CHAPTER IV

ANALYSIS AND INTERPRETATION

The present chapter deals with analysis and interpretation of the study. The chapter is divided into three parts according to the objectives of the study. The Part I of the study discussed on the psycho-social problems of Men who have Sex with Men (MSM). This part I is further divided into five sub parts that include profile of the respondents, sexual orientation and sexual identity of MSM that affects their psycho-social aspects, problems encountered by MSM, risk behaviours and coping mechanisms of MSM, and perceptions of MSM beneficiaries towards the available services of GOs and NGOs. Part II highlighted on Focus Group Discussion, Case Studies and response from family members. Part III dealt with the roles of government and non-governmental organization in providing services for MSM. The analysis of the study is done with the help of Statistical Package for Social Science (SPSS). This analysis and interpretation is consisting of figures, graphs and tables.

PART I

IV.1 Profile of the respondents

IV.1.1 Age

In the study of sexuality, age has become a major factor which is indeed a need of concern. Sexual activities are involved in some stages of human development. Sexual drive is active during young adulthood and they express their sexual behavior in various ways.

Table 4.1 (below) showed the age-wise and religion distribution of the respondents. It is seen that majority with 42.7% of respondents belong to the age group of 21-30 followed by 26.7% in 11-20 and only 4.0% are above 50 years. The study found that majority of respondents expressed their MSM behavior during the stage of young adulthood. During this stage, individual become more independent and there is not much restriction by family members.

Table 4.1 Age and Religion of the respondents

Parameter		**Frequency (Percentage)**
Age	11-20	40 (26.7%)
	21-30	64 (42.7%)
	31-40	20 (13.3%)
	41-50	20 (13.3%)
	Above 50	6 (4.0%)
	Total	**150 (100.0)**
Religion	Hindu	87 (58.0)
	Muslim	14 (9.3)
	Christianity	7 (4.7%)
	Meitei	42 (28.0)
	Total	**150 (100.0)**

Such independent and freeness nature may help them in exploring their sexual behaviour by exposing at various situations through friends circle, mass media, support network, etc. which further help them in exploring their sexual

identity. The finding of the study is also concurrence with Sherry (2005), Humsafer (2000) at Mumbai and Jafer (2000) at Lucknow that MSM were more seen in coming out at young adulthood.

It is further seen that majority with 58% of respondents belong to Hindu religion followed by Meitei religion (one of the indigenous religion of Manipur) with 28%, Muslim with 9.3% and Christian with 4.7% respectively. It can be noted from the finding that the present study area is mainly inhabited by Hindu people. Thus, the maximum of respondents are from Hindu religion.

IV.1.2 Education

Education plays an important role in individual's life as high level of education helps people earn respect, recognition and better opportunities in society. A study done by Sherry (2005) found that the educational level among MSM is low. The low levels of educational qualification among MSM make them unemployed due to their poor knowledge and skills.

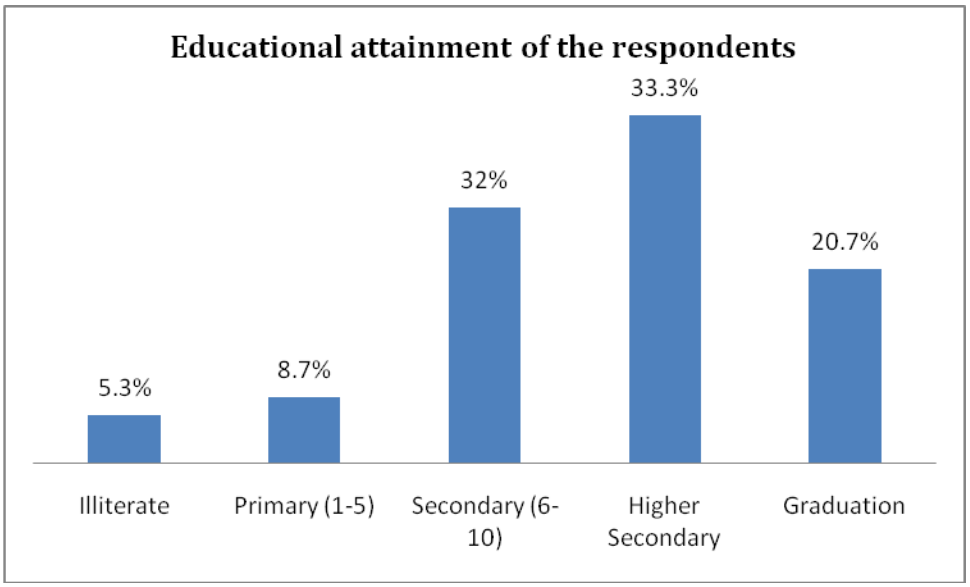


Figure 4.1. Educational attainments of the respondents

The above Figure 4.1 showed that majority with 33.3% of the respondents attained higher secondary followed by 32% at secondary level and 20.7% with graduation and only 5.3% were found to be illiterate.

IV.1.3 Occupation

Occupation is a person's usual or principle work for earning. It is an activity which serves and regulates the source of livelihood. Thus, the economic status of a person can be understood from their income and it can depict the living standard of the person. Skills, experience, competence, diligence, luck, profession, network and contacts are some of the factors which determine the income level of a person. Interestingly, MSM people are visible in certain professions like fashion, interior design, parlour, and make up. NACO (2006) found that the major occupations reported by MSM were service, unemployed/not working/retired, petty business and students. They preferred to occupy more of feminine occupations. Due to the hostile nature of society, many of them keep away from other professions like military and other white collar jobs.

Table 4.2 Occupation and Income level of respondents

Occupation	Income				
	Below 1000	Rs. 1001-5000	Rs. 5001-10000	Above 10001	Total
Any other	11 (7.3%)	9 (6%)	2 (1.3%)	3 (2%)	25 (16.7%)
Daily wages	11 (7.3%)	31 (20.7%)	22 (14.7%)	4 (2.6%)	68 (45.3%)
Self-employed	4 (2.7%)	17 (11.3%)	28 (18.7%)	7 (4.7%)	56 (37.3%)
Government services	-	1 (0.7%)	-	-	1 (0.7%)
Total	26 (17.3%)	58 (38.7%)	52 (34.7%)	14 (9.3%)	150 (100.0)

According to Table 4.2, it was found that 45.3% of respondents fell under the categories of daily wages. Out of these 45.3 %, 20.7% of respondents were having income between Rs.1001 to 5000. The finding revealed that their occupations were limited and unstable. They engaged in seasonal work such as agricultural activities and construction work, etc. When there is off season they spend their time without doing nothing. Their feminine sexual behaviour and identity made them more complicated in getting jobs. The finding indicated that the type of their occupations made more unstable in their income. Further, the Table showed that 40.7% of respondents engaged in self-employed where 18.7% of them were having income between Rs.5001-10000. The types of work which they engaged were mainly fashion designing, parlour, make-up, small shops for clothes, wine/bender, etc. Those MSM who engaged in fashion designing, parlour, make up, etc. were considered good and regarded as more effeminate MSM because of their feminine talents and skills in these professions. However, majority of MSM are not able to extend their business because of financial problems and also due to customers' negative attitudes towards their effeminate personalities. It is also seen that only few with 2% of respondents engaged in government jobs. The data further indicated that very few MSM were engaged in white collar job in Manipur. Lack of proper education, information, financial support and negligence from family members may be the reasons for losing opportunities from white collar jobs among MSM.

IV.1.4 Family type and marital status of respondents

According to Smart and Smart (1980), "Each family is unique in the expectations of the people in various roles, in its patterns of interaction, its history of development, and its relationship with other systems".

Table 4.3 Family type and marital status of respondents

Parameter		**Frequency (Percentage)**
Family type	Nuclear family	92 (61.3%)
	Extended family	25 (16.7)
	Joint family	33 (22%)
Marital status	Married	9 (6%)
	• Living together with wife	5(3.3%)
	• Separated	3(2%)
	• Divorce	1 (0.7%)
	Unmarried	141 (94%)
Age of marriage	18-26	-
	26-34	1(.7%)
	34-42	8 (5.3%)
	42-50	-
	Above 50	-
	No response	141 (94%)
	Total	**150 (100.0)**

The Table 4.3 (above) explained the types of family and marital status of respondents. 61.3% of respondents were from nuclear family followed by joint family with 22%. The finding suggested that the family structure and character of parents may make difference in child socialization. In case of nuclear family, there may be less personal interaction between parents and child. The lack of communications and interactions may impact on sexual orientation and identity which are against the social norms whereas in joint family, they get chances to live with three or more generations which give more opportunities to mingle with family members and relatives that may help them in learning the socially accepted sexual behavior and identity.

Marriage is regarded as a compulsory duty for maintaining family and community ties. It shows an individual a manhood and femalehood. Individual is considered as an adult when he/she gets married. It is considered to be one of the most important social institutions. It also marks the turning point of an individual from an adolescent identity to an adult identity. Remaining unmarried, except on religious grounds is not accepted in Indian society (Sherry, 2005).

Looking at Table 4.3, (above) it is seen that 6% of respondents got married and remaining 94% were unmarried at the time of study. It further revealed that out of (9)6% of married MSM, (5) 3.3% of respondents were living with spouses and (3)2% were separated and (1) 0.7% was divorced at the time of study. Further, the finding revealed that respondents got married at late adulthood (34-42 age group) which indicated that respondents might not considered marriage as important aspects of their life. In many occasions, parents or family members pressurized and

threatened them for getting married. However, they could not able to escape from such situations and thus unwillingly they had to get married. Marriage and procreation, which were traditionally considered 'duties' to be performed by every person are no longer considered appropriate by majority of the present generation especially by MSM (Khan, 1995).

IV.2 Sexual orientation and sexual identity of MSM that affects their psycho-social well-being

Sexual orientation refers to the gender i.e. male or female to which a person has erotic, emotional, affectionate, intimacy and sexual interaction. MSM are having homosexual orientation and their sexual behaviour leading to develop their identity based on it. Cass (1983/1984) defines sexual identity as a cognitive construct that refers to the level of a person see as definitely representing the self in a social setting or situation that may be imagined or real. For developing ones sexual orientation, socialization plays an important role. Usually, children learn or socialize of values, behavior, and belief from family and society. Many researchers believe that acceptance-rejection and control-autonomy are contributing factors that determine families' attitude towards child rearing. The family structure and character of parents may make difference in child socialization. The autonomy nature of parental character gives pressure to children and reduces their competency. This makes children struggle in fulfilling parents' expectations against their wishes and desires. Sometimes when the family does not have a girl child, out of love and affection, they treated the boy child like a girl by addressing girls' name, wearing girl's dresses, etc. Such kinds of socialization may affect the child in

developing his sexual orientation and sexual identity. In later life, this may create confusion and can lead to role conflicts and develop wrong identity. At same time, when there is fatherless at family, the child has a chance to develop homosexual identity due to lack of male role model within the family. Further, the influence from homosexual peer groups can lead to develop homosexual identity. It is also noted that those MSM who had experienced of child abuse may trigger to develop homosexual orientation and identity in later part of their life. The study of Pandya (2006) found that child sexual abuse give significant negative effects such as depression, stress, anxiety and such experiences bring low self-esteem and worthlessness that lead to indulge in intoxicated substances. Such effects may even affect the psycho-social well-being of MSM.

IV.2.1 Sexual orientation and sexual identity domain

a) **Dimension of sexual orientation**

In general, people are categorized as homosexual or heterosexual. There are also group of people who fall under the umbrella of bisexual. Sexual orientation is a complex and consists of various dimensions. Some of the dimensions of sexual orientation are sexual attraction, sexual behaviour, sexual fantasies and self-identification. Sexual attraction takes on different dimensions for different people. It may happen spontaneously in some, while in others it may happen after some period of association between the partners. At times, only one partner may be attracted to the other and the other may not feel the same. Getting sexually attracted is usually considered to be a pre-condition for sexual behaviour, but attraction may or may not lead to sexual behaviour/act (Sherry, 2005).

Table 4.4 Dimensions of sexual orientation

Parameter		Frequency (Percentage)
Whom to have sex	Female	-
	Male	140 (93.3%)
	Both male and female	10 (6.7%)
Whom to feel more emotional	Female	-
	Male	139 (92.7%)
	Both male and female	11 (7.3%)
Whom to feel more comfortable to spend time	Female	-
	Male	125 (83.3%)
	Both male and female	25 (16.7%)
	Total	**150 (100.0)**

The above Table 4.4 emphasised the different dimensions of sexual orientation of respondents. It revealed that 93.3% of respondents were having sexual relationship with only male partners where 6.7% were with both male and female. Further, 92.7% of respondents expressed of having more emotional attachment with male. 83.3% of them felt more comfortable in spending time with male than female. The study found that the respondents had their sexual attraction and fantasies of male than female. Only few respondents with 6.7% were attracted to both male and female. So we can conclude that being a man they do not have interest and attraction to their opposite sex; they prefer to have sexual relationship with man.

b) Types/Forms of homosexuality

There are different forms of homosexuality in India that are based on their sexual performances. Homosexual identities are framed according to roles which they have played during sexual intercourse. A study of SASO (1999, 2001) found that there are three types of homosexuality in Manipur: (1) Male role, aggressive in sexual behaviour, (2) Female role, aggressive in sexual behaviour and (3) passive, not aggressive in sex, not mingling in the group. In Manipur, there are two types of MSM i.e. MSM A and MSM B. MSM A are the partners of MSM B. MSM B played the roles of receptive and MSM A as penetrative during sexual intercourse. It can be noted that MSM A, who have sex with other men but living with heterosexual identity are not regarded as homosexual person. Within MSM B, there is also categorization of identity according to their characteristics, behaviours, attitudes and personalities. Those MSM B who have female mannerism are regarded as Transgender (TG) whether they had sex transplantation or not. Those MSM B who are married or unmarried but having sexual relationship with both spouse (wife)/girl and MSM A is regarded as bisexual.

Table 4.5 Types/Forms of homosexuality

Parameter		**Frequency (Percentage)**
Recognition of sexual orientation	Yes	150 (100.0%)
	No	-
Types/Forms of homosexuality	Transgender (TG)	40 (26.7%)
	Bisexual	8 (5.3%)
	MSM B	102 (68%)
	Total	**150 (100.0)**

Looking at Table 4.5, all respondents were recognized according to their sexual orientation. Majority of respondents with 68% were regarded as MSM B followed by 26.7% as Transgender (TG) and 5.3%, bisexual. The findings revealed that there were different categories of homosexuality in Manipur and were categorized according to their respective roles played during sexual intercourse. Some of them were regarded as MSM B, TG and bisexual. Those MSM B who have feminine mannerism such as having long hair, walking style, acting and clothing like girls were under the category of TG. Those who have short hairs and wear man's cloth but having homosexual nature and orientations are also under the categories of MSM B. Some of them who have maintained sexual relationship with both male and female are considered as bisexual.

c) **<u>Age of awareness of same sex attraction</u>**

The Table 4.6 (below) showed that 68% of respondents were aware of their same sex attractions at the age of 11-20 years i.e., during the adolescence period, followed by 32%, below 10 years of age. The studies of Pandya (2006); D' Augelli and Hershberger (1993) and Rosario et al. (1996); Russell and Joyner, (2001) also found that the modal age of a male's first sexual experience were at the age of adolescence. In this stage, individual tries to explore and test the various forms of sexual behaviours. They have got more information relating to their sexuality from peers, books, and magazines, internets, etc. The finding suggested that the attraction of same sex during childhood may lead to homosexual orientation in later life. An individual starts learning his sexual orientation in young age which can impact on later life.

