

STRUCTURAL VIOLENCE AGAINST KOTHI-IDENTIFIED MEN WHO HAVE SEX WITH MEN IN CHENNAI, INDIA: A QUALITATIVE INVESTIGATION

Venkatesan Chakrapani, Peter A. Newman,
Murali Shunmugam, Alan McLuckie, and Fredrick Melwin

This qualitative investigation explored the experiences and contexts of stigma and discrimination among HIV-positive and high-risk *kothi*-identified men who have sex with men (MSM) in Chennai, India, and ramifications for HIV prevention. MSM were recruited through community agencies ($n = 10$) and public sex environments ($n = 8$), along with three key informants. In-depth, semistructured interviews were conducted, audiotaped, and transcribed. Narrative thematic analysis and a constant comparative method were used to identify themes. Findings revealed multiple intersecting social and institutional contexts and experiences of stigmatization, discrimination, and violence across police, community, family, and health care systems, as well as illuminating consequences for MSM. Multisystemic structural violence places *kothis* at extreme vulnerability for HIV infection and AIDS. Public mass media antidiscrimination campaigns, education and training of health care providers and police, funding of indigenous MSM community organizations, and decriminalization of consensual sex between same-sex adults may help to combat stigma, discrimination, and violence against MSM, which is fundamental to effective HIV prevention.

From the Kama Sutra to numerous ancient temple carvings, it is evident that men who have sex with men (MSM) and *hijras/aravanis* (transgendered women or male-to-female transgendered persons) have existed in India for thousands of years. Strong condemnations of same-sex behaviour or attractions are also notably absent from Hindu

Venkatesan Chakrapani is with the Indian Network of People Living with HIV/AIDS, Chennai, India. Peter A. Newman is with the University of Toronto, Faculty of Social Work, Centre for Applied Social Research, Toronto, Ontario, Canada. Murali Shunmugam is with the Social Welfare Association for Men, Alan McLuckie is a doctoral candidate at the University of Toronto, Faculty of Social Work, Centre for Applied Social Research, Toronto, Ontario. Fredrick Melwin, MSW is with American College, Madurai, India.

This research was funded in part by a contract from USAID/Family Health International (FHI), India and grants from the Connaught Foundation and the University of Toronto, Ontario, Canada. The authors are most grateful to the staff of Social Welfare Association for Men (SWAM), Sahodaran, and Allaigal for their assistance in implementing the study and to participants for sharing their experiences. Thanks to Dr. Mahalingam Periyasamy, Dr. Joe Thomas, Sekar Balasubramaniam, Reginald Watts, Shiva, and Sunil Menon for their comments on an earlier version of this manuscript.

Address correspondence to Peter A. Newman, University of Toronto, Faculty of Social Work / Centre for Applied Social Research, 246 Bloor St. West, Toronto, Ontario M5S 1A1 Canada e-mail: p.newman@utoronto.ca

religious doctrine. In general, Indians tolerate, accept, and respect a wide range of difference in cultures, religions, languages, and customs. Despite Indian society's general climate of acceptance and tolerance, however, there appears to be limited public knowledge and understanding of men who have sex with men (MSM) or same-sex sexual orientation. Furthermore, Indian and international human rights organizations have documented human rights violations against sexual minorities (People's Union for Civil Liberties, Karnataka [PUCL-K], 2003), the transgendered community (PUCL-K, 2001), and HIV/AIDS peer outreach workers from MSM and sex worker communities (Human Rights Watch, 2002) in India.

Discriminatory practices, which may occur outside of the conscious awareness of persons who constitute the key institutions of society, may emerge from family, community, medical, and legal systems. Indirect forms of oppression, such as stigmatization and discrimination, are engaged by individuals or groups as methods of social control to prioritize and enforce their particular beliefs, worldviews, and their power within a society (Galtung, 1969; Link & Phelan, 2001). Power-wielding groups may have little awareness that the privileging of their own belief systems occurs at the direct expense or marginalization of other social groups, such as MSM. As Galtung (1969) wrote, "Personal violence shows . . . Structural violence is silent . . . Structural violence may be seen as about as natural as the air around us" (p. 173). Link and Phelan (2001) have indicated that indirect forms of oppression evolve into direct forms of oppression, such as violence and abuse, when stigmatized groups do not accept their assigned nondominant status. Thus, it is hypothesized that key institutional forces may be complicit, if not actively engaged in stigmatizing and discriminating practices against MSM. Overall, stigma and discrimination against MSM may need to be explored as a product of structural societal forces, as opposed to traditional models that focus on stigma as an individual-level phenomenon (Galtung, 1969; Parker & Aggleton, 2003).

The silence and secrecy associated with institutional stigma and discrimination may provide ideal conditions for escalation of the AIDS epidemic (Mann, 1987a; Mann, 1987b; Mawar, Sahay, Pandit, & Mahajan, 2005). The fact that HIV was first identified among female sex workers in Chennai and later spread to the general population may fuel the still popular presumption that the HIV epidemic in India is "predominantly heterosexual" (National AIDS Control Organization [NACO], 2005a). Nevertheless, institutional silence may be evidenced in MSM being largely overlooked in HIV prevention and treatment in India. Out of 455 HIV serosurveillance sites operated by NACO across the vast landscape of India in 2003, only three sites specifically collected data from MSM (NACO, 2005b). This lack of epidemiological data appears to be emblematic of inadequate national HIV prevention and care programs for MSM in India (Chakrapani et al., 2002) and may be a manifestation of structural factors, including institutional stigma and discrimination.

Limited investigations have focused on stigma and discrimination faced by MSM and *hijras* in India (Chakrapani, Babu, & Ebenezer, 2004), even less so among persons in these communities living with HIV. In fact, a recent 70-page UNAIDS (2001) report on stigma and discrimination faced by people living with HIV (PLHIV) in India included only one and a half pages with scant information on "gay and other homosexually active men." The authors noted that "[d]espite numerous attempts over several months, eliciting the voluntary participation of HIV-positive gay men in this study proved unsuccessful" (UNAIDS, 2001, p. 56).



FIGURE 1. Map of India.

The purpose of this investigation is to explore the lived experiences and contexts of stigma and discrimination among HIV-positive and high-risk *kothi*-identified MSM in Chennai, India, and ramifications for HIV prevention.

METHODS

Two qualitative studies were conducted in Chennai, a metropolitan city of 6 million people. Chennai, formerly known as Madras, is located on the Bay of Bengal in the southeast Indian state of Tamil Nadu (Figure 1). The studies were conducted in collaboration with three community-based organizations: Social Welfare Association for Men (SWAM), Sahodaran (Brother), and Allaigal (Waves). These organizations primarily serve *kothi*-identified MSM, including those who are HIV-positive and those who engage in sex work. Prolonged engagement (Lincoln & Guba, 1985) over the course of 6 years on the part of the research team with these agencies and the populations they serve greatly facilitated study implementation and interpretation of the findings.

