

CHAPTER I

INTRODUCTION

I.1 Overview of Manipur

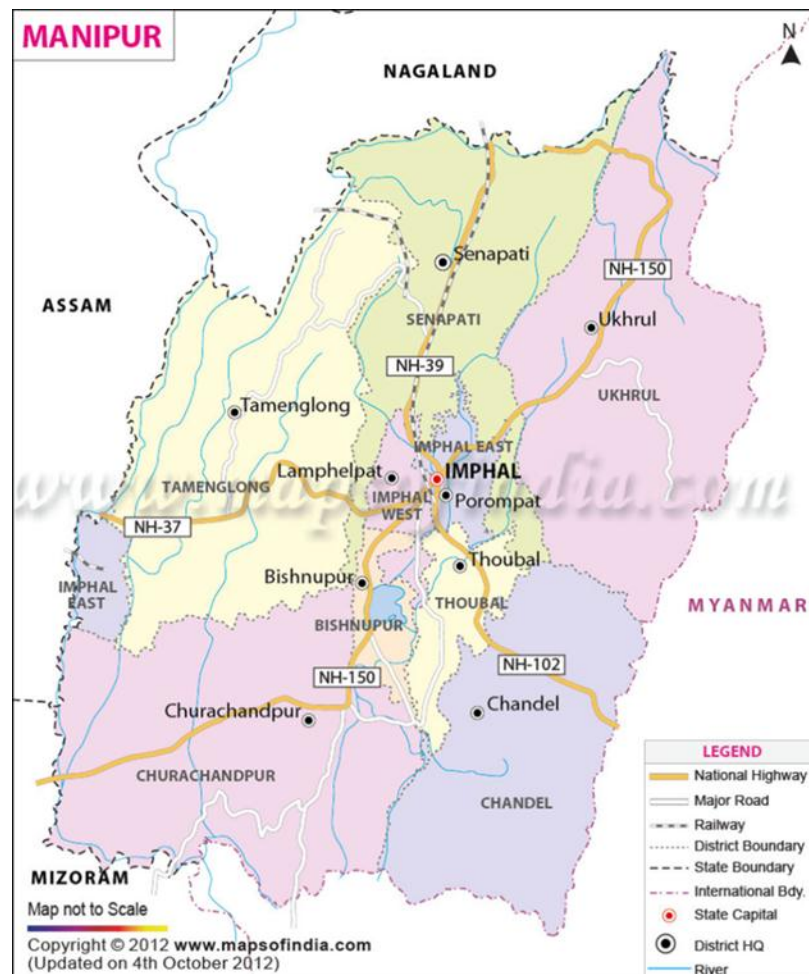


Figure 1.1: Geographical map of Manipur

Manipur (Pron: /məɳɪpʊr/) pronunciation (help•info) (Meitei: Maneepoor maṅipur) is one of the states in northeastern India. Lord Irwin described Manipur as

the 'Switzerland of India'. Manipur is situated between latitude of 23°83'N – 25°68'N and longitude of 93°03'E – 94°78'E 23.83. The land surface of Manipur is 22,347 sq. kms which is about 0.68% of India's total area. Manipur is geographically bounded by Nagaland in the North, Mizoram in the South, Cachar district of Assam in the West and bordering Burma in the East. It is predominantly a mountainous state but in its central there is a small plain which is thickly populated. The capital of Manipur is Imphal and it is inhabited by Meitei, Hindus, Muslims, Christian and 29 recognized castes or tribes. The majority of the people in the state follow Hindu religion. Manipuri (Meitei) and English are the official languages of the state.

Presently, the state is divided into nine revenue Districts viz. Bishnupur or Bishenpur, Imphal East, Imphal West, Thoubal, Chandel, Churachandpur, Tamenglong, Urkhul, and Senapati. Again in nine districts, Valley Districts consists of Bishnupur or Bishenpur, Imphal and Thoubal and Hills Districts includes Ukhrul, Senapati, Tamenglong, Churachandpur and Chandel. In addition to these, there are three sub-district administrative units. They are Jiribam in Imphal East, Kangpokpi in Senapati, and Moreh in Chandel District. There are 37 sub- Divisions in the state. The state is having 166 Gram Panchayats in four plain districts and six Autonomous Councils in five Hill Districts. There are six Autonomous District Councils such as Churachandpur ADC, Chandel ADC, Senapati ADC, Sadar Hill ADC, Tamenglong ADC, Ukhrul ADC. Besides, there are nine other important towns and about 2089 villages in the state.

According to 2011 Census, the population of Manipur is 2,721,756 persons of which 50.32 percent of the population i.e. 1,369,764 persons are male and

remaining 49.67 percent i.e. 1,351,992 persons are female. The population is approximately 0.22 percent of the total population of India. Manipur stands twenty-fourth positions among the state/UT in India. Imphal West with 514,683 persons accounting 18.91 percent is the most populous district among all the districts in Manipur. Imphal East district with 16.63 percent comes in the second position followed by Thoubal with 15.45 percent. Manipur has a population density of 122 persons per sq. km. in 2011 against 103 persons in 2001. There is increased by 19 persons per sq. km. during the last decade. Compared to all over India figure of 382 persons per sq. km in 2011, the density of population in this state is still very low. The low density population may be related to the law and order situation of Manipur which made many Manipuri migrate to other parts of India. Sex ratio of Manipur is 987 against 949 of India and occupies sixth position in India. The data shows that there is significant improvement of sex ratio over 2001 figure of 974. The data indicated that the status of women is increasing and there may be less discrimination in the state. It can be a good sign for the future of Manipur that there is less gender disparity in society and which will help in state development.

I.2 Background of the Study

I.2.1 Concept of Homosexuality

The term 'sex' refers to biologically determined differences, whereas 'gender' refers to difference in social roles and relations. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity, and religion, as well as by geographical, economic, and political environments (UNAIDS, 2011).The term 'sex' and 'gender'

are often used interchangeably. However, sex is biological and cannot be changed without surgery while the second is a social construct which can be changed. A social construct is a group of ideas, belief, norms that are specially manifested. Constructs are not natural or inherent but made, thus change with time and place. Gender is not a personal trait; it is “an emergent feature of social situations: both as an outcome of and a rationale for various social arrangements, and as a means of legitimating one of the most fundamental divisions of society” (West & Zimmerman, 1977). Historically, the term gender was adopted as means of distinguishing between biological sex and socialized aspects of femininity and masculinity (Merecek et al. 2004). Contemporary constructionist proposed gender as an activity (doing) of utilizing normative prescriptions and beliefs about sex categories based on situational variables. These “gender activities” constitute our belonging to a sex as based on the socially accepted dichotomy of “women” and “men”. Since gender is a construct which is based on biological sex, i.e. if you are a man you must be masculine and if you are a woman , you must be feminine, man and woman are expected to behave according to a set of norms, rules, and conditions which may be spelled out or unsaid. Therefore, some of the men and women may find difficult to live according to the expectations upon them.

To go in-depth of the concept of gender, one needs to understand gender identity. Gender identity refers to a person’s internal thinking and individual’s experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other

means, and other expressions of gender, including dress, speech, and mannerisms (UNIDS, 2011). According to Alsop, Fitzsimmons & Lennon (2002), "Gender is a part of an identity woven from a complex and specific social whole, and requiring very specific and local readings". Thus, gender identity can be defined as part of socially situated understanding of gender. La France, Paluck and Brescoll (2004) noted that a term, "gender identity" serves a specific function. It allows individuals to express their attitudes towards and stance in relation to their current status as either women or men. Gender identity is also referred to the private sense of, and subjective experience of their own gender i.e. being a man or a woman. It is a person's individual sense of femaleness or maleness. Gender identity conflicts can stem from an individual's gender identity but are not matching their biological sex, an individual's gender identity for being neither completely male nor female, or an individual's biological sex not being uniquely male or female.