Table 4.6 Age of awareness of same sex attraction

Parameter		Frequency (Percentage)
Age of awareness of same sex attraction	Below 10	48 (32%)
	11-20	102 (68%)
Experience of first sex as sexual abuse	Yes	107 (71.3%)
	No	43 (28.7%)
Person of sexual abuser	Friend	30 (20%)
	Partner	23 (15.3%)
	Local goonda/local elder/relative	39 (26%)
	Police/Army	15 (10%)
	No response	43 (28.7%)
	Total	**150 (100.0%)**

The above table further highlighted that maximum with 71.3% of them had experienced of first time sex as sexual abused. Out of 71.3%, they revealed that 35.3% of abusers were from their friend circles and partners, and 26% were local goonda/ local elder/ relatives. Pandya (2006) study found that 35% of subjects were physically abused by relatives, 25% by friends 12% reported by police. Majority of respondents experienced of sexually abused which may be due to their effeminate behaviour. The finding noticed that sexual abused is done by near and dear ones whom they were well acquainted with the client.

d) **<u>Age of disclosure of MSM behavior</u>**

'Coming out' stage is one of the crucial stages of homosexuality. In this stage, individual accepted and reconciled to their homosexual identity. 'Coming out' of

MSM from hidden private sexual identity is a big challenge among MSM. From the Table 4.7 (below), 92% of respondents had disclosed their sexual orientation and identity at the age of 11-20 years followed by 1.3% at 31-40 years. The study found that majority of the respondents came out during adolescent periods. Development of sexual identity during this period is a natural process.

Table 4.7 Age of disclosure of MSM behaviour

Parameter		**Frequency (Percentage)**
Age of disclosure	Below 10	-
	11-20	138 (92%)
	21-30	10 (6.7%)
	31-40	2 (1.3%)
Person whom to disclose at home	Mother	61 (40.7%)
	Siblings	7 (4.6%)
	Peer	42 (28%)
	Father	-
	Relative	13 (8.7%)
	MSM Community	27(20%)
	Total	**150 (100.0%)**

During this period, lot of changes happened physically and mentally. This change is culminating in sexual maturity. During this stage they get chances to interact with friends and gather information about sexuality. The information gathered by them has helped them in disclosing their sexual identity and sexual behaviour at public spheres. Those MSM who had come out might have unique consequences in later life in compared to those who had not disclosed of their sexual identity. It is seen that coming out with MSM identity is the hardest stepped

in MSM's journey. Coming out with MSM identity and living with MSM identity in society is associated with good sense of self-appreciation and acceptance, etc. Delaying disclosure or none disclosure of homosexual identity among MSM may lead to frustration, upset, anxious, stress, shame, self-hatred, self-worthlessness, low self-esteem, etc.

It is seen from the Table 4.7 that 40.7% of respondents disclosed of their sexual orientation and identity to their mothers, 28% to peer groups followed by 20% to MSM community, 8.7% to relatives and 4.6% to siblings respectively. The study found that majority of respondents expressed their sexual identity and behaviour to their mothers. Mothers were more closed to their sons due to their nurturing, loving and caring nature. Thus, the finding indicated that they were more closed to their mothers in expressing their behaviour and identities than anyone else. None of the respondents expressed or disclosed to their fathers. This may be due to fathers' unwelcome and withdrawal nature that limited their interactions. The finding is concurrence to the study of Rothman et al. (2012) that GB (Gay, Bisexual) males were most likely expressed with their biological mothers about their sexual orientation as they received adequate social and emotional support about their sexual orientation. It is also noticed that they have trust and confidence to peer group, relatives, own community and partners as well.

IV.2.2 Problems encountered in living with MSM identity

Looking at the Table 4.8, 85.3% of respondents faced problems in living with MSM identity whereas 14.7% of them did not face problems. It is also seen that 42.6% of respondents had experienced of verbal abuse, 36% physical abuse

followed by 6.7% with sexual abuse, 10% with physical and sexual abuse, 10.7% with physical and verbal abuse and 8.7% with physical, verbal and sexual abuse.

Table 4.8 Problems encountered in living with MSM identity

Parameter		Frequency (Percentage)
Problems encountered in living with MSM identity	Yes	128 (85.3%)
	No	22 (14.7%)
Nature of problems	Verbal abuse	48 (32%)
	Physical abuse	26 (17.3%)
	Sexual abuse	10 (6.6%)
	Physical and sexual abuse	15 (10%)
	Physical and verbal	16 (10.7%)
	Physical, verbal, & sexual abuse	13 (8.7%)
	No response	22 (14.7%)
	Total	**150 (100.0%)**

The finding revealed that the problems faced by MSM are because of their sexual orientation and sexual behaviour. It indicates that social stigma and discrimination, advantages of sexual relationship towards homosexuality are often encountered by MSM in day-today life. Their sexual behaviours and feminine characters made them more vulnerable in society.

a) <u>Problems encountered at Individual level</u>

- <u>Gender role with respect to gender identity</u>

Certain roles are provided according to each gender identity. Man has to perform or show the masculine characters whereas female with feminine characters in her

approach. However, for third gender, the roles and responsibilities are not distinct and particularized. They are in hanging position between man and female.

Table 4.9 Gender role with respect to gender identity

Parameter		Frequency (Percentage)
Gender roles with respect to gender identity	Agree	36 (24%)
	Slightly Agree	8 (5.3%)
	Neither agree nor disagree	13 (8.7%)
	Slightly disagree	4 (2.7%)
	Disagree	89 (59.3%)
Gender roles expectation	Yes	117 (78%)
	No	33 (22%)

Looking at Table 4.9, 59.3% of respondents did not agree that there were certain gender roles in accordance with gender identities whereas 24% of them agreed to it but 8.7% were neither agree or disagree with the statement. The findings revealed that majority of respondents were in favour of taking roles of female identity. The respondents expressed that their attentions were to behave like female and to perform women's roles. Some of the respondents expressed that they behaved like girls because they were treated like girls during childhood in their family for not having girl child. It indicated that parents had actively shaped children's gender roles at childhood stage. Parents tend to treat son differently from daughter. Parents always get excited when they have a baby boy in the family. Most parents are extremely interested in learning whether their new born infant is a boy or a girl, and intentionally or not, this knowledge elicits in them a set of expectations consistent with beliefs about gender-role-appropriate traits (Rubin et al. 1974; Wiberg, 1988).

The Table also highlighted that 78% of parents expected their sons to behave and act like man because they believed that their sons will carry forward their names in next generation. However, 22% of parents did not reveal their expectations of their sons' behaviours. It may indicate that parents are not aware of their sons' sexual behaviour and identity as most of MSM have kept hidden of their sexual identity from family members.

- Role conflict

Men have fear of appearing the feminine characters. This fear perpetuates four ideals masculine standard: men should be successful, powerful and competitive; men should be concealed their emotions; men should avoid affections with other men; and men should put school/work before other interests. For many men, this masculine ideal becomes central to their identity and subsequently affects their self-concept and interpersonal relationships (O'Neil, 2008). Most of the MSM are effeminate in nature and desired to perform or take the roles of women. Their effeminate natures influence their masculine personality trait. Some of them are hiding their sexual identities and live with heterosexual identity as they find difficulty in maintaining their sexual identity between private and public life.

Table 4.10 Role conflict

Particular		Frequency (Percentage)
Role conflict	Yes	120 (80%)
	No	30 (20%)
Family allow to perform household work	Yes	35 (23.3%)
	No	115 (76.7%)
	Total	**150 (100%)**

The Table 4.10 showed that 80% of respondents had reported of having gender role conflicts and 20% did not experience of it. The finding revealed that respondents found difficulties in taking up or performing their roles and responsibilities in family as well as in society. During the interview, some of the respondents expressed that they were not able to perform their roles like a straight man. They also expressed that they became weak and unable to work like other straight man and could not compete with them. The finding also indicated that feminine mentality may influence them and made them inferior and weak. Maximum of the respondents with 76.7% expressed that family members did not allow them to do household work at home. Most of the family members made them engage in man's work but they didn't have interest to do it. They preferred doing female work at home like cooking, cleaning utensil, washing clothes, mopping floor, baby-sitting, worshiping or praying. It further revealed that married MSM faced more difficulties in performing their roles and responsibilities in fulfilling family members' expectations. Before marriage they were not much engaged in man's work. The sudden change of roles and responsibilities made them confused and struggled. Even in sexual relationship they revealed that they became weak and could not make their wives satisfied. Very hardly, they had sexual relationship with wives but in the form of punishment. Most of them did not attract towards women. They preferred to have sexual relationship with male partners even after getting married. Some of them expressed that their wives complained of unsatisfaction in their work, responsibilities and even in sexual life. They hesitated to involve in social activities like funeral processes, social work in locality even in attending

festivals or cultural celebrations. The finding of the study suggested that the concept of masculinity in gender role affects effeminate MSM in various forms. The enact of traditionally masculine ideals made MSM fear in expressing their sexual identity and orientation. Because of role conflicts, they become victims of abuse, harassment, hostility by family members and at society. Such negative societal attitudes affect their self-image. Most of them feel insecure, inadequacy and inferiority. Some of the psychological problems which they have encountered are distress, low self-esteem, and internalized homophobia, guilty, loss of interest, irritable, loss of attention, upset, etc. Therefore, role conflict played a significant role in psychological well-being of MSM.

Thoiba (named changed) expressed

> *"I feel uncomfortable to do man's work with other man. I want to do household work such as cleaning utensils, mopping, cooking, etc. But my mom and sister scold me and do not allow me to do so".*

- <u>Experienced of harassment and blackmail</u>

Harassment is an unwanted conduct which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual. It may involve calling nicknames, teasing or other unwanted behavior. It is well documented that harassment based on sexual orientation of MSM is higher than that of heterosexual group. The below Table 4.11 showed that 80% of respondents had experienced of harassment and blackmail whereas 20% did not experience of it. 62% of

respondents expressed of not feeling comfortable in meeting police, local goonda and sometimes insurgency group.

Table 4.11 Harassment and blackmail experienced by respondents

Parameter		Frequency (Percentage)
Harassment and blackmail	Yes	120 (80%)
	No	30 (20%)
Police, local goonda, etc.	Least Comfortable	23 (15.3%)
	Somewhat comfortable	34 (22.7%)
	Complete Uncomfortable	93 (62%)
	Total	**150 (100.0)**

The respondents revealed that there were physically and sexually abused by police and local goonda. Police periodically patrolled the cruising area and chased them away. They even revealed that they were harassed and forced to have sex with them by few policemen and local goonda. They were even threatened if they refused having sex with them. Even MSM peer educators who worked in NGO were intervened and asked unrelated questions for their nature of work (carrying condoms which was supposed to be distributed) by policemen. Such actions of policemen made them insecure in carrying out their duties. Living in such stressful and anxiety might lead to poor mental and psychological problems.

Manglem (name changed) said:

"One day, I was coming back at home with a straight boy at night. We met three policemen who were patrolling and they forcefully took us to a place. By keeping my friend aside, they forced me and had sex one after another. I could not

do anything and they left us by giving some money. That incident was the most painful moment in my life".

b) At Family level

- Threatening by family members

Table 4.12 Threatening by Family members

Threatening by family members	Role conflicts		Total
	Yes	No	
Yes	104 (69.3%)	22 (14.7%)	127 (84%)
No	16 (10.7%)	8 (5.3%)	23 (16%)
Total	120 (80%)	30 (20%)	150 (100.0%)

According to Table 4.12, 84% of respondents had experienced of threatening by family members. Out of 84%, 69.3% experienced of threatening by family members due to their role conflicts. The respondents experienced threatening by family members because of not performing or taking their roles and responsibilities like a man in family. They also experienced of dominance, humiliation, isolation, threat, intimidation, denial and blame, discrimination and partiality in education, property, emotional support, caring, etc. Some of them also experienced of financial abuse such as rigidity in controlling their finances, making accounts of every penny spent by them and prevented them from working or choosing their own career. Such conditions made them isolated and lonely in life which reduced their competency in performing different roles. The finding

suggested that the nature of threatening and violence may elevate risk behaviour like suicidal ideation and suicidal attempt, leaving home, engaging in sex work, depression, drug use, etc. The studies of Pandya (2011); Goffman (1963); Link & Phelan (2001) found that discrimination of MSM in family and society were based on their effeminate behaviors leading to deep seated psychological unrest, creating psychological problems such as low self-esteem, shame, disgust, illness, depression and suicidal ideation.

- Family members' opinion on marriage

In Indian society, a person is considered as complete when he/she gets married and has wife and children. Marriage for a heterosexual person is not much a problem but for homosexual person it is a burden as it is against the social norms.

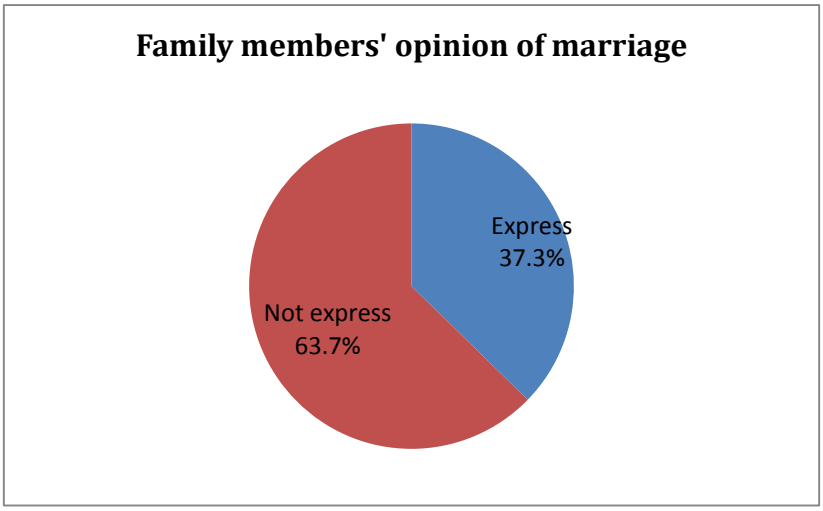


Figure 4.2 Family members' opinion of marriage

From the Figure 4.2, majority with 63.7% of respondents' family members wanted their sons to get married whereas 37.3% did not comment. The study found that maximum family members suggested them to get settle by getting married as

they believed and expected that marriage would bring a change to their sons' behaviours. The study also revealed that parent believes that their son's behaviour and sexual behaviour may bring a change when they become mature and understand of social norms.

c) Society Level

- Neighbour's attitude towards MSM

Ellen et al. (2001) expressed that the impact of neighbourhoods may be manifested through short-term influences on behaviour, attitudes, and access to health care, which affect immediate well-being. Living in impoverished neighbourhoods may bestow additional burdens to MSM. Risk may be exacerbated by the fact that these men must negotiate the reality of their sexual identities within residential neighbourhoods that reject and stigmatize people with non-heterosexual identities (Mays et al., 1998; Crosby & Grofe, 2001; Shafer et al., 2002) found that

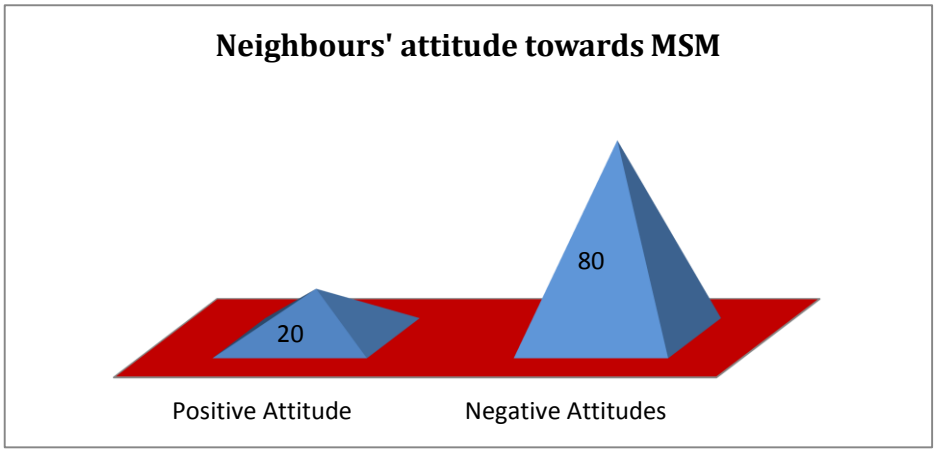


Figure 4.3 Neighbours' attitude towards MSM

the confluence of neighbourhood factors, socio-economic factors and access to services not only exacerbates HIV risk but also comorbid conditions of substance

abuse, including injection drug use. Truong & Ma (2006) also discussed that poor neighbourhood created a mental health burdens which in turn elevate vulnerabilities.