Previous experiences of the research team suggested that MSM, and even more so HIV-positive MSM in Chennai may be reluctant to meet in groups owing to fears of disclosure to both their own and the larger community and the criminalization of sex between men in India (Chakrapani et al., 2002). Accordingly, individual, in-depth

semistructured interviews were conducted by trained interviewers. Furthermore, all recruitment was conducted by word of mouth only in order to avoid potential risks to participants and research staff that might result from inadvertently advertising the study outside of select venues or invoking police involvement.

In Study 1 ($n = 10$), peer-driven and snowball sampling techniques were used to recruit HIV-positive *kothi*-identified MSM. SWAM staff informed known HIV-positive MSM who belong to their friendship network about the study and asked about their willingness to participate (peer-driven sampling). Additionally, some HIV-positive MSM referred other HIV-positive MSM, who then contacted the research staff (snowball sampling). To ensure exploration of issues faced by married MSM, research staff specifically included married MSM among those invited to participate. In Study 2 ($n = 8$), outreach staff recruited potential participants from in and around public sex environments (PSEs; i.e., “cruising areas”) in Chennai. Potential participants were invited to take part in a one-time anonymous interview. Additionally, three key informants with expertise on the *kothi* community were recruited from community agencies serving this population.

For both studies, interview venues were chosen according to the convenience of participants and the safety of participants and research staff. All the HIV-positive *kothi*-identified MSM were interviewed in a private room in the offices of SWAM or Allaigal. MSM recruited from PSEs were interviewed at SWAM or in safe places near the cruising sites. Some of these men preferred not to come to the offices of an MSM-identified agency. No interviews were conducted in PSEs owing to risks to participants and staff. Written informed consent was obtained from all participants, including consent for audiotaping of the interview. The investigation received approval from the Ethics Review Board of University of Toronto and the Community Advisory Board of SWAM.

Interviews were conducted using a semistructured in-depth interview guide in Tamil with scripted probes. Interview questions were modified or added over the course of the study in an iterative process to explore and reflect on emerging findings, a technique called progressive focusing (Schutt, 2004). The interview guide was translated into Tamil and back-translated into English to ensure accuracy. Interviewers were native Tamil-language speakers who received extensive training in interviewing and research ethics. All interviews and communications with participants were conducted in Tamil, except for two key informants who preferred to be interviewed in English.

The interviews of HIV-positive MSM and key informants (Study 1) were from 45 to 90 minutes. Interviews with MSM from cruising areas (Study 2) were conducted for about 30 minutes because most of these interviews took place near the cruising areas. An honorarium of 200 Indian rupees (U.S.\$ 4.50) was given to all HIV-positive MSM as recommended by SWAM’s community advisory board. No monetary incentives were given to MSM recruited in cruising areas; rather, snacks were provided after the interview. Key informants did not receive incentives. Interviews were tape-recorded and transcribed verbatim in Tamil and translated into English for data analysis. Three participants who agreed to be interviewed did not want their interviews to be audiotaped owing to concerns about confidentiality; notes were taken immediately following these interviews.

Multiple readings of the transcripts were performed by two independent investigators. Line-by-line review of the transcripts was conducted and first-level codes (descriptors of important components of the interviews), including in vivo codes (us-

ing the language of participants), were noted in the margins (Charmaz, 2006; Glaser, 1978). Next, text corresponding to each of the first-level codes was reviewed by at least two investigators. Using focused coding and a constant comparative method (Charmaz, 2006; Glaser & Strauss, 1967), first-level codes were refined and organized into categories. Finally, theoretical coding was undertaken to identify higher level codes, relationships among categories, and to ensure saturation of categories (Charmaz, 2006). Member checking was conducted with key informants to increase credibility of the findings (Lincoln & Guba, 1985). Peer debriefing (Lincoln & Guba, 1985) was undertaken with MSM community leaders and health care researchers to increase trustworthiness of the findings. The results correspond to the emergent categories; all quotations are drawn from the interviews.

RESULTS

UNDERSTANDING THE *KOTHI* CONTEXT

Kothi-identified MSM, as part of their self-defined role, ostensibly do not engage in sex with one another. *Kothis'* gender expression is feminine and they are attracted to masculine partners, who they call *panthis*. *Panthis*, however, do not self-identify as such; the label is used by *kothis*. *Kothis* are generally receptive partners in sexual encounters with *panthis*, who are assumed by *kothis* to be predominantly heterosexual. Men who engage in both insertive and receptive anal sex are labeled "double-deckers" by *kothis*. Nevertheless, some *kothis* report that behaviorally they fit in the double-decker category or that they may engage in various sexual behaviors to please their *Panthis* partners. *Kothis* are generally of lower socioeconomic status and some *kothis* engage in sex work for survival. The construction of sexuality among *kothi*-identified MSM is thus complex, and may differ from that of middle-class, educated gay-identified MSM in India (Chakrapani et al., 2002). The findings of this study are best interpreted in the context of *kothi* identity and may not be transferable to other groups of MSM in India.

PARTICIPANTS

Participants in Study 1 included 10 HIV-positive *kothi*-identified MSM and three key informants, who were service providers to *kothis*. Participants in Study 2 were eight high-risk *kothi*-identified MSM of unknown HIV serostatus. Participants across the two studies ranged from 19 to 52 years of age, with a mean age of 28.2 years. Key informants ranged from 29 to 40 years of age. All participants were of lower socioeconomic status, with an average monthly income of 1,500 rupees (U.S.\$34) or about \$1 per day. Five participants were unemployed at the time of the interview and half ($n = 9$) indicated working occasionally as sex workers, predominantly receptive partners in sexual encounters with *panthis*. Four participants reported being married (to women).

Multiple Contexts of Stigma, Discrimination and Violence. The experiences and consequences related to stigma, discrimination, and violence against *kothi*-identified MSM occurred across multiple social and institutional contexts and are presented in four categories: the police, community members, family, and the health care system. These categories are further structured into subsections that include direct and indirect forms of oppression. A fifth category describes the impact of direct and indirect oppressive forces on the lives of *kothi*-identified MSM.

The Police: Direct Forms of Oppression

Verbal and Physical Harassment. Participants reported being verbally harassed by police. *Kothi*-identified MSM may frequent PSEs in Chennai to locate potential male sex partners or male clients if they are sex workers. These *kothis* face problems from police who regularly monitor these public spaces. *Kothis* are of lower socioeconomic status and many *kothis* can be recognized by their feminine mannerisms; police often use abusive language and insult them. In particular, participants who reported frequenting the same PSEs over time in search of potential male sexual partners explained that policemen may easily recognize them. These men reported being physically accosted and beaten by police for no specific reasons. As a participant reported, “That policeman said to me, ‘Why are you standing here? I know who you are;’ and before I reacted he started to beat me with a *lathi* [police stick] on my back and legs.”