According to Newman (2008) there are certain factors which influence in the formation of gender identity: understanding the concept of gender, learning gender role standards and stereotypes, identifying with parents and, forming gender preference. Biological factors that may influence gender identity include pre and post-natal hormone levels and genetic makeup. Social factors which may influence gender identity include ideas regarding gender roles conveyed by family, authority figures, mass media, and other influential people in a child's life. Language has played a significant role in the process of gender identity. Adegaju (2000) expressed that the relationship between language and gender has largely reflected how linguistic practices, among other kinds of practices, used in the construction of

social identities relating to issues of masculinity and femininity. From this language, children try to identify the predetermined role of male and female. Children imitate and follow from their surroundings. In some cases, individual may be inconsistent with their biological sex features and act a diverse mode from it. Such kind of gender divergence is regarded as gender variant or transgender.

In society, there is a basic division between gender attributes that assigned to males and females. However, some individuals do not identify with some or all of the aspects of gender that are assigned to their biological sex. In our society, there is an acceptance of boys openly dressing like a girl. People have realized that there is an existence of 'middle space' in gender spectrum. Gender identity can be expressed through behavior, clothing, hairstyles, voice, or body characteristics, etc. which is a form of sexual orientation. There is a gender binary in most of the Western societies. Such social dichotomy enforced the ideals of masculinity and feminity in all aspects of gender and sex - gender identity, gender expression and biological sex. There is also called third gender in some of the societies that are used as a basis for gender identity by people who are uncomfortable with the gender that usually associated with their sex. Unlike others, in some of the society, there are open gender categories regardless of their sex. Our identity is expressed through our sexuality. On the basis of sexuality, a person can be identified as male or female and homosexual or heterosexuals. Homosexuality and heterosexuality are the forms of sexual orientation.

Sexual orientation refers to the gender i.e. male or female to which a person is attracted. It is an enduring emotional, romantic, sexual, or affectionally attraction

to another person. Sexual orientation refers to a person's choice of partners whether of the same sex, the opposite sex or both sexes for sexual and affectional relations. It is described as person's predisposition, capacity and inclination to enjoy various types of erotic, emotional and affectional desires, intimacy and sexual interaction. Alfred Kinsey et al. (1948, 1953) said that the conceptualization of sexual orientation comprises of sexual behavior and erotic fantasy. Shively and De Cecco (1977) also expressed that the sexual orientation are conceptualized as embracing physical, interpersonal and intrapsychic factors. Bell and Weinberg's (1978) described that the component of sexual orientation as sexual behavior (physical) and erotic fantasy (intrapsychic). Sexual orientation is dynamic in nature and can be seen from four aspects: sexual attraction, sexual behaviour, sexual fantasies and self-identification. There are different types of sexual orientation that are commonly described as heterosexual, homosexual and bisexual.

The words homosexual is a Greek and Latin hybrid with the first element derived from Greek homos, 'same' thus connoting sexual acts and affections between members of the same sex. The term 'homosexuality' was coined in the late 19th century by a German psychologist, Karoly Maria Benkert. As a sexual orientation, homosexuality referred to an enduring pattern of or disposition to experience sexual, affectional, or romantic attractions primarily or exclusively to people of the same sex. It is also referred to an individual's sense of personal and social identity based on those attractions, behaviours expressing them, and membership in a community of others who share them (American Psychological Association, 2013). The term was used as a clinical description of men who

displayed sexual desires to other men. In modern language, the term homosexuality is equally ascribed to male as to female same sex sexual behaviour. Homosexuality identity has developed in 19th and 20th centuries and diversified into a plurality of gay, lesbian, queer etc.

Scientific research shows that homosexuality is not a psychiatric illness. Among the scientific community, homosexuality is understood as a normal expression of human sexuality. 1973 is the landmark year for the people who considered themselves as homosexual. In this year, psychologist Evelyn Hooker enabled homosexuality to be declassified as a mental disorder in the Diagnostic and Statistical Manual of American Psychiatric Association. In 1992, the World Health Organization removed homosexuality as a psychiatric disorder from its International Classification of Diseases. 'The Chinese Psychiatric Association (2001)' and 'The Indian Psychiatric Association (2009)' supported the Western context, that homosexual behavior does not signal the need for psychopathological intervention. In that year, the Delhi High Court in India noted that "there is almost unanimous medical and psychiatric opinion that homosexuality is not a disease or a disorder and is just another expression of human sexuality". We further need to highlight the theories of homosexuality which influence in understanding of homosexuality.

1.2.2 Theories of Homosexuality

In recent decades, there are hot debate on the causation and origin of homosexuality. Many theories had analysed the root causes of homosexuality. The causes of homosexuality can be influenced by his biology, genetics and environmental factors. Both the aspects have evidence to support their arguments

regarding the causes of homosexuality. Homosexuality is one of the forms of sexual orientation. Charles Darwin expressed, "...we do not even in the least know the final causes of sexuality. The whole subject is hidden in darkness" (Fujita, 2003). But APA argued that sexual orientation is not a choice, rather than it emerges from most people in early adolescence with no prior sexual experience (APA, 2003). The following are some of the theories relating to homosexuality:

a) Psychoanalytic Theories

Psychoanalytic theory is a general term for approaches to psychoanalysis which attempt to provide a conceptual framework more-or-less independent of clinical practice rather than empirical analysis of clinical cases. Sigmund Freud, Melanie Klein, and Jacques Lacan are often treated as canonical thinkers within psychoanalytic theory, although there are considerable objections to their authority, particularly from feminism. Most psychoanalytic theories stress the role of parental and family dynamics in development of homosexuality, not the society as a whole. Behaviourists believe that some sexual and gender identification differences (Gender ID) result from roles imposed by family and friends upon children, such as the masculine and the feminine stereotypes. There is no evidence to support that homosexual children were raised differently than the heterosexual children.

Freud's psychosexual developmental model has theorized on sexual orientation. According to him, during the critical period, sexual orientation is fixed by a complex process of family relations which he referred as the oedipal crisis. The crisis is that the young boy begins to attach to his mother and later come to acknowledge where father is the priority to mother. The similar process is also

occurring in young girl that they begin to attach to his father and later come to know that mother is priority to father. Freud posed four different theories of the etiology of homosexuality. In each theory, he addresses different metapsychological issues in relation to homosexuality:

a. Libido and bisexuality (1905)

Homosexuality arises as a result of the Oedipus conflict and the boy's discovery that his mother is 'castrated'. This produces intense castration anxiety causing the boy to turn from his castrated mother to a 'woman with a penis'.

b. Narcissism (1910, 1914)

In the Three Essays, Freud (1905) theorized that the future homosexual child is so over-attracted to his mother that he identifies with her and narcissistically seeks love objects like himself so he can love them like his mother loved him.

c. Projective mechanisms (1911, 1922)

If a 'negative' or 'inverted' Oedipus complex occurs a boy seeks his father's love and masculine identification by taking on a feminine identification and reverting to anal eroticism.

d. Unsatisfactory Oedipal resolutions (1920, 1922).

Finally, homosexuality could result from reaction formation: sadistic jealousy of brothers and father is safely converted into love of other men.