The Figure 4.3 showed that 80% of respondents faced negative attitudes from neighbours whereas 20% of them did not experience of it. The finding revealed that MSM experienced some forms of negative attitudes from neighbours such as teasing, putting down, prejudice, angry, verbal abuse, disconnect communication, etc. Such neighbours' negative attitude made them sad, guilty, upset, feelings of different and shy in front of others. Thus, the unhealthy and unsafe environment may hindrance in socialization.

- Societal Homophobia

Martinez and Sullivan (1993) expressed "Statistics suggests that homophobia remains the nation's most enduring form of prejudice". Cloud (1997) states that homophobia may be a cause of the varied violent reactions that people have when they find out that someone is attracted to those of the same gender. There have been repeated incidents in which someone was harmed because of their sexual orientation in the form of personal rejection, hostility, harassment, homicide, verbal, sexual and physical violence.

Table 4.13 Societal homophobia

Parameter		Frequency (Percentage)
Societal homophobia	Yes	129 (86%)
	No	21 (14%)
Chance to involve in social life	Yes	43 (28.7%)
	No	107 (71.3%)
	Total	**150 (100.0%)**

The Table 4.13 showed that 86% of respondents reported of experiencing societal homophobia. The study revealed that there is prevalence of homophobia in various forms such as homophobic jokes, malicious gossip, and name-calling, intimidating looks, internet bullying rejection and sexual assault, physical attacks leading to discrimination. It is noticed that homophobia is resulted from myths, ignorance and misinformation about homosexuality. These may elevate psychological problems such as feeling of guilty, shame, self-loathing, low self-esteem, self-hatred, feeling worthlessness and feeling of being abnormal.

d) Experienced at work place/school/college

- Unfair treatment in educational places

School is a place where an individual develop socialization and learn social norms, knowledge, skills and culture. Educational institution has to be free from violence, fear and discrimination so that an individual can develop in a healthy environment. Bullying and stigma makes schools and other educational institution unsafe for homosexual people. Universal Declaration of Human Rights (1948) expressed that bullying poses a significant threat to the universal Right to education.

From the Figure 4.4 (below), 74% of respondents had experienced of unfairly treatment at school/college and 26% did not experience of such problems. The finding revealed that some of the common negative attitudes that they experienced at educational places were bullying, teasing, stigma, discrimination and homophobic. It is evident that school/college and any other educational places are not free and safe for MSM people.

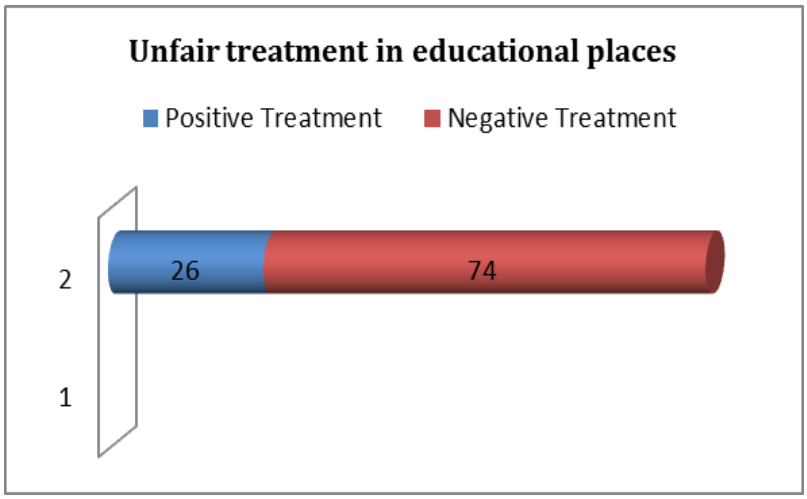


Figure 4.4.Unfair treatment in educational places

The respondents expressed that they had experienced of physical, emotional and sexual assault in school/college by class mates and even by staffs. They experienced of verbal abuse like by addressing them as 'homo', 'nupimanbi' (look alike a girl), 'thekoinakoi', etc. Such bullying from friends, staff hurt them emotionally leading to social exclusion and isolation. They had also experienced of physical abuse like harassment and assault in school/college. Thus, the consequences of unfair treatment in school/college resulted in poor academic performance, absentees and finally became drop out. Finally, those who do not manage to come out from such situations may lead to depression, stress, low self-esteem, etc. and finally can engage in risk behaviours.

- Unfair treatment of MSM at work place

Due to negative feelings or attitudes towards non-heterosexuals behaviour, employer looks down upon homosexual people at work place. Homosexual people have experienced of widespread discrimination at work place. Studies showed that gay people have experienced some forms of discrimination and harassment,

mistreatment at work place. These unfavourable attitudes at work place made homosexual people insecure. They have experienced of being judged by employers on their sexual orientation and gender identity but not on their job related performances. A survey by Williams on Sexual Orientation Law and public Policy found that 8% to 17% of gay and transgender workers reported of being passed over for a job or fired because of their sexual orientation or gender identity. 10% to 28% received negative evaluation on their performances or were passed over for a promotion because they were gay or transgender. 41% of gay and transgender worker were verbally or physically abused or had their workplace vandalized.

The below Figure 4.5 showed that 75.3% of respondents experienced of negative treatment at work place whereas 24.7% of them did not face of such experiences. The finding revealed that MSM had encountered stigma and discrimination at work place.

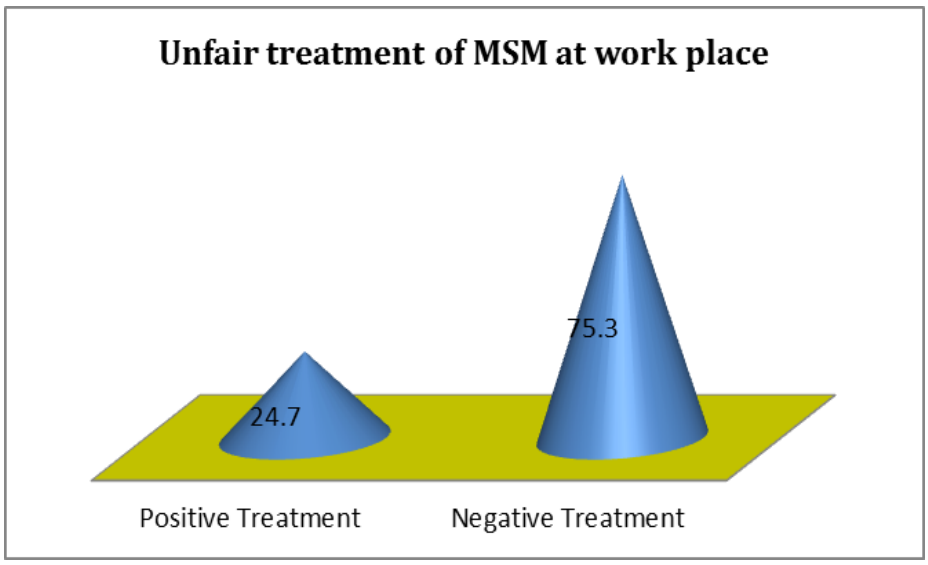


Figure 4.5 Unfair treatment of MSM at work place

The respondents expressed that they felt awkward in searching jobs because of negative attitudes from employer and official persons. The unfamiliar and unfriendly attitudes of employers and other staffs made them uncomfortable and pushed them to leave their jobs. Such conditions made them jobless or forced to engage in lower class jobs. Such conditions reduce their opportunities in getting jobs and made them dependent on family members. It leads to frustration, dissatisfaction, poor mental and physical health. The finding also revealed that some employers treated them positively and kept them in job, only because of sexual preference due to their feminine mannerism that attracted the employer. Thus, MSM live in fragile because they can be fired by employer at any time, so such incidents are kept secret from their other co-workers.

IV.3 Risk behavior and coping mechanism of MSM

The rate of HIV positive is decreasing among IDUs but the epidemic is still increasing in Manipur. According to Sentinel Surveillance Report 2006, Manipur, the rate of HIV prevalence among MSM is 11.6 percent which is against overall India with 7.3 percent. One of the reasons for increasing HIV/AIDS among MSM is due to lack of proper information of their partners that indulged them in unprotected sexual relationships with partners. A study by Social Awareness Service Organization (SASO) (1999) in Manipur found that out of 205 MSM clients, 87 indulged in anal sex, 48 oral and 20 were in both. Further the study revealed that MSM mainly performed their sexual activities at hotels, vendors, rest house, partners' houses, market site, parks, galleries, Shumang Lila offices, etc. The health seeking behaviour among MSM is poor due to their hidden identity. They are not

coming out in society because of fear of stigma, discrimination and prejudices in accessing the available services which have made them more vulnerable leading to increased risk of HIV/AIDS.

4.3.1 Sexual partner domain

a) <u>Sexual partner of the respondents</u>

MSM who engaged in oral and anal sex has his partners in the form of boyfriends, spouses, significant others or life partners whom he feel most committed. In India, pareek is regarded as the partner of kothi (self-identified MSM). Pareek is the name given by kothi and play the role of masculine i.e. to penetrate during sexual intercourse. Pareek are not taken as homosexual and but considered as heterosexual. The partnership pattern among MSM are based on their social (feminine-masculine) and sexual roles (active-passive during their sexual intercourse).

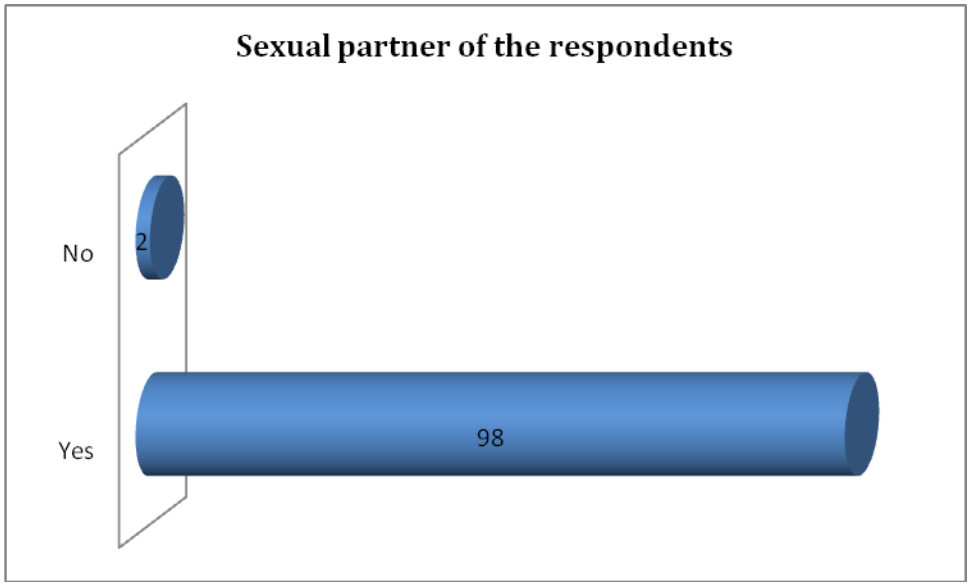


Figure 4.6 Sexual partners of the respondents

The Figure 4.6 showed that 98% of respondents had male sexual partners and 2% did not have at the time of study. The finding revealed that the culture of keeping male partner relationship is prevalent among MSM community. The finding is concurrence with NACO (2006) that the person who engaged in oral or anal sex with another man had had at least one male partner that would last for a month or more. The study also noticed that MSM were having primary partners as well as casual partners. Most of them took money and gift from casual partners but not from primary partners. Some of them regarded primary partners as their husbands or boyfriends. Those MSM who do not have partners were not respected within their MSM community. Some of them reported that they used to keep partners for upliftment of their status among MSM peer group. Younger MSM learnt MSM culture from senior MSM, of where and how to attract/ get partners and maintain relationship with them. It is also seen among MSM that those MSM who are unable to maintain relationship with their partners remained depressed, stress and anxious in life than those who maintained good relationships with partners. The finding indicated that the partner-partner (MSM B – MSM A) relationship played an important role in psychological well-being of MSM.

b) <u>Nature of Relationships among MSM</u>

There are different types of relationship among MSM such as monogamous, bigamous and multiple. Monogamous relationships are those relationships when one MSM maintains relationship with only one partner. But in case of bigamous relationship, MSM has maintained relationship with both female and male partners, and multiple relationships that have more than one MSM partners.

Table 4.14 Partner status

Partner status	Regret after sex		Frequency/Percent
	Yes	No	
Monogamous	24 (16%)	13 (8.7%)	(37) 24.7%
Bigamous	7 (4.6%)	13 (8.7%)	(20) 13.3%
Multiple	63 (42.0%)	30 (20%)	(93) 62.0%
Total	92 (62.6%)	57 (37.4%)	**(150) 100.0%**

The Table 4.14 showed that 62% of respondents were having multiple sexual partners followed by 24.7% with monogamous and 13.3% with bigamous sexual partners during the last three months. The finding is also similar with the study of He Q et.al (2011) that MSM have multiple male sex partners during the previous six months and engaged in unprotected anal intercourse during last sex. The finding noticed that the main reasons for keeping multiple sexual partners were due to unsteady partner-relationship. However in case of monogamous relationship there is more of trust, love, affection and support among partners. The respondents reported that they had experienced of partners problems. Usually, partners left them after getting advantages of them. Thus, they had experienced of regretting in relationships with their partners. Regret is the outcome of disclosing sensitive information. It is a negative, cognitively-based emotion which occurs when realizing or imagining that a present situation would have been better had a different decision been made (Zeelenberg, 1999). It is seen in the Table that 62.6% of respondents show regretting after having sexual act with partners. Out of these

62.6%, 42% were having multiple sexual partners. Moreover, the finding further revealed that they were afraid of getting sexually transmitted diseases such as HIV/AIDS and STI due to their sexual relationship with multiple partners. At the same time, they suspected their partners' health status even when they were in relationship. Sometimes, they engaged in sexual relationship without knowing the health status of their partners that lead to high chances of getting sexually transmitted diseases (STDs) among multiple sexual partners. It is further seen that bigamous relationship is a serious threat as it spreads sexually transmitted disease to general population.

c) **Partner length relationship**

From the Table 4.15, majority with 59.3% of respondents were able to keep relationship for more than a week but less than a month and 15.3% had only less than a week. There is only 7.3 percent who lasted their relationship more than a year which showed their commitment in relationships.