Sexual Assault and Rape. In addition to physical abuse, participants reported being sexually assaulted by police. One participant described that while in a deserted public area he was forced by a policeman to perform oral sex on the policeman. Another participant who was an HIV-positive MSM reported an incident in which a policeman took him to the police station and forced him to have sex with him:

Policemen took me to police station and during the night one policeman asked me to come to the bathroom. He had sex with me in the back. I did not have condoms at that time since I was only in my underwear. I also could not talk about condoms; even if we just show condoms they will beat us on our hands with the *lathi*.

This sexual assault by policemen also presents a direct risk of sexually transmitted disease (STD) and HIV transmission to both parties.

Blackmail and Extortion. Participants reported instances in which policemen had taken away driver’s licenses or identity cards and written down the addresses of *kothis* who come to cruising areas. The police then ask them for money or for periodic payments under threat of informing family members that the participant is engaging in public sex or sex for money with other men. A participant explained:

He [the policeman] took away my driver’s license and said that if I want to have it back I need to give him 200 rupees. I had no other option and gave it. I was only standing in that place when he found me. He might have been noticing me for many days before he came to me to get money from me.

Some MSM who are frequent visitors of a particular cruising area have to regularly pay the beat policemen so the men can remain at the site. *Kothis* who engage in part-time sex work may be particular targets, because they are seen as able to afford to pay: “Police usually get about 20 rupees almost daily from me . . . even if I go somewhere else I might need to pay money to the policemen on that beat,” explained a participant.

The Police: Indirect Forms of Oppression

Arrest on False Allegations. In addition to outright abuse, participants reported circumstances where police officials abused their powers when in contact with *kothis*. Police may target *kothis* because as a marginalized group within society they hold little power or influence to challenge such systemic abuses. One participant described the experience of being arrested on false charges:

Policemen want to book some cases to show that they are doing their job. Hence once in a while we become easy targets for them to book cases. They may book us under petty

crimes like pickpocket or chain snatching and will ask us to pay money to be released from or not to be booked in such cases.

Another participant reported that he had been arrested by a policeman, who alleged that one of his *aravani* (*hijra*, or male-to-female transgender) friends may have been involved in a theft that occurred in the area. Because this *kothi* was a frequent visitor to that area and known to be a *kothi* because of his feminine mannerisms, he was an easy target for the police.

Refusing to Offer Protection to MSM. In addition to reporting rampant abuses of police powers, participants also described the policemen as being derelict in their duty to serve and protect *kothis*. *Kothis* who reported physical or sexual abuse from “rowdies” explained that often they don’t report the incidents to police because they have lost faith in them. A *kothi* described a policeman’s reaction to a request to file a report: “Since you are a *pottai* [derogatory term] he must have done that. Why should we protect you? I’m not appointed by the government to protect people like you.” Thus, in addition to violence and extortion on the part of police, *kothis* are also at heightened risk from others since they cannot rely on police protection.

Harassment of Outreach Workers from MSM Community Organizations. Police were also reported to indirectly discriminate and oppress *kothis* by harassing and obstructing community outreach workers providing services to *kothis*. A key informant explained:

The outreach workers face problems from policemen if they have condoms with them. Outreach workers are even afraid to carry educational materials that show pictures of STDs. Some policemen don’t even look at the identity cards shown by the outreach workers. They will say, “I know who you are . . . don’t fool me by showing this [identity card].”

These activities on the part of the police pose substantial obstacles to outreach workers and directly obstruct their ability to implement HIV prevention activities in the field.

The Community: Direct Forms of Oppression

Kothis who frequent PSEs described being victimized by community members referred to as rowdies or ruffians. Ruffians are reported to engage in forms of violent oppression that include verbal abuse, physical violence, sexual assault, blackmail and extortion.

Violence by Rowdies. A participant explained, “We call those *panthis* who give us trouble *beelis*. *Beelis* beat us for no reason and may also take away money from us. Many times they also forcefully have sex with us and do not allow us to use condoms.” Another participant reported, “We can not report this to police since they join hands with one another,” referring to collusion between police and rowdies.

A participant reported that a rowdy:

had a large knife with him and cut me on my leg, maybe to scare me. He also later forced me to have sex with him. On another day, a rowdy demanded money from me and told me if I did not give him money he will cut me with a blade.

Another participant recounted an incident of violence from a rowdy:

One rowdy was angry that we come to his area and also earn money through sex work. Hence he threw a large stone in the face of my *kothi* friend and walked away. I took my friend to [government hospital], but there we did not have the guts to tell them that a

rowdy did that. We said that he tripped over a stone and injured himself. What shall we say if we want to file a case? . . . That we are homosexual men and also do sex work?

As participants explained, the actions of rowdies are enabled by a system that does little if anything to protect MSM, a system in which police are often as feared as the rowdies.

Some male sex workers who regularly stand in a particular site to find clients explained their inability to use condoms with ruffians:

They [ruffians] have sex with us. We cannot talk about condoms with them. They will beat us and show us a knife. They have hurt me using blades. They also take away our money.

Thus, the risk of HIV transmission is ever-present with rowdies.

Blackmail by Rowdies. A participant explained attempts at blackmail by rowdies: “That rowdy by some way got my home phone number and threatened me that he will tell my family members if I do not give him money periodically. Finally, I got rid of him only after changing our phone number.” *Kothis* do their best to protect themselves in a dangerous social context. Nevertheless, harassment, extortion and violence against *kothis* on the part of rowdies, powerlessness to report the events for fear of repercussions, and inability to gain the protection of police were recounted.

THE COMMUNITY: INDIRECT FORMS OF OPPRESSION

Rejection by Heterosexual Friends. In addition to experiencing direct oppression in the form of violence from ruffians, *kothis* may experience indirect forms of oppression from members of the community who are well known to them. Participants reported not disclosing that they are HIV-positive and/or MSM to most of their heterosexual (“general”) friends. A participant explained, “How can I tell our general friends that I am a homosexual and HIV-positive? They would break the friendship immediately and may also spread the news to others. We cannot show our face outside.”

Another participant recounted that his heterosexual friend would reject him and feared stigmatization from being associated with an MSM:

I once asked my “ordinary” [heterosexual] friend what he would do if he found out I am a homosexual. He said he would leave me at once. He also asked me what others would think of him if he was a friend of a homosexual. He said he did not want to face that risk.

Kothi-identified MSM may feel unable to reveal their sexuality to heterosexual friends, as well as their HIV status. Heterosexual friends of some MSM may not want to continue friendships with known *kothis* owing to fear of stigma by association and discrimination from others in the community. Confronted by the very real prospect of being ostracized from their established peer support networks, many *kothis* may remain secretive about being MSM or HIV-positive. Silence or denial may decrease the likelihood that *kothis* will engage resources and practices consistent with safer sex and deters utilization of resources for HIV/AIDS care and other health concerns.