From his four theories, it can be said that Freud believed the expression of homoeroticism but argued that psychoanalysis alone could not solve the problem of homosexuality.

b) Psychosocial Theory

Erikson Psychosocial Theory has put an argument against the Freud psychosexual development that homosexual people may deal with variety of mental health issues and have difficulty with the development of a stable identity. We can analyse the suitability of Erikson's theory to the life of homosexual people. Erikson believed that social environment has more influenced on individual than biological and physical aspects. His theory proposed a series of eight stages throughout the person's life span that includes Basic trust vs. mistrust, Autonomy vs. shame & doubt, Initiative vs. guilt, Industry vs. inferiority, and Identity vs. role confusion, Intimacy vs. isolation, Generativity vs. stagnation and Integrity vs. despair. Among the eight stages of Erikson Psychosocial Theory, homosexuality developed at the stage of adolescent and adults. Lytle et al. (1997) explained that in five stages, an adolescent faced identity versus role confusion. For some people these stages are easily come across but for others they stuck on particular stages which give a negative impact on their identity which further impact on their psychological development. From different studies and theories, an individual recognized of sexual orientation during teen age.

c) Planophysical Theories

D. Halperin's planophysical theories are those which cast homosexuality as an error of nature, a freak – produced, no doubt, by nature, but not in accordance with her grand plan. Halperin was a Freudian psychologist, and places stock in Freud's idea that homosexuality is derived from an unresolved Oedipus Complex. He postulates that a weak father and strong mother with an unresolved Oedipus

Complex will lead to a weak, and then homosexual son because the mother has too strong image in compared to weak state of the father. Psychologists argue that this same arrangement would also possibly lead to a stronger son striving for compensation of his father's weakness.

D. Halperin and J. Foucault have largely contrasting ideas on the environmental contributions to the formation of an individual's homosexuality. The theorists believe that the homosexual has an aberration, and then become a species, justifying itself with a new word. J. Foucault, another social theorist, argued, 'homosexuality became because we made it so'. Foucault believed that the depth of desire is only sexual preference, that it is nothing more than superficial tastes and preferences. Halperin contrasts this by saying that homosexuality does go deeper than superficial tastes, and that homosexuality is a psychological condition with much deeper roots than mere sexual preference.

d) Parental Relationship Theory

In 1962, Irving Bieber studied 106 male homosexual patients who were being treated by him or other psychiatrists and found that early cross-gender behavior including patterns that are thought as feminine was the most common element in their background. He thus realized that the phenomenon that became homosexuality among adults actually started very early, long before the hormonal surge at puberty. However, Bieber was also the source of another idea that seems to be an oversimplification or an error in interpretation: he attributed this early behavior to parental patterns that emphasized a strong binding relationship with mothers and weak or absent fathers.

e) Inclusive Fitness

In 1978, Edward O. Wilson hypothesized a possible genetic predisposition for homosexuality in certain humans by using a theory called 'inclusive fitness', that defined as the sum of the individual's reproductive successes plus the reproductive success of others who carry person's genes. He explained that there are homosexual genes that exist not only in the individual who is homosexual but in his relatives. Homosexual persons contributed to the survival of family by not having children so they were available to support and help other family members, by serving in roles such as aunt, uncle, shaman, or medicine man. Thus, genes for homosexual orientation increased in frequency, not because they aided the homosexual person in his or her own survival but because they aided the relatives who shared his gene pool. This broader spread of genes helps in explaining how persons with homosexual genes could be reproduced since they themselves often did not produce offspring.

f) Familial and cultural factors

In 2002, Joseph Nicolosi stated homosexuality is almost certain due to multiple factors and cannot be reduced solely to a faulty father-son relationship. Fathers of homosexual sons are usually also fathers of heterosexual sons so the personality of the father is clearly not the sole cause of homosexuality. Other factors he has seen in the development of homosexuality include a hostile, feared older brother; a mother who is a very warm and attractive personality and proves more appealing to the boy than an emotionally removed father; a mother who is actively disdainful of masculinity; childhood seduction by another male; peer labeling of the

boy due to poor athletic ability or timidity; in recent years, cultural factors encouraging a confused and uncertain youngster into an embracing gay community; and in the boy himself, a particularly sensitive relatively fragile, often passive disposition.

g) Biological Theories

A number of theories can be found regarding the root of homosexuality, as far back historically as Ancient time. Biological theorists have found substantial instances of anatomical, genetic, and endocrine evidence to support their argument. The current debate is whether or not homosexuality is a result of nature: a person's environment and surroundings, or of his biology and genetics. Alfred Kinsey, pioneer of human sexuality look from two dimensions in his study: 1) to find out how many adult males engaged in homosexual behaviour, and 2) to suggest theories about it came to be (Thompson and Devine, 2003). The study found that large percent of the sample said "no" to the question of engaging homosexual sexual orientation and for the question did they engage in same sex sexual relation, nearly half of the sample answered "yes". The study found that 30% of the sample had experienced at least orgasm in a homosexual act and the finding was widely popularized as Kinsey Scale of sexuality.

Hooker's (1957) study was innovative in several important respects. Karen Hooker executed the first psychological test to test for biological determinism in 1957, on a grant from the National Institute of Mental Health. The study was meant to explore the relationship between homosexuality and psychological development and illness. Hooker studied both homosexuals and heterosexuals. Both groups were

matched for age, intelligence quotient (IQ) and education level, and were then subjected to three psychological tests. First, rather than simply accepting the predominant view of homosexuality as pathology, she posed the question whether homosexuals and heterosexuals differed in their psychological adjustment. Second, rather than studying psychiatric patients, she recruited a sample of homosexual men who were functioning normally in society. Third, she employed a procedure that asked experts to rate the adjustment of men without prior knowledge of their sexual orientation. This method addressed an important source of bias that had vitiated so many previous studies of homosexuality.

J. Michael Bailey and Richard Pillard also studied the gayness between Monozygotic (or identical) twins, Dizygotic (or Fraternal) twins, and non-related adopted brothers. They examined how many of the sample population were gay and how many were straight. They found that 52% of monozygotic twins were both self-identified homosexuals, 22% of dizygotic twins were so, and only 5% of non-related adopted brothers were so. This evidence, repeated and found to be true in second time, showed to the biological camp that the more closely genetically linked a pair is, the more likely they both are to exhibit gay or straight tendencies.

Perhaps the theorists of both the aspects i.e. biological and genetic and environment and surrounding were unable to give concrete answer that sexual orientation, whether homosexual or heterosexual; gay, straight, lesbian, or bisexual, all are causes of complex interactions between environmental, cognitive, and anatomical factors that shape the individual's sexual orientation.

1.2.3 History of Homosexuality in India

From a historical perspective, there is evidence to suggest that existence of homosexuality and homoerotic expressions along with predominant heterosexuality in India (ABVA, 1991). Lillian Faderman and David Halperin argued that homosexuality and heterosexuality issues have been evolved in India during late 19th century. Homosexual existed even in ancient India but never attained social approval in any section of the Indian population. Heterosexual acts are the only socially acceptable sexual expression in Indian society. Pattanaik (2001) expressed that a review of temple imagery, sacred narratives and religious scriptures does suggest that homosexual activities in some form existed in ancient India. Early Buddhist and Hindu periods covered in ancient texts such as Manusmriti, Arthashastra, and Kamasutra refer to same sex attraction and behaviour. The Buddhist tradition, as indicated in the pillar caves of Karle (50-75 CE), shows two bare-breasted women embracing each other. In Hindu scripture, for example, Bhagiratha is born from the union of two women. Shikhandi changes gender and Arthnarishwar (half-man, half-women) are described. Ayyappa (dual gendered god) is worshiped and honoured by hijras. Several sculptures and carving in Khajuraho depict same sex behaviour, including mutual fellatio and orgiastic scenes (Kalra et al, 2010). The God Ayyappa was born of intercourse between Shiva and Vishnu when the latter temporary assumed the form of a beautiful seductive women-Mohini (Conner et al., 1997). A number of 14th century texts in sanskrit and Bengali (including Krittivasa Ramayana) narrate how king Bhagiratha was born of the union between two women blessed by Lord Shiva (Vanita et al., 2002).