Table 4.15 Partner length relationship

Particular		**Frequency (Percentage)**
Partner length relationship	Less than a week	23(15.3)
	More than a week but less than a month	89 (59.3)
	One to six months	22 (14.7%)
	Seven to 12 months	5 (3.3%)
	More than a year	11 (7.3%)
Partner's faithfulness	Yes	41 (27.3%)
	No	109 (72.7%)
Suspect of partner of having sexual relationship with others	Yes	107 (71.3%)
	No	43 (28.7%)
	Total	**150 (100.0%)**

Thus, the finding highlighted that the nature of partnership pattern among MSM is unstable and unsteady in nature. It is seen that 72.7% of respondents did not feel their partners as faithful whereas 27.3% of them experienced of faithful partners. The finding noticed that maximum of partners have come for only sex which may help in reducing their tiredness, stress, and for time past, etc. The respondents reported that they had experienced of disappointment and painful relationship. Thus, they lost trust to their partners and had mixed-feelings of emotions like anger, hurt, hatred, and revenge. Unfaithful nature of partners made some of MSM suspicious to their present partners. 71.3% of respondents expressed of suspicious to their partners of being maintaining sexual relationship with others. The finding indicated that among MSM who are in relationship, they are not free from tensions. Living in such stressful relationships lead them frustrated, disappointment, painful, guilty, regret, tension, anxiety which may increase in risk behaviours.

d) <u>Receive money/gift for sex</u>

Gift sex is a form of prostitution which involved direct payment for sexual services such as piece of cloth, a present or even a meal or sleeping space. It is prevalent among the effeminate behaviour of MSM and is usually seen in hotels, restaurants and guest houses through room service and housekeeping.

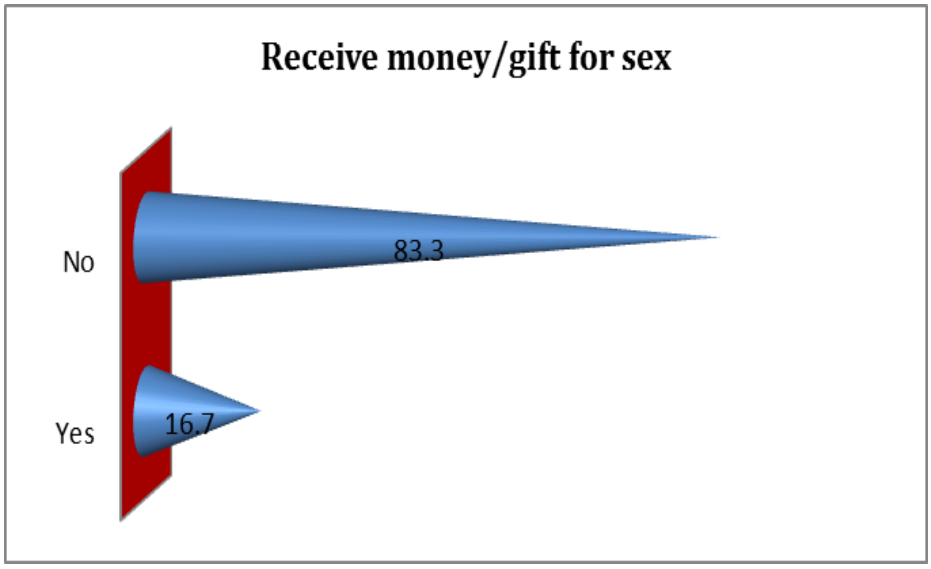


Figure 4.7 Receive money/gift for sex

In the Figure 4.7, 83.3% of respondents did not receive money or gift for sex whereas 16.7% of them received money or gifts from partners. The finding showed that respondents had sexual relationship only for satisfaction, pleasure and enjoyment. Such sexual relationship may lead them to have more partners and engaged in risk behaviours. The finding of the study is contradictory to the finding of Vijay (2013) that MSM in the study reported of exchange of sex for money.

e) <u>Condom use during last three months</u>

Safe sex is sexual activities that are engaged by taking precautions for protecting themselves from sexually transmitted infections. Safer sex reduced the risk of sexually transmitted diseases. Condoms are not 100% safe, but if used properly, it will reduce the risk of sexually transmitted diseases, including AIDS. Condom use during sex is one of the ways of safer sex. Unprotected anal sex between men is a major cause of HIV transmission among MSM. MSM community is

regarded as one of the risk groups of sexually transmitted diseases because of their role as penetrator and receptor during sexual intercourse.

Table 4.16 Condom use during last three months

Partner status	Condom use during last three months							Total
	Above 50	41-50	31-40	21-30	11-20	0-10	Nil	
Monogamous	-	3 (2%)	4 (2.6%)	1 (0.7%)	6 (4%)	11 (7.3%)	12 (8%)	37 (24.7%)
Bigamous	-	3 (2%)	-	3 (2%)	5 (3.3%)	3 (2%)	6 (4%)	20 (13.3%)
Multiple	1 (0.7%)	6 (4%)	7 (4.7%)	12 (8%)	21 (14%)	10 (6.7%)	36 (24%)	93 (62%)
Total	1 (0.7%)	12 (8%)	11 (7.3%)	16 (10.7%)	32 (21.3%)	24 (16%)	54 (36%)	150 (100%)

The below Table 4.16 showed that the use of condom during last three months. Majority with 64% used condoms for at least 0-10 times (16%), 11-20 times (21%), 21-30 times (10.7%), 31-40 times (7.3%) 41-50 times (8%) and above 50 (0.7%). It further seen that out of these 36% who did not use condom, 24% were having multiple sexual partners. Likewise in case of bigamous, only 4 percent did not use condom. Thus, the study found that the rates of condom used among respondents who have multiple sexual partners were very low. The finding revealed that safer sex is inconsistent and not considered as important as they were prevented from using condoms due to refusal by partners, lack of condom availability, unable to access condom, sub-standard and lack of awareness, etc. The finding of the study is

concurrence with studies of Nina (2006) and Vijay (2013) that condoms always or never used when having sex, but many reported of inconsistent used of condoms.

f) Problems in searching places for sexual act

The sexual acts between the same sexes are regarded as abnormal and a sin in Indian society. Society doesn't accept sexual activities between the same sex people. MSM sexual act is hidden in nature. Usually, MSM had sexual relationship with partners at various places, for instances, their partners' rooms, hostels, hotels, restaurants, public places like public toilets, bus stops, alleys, cinema halls, railway/bus stations, construction sites and parlour, etc. Such places are well known as cruising place for MSM.

Table 4.17 Problems in searching places for sexual act

Parameter		**Frequency (Percentage)**
Problems in searching places for sexual act	Yes	21 (14%)
	No	129 (86%)
Place of sexual act	Your house/his house/friend house	31 (20.7%)
	Hotel/bender	59 (39.3%)
	Public place-park, woods, streets, car	42 (28%)
	Other	18 (12%)
	Total	**150 (100.0%)**

The Table 4.17 showed that 86% of respondents did not face problems in searching places for sexual act whereas 14% had experienced of it. The finding revealed that respondents were aware of places where they can get partners. In day

time, they hesitated to come out openly at public place. Most of them performed sexual act at night time. During night time, they come out to meet or search their partners. Thus, the easy availability of place for sexual act may lead them for engaging in risk behaviour. Further, 39.3% of respondents had sexual act at hotels/vendors, 28% of them had sex at public places such as parks, woods, streets or car, 20.7% at their own house or partner's house and 12% at other places such as parlour, programme or function place, shop, school/college, or restaurants, etc. It is interesting to note that respondents had revealed that they preferred having sex at own or partner' house as they did not face much problems from family members because family members were not aware of their homosexual act.

IV.3.2 Intoxicated Substance abuse

a) **Substance abuse**

Certainly, if a category or group is defined only in terms of sexual activity, it is unsurprisingly that STIs feature is large. However, there is some evidence of health risks other than sexual health risks in MSM, which nevertheless derive from HIV studies. These indicated a higher use of alcohol and injecting drugs and other illegal drug use among MSM (Marian et al., 2006). Unique behavioural and psychological factors are also associated with substances abuse among MSM. Some of them use substance/consume as a coping mechanism from stress and other reasons.

Looking at Table 4.18, 84% of respondents used intoxicated substances. Out of these 84%, 57.4% of them belonged to the age group of 11-30 years. There are few respondents in the age group of above 50 years who consumed intoxicated

substance with 3.3%. Thus, the study found that there is prevalence of used of intoxicated substances among adolescent and young adulthood.

Table 4.18 Intoxicated Substance abused by different age group

Age	Intoxicated Substance use		Total
	Yes	No	
11-20	37 (24.7%)	3 (2%)	40 (26.7%)
21-30	49 (32.7%)	15 (10%)	64 (42.7%)
31-40	18 (12%)	2 (1.3)	20 (13.3%)
41-50	17 (11.3%)	3 (2%)	20 (13.3%)
Above 50	5 (3.3%)	1 (0.7%)	6 (4%)
Total	126 (84%)	24 (16%)	150 (100.0%)

The finding of the study noticed that during this stage they may have experienced of partner problems, problems of coming out in family and society, tensions for their career, lack of opportunities and problems of employment. All these conditions may make them stress, depress and low self-esteem. According to Erikson (1975) young adulthood stage is the stage of identity formation. In this stage, individual is ready to intimacy that is, the capacity to commit to concrete affiliations and partnerships. They have the ability to face the fear, and develop self-ego. Those who are unable to meet such experiences may lead to isolation and self-absorption. This may be the reason for taking substances for coping up from partner problems, identity crisis, threatening by family members, and stigma and discrimination in society.

b) Types of intoxicated substance abuse

Despite of having HIV intervention programme and policy, there is no sign of reducing HIV infection among MSM in India. Intoxicated substance abuse may be one of the factors that increase HIV/AIDS among MSM community. Most of MSM used different type of substances such as tobacco, alcohol, drug, etc.

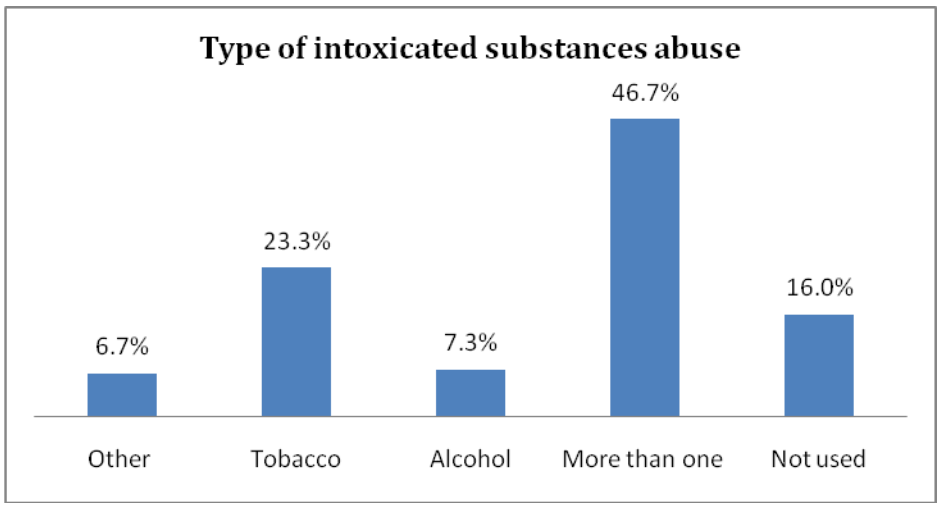


Figure 4.8 Types of intoxicated substances abuse

Looking at the Figure 4.8, majority of respondents with 84% used intoxicated substances that include tobacco, alcohol, beri, ganja, etc. Only 16 percent of respondents did not use any kinds of intoxicated substances. Out of 84%, 46.7% of respondents used more than one substances (tobacco, alcohol, drug etc.) followed by 23.3% with only tobacco and 7.3% with alcohol. Very few respondents with 6.7% consume others that include beri, cigarette, ganja, etc. The finding revealed that used of multiple substances is prevalent among MSM in Manipur. The similar finding is also found in the study of NACO (2006), Thomas B et al. (2009) that MSM consume substances such as alcohol, tobacco and drug.

c) Reasons for intoxicated substance abuse

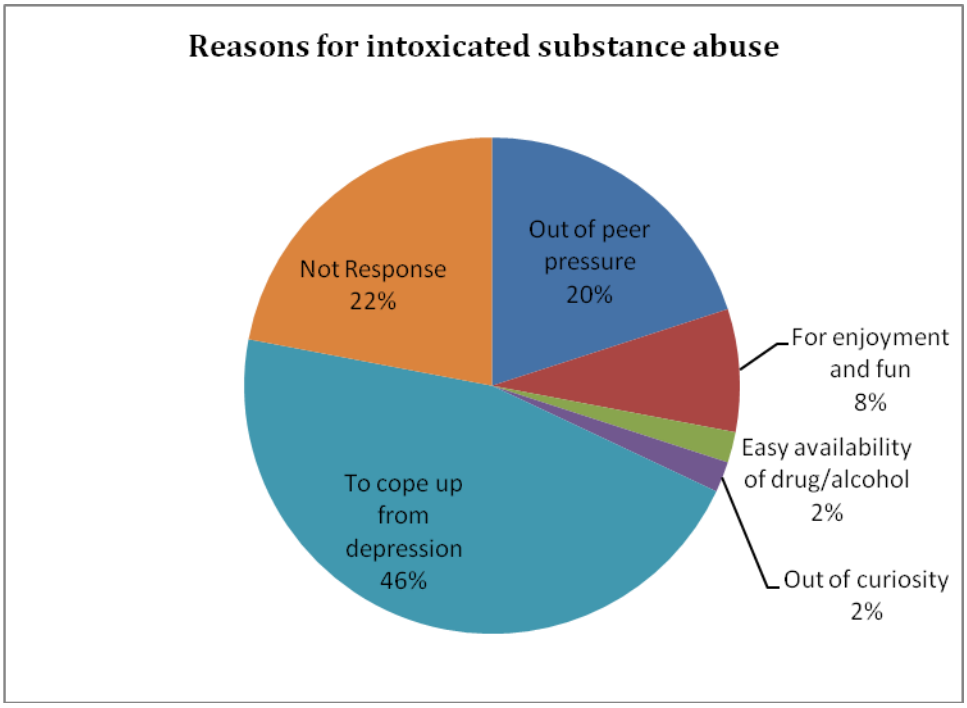


Figure 4.9 Reasons for intoxicated substance abuse

Looking at the Figure 4.9, 46% of respondents used substances to cope up from depression/stress followed by 20% and 8% of the respondents used substances due to peer group pressure and for fun and enjoyment. Thus, the finding indicated that psychological disturbances and pressure from peer group made MSM used of intoxicated substances. They used substance as a means of coping mechanism from stress, depression, painful relations, family threatening, societal stigma and discrimination, homophobia, prejudices, etc.

d) **Habits of drinking or substance abuse before/after sexual act**

MSM communities are regarded as one of the most risk group of HIV/AIDS. Some of the factors which put them at risk are biological and behavioural factors. The behaviour of MSM such as unprotected receptive and penetrative sexual

intercourse and indulging in drugs, alcohol, tobacco, etc. enhances the vulnerability of MSM to HIV infection.

The Figure 4.10 (below) is the data distribution of habits of drinking or substance abuse before/after having sexual act. Looking at the Table, 54% of respondents were having habits of drinking before/after sex with partners while 46% of respondents did not have such habits. It is noted that such situations may increase risk behaviour such as sex without condom, substance abuse, gift sex, etc.