Rejection by Other Kothis. HIV-positive participants also described stigma and discrimination from within their own *kothi* community. A participant recounted an incident of having his confidentiality compromised while reaching out for support to another *kothi*:

I cried when I was told I was HIV-positive. Another *kothi* saw this and asked why I was crying. At that moment I told him I was positive, without thinking about the consequences. Then that *kothi* spread the news to everyone.

Another participant who reported being open about his HIV status to his *kothi* friends narrated an incident that occurred in the drop-in center of a community organization:

Usually I also assist in cooking in the drop-in center kitchen. After I was known to be HIV-positive, I was asked not to participate in any cooking activities. One *kothi* said, "Do you think others would like to eat the food cooked by you? They will throw away the food once you go that side." I was very saddened to hear those comments.

Some *kothis* evidence lack of knowledge about HIV transmission and endorsement of myths, and may discriminate against other *kothis* who are HIV-positive.

Another dimension of discrimination within the *kothi* community occurs around marriage. Although many *kothi*-identified MSM get married, some *kothis* mock these marriages and may even target married *kothis*. A married *kothi* explained his fear of being targeted by other *kothis*:

I was very afraid of going out with my wife after we newly married. I was worried about what other *kothis* would say. Will they laugh at me? Whether they will come and talk to me when I was with my wife? What if they tell my wife about me? I was going mad with all these thoughts.

Kothis may experience stigma and discrimination within their own communities, which may manifest as unwanted disclosure of their being HIV-positive, discrimination as a result of living with HIV, and fears of being "outed" (i.e., revealed as an MSM) to their wives. Marriage by *kothis* to women, in turn, is strongly linked to family pressures to adopt the expected male role and fears of rejection from the family.

The Family: Direct Forms of Oppression

Participants reported stigmatization as well as violence from within their own families, who might otherwise represent an invaluable source of support.

A participant reported the repercussions of his father finding out about his sexuality: "By some way my father came to know about my same-sex behavior. From then onwards, he started to hate me and beat me then and there."

Kothis may leave the family home to escape the abuse and violence inflicted by family members in response to discovering their sexual orientation. A participant reported experiencing violence from his siblings: "My brothers had beaten me black and blue after they came to know about me. Later I had to run out of my family to settle in Chennai." Another participant indicated that his family "verbally abused me for bringing shame to the family name."

The Family: Indirect Forms of Oppression

In addition to leaving home to escape direct violence, many *kothis* consider leaving their family to avoid the conflict and stress arising from the clash of traditional Indian family values and their sexuality. A key area of conflict within the family may arise from the social pressures for men to marry regardless of their same-sex orientation. A participant described the stress within the family by saying that "there were frequent quarrels between my father and mother regarding my behavior. Once I got sick of it and ran away from my home and stayed in a market area." Upon leaving the family system *kothis* are likely to face other stressors, including poverty. A participant

reported that after leaving home he “survived by exchanging sex with other men for money.” Faced with the need to satisfy their basic survival needs, some *kothis* may place themselves and others at increased risk for HIV infection.

Regardless of whether or not *kothi*-identified MSM leave the family home they are likely to be held responsible by family members for the stress and conflict within the family system as a result of their failure to fulfill their expected male roles and transgression of male gender norms. A participant describes this process: “When I returned to my home after some time, I came to know that my father had passed away. My entire family hated me, since I was thought to be responsible for my father’s death.”

Kothis are also the target of blame by family members for bringing public shame to the family, owing to their sexual orientation. Participants explained that for some family members, their being HIV-positive might be more acceptable than being gay. For example, a participant reported: “[M]y father told me that he could tolerate that I was HIV-positive but asked me not to tell others that I got it by having sex with men.” Although HIV is stigmatized, the stigma attached to homosexuality among some families may be even greater.

The Health Care System: Direct Forms of Oppression

Health Care Providers. Participants reported discrimination and stigmatization by health care providers, which took the form of derogatory labeling, demeaning interactions, outright insults, breaches of confidentiality, and refusals of service. Together these forms of direct oppression appear to contribute to substandard care of *kothis*.

Kothis may be uncomfortable reporting symptoms that might disclose they had sex with other men for fear of provider repercussions. Furthermore, some providers are negligent in asking about sexual histories and outright insulting and/or incompetent in working with MSM.

A participant reported being asked by a physician in a derogatory way, “Are you a man? . . . You have a moustache and why do you want to have sex with other men? Try women.” This illustrates lack of sensitivity and knowledge in working with MSM. An HIV-positive participant described discrimination experienced at a government (public) hospital: “As soon as you are found to be HIV-positive they [physicians] send us to [another facility]; they don’t even touch us then.”

A participant described his embarrassment in recounting anal STD symptoms to his doctor:

Once I had pain in the back [anus] and was afraid to tell the doctor when I went to [a government hospital]. I came back without telling. Then my friend took me to a private doctor known to him. I told him about the pain and he prescribed some tablets for it . . . No, he did not see the back.

Some MSM may not reveal their anal STD symptoms for fear of being revealed as having sex with men. Furthermore, physicians may not conduct proper clinical examinations even if symptoms, such as those suggestive of anal STDs, are reported by the patient.

The Health Care System: Indirect Forms of Oppression

Health Care Providers. *Kothis* also report that some medical practitioners, agency staff, and programs engage in indirect oppressive practices through being poorly educated about HIV transmission or treatment, engaging in negligent profes-

sional conduct that fails to adequately explore risk factors, hiring staff who are incompetent in working with MSM, and/or designing programming that fails to account for the needs of MSM and/or denies equal accessibility to MSM. A participant shared an incident in which a private medical practitioner neglected to inquire about any sexual history or details of his anal symptoms when he mentioned that he had an ulcer “in the back.” “[The doctor] then asked, ‘Did you wash your legs [a euphemism for washing buttocks] in a pond?’ I said ‘yes.’ No . . . he didn’t ask anything about my sexual activities.” This suggests possible embarrassment on the part of this physician in asking about same-sex behavior even though it was relevant in the clinical context. Consequently, one cannot be sure about the accuracy of the clinical diagnosis and provision of proper treatment for STD symptoms.

Participants also expressed that safer sex information for HIV-positive persons is either not given at all or different messages are given by different providers. A participant reported:

Tell me . . . when one has become HIV-positive should they no longer have sexual feelings? We are also human beings; why is this not discussed by doctors? They tell us, ‘Do not have sex.’ Many do not even talk about it [sex].

Another participant explained,

I told that doctor that I had sex last month. He gave back my [outpatient case] sheet and asked me to get out. I was told later that he actually slapped one patient for having had sex. I was fortunate [giggles]. He is no longer in [name of government hospital].