Although same-sex love desire and behaviour existed in India since pre-historic periods (Thadani, 1996; Vanita and Kidwai, 2000), mainstream society looks down upon homosexuals as 'socially inferior', 'abnormal', 'sick', 'criminal', etc (Thadani, 1996). Hijra in India have a degree of importance. They would come and dance in Hindu households at the times of marriage and when a male child is born. They often refer to themselves as those having no (sexual) desire for women (Rowland et al., 2008). They are differentiated clearly from effeminate or gay men in India (Cohen et al. 1995). Reddy (2005) noted that, by virtue of their importance, the hijras are man-minus-man, but also man-plus-women. They wore female attire, use make up, have feminine names and behave in a feminine manner-some more than the others. They may be born as hermaphrodites or castrated (Rowland, 2008).

In Persian and Sufi traditions, love of a man for another man is described, although it can be argued that it is mortal man loving god. Muslim presence in India raised the notion of poetry in the form of love songs-ghazals and the concept of one male's love for another. Gupta (2008) argued that in Baburnam, the Mughal Emperor Babur is quite clear about indifferent love for his wife and his preference for a young man. It is quite possible that such attachments were those of a mentor and guide in an emotional sense rather than a sexual one. Many paintings and works of fiction dating from several centuries depict same sex love and loss. For example, in Siraj Aurangabadi' poem Bustani-i-Khayal the narrator, heart-broken over the loss of his (male) beloved, seek solace in the company of courtesans who cheer him up (Sarvari et al., 1998).

1.2.4 Different forms of homosexuality in India

Troiden (1993) expressed that the existing socio-cultural environment defines sexuality. The meaning has been changing from time to time and culture to culture. Simply we can say that it is the perception of self as homosexual, heterosexual, bisexual, etc. Thus there are different forms of homosexuality in society which are based on their sexual performances.

a) Dhurani/Koti and Pareek

Koti/Dhurani is referred as effeminate man and take the role of passive partner i.e. receive penetration. Dhurani are those people who are in the receptive role in anal intercourse. Though some Koti penetrate, however, their sexual role is passive. They express their femininity among Koti or with partner privately and to those who are come-out in the society. They call their partners or any masculine men, Ghadiya. They always refer their partners as Ghadiya. All the koti has desired to perform feminine roles such as cooking, dressing, caring of others, etc. They don't feel uncomfortable of doing all these feminine works. They expressed their feminine traits through behavior and gender roles which they had adopted. Thus there is a difference between their sexual and gender identities and gender expressions. Some of the characteristics of koti/dhurani are:

- They are clean-shaven and mustache is not preferred
- Extreme outward feminine demeanor
- They use cosmetics like rouge, blusher, eyeliner and lipstick used by women
- Eyebrows plucked, hair styled and nails polished

- Wearing of female ornaments like necklaces, earrings, finger –rings and bracelets, with flashy and colourful clothes.
- Body move like swirling of the waist, arms and legs, etc.
- Consumption of hormonal tablets like Ovral and Lindiot to promote breast growth.
- Wearing of saris and blouses stuffed to give the appearance.
- Using common language among them to define themselves in the group

The above characters were expressed to attract the masculine partners. **'Pareek'** is the identity which is given by dhuranis to their masculine partners; they took the role of penetrative during sexual intercourse. They are not described as homosexuals, if so took as offence among them. So, the identity of dhurani and pareek is based on the social and sexual roles of feminine-masculine and active and passive. Purkayatha (1999) expressed that the sexual orientation of Pareek ranged through the continuum of exclusive homosexuality to exclusive heterosexuality. Thus, the sexual identities of Men who have Sex with Men (MSM) fall under various points in the identity continuum.

b) Gay

Gays are often described as educated people, modern, English speaking. Their sexual role is flexible. They often penetrate and as well as be penetrated. They usually call their male partners "Boy friend," or "Gay." They maintain their class and often do not mingle with Koti, Bisexual, and Double-decker.

c) Double Decker

Double Decker is versatile, penetrates as well as penetrated by their partners. They are also considered as Koti. They try to maintain masculine traits though they are of feminine traits.

d) Bisexual identity

Bisexuality is that person who is having erotic, romantic, and sexual attraction to both genders. All men who keep bisexual relationship are not necessarily bisexual men unless they feel equally erotic and romantically attracted to both genders as sexual behavior and sexual orientation are two distinct matters. They may or may not have any attraction to women or any female sexual partners other than the spouse. Many bisexually identified men also resembled themselves with Koti. Marriage and sexual activity with spouse determined themselves as bisexual men. It is confirmed that sexual identities are fluid and are not watertight compartments.

Therefore, the above discussion shows the diversity of homosexual identity framework in India. Different terminologies are referred as homosexuality, thus the term “Men who have Sex with Men” (MSM) is also used as a synonym of homosexuality.

1.2.5 Framework of MSM term

In 1980s, HIV/ AIDS have become a socio-economic and health challenges in India. HIV/AIDS was first discovered in USA among gay population. Earlier AIDS was called GRIDS (Gay Related Immunodeficiency Syndrome) and later change to AIDS. Since AIDS was first identified among gay and they were regarded as ‘risk group’

that lead them stigmatized by social stigma and discrimination. So it becomes a challenge to work with this group of population. Those gay who were AIDS infected became reluctant to come out in society and approached for health services. This makes them more vulnerable to HIV/AIDS and other related diseases. There was a need to combat HIV/AIDS especially in African and Asian countries. The laws of criminalizing sodomy have become obstacles in implementing HIV/AIDS programme for the gay population. In order to adopt programme for HIV/AIDS, in 1992-93, Global Programme on AIDS (GPA) conference in Geneva decided to use the term 'Men who have Sex with Men' as a depoliticized 'gay men'. The new phenomenon of MSM has evolved in sexual identity and some men are identified as 'MSM' and it becomes a distinct identity later.

1.2.6 Concept and definition of MSM

Homosexuality is one of the main categories of sexual orientation, along with bisexuality and heterosexuality. Some synonyms of homosexuality include MSM (from public health perspective) and homoerotic (referring to works of art). MSM are behavioral aspects of those men who have sexual or emotional relationship with another man. MSM refers to men who engage in sexual activity with other men, regardless of how they identify themselves. The category MSM encompasses a range of sexual and gender identities and behaviour among people in various socio-cultural contexts. It includes men who identify as gay or bisexual, as well as some who identify as heterosexual or transgendered (such as the Katoey in Thailand or the Hijras in India). The term MSM often used in medical literature and social research to describe a group for clinical study without considering issues of sexual

self-identity. The term was created in 1990s by epidemiologists in order to study the spread of disease among MSM regardless of identity. The acronym of MSM was coined in 1994 by Glick et al. as a crystallization of a new concept. The concepts of construction of MSM behavioural come from two perspectives. Firstly, MSM was pursued by epidemiologists for seeking behavioural categories that would offer better analytical concepts for the study of disease-risk than identity-based categories (such as “gay”, or “bisexual” or “straight”); because a man who self-identifies as gay or bisexual is not necessarily sexually active with men, and someone who identifies as straight be sexually active with men. Secondly, the term usages of MSM is tied to criticism for using as a particular term by social construct and it is often rejected for using identity-based concepts in many socio-cultural context.