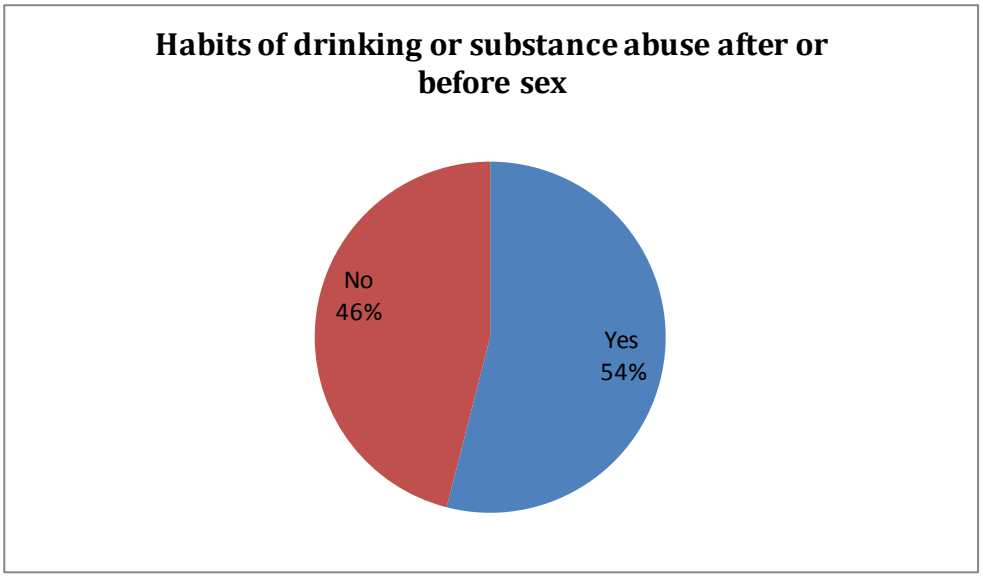


Figure 4.10 Habits of drinking or substance use before or after sex

Further, the finding also indicated that some of them did not have the habits of drinking and substance abuse during or after sex. It is noticed that they had sex only for satisfaction and pleasure with their regular or casual partners.

Sanathoi (name changed) reported:

"Every evening, I go to my friend's hotel to help him and use to wait for sexual partners. I always have alcohol with customers who visit the vendor and have sex with them".

IV.3.3 HIV/AIDS

a) Awareness level of HIV/AIDS

100% of respondents had heard of HIV/AIDS. All the respondents were aware of HIV/AIDS, its causes, transmission, etc. Maximum of respondents got information of HIV/AIDS from newspaper, TV/radio, advertisement, health care providers, partners, friends and public meeting. Manipur is regarded as one of the most HIV/AIDS affected state in India. Government has given more emphasis in controlling the spread of HIV/AIDS in Manipur. The finding indicated that GOs and NGOs who are working for MSM and mass media have taken vital roles in prevention and control of HIV/AIDS by spreading information and knowledge especially among MSM community in Manipur.

b) HIV test during last six months

Unprotected anal sex is the main route of HIV transmission among MSM community. HIV is a serious issue among MSM because of their nature of having multiple partners and used of intoxicated substances. Thus, testing of HIV is one of the ways for prevention of HIV/AIDS among MSM.

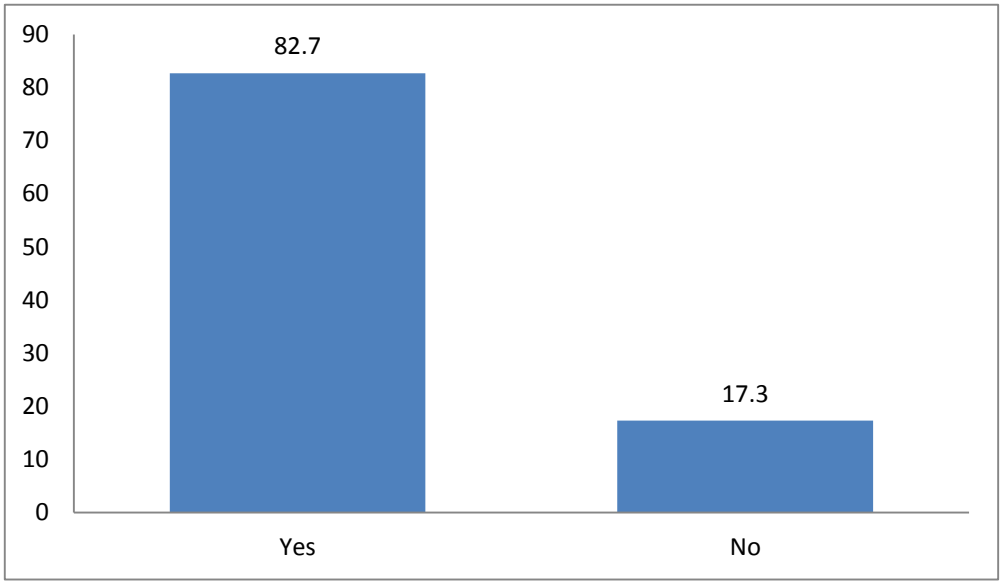


Figure 4.11 HIV test during last six months

Looking at the Figure 4.11, 82.7% of respondents did HIV test during last six months whereby 17.3% of them did not. The finding noticed that the rate of HIV test is high in the study area. The reasons for high rate of HIV test may be due to high awareness level of HIV/AIDS among MSM and out of fear of having HIV/AIDS infection after they indulged sexual act with unknown partners. Further, it is also seen that some of them did not do undergo for HIV test. The possible reason may be afraid of disclosing HIV status, fear of stigma and discrimination associated with HIV/AIDS, poor health seeking behaviour.

c) <u>Place of HIV test</u>

For achieving the goal of National AIDS Control Programme (NACP), there is a need for comprehensive, multi-layered approaches for HIV prevention that address the unique needs of MSM. HIV test is an important strategy for preventing HIV/AIDS among MSM. MSM is a hidden population and always

associated with a double stigma thus, the percentage of MSM who come for HIV/AIDS test is less in India.

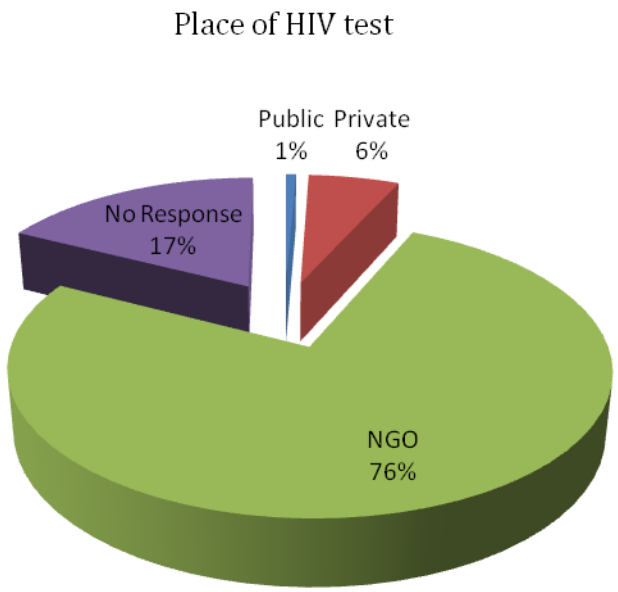


Figure4.12 Place of HIV test

From the Figure 4.12 shows the data distribution of HIV test of MSM during the last six months. It is seen that 76% of respondents conducted HIV test through NGOs followed by 6% in private hospital and 1% in public hospital whereby 17% did not undergo for HIV test at the time of study. The data revealed that maximum of respondents underwent HIV test through NGOs because they felt free, approachable and easy in accessing the services. They were also provided test at free of cost. Further, NGOs have facilities for Mobile ICTC i.e. HIV testing at the spot for free of cost. At the same time, NGO Peer Educators also play a vital role in spreading information, motivating for the needs and necessity for HIV test among the MSM in Manipur. The rate of HIV test in public and private hospital is very low due to high charges of fees for HIV test and unfamiliar attitudes from services providers.

Rani (name changed) reported:

"I did HIV test before one month in NGO. I did not know much about the test before. One of my friends visited to my house and we talked about the test because I had sexual intercourse with unknown partner and suspected of HIV infection. My friend told me about a NGO which provided free of service for HIV test. I went there with my friend and did HIV test".

d) HIV test Result

According to National AIDS Control Organization, the HIV/AIDS prevalence in India is 0.27% in 2013. There were estimated 2.39 million people living with HIV/AIDS in India in 2008-09. The contribution of MSM to HIV/AIDS epidemic in India is 1%.

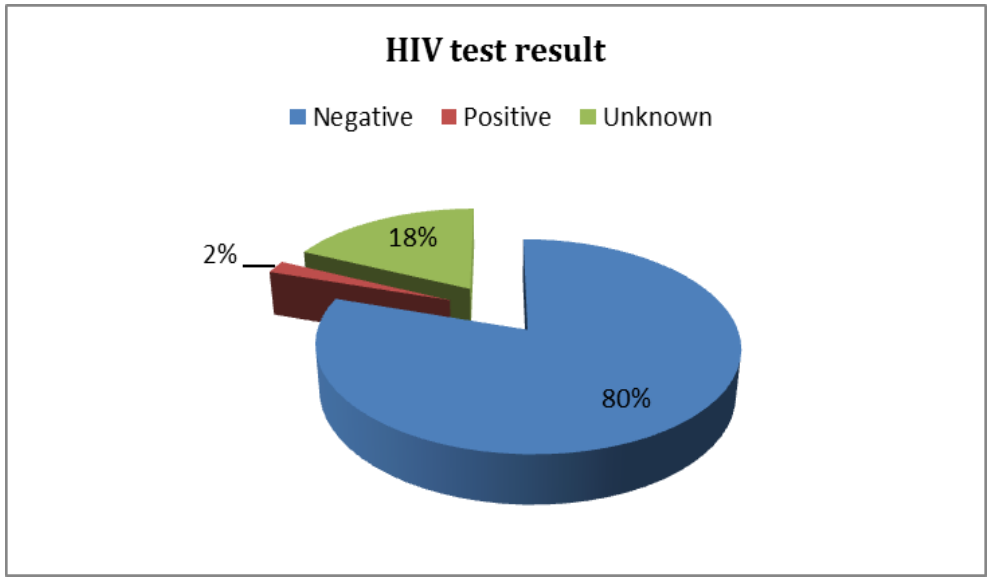


Figure 4.13 HIV test result

The Figure 4.13 showed that 80% of respondents found to be HIV negative whereas 2% reported of HIV positive. According to Sentinel Surveillance

Report (2006), Manipur, HIV prevalence among MSM is 11.6%. The study noticed that 2% of MSM were infected by HIV against 11.6% of total HIV infection persons among MSM in Manipur. The finding of the study suggested that government and non-government organizations need to work and re-formulate the programme and services based on the issues of MSM to reduce HIV infection among MSM.

e) <u>Sexual transmitting diseases (STDs) among MSM respondents</u>

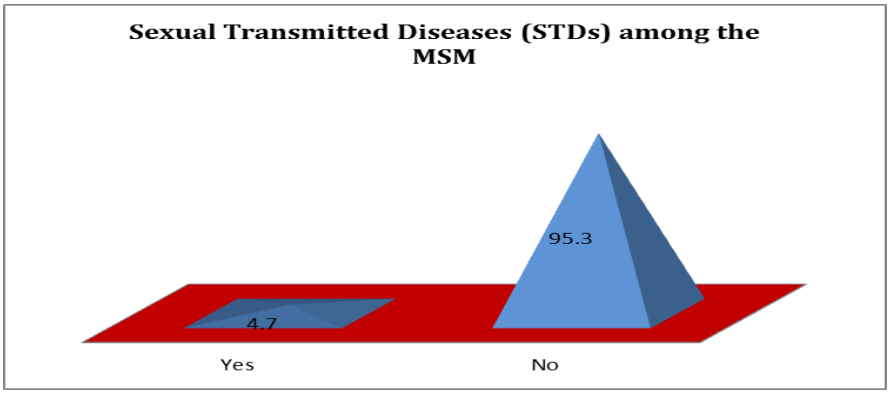


Figure 4.14 Sexually transmitted diseases (STDs) among MSM respondents

Everyone can be extremely vulnerable to sexually transmitted diseases such as STDs/HIV. Safer sex is one of the ways to save from STDs. From the Figure 4.14, majority of respondents with 95.3% did not have sexually transmitted diseases whereas 4.7% of them had revealed of suffering from STDs. It can be noted that they may not reveal at the time of data collection due to ashamed of, fear of stigma and discrimination or not visit STD clinic for diagnosing the disease. If in case they have the diseases, they might have undergone self-medication at home, quacks, etc.

IV.4 MSM perceptions towards the available services

In Manipur, both GOs and NGOs are working for MSM community. The NGOs working for MSM community are All Manipur Nupi Shabi Association, Imphal, a

coalition of three CBOs 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). But those services for MSM are limited to HIV/AIDS only and it hardly focuses on other aspects of their life such as livelihood, income generation, mental health, etc. It is therefore needed to look into the perceptions of MSM towards the available services under the study area.

IV.4.1 Heard of programme and policy related to MSM

MSM are regarded as one of the high risk group of HIV/AIDS and one of the targeted groups for prevention and treatment programme of HIV/AIDS. The main aim of HIV/AIDS programme and policies are to reduce the risk behaviours among the risk groups such as MSM, Intra Drug Users (IDUs), Female Sex Workers (FSW), etc. by making them accessible towards the health services.

The below Table 4.19 showed that 100% of respondents had heard of HIV/AIDS programme and policy where 61.3% of respondents did not satisfy of services of GOs and NGOs while 22.7% found satisfied, 8.7% were slightly unsatisfied and 7.3% with slightly satisfied. It is noted that almost all the respondents were aware of the services provided by GOs and NGOs. In other ways, mass media, GOs and NGOs who are working for MSM population take vital roles in controlling or halting HIV infection among MSM. Maximum respondents mentioned that they came to know about health services through NGOs.

Table 4.19 Heard of programme and policy related to MSM

Parameter		Frequency (Percentage)
Heard of programme and policy	Yes	150 (100%)
	No	-
Attitude towards the available services	Satisfied	34 (22.7)
	Slightly satisfied	11 (7.3%)
	Slightly unsatisfied	13 (8.7%)
	Unsatisfied	92 (61.3)
	Total	**150 (100%)**

It is noticed that the programme and services related to MSM are part or partial of HIV prevention and treatment progamme under Targeted Intervention (TI) programme. There are no specific programmes for MSM community which addresses of their issues and problems besides HIV/AIDS. However some of respondents were found to be satisfied of GOs and NGOs services. The respondents reported that they had accessed to NGO's services such as condoms and lube, health check-up, free HIV test, medicines, etc.

IV.4.2 Fundamental rights

MSM community is regarded as one of the marginalized group of people because of their sexual behaviour. Being a marginalized group, they are not able to access government beneficial schemes to improve their living standard. Unfortunately, they are deprived of such opportunities due to social stigma, discrimination and prejudice and homophobia. Their rights have been always violated in every aspect. The Constitution of India has provided fundamental rights to every citizen of India. Fundamental right is a charter rights contained in the

Constitution of India. The rights include such as equality before law, freedom of speech and expression, peaceful assembly, freedom to practice religion and right to constitutional remedies for the protection of civil rights by means of writs such as habeas corpus. It guarantees civil liberties that all Indian can lead their lives in peace and harmony. Every citizen has the rights to enjoy for a proper and harmonious development of personality. These rights universally apply to all citizens irrespective of race, place of birth, religion, caste or gender. In respect of sexual minorities, rights are denial and regarded as criminal act. At present, transgender people are forced to identify themselves either as male or female in different official identity documents and are subjected to humiliating acts like stripping or body checks, and made to undergo medical test to prove their declared identity (Dinesh, 2014). Male-female dichotomy in hetero-normative societies has created havoc in the life of sexual minorities thus obscuring the fact that they are also human being.