Participants recounted confusion at inconsistent safer sex information from different providers. As a participant reported:

The doctor told me not to have anal sex but that I can have oral sex . . . that too with condoms. That nurse told me I should not be having sex at all, since I should not infect others. The counselor was telling me to reduce the sex[ual activity]. He didn’t even talk about condoms.

Participants explained that even less information on sex with women is given to self-identified MSM, and their need for information about how to address women, including their wives.

Often, no, always, they [outreach workers] talk about male–male sex but not much information is given on sex with women or STDs in women; and many *kothis* are married too. How can they tell their wife that they have HIV? They cannot use condoms with their wife . . . I do not know.

Even providers or counselors who do address sex between men may omit discussion of sex with women, perhaps having judged that these men are not sexually active with women. MSM as well may be reluctant to raise the issue of sex with women, or that they are married, for fear of greater stigmatization and blame, and fear of compromising their confidentiality.

HIV-Positive Support Groups. Entire programs ostensibly engaged in HIV prevention or HIV treatment may be perceived as oppressive by *kothis*. For example, some HIV-positive participants indicated awareness of support groups and organizations, but were wary of attending groups designed to primarily serve HIV-positive heterosexuals: “Someone told me there is one [support group] in Chennai for ordinary [heterosexual] positive people. What will be the use in going there?” Another partici-

participant expressed his fear of being discriminated against: “Will they understand us? Maybe they will not talk to us when we go there.” A participant described his experience attending a group for HIV-positive heterosexuals: “There one can talk about medical issues, but how can I talk about my personal life? They do not talk about that.” Another participant, however, expressed optimism that other groups for persons living with HIV would understand the issues faced by MSM: “They will understand us [MSM]; they are also suffering from HIV and face discrimination, hence they could understand our condition too.”

A key informant suggested the benefits of HIV-positive MSM having the option to attend any HIV-positive group: “They should be given options . . . should be able to go there [to mainstream groups] and use their services, as well as should have their own support groups so that they can talk about the sexuality issues . . . can move back and forth between the groups and then can ultimately choose where they want to be, after experiencing both.” Nevertheless, participants’ generally perceived that mainstream HIV-positive support groups, ostensibly serving heterosexuals, would not be able to serve their needs.

Consequences of Stigma and Discrimination in the Lives of *Kothis*

Depression and Suicidality. Some HIV-positive participants described waiting for their feelings of sadness, depression, and alienation to abate by themselves. The latter is understandable given reality-based fears of discrimination from many constituencies who they might otherwise reach out to for support: health care providers, family, *kothi* friends, heterosexual friends, and HIV-positive support groups. Nevertheless, some participants who described suicidal feelings after finding out they were HIV-positive reported positive experiences in seeking support from other *kothis*:

I would have committed suicide. I told my suicidal feelings to another *kothi*. He said why die now, when anyway we will be dying owing to AIDS in the future. Then, I also thought what was the point in dying; as long as I live let me remain jolly.

Another participant explained: “When we [*kothis*] are together, we laugh, tease one another, and chat a lot . . . we would be very happy. Once I have to leave to my home I would feel very lonely; I could not share these things in my home.” Although some HIV-positive *kothis* described fears and experiences of being ostracized by their own community, other *kothis* expressed their experience of the *kothi* community as a primary source of emotional support.

Nondisclosure of HIV Status / Lack of Social Support. HIV-positive participants expressed fears of rejection and isolation that prevented them from revealing their serostatus to nonsexual friends and family. “I cannot tell this to my *panthi* [nonsexual masculine] friends,” noted one participant. “They cannot understand . . . if I tell my general [heterosexual] friends then they will tell my family.” Another participant explained, “I do not want to tell my *kothi* friends. If one knows then everyone will come to know; I have seen how some [HIV-]positive *kothis* have suffered from problems created by other *kothis*.”

Reasons for not disclosing one’s HIV status to family members included fear of bringing shame to one’s family, not making the family suffer, and fear of rejection. Some HIV-positive participants expressed shame about their sexual orientation. In particular, some respondents reported feelings of guilt about their sexual orientation, which reemerged after learning of their HIV status. As a participant reported, “It is because I’m born like this I got this infection.” Anti-gay stigma and HIV/AIDS stigma

may be mutually reinforcing and inextricably linked for some MSM. A participant described wanting to protect his family from shame: “What will the neighbors speak of my family? They could not show their face outside.” Another participant asked, “But why should we tell our family that we are positive? That will only make them suffer.” Another HIV-positive participant explained his fear of being further rejected by his family: “Already my brothers do not talk to me because of my feminine nature and if they came to know I am also positive then they will just drive me away.”

HIV-positive *kothis* may experience reality-based fears and concerns that prevent them from disclosing their HIV status to family members. Participants described both wanting to protect themselves from rejection from within their own families as well as wanting to protect their families from stigma and discrimination from the larger society. Thus, stigma and discrimination operate in multiple ways that present obstacles to HIV-positive *kothis* in reaching out to their families, who might otherwise represent an important source of psychosocial support.

DISCUSSION

Kothi-identified MSM face stigma, discrimination and violence across multiple social and institutional contexts in Chennai. Experiences of victimization appear to be exacerbated for HIV-positive *kothis*, who face additional stigma and discrimination within the health care system (which they are more likely to have to interact with as a result of being HIV-positive), within the larger *kothi* community, and from mainstream HIV and AIDS support groups. As difficult as it may be to contend with stigma and discrimination from within one context, such as law enforcement, the family or the health care system, the multiple overlapping contexts of stigma and discrimination faced by *kothis* present monumental challenges not only for HIV preventive intervention, but for overall health and survival. This network of “ubiquitous social structures,” as depicted in Figure 2—across legal, community, family and health care systems—is emblematic of structural violence (Galtung, 1969), which places MSM at extreme vulnerability for HIV and AIDS.

The present findings suggest interlocking subsystems of discrimination and victimization of *kothi*-identified MSM—including police, community members, family members and health care providers—that are embedded in structural factors, and which must be understood beyond an additive or individual-level model. For example, rowdies are able to extort money from *kothis* because of *kothis*' reality-based fears of rejection from family if their sexual orientation and/or HIV status became known. Rowdies can engage in unmitigated exploitation and violence against *kothis*—on an ongoing basis—because police, who might otherwise be called on to protect people from such violence, themselves engage in violence, rape, harassment, and blackmail of MSM. Without police enabling, the behavior of rowdies might otherwise be punished and reduced. The social context in which disclosure of one's sexual orientation to family is tantamount to family and community rejection also enables the threat of blackmail and extortion, which otherwise might prove less likely to be effective threats.