UNAIDS (2006) defined MSM as males who have sex with males where male persons who engage in sexual activity with members of the same sex, regardless of how they identify themselves; many men do not (or cannot for other reasons) sexually identify as gay, homosexual or bisexual. Homosexual is used to describe the behaviours that are taking place as a part of sexual act or series of acts between two individuals of the same gender. It is seen that “MSM”, “gay”, and “homosexual” are interchangeable terms. In India and other countries, MSM has developed as independent social connotations relating purely to homosexual behaviour within varieties of social contexts, and it is equally applicable to married men as well as those who define themselves as gay.

I.3 Context of the Study

I.3.1 Challenges Encountered by MSM due to their Sexual Orientation and Sexual Identity

Homosexuality is considered inappropriate and secrecy in Indian society. Identity is the self-perception and role adopted by an individual in a specific social setting. Negative attitudes of people towards homosexuality create a dilemma to the homosexual oriented men. Sometime they were confused with their own same-sex activities. They blamed themselves for being homosexual orientation. It is expressed through non-acceptance of one's sexuality as secret homosexual activities, risky sexual behavior with multiple sexual relationships, self-destructive behavior, indulging in substance abuse, unstable relationship and internalization of homophobia. Thus, their lives are not free from stress and always bound by problems and issues because of their sexual behaviour and sexual identity. Following are some of the problems and issues faced by homosexual people in their life time:

a) Homophobia, Stigma and Discrimination

Hudson and Ricketts, (1980) said homophobia is the fear, disgust, anger, discomfort, aversion that individuals experience in dealing with gay people. Weinberg (1972) also further explains that homophobia as a 'dread of being in close quarters with homosexuals'. Morin et al. (1978) also express that the term has come to be more broadly defined as any belief system which support negative myths and

stereotypes about homosexuality people. Hereck (1990) refers to it as the irrational fear or hatred towards homosexual or homosexuality.

Homophobia can be manifested in two levels i.e. societal and personal. There is a differentiation between societal homophobia and internalized homophobia. In society, homophobia can be resulted from myths, ignorance, and misinformation about homosexuality. There is a serious implication of homophobia at personal level. Homosexual people are devalues because of their homosexual behaviors. The result of negative attitudes towards homosexual people leads to develop low self-esteems and create identity crisis. Same-sex fantasies and behavior are considered as 'wrong', 'unnatural' or 'sin' in Indian society. They internalized the stigma and took up coping mechanisms such as self-destructive behavior like substance abuse, leaving their studies and job. Such situations can create a maladaptive leading to varying degree of stress that can further increase their vulnerability.

Homosexual person are not free from any kinds of social stigma and discrimination. Social discrimination is the unfair or unequal treatment (including acts of verbal or physical violence) that intended to marginalize or subordinate individuals or communities based on their real or perceived affiliation with socially constructed stigmatized attributes. Social discrimination against homosexual people has been well documented in many regions around the world, regardless of the culture, social, political, economic or legal environment in which they live. The range of challenges faced by homosexual people is varying from place to place and person to person. They often hide their feelings, behaviours and relationships due to harassment, ridicule, rejection, and violence. This made them to disconnect from

society. In India, civil, criminal, labour and even section 377 of IPC laws discriminate homosexual people. Cochran et al. (2003) expressed that over the past decade, consensus has grown among researchers that there is elevated rates of suicide attempts and mental disorders among LGB people. They further emphasized that such problems are mainly due to social stigma, prejudice and discrimination associated with minority sexual orientation. Rosario et al. (2002) further mentioned that the term gay-related stress and minority stress have been used to describe a range of stressors resulting from individual and institutional discrimination. Thus, stigma, discrimination, homophobia, racism, and internalized oppression lead to increase risk of HIV infection among MSM. Such factors have enhanced the risk of drug use before or during sexual encounters, unprotected insertive/receptive anal sex, multiple sexual partnership, and inconsistent condom use.

Thus, prejudices and discriminations have social and personal impact. MSM community encountered prejudices and discriminations in their everyday. For example, limitations on job opportunities, parenting, and relationship recognition are often justified by stereotypic assumptions. It may also have negative consequences, especially attempt to conceal or deny their sexual orientation and finally it is affecting on health, mental and psychological well-being.

Following chart is the model that reflects the various factors that affect the psycho-social well-being of MSM:

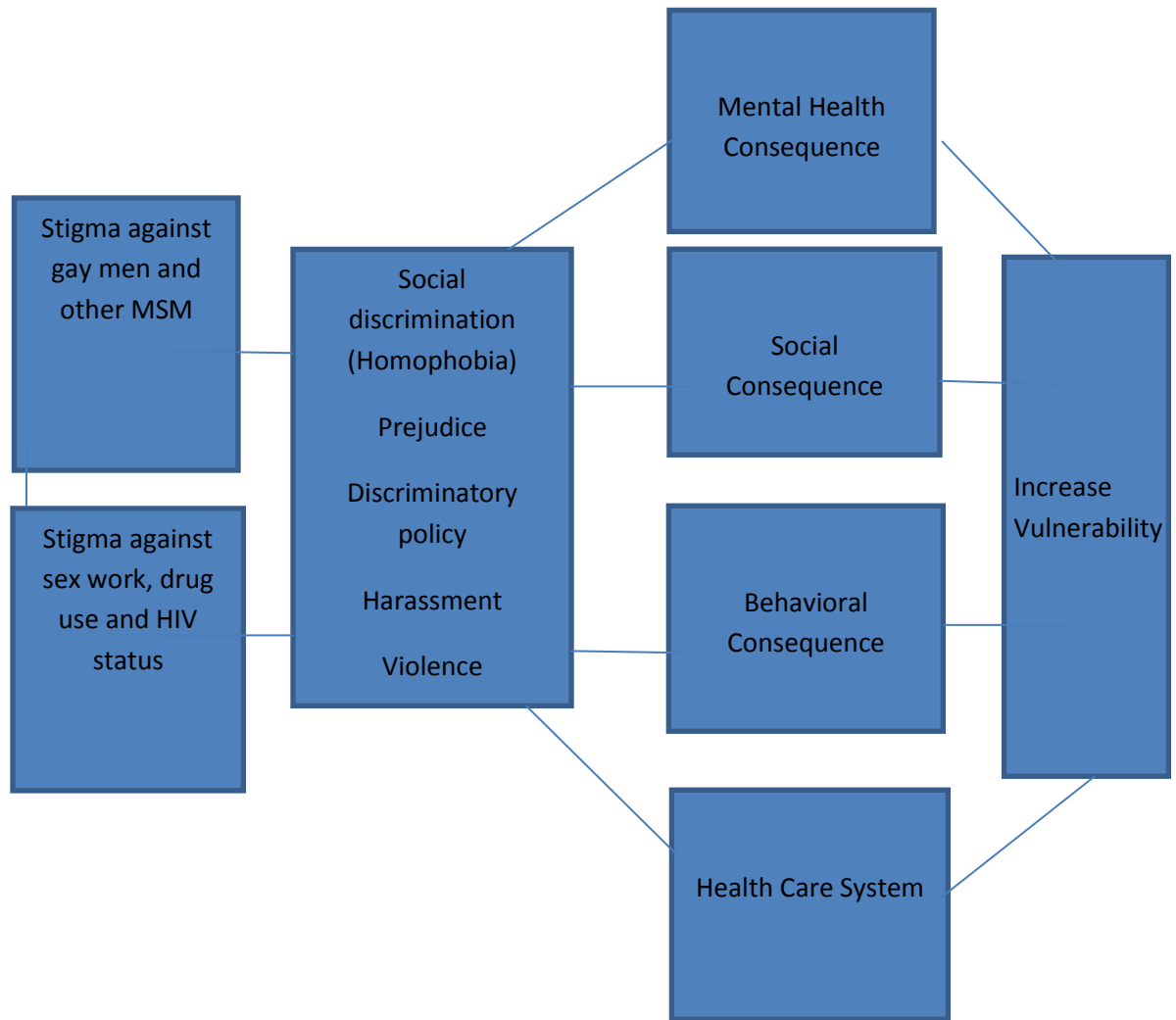


Figure 1.2 Schematic Representation of Linkages of Homophobia, Stigma and Discrimination and Risk group