Table 4.20 Fundamental Rights related information by respondents

Parameter		**Frequency (Percentage)**
Heard of Fundamental Rights	Yes	135 (90%)
	No	15 (10%)
Able to enjoy Fundamental rights	Yes	36 (24%)
	No	102 (68%)
	No response	12 (8%)
	Total	**150 (100%)**

In the above Table 4.20, it is seen that 90% of respondents had heard of fundamental rights while 10% did not. It is also seen that 68% of respondents were not able to enjoy their rights whereas 24% agreed that they could enjoy their rights.

Furthermore, the finding indicated that MSM experienced of disparity in accessing their rights such as health care treatment in private and public hospitals. For instances, there is no separate wards in any hospital or any beds reserved for sexual minorities people. In this situation, they may find uncomfortable to access the health care services. Cochram et al. (2009) expressed that often sexual minority are not even allowed to enter inside hospitals and do not have separate wards that earmarked for in-patient care. Their access to health care needs have to be ensured because they are suffering from various physical and mental illnesses. Sexual minority people are deprived from WHO definition of health-physical, mental and social well-being documented in the preamble of constitution of World Health Organization (1946).This denial of their rights may give negative impact on their mental, social, and physical well-being.

IV.4.3 Knowledge of Section 377

Section 377 of Indian Penal Code described homosexuality as an unnatural offence. The section state that whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for term which may extend to ten years, and shall also be liable to fine. The section is against homosexual action and made homosexual people deprived from Article 14 of Indian Constitution i.e. Equality before law irrespective of race, place of birth, religion, caste and gender. Section 377 of IPC made MSM to keep their sexual identity hidden which made them to deprive from human rights.

Table 4.21 Knowledge of IPC Section 377 and perception towards IPC Section 377

Parameter		Frequency (Percentage)
Heard of IPC Section 377	Yes	88 (58.7%)
	No	62 (41.3%)
Perceptions towards IPC Section 377	Amendment	26 (17.4)
	Withdraw	62 (41.3%)
	No response	62 (41.3%)
	Total	**150 (100%)**

The Table 4.21 showed that 58.7% of respondents heard of IPC Section 377 while 41.3% of respondents did not hear of it. Out of 58.7% respondents, 41.3% of respondents wanted to withdraw the Section from the IPC and 17.3% of them expressed of amending the Section because they perceived that the said Section is one of the reasons of hiding their identity. It is evident that law enforcement took advantages of the Section and harassed them physically, sexually and emotionally. In such situations, this IPC Section 377 is preventing them from approaching legal help or protection. The finding noted that the Section is violating Article 21 of the Indian Constitution i.e. Right to live with dignity and Right to privacy.

IV.4.4 Networking and advocacy

Collectively social and cultural denied of existence of same sex activities in India. Such social perceptions made MSM social fabric, marginalized and subjected to discrimination. In national space, there is a complete lack of public discourse on homosexuality and an overtly heterosexual discourse of marriage and reproduction, which has not allowed other sexualities any legitimacy status (Sabina et al., 2011).

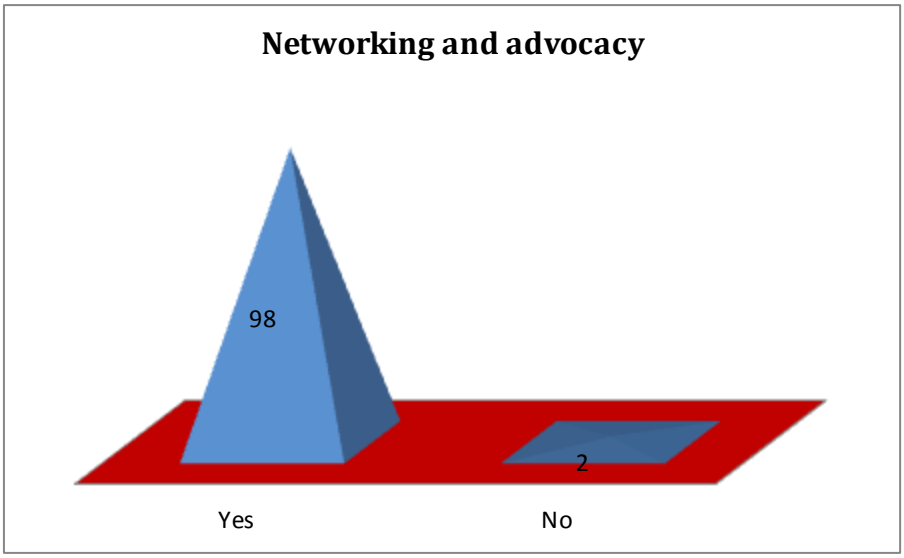


Figure 4.15 Networking and advocacy

Looking at the Figure 4.15 that 98% of respondents expressed of needs of networking, advocacy and sensitization with different levels that include government officials, civil society, local elected persons or leaders, police, local goonda, health service providers and masses, etc. It is also noted that stigma and discrimination at family, society, institutional places, and health care setting made them delay in 'coming out' process. They find uncomfortable due to unfamiliar and unfriendly attitudes of service providers which make them hesitated to go for further treatment. They did not feel free to share their sexual histories and problems to doctors or nurses. Thus, the gap between the clients and service providers prevented MSM from getting appropriate treatment or information. Chakrapani et al. (2007) study found that discrimination and stigmatization by health care providers in the form of derogatory labeling, demeaning interactions, outright insults, breaches of confidentiality, and refusals of services, negligent in asking about sexual histories and outright insulting and/or incompetent in working

with MSM. Further, the respondents expressed their disappointment on government attitudes towards MSM issues and problems. In other way, government officials do not want to acknowledge of their sexual and gender identity. During the interview, the respondents also expressed of having family welfare services for them like family counselling centre, crisis intervention centre, etc. that may help in improving their living standards. Therefore, there is need to highlight the issues and problems of MSM to public and laws enforcement for enhancing their quality of life. Thus, social advocacy/sensitization is an important tool in reducing social stigma and discrimination against MSM so that they can come out in society and can able to enjoy their rights.

PART II

Part II of the chapter deals on the Family member's perception, Focus Group Discussion and Case Studies of the study.

IV.5 Family member's perception

This part intends to explore the perception of family members towards MSM sexual behavior. It will help in understanding the family members' reaction after recognition of their sons, brothers' sexual behaviour. It will also highlight the emotional feelings that are reacted by family members in overcoming the situations within family and society at large.

IV.5.1 Recognition of sexual behaviour

Maximum of parents of the study recognized of their son's sexual behaviour in childhood. However, some of them had recognized in puberty and

teenage period. Some parents identified their sons' behaviour in concurrence with the style of walking, talking and playing and dressing. This can be recognized from the following expression:

Linthoi (name changed) expressed:

"Since childhood, I found some kinds of strange behaviour in my son. He did not like playing with boys and used only girls' things like toys, clothes, etc. Since young age, I tried to change his behaviour".

IV.5.2 Feeling of grief and guilty

Grief is a response particularly to the loss of someone or something which a bond was formed. Grief and guilty is seen when the relationship between parent and child becomes deteriorated due to the discovery of his or her son's homosexual identity. Majority of parents of MSM respondents under the study area felt grief when they came to know of their sons' homosexual behavior. They felt that having homosexual child in the family entailed the loss of future dreams, loss of control, loss of security, and loss of relationship and loss of generation. These multiple losses faced by family members might trigger a grief reaction that could last for months or even several years.

Some parents felt guilty of their sons' homosexual behaviour. They even asked themselves why such things were happening with their children, is it because of not looking after their children properly or of their bad parenting that affected their sons'/ brothers' behaviours. Parents often take years for realizing of their sons' sexual behavior. So, parents commonly asked to themselves that 'Where did

we go wrong". Therefore, feeling of guilty is one of the aspects encountered by MSM family members.

IV.5.3 Denial of sons' homosexual identity

The study found that maximum of family members denied of their sons', bothers' homosexual identity. The finding revealed that family members did not believe of their sons' or brothers' homosexual behaviour. So they denied of their sons' homosexual identity even after coming out. Soon after acknowledgement of their sons' homosexual behaviour, parents often experienced of fear, guilty and denied of their son's identity. Sometimes parents got angry and blamed to someone else for their son's sexual orientation, such as peer group, sexual abusers, etc. During those stages, parents often threatened, abused their sons or forced them for changing their behaviours. Such action drives a wedge between the parents and son leading to escape or run away from home. It is also seen that some parents themselves had thrown them out of the house thus MSM were forced to live on the streets and tend to engage in risk behaviour such as sex work, multiple sexual partners, substance abuse, etc. However, few family members do accept of their son's homosexual identity as MSM sons' were financially supporting them to run their families. Some families remain in denial and expelled their sons from home or from families' name.

IV.5.4 Fear of social rejection

Fear and misunderstanding about homosexuality are wide spread. It became challenges to the development and maintenance of a positive self-image of MSM and to their families as well. When a MSM person comes out of their sexual

orientation and sexual identity in front of parents and family members, it can be a very emotional stage. Maximum of the parents expressed that they feel fear of social rejection of having homosexual sons. Society looks down upon homosexual people as well as their family members. They are even regarded as bad omen. Family members even considered that their homosexual sons have put down the families' prestige. Therefore, parents have fear of rejection by their own neighbours, friends, relatives, religious person, or social groups.

Memma (name changed) said:

> *"Sometimes I feel shy to go out and meet others. People in society have looked down upon me because of son's homosexual identity. Some of my friends have commented with abusive words in front of others. I did not have words to express but was very angry and felt rejected".*

IV.5.5 Conflicts at family atmosphere

Peaceful family is regarded as happy family and it depends on the types of people living together that reflect the understanding and respecting, etc. among the members. Having a deviant character of child in family disturbs the peaceful atmosphere of the family. Maximum of family members expressed that their sons' homosexual behaviour had affected badly the peaceful family atmosphere. So the finding of the study revealed that there is conflict, misunderstanding, quarrelling due to homosexual nature of their sons' behaviour.

Komla (name changed) said:

"My husband started drinking after my son had disclosed his homosexual behaviour in public. My husband scolded, beaten and blamed me that I did not look after my son's behaviour".

IV.5.6 Experienced of depression

Parents have consistently tried to bring a change of their children's sexual behaviour to normalcy but in vain. At such situations, parents usually experienced of shame, guilt, and depression. Maximum of family members had experienced of stress after knowing their sons' homosexual behaviour. The finding revealed that family members felt upset, guilty and grief of being having homosexual sons.

Nando (name changed) expressed:

"I am very upset, disappointed with my son's homosexual behaviour. He is the only son in the family. Now I give up of bringing a change to his behaviour. I am totally helpless and hopeless. I can't think of my next generation. I do not know what to do?"

IV.6 Focus Group Discussion and Observation

In this part, researcher highlighted the findings of focus group discussions (FGDs). According Wilkinson (2004) a focus group discussion is an informal discussion among a group of selected individuals about a particular topic. A focus group discussion, as a research method, 'involved more than one participant per data collection session. Focus groups are group discussions which are arranged to examine a specific set of topics. The group is focused because 'it involves some kind of collective activity' (Kitzinger 2005). The primary aim of a focus group discussion is to describe and understand the meanings and interpretations of a selected group of people to gain an understanding of a specific issue from the perspective of the

participants of the group (Liamputtong 2009). The detail discussion on focus group discussion will be presented as follows:

Group: 1 (Married MSM Group)

Place: Awaken Artisan Shelter Association (AASHA)

No. of participants: 7 (seven)

Duration: One hour and twenty minutes

Facilitator: Kumar (name changed)

Note taker: Researcher (Kh. Pramodini Devi)

Theme 1: Experience in living with MSM identity

A participant said, *"Society doesn't look us with positive attitudes as it follows the traditional norms. It always looks down upon MSM especially those who are unmarried. People think that there is something wrong with us and we won't be able to settle down and have family. I got married to show the society that I also have the ability like a straight man."*

One participant said, "*I have tried to work and live like a straight man but I fail to do so. Physically, I am weak in compared to other men. Sometimes my wife and family members scold me for not performing like them. I am unable to fulfill their expectations. I feel embarrassed in front of them"*.

A participant expressed, *"When I was young, I was pretty and attractive, so partners approached me for favouring sex. Now, I am getting old, I don't think I will be able to*

live like before as my sexual urge is also diminishing. Sometimes, I feel like changing my behavior and live like a straight man. Moreover, marriage will save me from risk behavior".

One participant said, *"My parents pressurized me for my marriage. They always said that they want to fulfill their responsibilities towards me before they leave this world. I was the only one who was not married in the family at that point of time. Marriage happens to be a burden to me. So, finally, I could not escape from their pressures and got married at the age of 36"*.

"My parents expressed their concerns of my marriage so they neglected my partners who visited me at home. My friends felt that my parents restrained them from meeting me. I felt so shy in front of my friends. They stopped visiting me and so I became lonely and isolated. Finally, I got married after two years" expressed by a participants.

Another participant expressed, *"My neighbours teased me that I would never get married in my life. From their perceptions, no girls would marry me and I would become useless in future. My parents were very upset on hearing such words. Finally, I decided to get married to give a peace to my parents and answer to my neighbours".*

Another participant said, *"Marriage changed my behaviour. Before marriage, I loved dressing and acting like a girl, gradually, my ways of walking, dressing and acting has changed and now I behave more like a straight man"*.

Another participant also expressed, *"Even after my marriage, I like to spend time with my earlier partners"*.

One participant said, *"After getting married I am bound with responsibilities. My freedom has snapped or ends down. The sudden change in my life made me sad and distress. I am in dilemma; I am unable to come out from such situations"*.

One participant said, *"After my marriage, I was given respect by society and abuses were reduced in family as well as in society. My words and decisions are taken more valuable than before"*.

Theme 3: Reasons for taking up risk behaviour and coping mechanism

"After marriage, I noticed lot of changes had happened in my life. It was tough in adjusting the environment. Many times there were conflicts in family for not sharing responsibilities like straight man. In order to escape from such pressures or to divert my mind, I visited vendors and consumed alcohol. Sometimes, I met partners and had sex with them" as shared by a participant.

Another partner expressed, *"I can't forget my partner even after my marriage. I am not sexually satisfied with my wife. Still, I meet my partners and have sex with them"*.

A participant shared, *"I shared everything of my sexual relationship to my wife so that she might not misunderstand me of my social orientation and preference"*.

Another participant said, *"Sometimes, I avoid my wife. It has been difficult satisfying her sexual urges"*.

Theme 5: Perceptions towards the services provided by GOs and NGOs

One participant expressed, "*Many of us were not much concerned of safer sex. I agree that some NGOs are providing free condoms but how far does it help us? Chances of getting sexually transmitted diseases are very high among our community because of our dual roles i.e. receptive and penetrative during sex. At the same time, sexual*

partners are emotionally blackmailing and threatening us for using condoms during sex".

Another participant also said, *"Mobile ICTC of NGOs are so effective and important for our MSM community. Most of us are hesitated to visit public and private hospitals for HIV test. It is easily accessible and affordable for HIV test as it is free of cost".*

Group: 2

No. of Participants: 7 (Seven)

Duration of the discussion: 1.30 hours

Facilitator: Surchandra (name changed)

Note taker: Researcher (Kh. Pramodini Devi)

In Manipur, TG is a sub-group of MSM and called 'homo' (effeminate man). The concept of TG is existing since years back in Manipur. Terminology within the transgender (TG) community varies and has changed over time i.e. place, religion, language, culture, caste, creed, and custom. The term TG is used to the people whose gender identity, expression or behavior is different from those who assigned sex at birth. TG often expressed their gender identity through behavior, clothing, hairstyle, voice or body characteristics.