Interlocking subsystems that support direct and indirect victimization of *kothi*-identified MSM are enabled and fomented by structures embedded within Indian society. A legal system that criminalizes sex between consenting male adults provides an example of a structural-level factor that creates conditions which enable discrimination and stigmatizing practices. Inequality and discrimination that is codified within the legal system establishes social conditions that facilitate the disempowerment and marginalization of MSM. Apparently commonplace police ha-

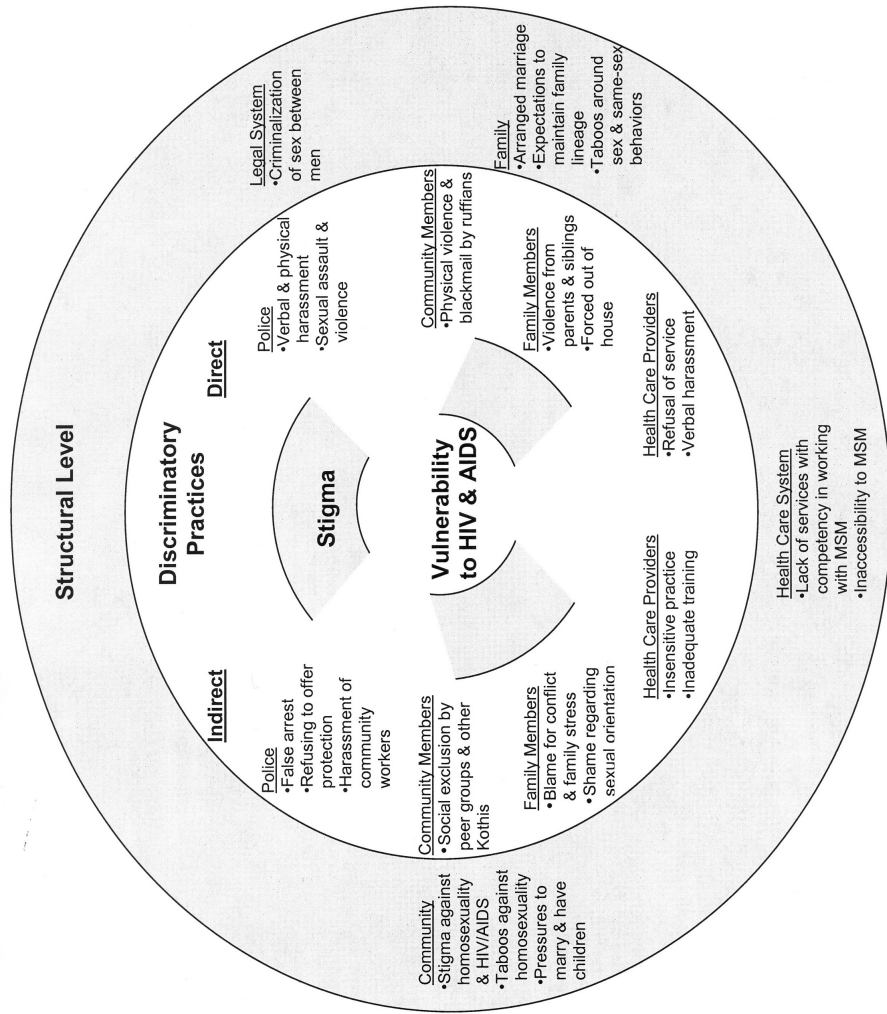


FIGURE 2. A Conceptual Model of Structural Violence and Vulnerability to HIV and AIDS among Kothi-identified Men who have Sex with Men in Chennai, India.

rassment of MSM and health care workers, for example, is supported as MSM represent easy targets for “filing a case,” which provides a demonstration to the public that the police are doing their jobs. These unjustifiable arrests also function to avert concerns regarding possible public complaints and media attention if MSM “cruising areas” on police beats appear to be uncontrolled or unchecked. As long as male-to-male sex is criminalized, there exists state-sponsored justification and motivation for police harassment and violence against MSM, and the likelihood of individual MSM coming forward to report or combat such violence and abuse is greatly diminished as they are always at risk for arrest and for being blamed themselves. The extensive harassment of MSM suggested by the present study is supported by a recent investigation in which two thirds of 62 MSM HIV prevention outreach workers surveyed in Chennai reported at least weekly harassment from police and rowdies (Safren et al., 2006). Our study suggests that while police violence against MSM may occur on an immediate personal level, which may be more visible, such personal violence is “called into action by expectations deeply rooted in the structure” (Galtung, 1969, pp. 179–180) of Indian society—or structural violence—which is more difficult to pinpoint and control. Nevertheless, the present findings suggest that HIV prevention research and interventions for MSM in Chennai must target this structural level.

The sexual and physical harassment and violence faced by *kothis* from both rowdies and police also may be understood as punishment for transgressing traditional gender boundaries and as an affirmation of the masculinity of the perpetrators. Perhaps paradoxically, such violence and victimization may enable sexual activity between *kothis* and police or rowdies; the perpetrator is perceived as male and not homosexual, even as he is engaging in sex with another man, because of the violent nature of the encounter and his role as the insertive partner in anal or oral sex.

Interwoven systems of stigma and discrimination also present tremendous obstacles to families who might otherwise serve as important sources of support for HIV-positive *kothis*. Our findings suggest that for some families it may be easier to accept their son’s being HIV-positive than to accept his sexual orientation. Nevertheless, being HIV-positive is seen as a sign of sexual immorality; not only the individual, but the entire family risks being stigmatized by the larger community. Courtesy stigma (Goffman, 1963), or stigma by association, has been documented in regard to both gay men (Herek, 1999; Sigelman, Howell, Cornell, Cutright, & Dewey, 1991) and PLHIV (Alonzo & Reynolds, 1995; Herek, 1999) and appears to be a potent phenomena among *kothis*. Many *kothis* may be reluctant to bring shame to their families by revealing their HIV status, in addition to fears of being rejected by their families, which obviates even the possibility of disclosure and family support. Families as perpetrators of both indirect and direct discrimination and violence on a personal level also form part of the superordinate system of structural violence in enacting oppressive social codes that disenfranchise and victimize MSM.

In a similar vein, stigmatization and discrimination against *kothis* within mainstream HIV-positive support groups that largely serve heterosexuals may reflect fear of stigma by association. PLHIV may experience particular vulnerability to stigma and may actively resist association with homosexuality, which may threaten the construction of “innocent victim.” As a result, PLHIV who might otherwise serve as resources and provide social support for *kothis* living with HIV and AIDS may be constrained by structural forces that threaten their own survival in a system of oppression against all PLHIV. Fear of stigma by association, and the power of structural violence, also appears to be manifested among heterosexual friends of *kothis* and

HIV-positive *kothis*, which often precludes *kothis*' seeking social and emotional support from heterosexual friends.