b) Heterosexism

Heterosexism or prejudice is the discrimination against homosexuals. Herek (1993) expressed that heterosexism is defined as an ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship or community. It is manifested both in societal customs and institutions, such as religion and the legal system (referred to as cultural

heterosexism) and in individual attitudes and behaviors (referred to as psychological heterosexism). Such prejudices can be seen in Indian law books itself. Indian Penal Code Section 377 describes homosexual as unnatural offences. Newman (1976) mentioned that 74% of Indians opined that homosexuality in private between consenting adults should be prohibited by law. From his finding it can be said that there is dominant mindset against sexual minority in society.

c) Heterocentrism

Heterocentrism is the subtle form of bias. Khan (1994) stressed that new discourse of dividing homosexual and heterosexual into sharply antagonistic binaries has evolved. Under this discourse, procreative heterosexuality became the normative process. The dichotomized, hierarchical and opposition structure of what were deemed 'masculine' and 'feminine' helped in framing these new concepts of homosexuality and heterosexuality. The division between sexual behavior responding to procreative instincts and sexual behavior responding to pleasure/lust instincts formed the nucleus of the debate on what was deemed 'normal' or 'abnormal' and 'perverse'.

d) Compulsory Heterosexuality

Compulsory heterosexuality implies individual who pressured and coerced into heterosexual behavior, irrespective of their sexual orientation. Khan (1995) expressed that marriage in India determines a person's eligibility to be considered as an adult. Singlehood, especially in the case of women is not socially acceptable except on religious grounds and marriage becomes a norm for procreation followed by procreative has become the norm. Without marriage the person is considered

'irresponsible', 'incomplete' and 'unsettled'. According to studies of Khan (1994), Seabrook (1999), Parksyastha et al. (1997), Humsafer (2000) and Kavi (1993) married homosexual were 80%, 40%, 34%, 29%, and 23% respectively. Many of homosexual people got married because of family and societal pressure. Keeping family life aside and they continue to have sexual relationship with partners after marriage. They felt afraid of disclosing their sexual behaviour to wife and family members. A study conducted by Seabrook (1999) indicates that only one among 28 married subjects had disclosed their sexuality to their wives. So they are living in a contradictory life between real self and false sense of self to wives and family. A situation has arisen that some of them are in dilemma between singlehood or same-sex marriage and 'marriage of convenience'.

1.3.2 MSM and HIV

a) MSM and HIV

➤ Global level

Worldwide, the prevalence of HIV infection between same sexes is 5-10%. In developed countries like USA, Canada, Australia, New Zealand and Western Europe countries, HIV infection are mainly through male-male sex than any other mode of transmissions. A study in USA found that 1 in 5 MSM were infected with HIV while US statistics show that the rate of new HIV infection is 44 times among MSM than that of other men. In Latin America, sex between men is the root causes of HIV transmission. The HIV prevalence in Colombia ranges from 10% to 25%. Eastern Europe and Central Asia official statistics reported that only 1% of HIV infections are transmitted through same sex. However in Georgia, Russia and Odessa and

Ukraine, the HIV prevalence among MSM are 5%, 6%, 6% and 23% respectively. In Asian countries, the HIV prevalence among MSM is 18% in India, 29% in Myanmar and 31% in Thailand.

In African countries, HIV transmission through same sex becomes a significant problem. In this region, there is lack of data and the prevalence rate is 25.3% in some West African countries. In Kenya, HIV prevalence is 43% among MSM. Overall in Africa, the prevalence of HIV positive among MSM is 4 times higher than general population. Thus there is possibility of increasing the rate of HIV prevalence among MSM because they are hidden population and they do not have separate social identity.

➤ National Level

HIV infection among MSM has been increasing in recent years around the world, particularly in Asia (Griensven et al. 2010). The United Nations General Assembly Special Session on HIV/AIDS report estimates that there are about 3.1 million MSM in India. This global trend is being seen in India, with current estimated HIV prevalence among MSM ranging between 7 and 16.5 per cent, (Thomas, 2009). This is in comparison with overall adult HIV prevalence estimated to be 0.31 per cent (0.25-0.39%) in 2009 (United Nations, 2010). Most of MSM are married and had female sexual partners as well. They are acting as a bridge population between high risk groups and general female population. In 2007, the HIV prevalence was highest among MSM (7.4%) followed by IDUs (7.2%) and FSWs (5.2%). The HIV transmission among IDUs and FSWs are declined but there has been increasing trend of HIV among MSM in India. In India, the high prevalence states of HIV among

MSM are Delhi, Gujarat and West Bengal. According to the BSS 2009, twenty eight districts have 5 per cent or more of HIV prevalence among MSM. By 2008, the States that have the highest mean of HIV prevalence amongst MSM are Karnataka, Andhra Pradesh, Manipur, Maharashtra, Delhi, Gujarat, Goa, Orissa, Tamil Nadu and West Bengal. There is an increasing trend of HIV infection among MSM in South Indian States and Delhi.

NACO releases HIV figures each year based on data gathered from HIV Sentinel Surveillance sites. In 2010, surveillance was conducted at 1,359 sites and 358,797 samples were tested for HIV among the high-risk groups.

Table 1.1: NACO HIV Sentinel Surveillance Report 2010-2011

State/Union Territory	IDU prevalence 2010-2011 (%)	MSM prevalence 2010-11 (%)	Female sex worker HIV prevalence 2010-11 (%)
A &N Island	-	-	-
Andhra Pradesh	3.05	10.14	6.86
Arunachal Pradesh	0.24	-	0.28
Assam	1.46	1.40	0.46
Bihar	4.54	4.20	2.30
Chandigarh	7.20	0.40	0.00
Chhattisgarh	0.42	14.98	2.73
D&N Haveli	-	-	-
Daman & Diu	-	-	-
Delhi	18.27	5.34	0.70
Goa	-	4.53	2.70
Gujarat	1.60	3.00	1.62
Haryana	0.80	3.05	0.48
Himachal Pradesh	4.89	1.23	0.53

