy reform related to sex–gender–sexuality to ensure a supportive and congenial environment where, along with men and women, the *hijra,* as the citizen of Bangladesh, can safely survive by upholding

their human, gender, and sexual rights. The *hijra* deserve access to mainstream educational institutions and job markets. The issues related to condom use of the *hijra* are deeply grounded in the context of poverty, discrimination, and violations of human and sexual rights. Therefore, any work for the *hijra* community, including condom promotion, must be designed in the health, economics, and human rights framework. Thus, a paradigm shift is required in the framework of protecting their basic human and sexual rights, where HIV interventions, including condom promotions, enhance the dignity and quality of the lives of *hijra* beyond the framework of disgrace, disease, and death.

REFERENCES

Anyamele, C., Lwabaayi, R., Nguyen, T., & Binswanger, H. (2005). *Sexual minorities, violence and AIDS in Africa* [Africa region working paper series no. 84]. World Bank.

Beall, J., & Piron, L.-H. (2005). *DFID social exclusion review*. London: Department for International Development (DFID).

Denzin, N. K. (1997). *Interpretive ethnography: Ethnographic practices for the 21st century*. London: Sage.

Dowsett, G., Grierson, J., & McNally, S. (2006). *A review of knowledge about the sexual networks and behaviours of men who have sex with men in Asia*. Melbourne: Australian research centre in sex, health and society, La Trobe University.

Gagnon, J. H., & Simon, W. (1973). *Sexual conduct: The social sources of human sexuality*. Chicago: Aldine.

Gagon, J. H., & Parker, R. G. (1995). Conceiving sexuality. In R. G. Parker & J. H. Gagon (Eds.), *Conceiving sexuality: Approaches to sex research in a postmodern world* (pp. 3–18). New York: Rutledge.

Government of People's Republic of Bangladesh. (2004). *National HIV serological surveillance, fourth round technical report, 2002 Bangladesh.* Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

Government of People's Republic of Bangladesh. (2005). *National HIV serological surveillance, sixth round technical report, 2004–2005 Bangladesh*. Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

Government of People's Republic of Bangladesh. (2007). *National HIV serological surveillance, fifth round technical report, 2003–2004 Bangladesh.* Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

Government of People's Republic of Bangladesh. (2009). *Behavioral surveillance survey 2006–07*. Dhaka: National AIDS/STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of Bangladesh.

Herdt, G. (Ed.). (1993). *Third sex, third gender: Beyond sexual dimorphism in culture and history*. New York: Zone.

Khan, S. I., Parveen, S., Hussain, M. I., Bhuiyan, M. I., & Gourab, G. (2007). *Socialization and sexuality constructions of hijra: Implications for STIs/HIV intervention*. Dhaka. Bangladesh: International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B).

Khan, S. I., Hussain, M. I., Parveen, S., Bhuiyan, M. I., Gourab, G., & Bhuiya, A. (in press). Living on the extreme margin: Social exclusion of the hijra in Bangladesh. *Journal of Health, Population and Nutrition*.

Laumann, E. O., & Gagnon, J. H. (1995). A sociological perspective on sexual action. In R. G. Parker & J. H. Gagon (Eds.), *Conceiving sexuality: Approaches to sex research in a postmodern world* (pp. 183–214). New York: Routedge.

Lopez, K. A., & Wills, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14*, 726–35.

Mazumder, A., & Basu, N. (1997). *Bharater hijrah samaj* [*The hijra society in India*]. Kolkata, India: Komola Press.

Nanda, S. (1990). *Neither man nor woman: The hijras of India*. Belmont, CA: Wadsworth.

Nanda, S. (2000). *Gender diversity: Crosscultural variations*. Long Grove, IL: Waveland.

Parker, R. (2001). Sexuality,culture, and power in HIV/AIDS research. *Annual Review of Anthropology*, 30, 163–179.

Parker, R. G, Barbosa, R. M., & Aggleton, P. (Eds.). (2000). *Framing the sexual subject: The politics of gender, sexuality, and power.* Berkeley, CA: University of California Press.

Popay, J., Escorel, S., Hernandez, M., Johnston, H., Mathieson, J., & Rispel, L. (2008). *Understanding and tackling social exclusion. Final report to the WHO commission on social determinants of health from the social exclusion knowledge network*. Geneva, Switzerland: World Health Organization.

Reddy, G. (2003). "Men" who should be kings: Celibacy, emasculation and reproduction of *hijras* in contemporary Indian politics. *Social Research, 70*, 163–170.

Sarkar, D. (2001). *The hijra community in Bangladesh*. Dhaka: CARE Bangladesh.

Thompson, E. H., & Pleck, J. H. (1995). Masculinity ideologies: A review of research instrumentation on men and masculinities. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 129–163). New York: Basic.

UNAIDS. (2006). *International guideline on HIV/AIDS and human rights: 2006 consolidated version*. Geneva, Switzerland: Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS.

Vance, C. S. (1999). Anthropology rediscovers sexuality: A theoretical comment. In R. G. Parker & P. Aggleton (Eds.), *Culture, society and sexuality: A reader* (pp. 39–54). London: University College London (UCL) Press.

Van-Mannen, J. (1998). *Tales of the field: On writing ethnograph*y. Chicago: University of Chicago Press.

Weeks, J. (1995). History, desire, and identities. In R. G. Parker & J. H. Gagnon (Eds.), *Conceiving sexuality: Approaches to sex research in a postmodern world* (pp. 33–50). New York: Routledge.

Copyright of Journal of LGBT Health Research is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.