Finally, discrimination against *kothis*, and HIV-positive *kothis*, in particular, occurs within the health care system. Disparaging comments, outright refusal of service, lack of appropriate clinical examination and lack of appropriate safer sex counseling suggest a health care system that is largely inadequate in serving MSM. It is not surprising that MSM may choose not to volunteer information about sexual behaviors and STDs in a hostile context, which further obviates the possibility of receiving appropriate care and safer sex counseling. Health care providers may limit the possibility of appropriate care by denying and even supporting crucial structural impediments to health (Farmer, Nizeye, Stulac, & Keshavjee, 2006). Police harassment of HIV/AIDS outreach workers further contributes to a system that presents myriad obstacles to HIV prevention. In fact, HIV prevention targeting MSM and sex workers is itself treated as a subversive act, which may be met with systematic and coordinated violence. As a consequence, key opportunities for HIV prevention among both HIV-positive and high-risk HIV-negative MSM are squandered. The health care system as an instrument of stigma and discrimination, along with the legal system, may become an agent of structural violence (Padilla, Vasquez del Aguila, & Parker, 2007)—in direct antithesis to the mandates of public health and safety—thereby placing MSM at increased vulnerability to HIV infection.

A small but increasing number of U.S. studies have addressed the association between stigma and discrimination, respectively, and HIV risk among gay men (Herek, 1999; Meyer, 2003), and ethnic minority MSM (Fullilove & Fullilove, 1999; Ramirez-Valles, Fergus, Reisen, Poppen, & Zea, 2005), and stigma and discrimination as obstacles to HIV preventive intervention (Fullilove & Fullilove, 1999; Herek, Capitanio & Widaman, 2003; Ramirez-Valles et al., 2005). A related embryonic, yet vital, area of research is focused on the role of structural factors in producing HIV risk (e.g., Blankenship et al., 2006; Parker, Easton, & Klein, 2000; Rhodes et al., 2005) and, specifically, the role of structural violence in HIV risk and prevention (Farmer et al., 2006; Lane, 2004). The paucity of such research in India (Godbole & Mehendale, 2005) may be owing to lack of awareness regarding the tremendous challenges faced by MSM and the fact that structural factors are less obvious and less easily studied as determinants of health than personal factors (Farmer et al., 2006; Lane, 2004). Furthermore, neither health care professionals nor researchers are exempt from the constraints of structural violence or stigma by association.

In the context of multiple subsystems engaged in indirect and direct stigmatization and discrimination against MSM in India, the importance of gay-affirmative community-based organizations, such as SWAM, Sahodaran, and Allaigal in Chennai, and the Humsafar Trust in Mumbai, cannot be overstated. These community-based organizations serve as vital points of resistance in a system of structural violence, through combating stigma, promoting and facilitating access to care and education, and engaging MSM as active agents in community and advocacy networks in India. On a more micro level, community engagement also may mitigate the negative effects of stigma, such as depression and low self-esteem (Ramirez-Valles et al., 2005), which may be associated with increased HIV risk behaviors (Diaz, 1998; Meyer, 2003). Indigenous, gay-affirmative community-based organizations, while scarce, remain bastions of support and advocacy, and islands of HIV/AIDS outreach and education for MSM in Chennai. All too often they operate on shoestring budgets, given difficulties in procuring federal or local governmental funding—another mani-

festation of structural violence against MSM. Community-based organizations serving MSM in India also represent vital nodes for international collaboration and structural interventions, and access to stakeholders from MSM communities, who are crucial to the implementation of culturally competent and ethical HIV prevention research and effective preventive interventions.

Further investigations of stigma and discrimination faced by MSM in India, and the superordinate context of structural violence, should address institutional contexts of discrimination and oppression; sociocultural constructions and expectations regarding gender roles and norms, Indian male sexuality and masculinity; and a critical understanding of Indian history and postcolonial influences as reflected in present societal institutions and cultural practices. It is important that such studies give voice to multiple stakeholders across diverse MSM and transgender communities in different geographical locations, including specific attention to the experiences of MSM living with HIV and AIDS, which may shed further light on the experiences of MSM in India and support culturally syntonc structural interventions for HIV prevention and social change.

Limitations to this study include the small purposive sample; caution should be exercised in drawing inferences about other MSM, particularly those who are not *kothi*-identified, and MSM from other geographical locations in India. The purpose of this study was to explore in depth the lived experiences of HIV-positive and high-risk *kothis* in Chennai; and we were successful in recruiting individuals from these highly vulnerable populations from several different venues, which increases the transferability of the findings. Additionally, because of the risks that PSEs pose to participants and research staff, and the fact that men attending these sites may not wish to come to a community agency setting, the interviews of these men were limited in duration as compared to those of the agency-based participants. Nevertheless, many common themes emerged across the two samples, as well as some concerns that appear to be intensified for HIV-positive MSM. An additional strength of the present investigation is that it involved training and funding of Indian researchers, interviewers and outreach staff, many of whom are part of the MSM community or provide services to MSM.

RECOMMENDATIONS

The present findings suggest that challenging the Indian government to uphold human rights and to combat stigmatizing and discriminatory practices against MSM may be a central component in reducing HIV and AIDS vulnerability among MSM in India (Mawar et al., 2005). Direct challenges to Indian federal laws that effectively criminalize sexual relations between consenting same-sex adults are central to resisting structural violence, which promotes extreme vulnerability to HIV and AIDS among MSM. Decriminalization of same-sex behaviors would also be a first step toward enacting and enforcing anti-hate crime legislation that would hold individuals accountable for violence and abuse targeting *kothis* and other MSM.

Antidiscrimination education campaigns in the mass media targeting the general public also may be an important intervention to combat stigma and discrimination associated with MSM and HIV/AIDS. Furthermore, designing and implementing specific education and sensitization programs for health care providers, both to counteract ignorance and end outright prejudice and discrimination, is also essential to supporting HIV prevention and treatment among MSM. The implementation of collaborative efforts with the health care system will need to be conducted in a manner that acknowledges cultural taboos related to sexuality (Brahme et al., 2005) and that influences medical staff (Elamon, 2005). Additionally, extensive education and wide-

spread monitoring of police is a vital component of reducing vulnerability among *kothis*. The establishment of connections between each of these subsystems with community-based programs that serve MSM communities may promote awareness of the needs of MSM and specifically protect community outreach workers from harassment and abuse.

Given the importance of grassroots community-based organizations to the health and survival of *kothis*, government and international efforts to stabilize funding and offer technical support to organizations led by *kothis* and other MSM may be an effective method to promote empowerment, HIV prevention, and human rights. Access to stable funding from the government for MSM community groups may be facilitated by stakeholders within the health care system through tapping the growing will of the Indian government to implement programming that recognizes the threat of a growing AIDS epidemic (Godbole & Mehendal, 2005).