Jammu & Kashmir	0.00	-	0.00
Jharkhand	2.02	0.40	0.82
Karnataka	0.00	5.36	5.10
Kerala	4.95	0.36	0.73
Lakshadweep	-	-	-
Madhya Pradesh	5.13	7.94	0.93
Maharashtra	14.17	9.91	6.89
Manipur	12.89	10.53	2.80
Meghalaya	6.44	-	-
Mizoram	12.01	-	-
Nagaland	2.21	13.58	3.21
Orissa	7.16	3.79	2.07
Pondicherry	-	1.21	1.21
Punjab	21.10	2.18	0.85
Rajasthan	-	-	1.28
Sikkim	0.00	-	0.00
Tamil Nadu	-	2.41	2.69
Tripura	0.45	-	0.21
Utter Pradesh	2.03	1.56	0.62
Uttarkhand	4.33	-	-
West Bengal	2.72	5.09	2.04

Source: NACO HIV Sentinel Surveillance Report 2010-2011

(<http://www.avert.org/india-hiv-aids-statistics.htm>)

Across India HIV prevalence appears to be low among general population, but disproportionately high among high-risk groups, such as IDUs, female sex workers, and MSM. Much higher percentages are found among female sex workers

(2.67%), injecting drug users (7.14%) and MSM (4.43%). The Government of India, National AIDS Control Organization (NACO) 2010, estimates an overall HIV prevalence among MSM is 6.41 per cent, although this may be lower-limit estimation. In the context of this disproportionately high level of HIV risk, it becomes extremely important to understand the factors which may exacerbate of sexual risk among MSM.

➤ In Manipur Context

In Manipur, first HIV positive was found among the blood sample of IDUs in February, 1990. According to Manipur State AIDS Control Society (2008), there were more than 29,000 HIV positive cases in Manipur. It was pointed out that the mode of transmission is through mainly sharing of needles among intravenous drug users. The data further highlighted that the rate of HIV positive among the IDUs is decreasing till 2004 however the rate of HIV in Manipur is still very high in compared to world data. MSM has identified as one of the high risk groups of HIV in Manipur. According to NACO Sentinel Surveillance Report 2010-2011, the rate of HIV prevalence among MSM is 10.5%, stood third position next to Nagaland. A study conducted by SASO (1999 & 2001) found that MSM performed their sexual activities at hotels, vendors, rest house, partners' houses, bazar gallies, parks, galleries, Shumang Lila offices, etc. Most of the MSM are married and did not disclose of their sexual relationships with partners. Without the knowledge of health status, MSM engaged anal and oral sex with partners. The study further indicated that out of 205 MSM clients, 87 of them had anal sex, 48 had oral and 20 are engaged in both activities. MSACS (Annual Report 2006-2007) reported that there are 4843 MSM in

Manipur. The data of HIV prevalence among MSM in Manipur is quite high in compared to other states of India. There are certain factors which made MSM a vulnerable group of HIV/AIDS. Behavioral factors such as multiple sex partners, inconsistent condom use, lack of knowledge about risk of HIV infection, and negative attitudes towards safer sex, etc. enhance the rate of vulnerability of MSM to HIV. The prevalence of alcohol and drug use is high among MSM which in turn increase the risk. In another way, biological factors such as anal intercourse make them increase in individual risks. The chances of getting HIV are high for the receptive partners and a significant risk for the insertive partners. If a man has sexually transmitted infection (STI), this can be an extra biological factor that increases the risk of HIV infection. The socio-cultural factors are also playing vital roles in increasing the rate of HIV infection among MSM in Manipur. Societies and governments are in denial about the fact that sex between men and men happen. As a result, HIV prevention campaigns often talk about the risks of heterosexual sex, and there is little appropriate information available for MSM, which can give them false impression that they are not at risk. For this reason, MSM are excluded from sexual health services and may find it hard to access condoms and lubricants to protect themselves from HIV. Moreover, they hesitate to come out openly and access health services. This double stigma makes them marginalized and left without preventive and treatment measures. Though they are in high risk to HIV/AIDS, there has been little attention for their livelihood by government, non-government organization and civil societies. Thus, there is in need of support from GO, NGOs and public at

large for improving and preventing MSM from HIV/AIDS and other social stigma and discrimination.

1.3.3 MSM and Human rights

Everyone have rights to enjoy human rights as described in Universal Declaration of Human Rights. Yet millions of people across the globe face execution, imprisonment, torture, violence and discrimination because of their sexual orientation or gender identity. When someone is diverted from societal notion they are often seen as a legitimate target for discrimination or abuse, the infliction of torture and cruel, inhuman and degrading treatment; arbitrary detention on grounds of identity or beliefs; the restriction of freedom of association and basic rights. Muslim and Christian communities supported the repressive legal environment against the MSM and they have objection of having sex among same sex and belief that heterosexual intercourse is natural. There is often conflict between such communities and human rights approach. But in recent years, the attitude towards homosexuality has been changed. However, in history, Christian and Islamic religious bodies have supported criminalization of homosexuality. For example, Sharia law impose penalty for homosexual conduct. Hindu scripture are silent on homosexual. They are generally tolerant and recognize the third gender. Buddhism also does not considered homosexuality as sin and no legal status against them.

According to Federal Hate Crimes Statistics Act of 1990, during 2003, 7,489 hate crime incidents were reported to FBI by law enforcement agencies. Of those, 1,239 were reportedly motivated by sexual orientation biasness, representing

approximately 16.5 percent of hate crimes. A report by Human Rights Campaign, entitled 'A Chronology of Hate Crimes: 1998-2002', lists 651 violent incidents motivated by sexual orientation or gender identity biasness that resulted either death or bodily injured.

The Yogyakarta Principle unequivocally demonstrate that the application of rights is universal and that MSM living with HIV should also enjoy the universal human rights; the rights to equality and discrimination; the right to recognition before the law; the right to life; the right to security of the person; the right to privacy; the right to freedom from arbitrary deprivation of liberty and 22 further named rights, including the right to health (Yogyakarta principle). However, the HIV+ MSM are not able to access their full rights, due to repressive laws or discrimination practices. With the exception of very few countries, however, the experience of MSM that include discrimination, imprisonment and even death in some countries (Wikipedia, 2009). HIV-positive MSM experienced double stigma and discrimination due to their sexuality and their HIV status.

Sexual acts with the same sex have long been an issue of legal debate in India. The act of homosexuality was mentioned as an "unnatural offence" under Section 377 of Indian Penal Code, enacted originally in India by the British colonial rulers in 1860. It included a judicial provision that criminalized anal intercourse, and therefore would also criminalize male homosexuality. This section from Indian Penal Code has been debated over years by different social activists and organizations as it was considered a violation of the fundamental rights under Indian Constitution. In 1992, a report was submitted with a petition to Petitions

Committee of Parliament for the repeal of Section 377. No positive feedback was received from concerned committee. The most remarkable events in the history of homosexual struggle of rights in India were the demonstration in New Delhi by social activist and homosexual in 1992. 18 people were arrested and suspected of being homosexual. In 2001, a non-governmental organization named Naz-India Foundation, which had been working in the field of HIV/AIDS intervention and prevention, filed a case with Delhi High Court challenging the validity of this Section 377 from constitutional viewpoints. In the same year, four workers of Naz-India Foundation were arrested and charged for conspiracy for committing sodomy. In 2009, the Delhi High Court repealed Section 377 of Indian Penal Code and declared it as a violation to human rights granted by the Indian Constitution.

Likewise, MSM of Manipur experienced lack of legal recognition which affects their life. Maximum of MSM in Manipur are facing problems of livelihood due to legal and social unacceptance of their sexual behaviour. Therefore, the law makers need to change their perceptions and acknowledge the problems and issues of MSM. They need special care and open space to exercise their full rights as citizens, including the right to life, the right to have families and the right to health.