For the present study, a group of TG has taken up for the focus group discussion. In Manipur, TG is regarded as one of the marginalized group because of their sexual orientation and sexual identity. They had experienced social stigma and discrimination such as use of abusive words, vicious names calling and hurtful words like bad luck, heckling, teasing and mocking and even physical attack are

common at work place, public spaces, educational institutions and in their respective families and neighborhoods. Such conditions lead them to have emotional and psychological distress. Following are the discussions with TG group according to theme wise:

Theme 1: Experience in living with MSM identity

One participant said, *"I had experienced of threatening from my family members because of my sexual orientation and behaviour. My family members did not understand of my feeling and only worried about family prestiges. They believed that my sexual preference may put down family image in society. I find it difficult to convince them. In order to escape from their threatening, sometimes I left home and stayed with friends"*.

"I played dual roles in family. But my parent did not recognize of my works" expressed by a participant.

Another participant also said, *"I had experienced of less guidance in my study and career by family members because of my MSM behaviour. Family members used to neglect and reject my words and opinions in family decision making. Now, I am having difficulties in applying jobs due to my poor educational qualification. My income is low because of not having stable income sources which makes me worried about my future"*.

"I don't feel free to roam around in public places. Sometimes, I felt uncomfortable to go in front of police and local goonda. Some of them have also expressed of their sexual preference" shared by a participant.

One participant said, *"I had to quit my schooling as my classmates and friends teased me often. There was no one in the class who has similar behaviour like me. Eventually, I left school when I was in class IX"*.

Another participant said, *"Few years before, I applied for a post for Forest Ranger. During the interview, some of the officers abused me and doubted my calibre. I did not reply but felt embarrassed and sad. From that experience, I am hesitant to apply for jobs".*

Theme 3: Reasons for taking up risk behaviour and coping mechanism

A participant expressed, *"I did not take alcohol before. I started drinking after break up with my partner. Simultaneously, I found difficulty in managing my parents. So, I have been drinking to reduce my daily stress"*.

Another participant also said, *"My parents and family members always scolded and threatened me for my behavior. It irritated me, so I left home to escape from scolding and stayed with friends. I followed my friends and had sexual relationship with partners".*

One participant said, *"I suffered from STI since last year. I suspected that I got infection after having sexual intercourse with multiple partners. I was confused and unable to do anything with the disease but finally, I did treatment at NGO's clinic"*.

Another participant said, "*My partner left me after two years of relationship. After the breakup of our relationship, I was sad and depressed for a long time"*.

One participant said, *"Whenever my parent scolds me, I go out and mingle with my friends"*.

Another participant expressed, "I do accept of my mistakes for staying at partner's house and spending all my money on him".

"Sometimes my previous partner who had cheated me came for patching up of our relationship but I avoided him" shared by a participant.

Theme 5: Perceptions towards the services provided by GOs and NGOs

One participant said, *"The programs and services of NGOs like AASHA, SASO, SODO, and Maruploi Foundation help us to get information about HIV/AIDS and other related health diseases. It enriches our knowledge by making aware of the consequence of diseases".*

Another participant also said, *"Some NGOs are providing nutritional support and helping to those clients who have infected by HIV/AIDS and are unable to buy medicines and nutritional foods"*.

"NGOs clinic were helping us to get some general medicines and treated by specialized doctor. Such services are helping us but there is limitation of medicines and doctors' visit in the clinic and sometime that delay the treatment process". said by a participant.

Group: 3 (Three)

No. of participants: 7 (seven)

Duration of the discussion: 1.30 hours

Name of the facilitator: Raj (name changed)

Name of the note taker: Researcher (Kh. Pramodini Devi)

Theme 1: Experience in living with MSM identity

A participant said, *"There is always biasness among MSM due to our sexual behaviour in society which made us feel uncomfortable in society. Such situations made me feel guilty and rejected.*

Another participant also said, *"In order to escape from threatening from my family members, I used to behave like a straight man at home but outside, I act according to my wishes"*

"When I was having short hair and acting like a straight man, there was not much problem in public places. But after keeping long hair, I experienced confusion while standing in queue, hospital, attending public function, public toilet, etc." said by a participant.

One participant said, *"My family members were surprised when I disclosed my sexual behaviour and identity in public. They tried to change my behaviour by threatening, scolding and using abusive words, beating, and burning clothes, throwing my make-up box, etc."*

"My father always mentions that I won't get my share of family property as long as I do not change my sexual behaviour. He told me to leave home" said by a participant.

One participant said, *"One day, when I came back at home, some of the local boys stopped me and called me. They threatened me to have sex with them. I could avoid and escape from them. From that incident, I am scared to go alone, especially during night time"*.

Another participant said, *"I had experienced of my neigbours' misconceptions and their prejudices towards MSM. They took us as bad omen, commented with abusive words, etc. It discouraged me and disturbed mentally.*

Theme 4: Reasons for taking up risk behaviors and coping mechanisms

One participant said, *"In our society, there is less restriction for boys in compared to girls. Boys always get some kind of freedom and independent. Such freedom sometimes provides an opportunity to involve in risk behaviour".*

"Those MSM who do not have partners were looked down upon among MSM community. Sometimes, I used to keep partners without knowing anything of my partners but just to show to my MSM group" reported by a participants.

Another participant also said*, "I am unable to read and write properly. So, I don't have much information and knowledge about risk behaviour. So I might have engaged more in risk behaviour".*

One participant said, *"My parents became sad after I disclosed my sexual behavior and identity to them. They told me not to go beyond the limit. They advised me to focus on education and in my future career. Their acceptance makes me happy and improve my self-esteem"*.

Another participant said, *"Since childhood, I have the orientation of a girl but I could not express it out of fear of my parents. I expressed it to my best friend when I was at 15 years of age. After confessing it, I felt relax and developed self-confidence"*.

"My parent advised me to get married with a girl. I was not mentally prepared for getting married. So, I refused the proposal" said by a participant.

Theme 6: Perceptions towards the services provided by GOs and NGOs

One participant said, *"Some of the NGOs in Manipur conducted awareness programme for imparting knowledge and information on HIV/AIDS and related health issues to MSM community. However, the services of the MSM are limited only on HIV/AIDS. We want them to extend services beyond HIV/AIDS"*.

Another participant also said, *"The services provided by NGOs were useful to us but it needs proper maintenance of the quality and more accessible for MSM community.*

Group: 4 (Four)

No. of participants: 8 (seven)

Duration of the discussion: 1.10 hours

Name of the facilitator: Suraj (name changed)

Name of the note taker: Researcher (Kh. Pramodini Devi)

Theme 1: Experience in living with MSM identity

"Sometimes living with MSM identity made me feel upset. I have tried a lot to change my behaviour but I failed to do so. I could not make my parents happy and fulfill their expectations. Such situations made me upset and depressed" shared by a participant.

One participant expressed, *"Living with MSM identity is like a sin especially those who don't have proper sources of income but dependent on others. Family members did not give much importance to us because of our behaviour. We are living like rejected/ neglected child in the family".*

A participant reported *"My father told me not to wear girl clothes and behave like a man. I didn't listen to him and had lived according to my wishes. My father got angry*

and told me to leave home and never return at home. I was very sad and even attempted for suicide".

Another participant expressed *"Once my step father beat me for behaving like a girl. I got fainted and they took me to hospital and hospitalized for three days. Since that incident I have developed heart problem"*.

Another participant also said *"Society is taking homosexuality as a sin and a bad omen. Many times I had experienced of verbal, physical and sexual abuse because of my sexual orientation and behaviour"*.

Theme 3: Reasons for taking up risk behaviors and coping mechanisms

*"I received gifts and invitation from my friends for party and other functions. I used to attend those functions or parties. Such functions and parties gave me chances to interact with other partners and could engaged in risk behaviour such as intoxicated substance abuse and unprotected sexual activities" r*eported by a participant.

Another participant said *"I am not able to maintain stable partners. Frequently, I changed my partners and had sexual relationship with them with or without condoms. Without any second thoughts, I used to accept partners' opinion or words to make them happy".*

A participant shared *"I have now realized of whatever my parents have said to me. They scolded me of behaving like a girl because I was unable to fulfill their expectations"*.

"I balanced myself in handling both my family and outside. When I am at home, I used to wear boy's clothes and behaved like a man. But at outside I like wearing make-up on

my face, dressing, walking and acting like any other girls" as expressed by a participant.

Theme 5: Perceptions towards the services provided by GOs and NGOs

A participant said *"The main GO's and NGO's services of MSM are HIV/AIDS programme. There is no separate programme and services based on livelihood, employment, education, reducing stigma and discrimination, etc. of MSM community"*.

"The services of the MSM will be more effective if it is extended beyond HIV/AIDS. Extension of services to families and partners may also be useful and helpful in reducing our problems" reported by a participant.

Discussion of the FGD

Focus group discussions of the study revealed that stigma, discrimination, prejudice and homophobia are the main problems encountered by MSM people due to their sexual orientation and behaviour. They had experienced of role conflicts leading to identity crisis. Due to their role conflicts and identity crisis, family members showed negative attitudes by using abusive words, threatening, neglecting and expelling from home. Some of the families accepted their identities because of their financial support to family. They had also experienced of pressurizing by family members for marriage as family members believed that their behaviors would be changed after marriage. Thus, marriage became one of the challenges in MSM life. Some of them used coping mechanism by accepting or rejecting the marriage proposal or leaving home, etc. Those MSM who got married had bitter experienced while managing their roles and responsibilities within family and society. But, some of them had felt

that they were respected after their marital status. In society, they are regarded as bad omen. They felt insecure in the society as they were abused and harassed by police, local goonda, friends and partners, etc. MSM had also experienced of negligence and unfair treatment in educational institutions and harassment by employers at work places. Therefore, harassment and abuse in school/ college and work place made them more vulnerable and miserable. Thus, in order to come out from the situations they engaged in risk behaviour such as keeping multiple sexual partners and intoxicated substance abused to overcome those problems of social ostracism. Such condition made them suffer from psychological problems such as stress, depression, worried, anxiety, guilty, isolation, suicidal thoughts, etc. Regarding governmental and NGOs programme, maximum of the respondents expressed that they do not easily access the services due to unfamiliar attitudes of service providers. Moreover the services provided by GOs and NGOs are only focused on HIV/AIDS. So they hesitated in accessing the services due to this double stigma attached with their community.

IV.6 Case Studies and Observation

The present section deals with selected case studies of the respondents who faced psycho-social problems in their life. The case will highlight the different experiences and aspects encountered during their life time. The detail discussions on case studies will be presented as follows:

Case 1

Thoiba (name changed) is from a middle class family. He is 33 years old and belongs to Christian religion. He is the fourth among five siblings in family. Thoiba's father was an artist and mother, a house wife. He has two brothers and two sisters. He left study in the middle of graduation.

Since childhood, Thoiba behaved like a girl in terms of talking, walking, playing, etc. He felt happy playing and mingling with girls than boys. When he was around 6 years, he asked his mother to buy girls clothes for him. Thoiba's parents recognized his behavior at that time and tried to modify his behaviour by threatening and scolding. Many times his father trimmed his hairs and did not allow him playing with girls. But he did not change his behaviour and grew up with female behaviour.

Thoiba was average in his studies. He did not experience much of stigma and discrimination during his school time. Teacher told him to cut his hairs and to behave like a boy. However, some of his friends teased him and neglected him in their group. He was around 15 years when he recognized of same sex attraction. One day, he went with his local brother for evening walk. His local brother took advantages of dark and took him at the site of a school and forced him to have sex. He tried to escape from his local brother but he could not do it. The incident shook him and became depressed and he was unable to express to anyone. However, he came to know about the same sex from that incident.

When he was around 17 years old, he found some friends who had similar behaviors with him. He started mingling with them. His friends encouraged him and

taught about the culture of MSM. He got an opportunity to meet other MSM at Thabal Chongba (Full moon night dance) which was organized by MSM group. Thabal Chongba performed at the time of Holi in Manipur. Most of MSM met there. After interacting with his own community and seeing their nature, he got courage to come out in public. Then he started searching partners through his friends and senior MSM. He found partners and gradually involved in sexual act with them. But he was not serious in any of the relationships with partners but maintaining the relationship only for sex or time pass. He was not interested in other work but busy with his MSM companion. His parents were disappointed because of his behaviors, so they threaten him for changing his behaviour. In the meantime, he was well known among his MSM community. He was happy spending time with his multiple sexual partners. He used to receive gifts from his partners and he exchanged with sex. He even brought his partners at home and partied with them. Frequently, he went to restaurants with partners and had sex there. Family members were very annoyed with his behaviour.

Thoiba's parents could not manage his behavior so they decided of getting him married with a girl. His parents believed that his behavior might change after marriage. Therefore, they started searching a girl for him. He was upset with the decisions of family member and was unwilling for marriage. He left home for few days to avoid family members' pressure. However, his parents emotionally blackmailed him and finally he had to agree for the marriage. During those days, he had serious relationship with a married man. The man was his first love and they even decided to live together. Finally, he could not avoid his parents' decision, later he got married at the age of 33.

After marriage, he was unable to talk to his wife. Most of the time, he went out and spent time with his partners. He felt uncomfortable in spending time with his wife and did not even touch her for the first few days. Thoiba's wife was unhappy of his attitudes and even expressed of her desires for returning to her parent's house. After some days he tried to have sex with his wife but he could not. One day he imagined of those days which he spent with his partners and took the advantages of it and had sex with his wife. After few days, she came to know about his husband's behavior and became depressed. Thoiba's wife did not know of his sexual preference before. They did not meet even once before their marriage. After knowing of his behaviour, she went to her parents' house and stayed there for some days. She was called back by Thoiba. After that incident, his wife was more careful of his behaviour and imposed lot of restrictions to him. Despite of restrictions he continued meeting his partners. His behaviour created tensions between the couple. She even changed his mobile Sim cards and compelled him to stay at home. He struggled a lot in taking up his roles and responsibilities like a straight man. So, marriage became a burden for him.

Case 2

Radharani (name changed) is the only boy child among four siblings in his family. His father was a carpenter and mother, a house wife. From his young age, he adopted by his paternal uncle. During childhood, he got special love and care from his family members. Being the only son in the family, he got whatever he demanded. Most of the time, he preferred spending time with his sisters and played with them. He had less interaction with boys during his childhood. Sometimes he stole his sisters' clothes

and participated in school and at local programmes. His parents beat and warned him for his actions however he continued doing so.

He had been experienced of teasing and abusing from his local and school friends. His local friends didn't allow him to play in their group, so he joined the girls' group and played with them. In class IX, his family members compelled him to change his school for bringing a behavioral change. At the beginning, he was sad, isolated and lost interest in school. Fortunately, he found a friend who had similar behavior with him and they became friends. They started opening up their MSM behaviour.

Radharani had same sex attraction since childhood but did not express to anyone. He had sexual intercourse with one of his local boys. He influenced the boy to have sex with him. He started keeping boyfriend at class IX from same school. Being in first relationship, he was serious and happy. They used to spend time together and had sexual relationship at his boyfriend's rented house. After class X, they got separated from one another and he got admission in new college. In the meantime, he got an offer from drama where his parents refused to send him but he did not listen to them, later he joined the group. He played the role of female in the play, people appreciated his performance. After some days, he fell in love with his co-actor and had spent most of the time together. Unfortunately, after few months, the play group was separated and thus they became separated. He went to Jiribam to join another play group. He met a man there and he again started loving him and they lived at his house like husband-wife. He was taking every responsibility of woman. After two years of living together, his partner came with a marriage proposal. On hearing the news, he was depressed but he could not do anything. He could see the changes in his partner's

behaviours. They often quarreled thus he left the place and came back to Imphal. When he reached Imphal, he went into depression. Radharani's family members and friends supported him to overcome from the situation.