Overall, this investigation suggests a system of structural violence against *kothi*-identified MSM that creates extreme vulnerability to HIV infection and AIDS. To marshal effective HIV prevention, interventions must combat stigma, discrimination, and violence against *kothis* and other MSM in India. In the multisystemic context of structural violence, HIV preventive interventions that merely address the individual level—for example, safer sex education, HIV/AIDS knowledge, condom use and sexual negotiation skills—are unlikely to be effective (Newman et al., 2006). HIV prevention also must target the structural level, including social, economic, political, legal, and medical systems, which otherwise are likely to promote continued morbidity and mortality among MSM in India.

REFERENCES

- Alonzo, A.A., & Reynolds, N.R. (1995). Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Social Science and Medicine*, 41(3), 303–315.
- Blankenship, K.M., Friedman, S.R., Dworkin, S., & Mantell, J.E. (2006). Structural interventions: Concepts, challenges and opportunities for research. *Journal of Urban Health*, 83(1), 59–72.
- Brahme, R.G., Sahay, S., Malhotra-Kohli, R., Divekar, A.D., Gangakhedkar, R.R., Parkhe, A.P., et al. (2005). High risk behaviour in young men attending sexually transmitted disease clinics in Pune, India. *AIDS Care*, 17(3), 377–385.
- Chakrapani, V., Babu, P., & Ebenezer, T. (2004). *hijra*s in sex work face discrimination in the Indian health-care system. *Research for Sex Work*, 7, 12–14.
- Chakrapani, V., Kavi, A.R., Ramakrishnan, R.L., Gupta, R., Rappoport, C., & Raghavan, S.S. (2002). *HIV prevention among men who have sex with men (MSM) in India: Review of current scenario and recommendations*. Retrieved March 4, 2005, from http://www.indianglbtthealth.info/Authors/Downloads/MSM_HIV_IndiaFin.pdf
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Diaz, R.M. (1998). *Latino gay men and HIV: Culture, sexuality, and risk behavior*. New York: Routledge.
- Elamon, J. (2005). A situational analysis of HIV/AIDS-related discrimination in Kerala, India. *AIDS Care*, 17, 141–151.
- Farmer, P., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLoS Medicine*, 3(10), 1686–1691.
- Fullilove, M.T. & Fullilove, R.E. (1999). Stigma as an obstacle to AIDS action: The case of the African American community. *American Behavioral Scientist*, 42(7), 1113–1125.
- Galtung, J. (1969). Violence, peace and peace research. *Journal of Peace Research*, 6, 167–191.
- Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Godbole, S., & Mehendale, S. (2005). HIV/AIDS epidemic in India: Risk factors, risk behaviours & strategies for prevention & control. *In-*

- dian Journal of Medical Research*, 121, 356–368.
- Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.
- Herek, G.M. (1999). AIDS and stigma. *American Behavioral Scientist*, 42(7), 1102–1112.
- Herek, G.M., Capitanio, J.P., & Widaman, K.F. (2003). Stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychology*, 22(5), 533–540.
- Human Rights Watch. (2002). *Epidemic of abuse—Police harassment of HIV/AIDS outreach workers in India*. 14(5). Retrieved March 5, 2005, from <http://www.hrw.org/reports/2002/india2/india0602.pdf>
- Lane, S.D. (2004). Structural violence and racial disparity in HIV transmission. *Journal of Health Care for the Poor and Underserved*, 15(3), 319–335.
- Lincoln, Y.S., & Guba, E. (1985). *Naturalistic enquiry*. Newbury Park, CA: Sage.
- Link, B.G., & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–385.
- Mann, J.M. (1987a). AIDS—A global perspective. *Western Journal of Medicine*, 147(6), 693.
- Mann, J.M. (1987b). The World Health Organization's global strategy for the prevention and control of AIDS. *Western Journal of Medicine*, 147(6), 732–734.
- Mawar, N., Sahay, S., Pandit, A., & Mahajan, U. (2005). The third phase of HIV pandemic: Social consequences of HIV/AIDS stigma & discrimination & future needs. *Indian Journal of Medical Research*, 122, 471–484.
- Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697.
- National AIDS Control Organization. (2005a). *An overview of the spread and prevalence of HIV/AIDS in India*. Retrieved January 2, 2005, from http://www.nacoonline.org/facts_overview.htm
- National AIDS Control Organization (NACO). (2005b). *HIV estimates (2003)—National AIDS Control Organization: A note on HIV estimates 2003*. Retrieved February 5, 2005, from http://www.nacoonline.org/facts_hivestimates.htm
- Newman, P.A., Venkatesan, C., Row Kavi, A. & Kurien, A.K. (2006). HIV-1 prevalence in young adults in south India. *The Lancet*, 368(9530), 1115.
- Padilla, M.B., Vasquez del Aguila, E., & Parker, R.G. (2007). Globalization, structural violence, and LGBT health: A cross-cultural perspective. In I.H. Meyer & M.E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 208–241). New York: Springer.
- Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine*, 57, 13–24.
- Parker, R.G., Easton, D., & Klein, C.H. (2000). Structural barriers and facilitators in HIV prevention: A review of international research. *AIDS*, 14(Suppl. 1), S22–S32.
- People's Union for Civil Liberties, Karnataka. (2001). *Human rights violations against sexuality minorities in India*. Retrieved March 3, 2005, from <http://www.pucl.org/Topics/Gender/2003/sexual-minorities.pdf>
- People's Union for Civil Liberties, Karnataka. (2003). *Human rights violations against the transgender community: A study of kothi and hijra sex workers in Bangalore, India*. Retrieved March 5, 2005, from <http://www.altlawforum.org/PUBLICATIONS/PUCL%20REPORT%202003>
- Ramirez-Valles, J., Fergus, S., Reisen, C.A., Poppen, P.J., & Zea, M.C. (2005). Confronting stigma: Community involvement and psychological well-being among HIV-positive Latino gay men. *Hispanic Journal of Behavioral Sciences*, 27(1), 101–119.
- Rhodes, T., Singer, M., Bourgois, P., Friedman, S.R., & Strathdee, S.A. (2005). The social structural production of HIV risk among injecting drug users. *Social Science and Medicine*, 61(5), 1026–1044.
- Safren, S.A., Martin, C., Menon, S., Greer, J., Solomon, S., Mimiaga, M.J., et al. (2006). A survey of MSM HIV prevention outreach workers in Chennai, India. *AIDS Education and Prevention*, 18(4), 323–332.
- Schutt, R.K. (2004). *Investigating the social world—The process and practice of research* (4th Ed.). Newbury Park, CA: Sage.
- Sigelman, C.K., Howell, J.L., Cornell, D.P., Cutright, J.D., & Dewey, J.C. (1991). Courtesy stigma: The social implications of associating with a gay person. *Journal of Social Psychology*, 131(1), 45–56.
- UNAIDS. (2001). *India: HIV and AIDS-related discrimination, stigmatization and denial*. Geneva, Switzerland: PAIS: Author.
- kothi-identified MSM in India*