1.3.4 Available services of MSM

According to Independent Impact Assessment Study, the National AIDS Control Programme (NACP) is steadily halting the HIV epidemic in India over the period 2007-2012. NACP provide HIV preventive intervention programme for MSM under TI programme. Some of the key elements of NACP TI programme are Behaviour Change Communication Strategies and Material Development, Condom

Promotion, STI/HIV/AIDS Counseling, Testing, and Treatment and Psycho-social counseling. The services under Behaviour Change Communication Strategies and Material Development are awareness generation, building motivation for behavioural change, providing accessibility to the means for change and finally ensuring sustainability.

In the study area of Manipur, both GOs and NGOs are working for MSM community. Some of the NGOs working for MSM community are: All Manipur Nupi Shabi Association, Imphal; Awaken Artisan Shelter Association (AASHA); Maruploi Foundation and SAVE. These three organizations are implementing project under Project Pehchan funded by Global Fund through Indian Alliance HIV/AIDS and SAATHI Kolkata. Manipur AIDS Control Society is also implementing MSM Project through Social Awareness Service Organization (SASO). Despite of having NACP programme and services for MSM, the rate of HIV prevalence among MSM and general population is still high in Manipur. The current HIV prevention and intervention programmes under NACP for MSM are limited to HIV/AIDS programs only and it hardly focused on other aspects of their life such as livelihood, income generation, mental health, legal, etc. Therefore, MSM tend to avoid the available services of HIV/AIDS due to the association of stigma and discrimination. They in fact, are a section of people who are in need of empowerment and support besides control and prevention of HIV/AIDS.

From the above context, it is seen that the determinant of MSM to be vulnerable is rooted in complex social, political and legal issues. Due to social stigma and discrimination, they are not openly coming out in society and made more

vulnerable in every aspects of their life. Many of them live behind the curtain and accept their faith of being diverted from normal and live with a conflict between private and public identities. They are often discriminated by their own families, health care providers, community workers and law enforcement. Families also subject to harassment both verbally and physically, reject and neglect them. Apart from family, police, local goonda and pressured group are also not leaving them. In this condition, they often feel isolation and disconnectedness from family and live with distress. Homophobia, prejudice and stigma reduce their self-esteem and made themselves rejected, depressed, anxious, self-destruction, feeling of worthlessness, etc. It has a great linked to increase risk behaviors such as unprotected anal intercourse, drug and alcohol use, inconsistent condom use, and multiple sexual partnerships. Thus, there is a need for the researcher to study the psycho-social problems encountered by MSM community in the study area of Manipur. In Manipur, society is yet to come to know the vulnerable groups MSM. There is also a need for in-depth study on the factors that affects the psycho-social problems that include sexual orientation, sexual identity, socio-cultural factors, risk behaviours, coping mechanisms and also the available services that are implemented by GO and NGOs for the development of MSM community.

1.4 Statement of the Problem

MSM are regarded as problematic because of their sexual orientation and sexual identity. Since 1990, MSM has been used in the literature of HIV. The acronym MSM coined in 1994 was a crystallization of a new concept. Since 1990s, Indian society has changed a lot because of liberalization and globalization of

economy. Individual has become free to express their freedoms, rights and self-determination due to the spread of light of education. Unfortunately, MSM populations haven't received positive attitudes from family and society at large. They are facing psycho-social problems in everyday life. Sexual identity crisis is the main problem they have encountered during their life time. The consequence of such situation is forcing them to become impairments in judgment, stability, reliability, or general social and vocational capabilities. So there is a lack of social acceptance of diversity in gender identities which in turn affects an individual self-worth and functioning. It makes them reduce their mental capability and put them in the mouth of stress, depression, anxiety, worried, suicidal tendency, etc. In Manipur, MSM are not free from such tensions and stress. Some of them are coming out and mingling with others and try to live in normal life but people's acceptance towards them is very low due to social unacceptance of same sex behaviour. Moreover, sometime man folk take advantages and trap them through their artificial love as MSM easily trust them as they seek for love, care, support and acceptance. Due to their womanly physical appearance, male are attracted towards them but the intentions are only for sex. Some of MSM are living with partners only for money and for a means of livelihood. The consequence of such behaviour is to engage in risk behavior. Due to such activities many of them got health problems such as HIV/AIDS, STD, and STI, mental and psychological problems. The double stigma of HIV/AIDS and homosexuality identity made them struggle to live fully in the society. The social ostracism such as stigma, discrimination, prejudice and homophobia makes them suppress their feelings and desires which trigger them in developing

low self-esteem, feeling of worthlessness, feeling of guilty, isolation, feeling of rejection and neglected, etc. There is less recognition of their uniqueness of being human and unable to enjoy their rights in society. They experienced of less opportunity to show their talents and personality. Thus, it is therefore, necessary for the researcher to study the psycho-social problems of MSM in the context of Manipur.

1.5 Scope of the study

Psycho-social problems may be one of the major factors which MSM have experienced in their life span. In-depth understanding of the issues of MSM will help in providing the feasibility, acceptability and reducing the practical constraints and related issues of MSM. The cornerstone of preventive health promotion for changing sexual risk behaviours are the development, careful evaluation and rapid dissemination of intervention strategies. The finding of the study will help to design intervention that will reduce stigma, discrimination and prejudice associated to MSM. It will help in addressing the misconception and myth towards such community and also provide the right approaches of intervention. This increased understanding would enhance the quality of services extended by social workers. Therefore, this study will help to those people who are working with MSM. Addressing the problem of MSM will help to revise the programme and policies and could give an idea for developing a practical solution to the problem.

1.6 Delimitations of the study

The study is limited to Imphal East and Imphal West districts of Manipur hence, the findings cannot be generalized to all population of MSM because of different socio-cultural contexts. Therefore, the conclusion drawn cannot be applied to all the MSM.

- **Sample size-** The sample size of the study is small in compared to the actual availability of respondents. The reason for collecting the small sample size is due to the hidden nature of respondents during data collection. So the finding of the study will not be fitting to all MSM.
- **Lack of available and reliable data-** Since the study is on psycho-social problems of MSM, there is limited literature related to the topic. This is one of the hindrances to go for in-depth literature of the study. It can be a significant obstacle in finding a trend and a meaningful relationship.

1.7 Format of the Report

The report of the present study consists of five chapters:

Chapter I: Introduction

The chapter introduces the concept of gender, theories and its various forms. It discusses sexual orientation, sexual identity and the concept of development of MSM.

Chapter II: Review of Literature

The chapter highlights the critical points of current knowledge including substantive finding as well as theoretical and methodological contributions in the form of brief report.

Chapter III: Methodology

The chapter presents the systematic, theoretical analysis of the methods applied for the study.

Chapter IV: Analysis and Interpretation

The chapter is divided into three parts:

Part 1: Psycho-social problems of MSM

- a. Profile of the respondents.
- b. Sexual orientation and sexual identity that affects their psycho-social aspects.
- c. Socio-cultural problems encountered by MSM.
- d. Risk behaviour and coping mechanisms.
- e. Perceptions of MSM beneficiaries towards the working of related GOs and NGOs.

Part 2: Family Perceptions towards MSM, Focus Group Discussion, Case studies and Observation.

Part 3: Roles of government and non-government organization in providing services for MSM community.

Chapter V: Summary and Conclusion

The chapter lays out the summary, finding, conclusions and suggestions of the study and its implication on Social Work practice.

The next chapter will discuss the review of literatures in related areas of studies to understand the different aspects of problems encountered by MSM. In literature of review, we will come to know the different problems encountered by MSM at various levels. This will further help in better understanding of the topic.

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