After two years of that incident, Radharani came out from depression and he started a business at Imphal, there he met a Muslim guy, again he involved in relationship with Muslim guy. But both the family members were unhappy of their relationship and tried to separate them. In order to escape from family threatening, they went to Goa for some months. Both the families called them back and told them to separate. So, they decided to separate for time being just to pretend in front of family members. They further planned to go to Delhi and settle there. But unfortunately, on a particular day, he got information of his partner's death due to overdose of SP tablets. He became depressed and felt guilty of the situation. After that incident, he tried to change his behaviour. His family members were worried and pressurized him for marriage so that he could come out from depression. But he refused the marriage proposal. Now he is trying to focus on his work for earning money and also to keep him busy in work.

Case 3

Sanatomba (name changed) father was from a Hindu Brahmin family and mother, Naga from Nagaland. His father was a tailor at Kohima. From there, his parents came to know each other and they got married and settled at Kohima, later they shifted to Manipur. Sanatomba was born at Kohima. Sanatomba's father passed away when he was 5 years old. After his father passed away, his mother took them to Kohima and stayed there for few months. His grandmother called them back and they

started staying at Imphal. But his mother found difficulty staying at Imphal so she went back to Kohima. His grandmother and uncle did not allow them to shift along with his mother. After his mother left them, he was adopted by his youngest uncle and his younger sister by elder uncle.

Sanatomba grew up as a normal child. He preferred playing and spending time with girls than boys and had sexual attraction to boys than girls. Sanatomba had experienced of same sex attraction when he was in class VI. His first sexual act started with one of his local friends. Later, his friend showed him places where he could get other MSM.

After few months, Sanatomba met a partner who was the elder brother of one of his close friends. His friend's brother showed interest to him and expressed his desire to have relationship with him. He accepted the proposal and had relationship for some months. He learnt substance abuse from his partners. They used to drink before and after sex. After some months he came to know that his boyfriend had other relationship with girls. They had quarreled and he left his partner. He was sad and unable to come out from the situation and lost interest to do anything. He attempted suicide after their break up. In order to come out from the situation, he engaged in relationship with a business man. But the relationship didn't last. For the third time he was involved in a relationship with one of his friends. He was happy with his third partner. After few days of relationship he came to know that his partner was a drug addicted. He tried a lot to leave his partner but he was madly in love and could not leave him. In the meantime, his partner eloped a girl that made compulsion for him to

leave his partner. After the break up, he started taking his life as meaningless and useless.

Accidentally, he met a friend who was working for an NGO. His friend invited him for HIV programme which was especially conducted for MSM community. He attended the programme and learnt about HIV/AIDS. The NGO officials asked him to join as volunteer in the organization. He then worked there for some months as a volunteer and then left Imphal for Mumbai with one of his friends and stayed there for one and half years.

In 2003, suddenly he got sick and went to doctor for treatment. He was diagnosed of suffering from Tuberculosis. He found difficulty in managing money for his treatment. One of his friends suggested him to take help from the NGOs which was working for MSM community. He went to an NGO and took help for his TB treatment. After examining his health condition, NGO clinic doctor suggested him for HIV test. He went for HIV test and found to be HIV positive. He was shocked and depressed for long time. After disclosing his illness to his family members, they started showing negative attitudes and discriminating him. It disturbed him mentally and psychologically. During those days, one of his friends visited and encouraged him to come out from the situation. Finally, he managed to come out from the situation and mingled with friends. Later, he got information for a post of Peer Educator in 2005 and applied for the post. He got the job which gave him a new life. Now, he is taking the leading roles in that NGO. He is one of the most prominent persons among MSM community in Manipur.

Case 4

Basanta (named changed) was from a poor family. Basanta's father was a farmer and mother, a house wife. He had five brothers and four sisters. All of them got married and stayed at different places. In childhood, Basanta behaved like a girl and his parents tried to change him. When he was at class IV, a local uncle sexually abused him. He was very young and did not understand anything about same sex. From that incident he came to know of the sexual act between the same sexes. Since childhood, Basanta had attraction towards boys but did not share to anyone. He was not able to disclose his sexual behaviour due to fear of family members. When he was in graduation, he found some MSM friends and he started showing his MSM behaviour in public. After BA 2nd year, he was not able to continue his study due to lack of financial support. After dropout, he left home and went for daily wages. At work place, he had sexual intercourse with many co-workers. He met a partner near his work place and had a long term relationship. His partner's family members came to know about their relationship and told them to separate from one another. His partner's family members scolded him and insisted him to leave his partner. Later, he left his partner's place and came home. He ran a small shop and managed his personal expenditure from that income. He had tough time as no one was supporting him. His parents insisted him for forgetting married with a girl. He refused the marriage proposal for long time but got married at the age of 36 years. He experienced changes after getting married such as difficulties in handling families' responsibilities. After two years of marriage, his wife became sick due to uterus problem. Doctor suggested her to undergo operation for removing tumour from uterus. There was necessary for blood at

the time of operation. Basanta went to give blood for his wife's operation but his blood was found to be HIV positive during the blood screening test. At the same time, Basanta's wife too was also HIV positive. He became very sad and felt guilty of his wife.

One day, he shared his problems to one of his friends. His friend suggested him to take counseling and support from an NGO which was working for MSM community. He went to the NGO and took help from them such as free treatment, medicine, counseling, etc. He works there as volunteer.

Case 5

Chaoba (name changed) is the youngest among ten siblings in his family. His father was a farmer and mother, a house wife who passed away. Chaoba had four brothers and five sisters. His family was run by his father's income. His brothers were married and living separately. Being the youngest child in the family, he was loved and cared by his parents and siblings. He lived with his elder sister.

Chaoba had different experiences in childhood. In childhood, he liked to wear girls' clothes and played with dolls. He found himself to be different from others. He had experienced his first same sex attraction with one of his local brother at the age of 12 years. He was young and could not understand of what was happening to him. He thought that it was common thing and happened to all. After few months, he came to know about the same sex attraction from his friend. He preferred spending time with boys but was unable to express his feelings to them. Some of his friends came to know about his behavior and tried to discriminate him from their group. He became unwanted among the peer group and was isolated from friends. When he was 16 years

of age, he had first sexual intercourse with his local friend. He was not happy with his sexual orientation and sexual behaviour. In order to gain respect among friend circles, he tried and lived like a straight man. He started mingling with boys but unfortunately his friends were involved in substance abuse. He could not leave them, and his friends made him involved in drug abuse. Initially, he was uncomfortable but slowly he became familiarized and got addicted to drugs. He could not afford for drugs, so he left drugs and returned back to his normal life.

Chaoba left study after BA 1st year due to lack of financial support by family members. After leaving study, he started earning through daily wages. While coming back from work he often see a group of MSM roaming at the park in the evening. One day, he stopped his bicycle and went to the park. One man called him and took him to the corner of the park and expressed his desire to have sex with him. He was surprised by his act but he accepted the request. From that day onwards, he visited the park daily whenever he returned from work. He became famous among the MSM community. In a day, he had sex with known partner of more than three to four times. He was happy in his act and expressed his homosexual behaviour in public. His family members threatened him of his behaviour but he did not listen to them and continued doing his act.

Chaoba did not keep permanent partners. He enjoyed with casual partners. Sometimes he took gifts from partners and exchanged it with sex. After some years, he met a partner and fell in love with him who was a drug addicted. Later, he came to know of his partner's addiction. Later they parted as he lost his interest to his partner and had desired to have sexual relationship with casual partners.

In 2000, suddenly he got sick and went for treatment. He was given medicines for fever. The fever stayed for more than two weeks and his condition became serious and was admitted to hospital. Doctor suggested for HIV test, later he came to know that he was HIV positive. He was shocked and even attempted for suicide. He regretted of what he did in his past life. With lot of struggle he came out from the situation and started earning money by tailoring. Simultaneously, working in tailoring shop kept him busy. Gradually, his health became weak and doctors suggested him for CD4 test. But he had no money for it and took help from his friend. He tested CD4 through an NGO and was found to be very low. So doctor suggested him to start ART treatment. He later worked as Out Reach Worker (ORW) in that NGO.

Case 6

Thoisana is the fifth child among eight siblings in his family. Their family economic was very bad. Thoisana's behaviour and characters were much alike with girls. Therefore, his family members tried to change his behaviour by threatening him. Even his mother requested his aunty to look after him.

Thoisana's father was a drunkard and did not look after his family. Most of the time, his brother and elder sister looked after him. He was an arrogant child in the family. He did not listen to his parents but he was afraid of his elder brother. By force, his brother made him study. When he was at the age of 12 years, he stopped wearing girl's clothes. At that time, his mother passed away and his family conditions became worse than before. His brother was not able to support him for study and he dropped out his study at class VII. After drop out, he spent doing nothing. In those days, there

was play groups (drama) in every locality. He used to participate in the play for time pass. He always plays girl's roles and local people appreciated his roles in the play. Some of the local elders encouraged him to join one of the famous play groups which can make his career as a female artist. He joined a play group with the help of his local elders. He was happy and dedicated most of his time in play. After some time he became close to one of his co-actors and fell in love with one another. He used to stay at his partner's house and there were no problems from his partner's parents. Their relationship was strong and he was also progressing in his career.

Thoisana's family members came to know about the relationship and called him back at home. His brother expressed of his marriage and started searching a girl. He refused the marriage proposal and tried to escape from home to meet his partner. His partner visited his house many times but his family member sent him back. After lot of struggles, he met his partner and stayed with him for one month. He told his partner to get married with a girl and settle his life. Then he left his partner's house and came back home. His father did not allow him to enter the house as he sold his father's hen and bought a pant and a shirt. Then he stayed with one of his relatives for two years. During those days, he met many partners and engaged in sexual relationship with them. He left his relative's house and again stayed with a friend. His brother called him back again. After one month of staying at home, his father passed away. In the meantime, his family members again brought the issue of his marriage. This time he could not escape so he got married at the age of 37 years. Thoisana's wife did not know much of his sexual behaviour before marriage but after getting married she came to know of his real sexual behaviour. In the beginning, he did not sleep with

his wife. Even after marriage he used to meet his partners and spent time with them. As time passed by he could change his behaviour and was able to take his roles and responsibilities like a straight man. He started receiving respect from society. Now, he is happily living with his wife, two daughters and a son.

Case 7

Chandani (name changed) is the youngest among six siblings in family. Father owned a fishery farm and mother, an assistant teacher in school but she took voluntary retirement at early stage. All the brothers and sister got married and lived separately. Being the youngest in the family he took care of his parents.

In childhood, Chandani did not behave like a boy. His parents did not see any behavior of boy in him. The way he walked, played and talked were different from other children. He preferred wearing girl's clothes. He got angry when his parents bought him boy's clothes. He stole his sister's clothes and played with it. His family member threatened him and imposed lot of restrictions to him so that he could change his behaviour. He felt bored and lost interest to do anything. His brother beat him in front of others for behaving like a girl. He used to keep long hairs and his brother forcefully cut his hair. Even in school, teacher told him to cut his hairs but he did not give any heeds. Sometimes he used to bunk classes from school for escaping scolding from teacher on his behaviour. His family was very strict to him, so he could not express his feelings. He suppressed his feelings and lived according to the wishes of his family. He sometimes felt useless of his life as he could not live accordingly to his choices. In school, his friends gave him female role to play in school functions and he

was happy to perform female roles in plays where he could express his feelings. Many times his brother beat him on the spot of the function in front of others.

At the age of 13, Chandani started mingling with other MSM. Some of his local senior MSM suggested him to participate in plays. At the same time, he learnt about MSM behaviour from his senior MSM friends. He was afraid of his family members and kept it hidden of his behaviour and identity. At the age of 15 years, one of his local elder brothers forcefully had sex with him. The same boy also taught him about the same sex after their sexual act.

When he was in class X, he disclosed his sexual behavior in family and public with the help of his local senior MSM who encouraged and influenced him. He studied till class IX and could not proceed for further study due to financial problems of family. Chandani changed his attitude and behavior after he dropped out from study. He became morally down and did not like to stay at home. His family members gave more restrictions to him and did not allow him to go out from home. He was irritated and angry with his family members, so he left his home. He came to Imphal and stayed there with a friend. He spent time without doing anything. He made a partner and fell in love with him. He was serious in their relations. One day, they quarreled for a silly reason and his partner took it seriously. Before leaving, his partner said that he would die for him. Chandini did not take his partner's words seriously. After some days, his partner joined an insurgency group and died in an incident. He was sad and regretted of what he did to his partner. He accepted his mistake and took himself responsible for his partner's life. In order to forget the incident, he started taking alcohol and tobacco. In the meantime, he got a chance to go to Guwahati for parlour course of six months.

After coming back from Guwahati, he did not return at home. He stayed with his friend for somedays then only he went home. After the short course of parlour, he dreamt of opening a parlour shop but due to financial problems he could not open it. He felt angry of his situation but he could do nothing. One day he met a MSM person who worked in an NGO. He suggested him to join NGO. Fortunately, there was a vacancy in the NGO for a post of Peer Educator. He applied for the post and started career as Peer Educator but he was finding difficulty in managing his personal expenditure with the salary, so he left the job. After leaving the job, he is not doing anything and staying at home.

Case 8

Sunil (name changed) is the youngest among six siblings in his family. Sunil's father was a ward member of their village and mother, a house wife. Sunil's eldest brother ran a jewellery shop and second brother was doing small business. His father passed away few years back and mother lived with his second brother.

In childhood, Sunil's behaviour was very much similar with a girl. His parents were not serious about his behavior and did not impose any restriction to his behavior. He even wore girls' clothes and went out with his mother. His mother told others that he is her younger daughter. His parents believed that his behaviors would change when he grew up. Sunil's friend circle and local people did not say much of his behavior. He did not face problems in family and society during his childhood. When he was in class III, he stopped wearing girl clothes.

Sunil came to know something about MSM from his local brother who was an MSM. That MSM brother used to called Sunil "B Nao" meaning young MSM. He was surprised when he saw his local brother's behavior. When he was in class VIII, he started wearing make-up and his sister's clothes. He had first sexual intercourse with his school friend when he went to school camp. During the camp, he had sex for many times with his friend but they separated when they came back from the camp. He was addicted to sex during the school camp and after his return he started looking partners for sex.

After coming back from the camp, Sunil's behavior had changed. His family members suspected of his behavior accordingly they put him to boys school so that he can change his behaviour. In the new school, he did not find any friend who had similar behavior like him. His school friends often teased him and called him 'homo'. He was not happy and lost his interest to school. Later, in that new school, he found some boys who had similar behaviour like him. He made friendship with them and started showing feminine behaviour in school. In school, he became famous and everyone called him 'heroine'. One of his teachers showed interest to him & gave more attention in the class. Sometimes the teacher gave more marks in class test. His school friends teased on his relationship with the teacher. Till class X, he kept sexual relationship with the teacher. Instead of changing his behaviour, Sunil became more interested in showing his MSM behaviour than before. Family members were worried about him.

Sunil got an offer from a play group but his parents did not allow him to join the group. Later he convinced his family and joined the group. He became a good actress in the play group. Some of his co-actors had relationship with him. He had

relationship and enjoyed sex life with them. His family members came to know of his behaviour and relationship with other co-actors so they called him back at home for further studies. He was reluctant to leave the play group but family members threatened him. Then he further continued his study and appeared class X exam but he failed in the first attempt. He could not concentrate in his study but he was more keen and interested in spending time with partners. He appeared class X exam again and passed in second attempt. After passing class X exam, he joined play group again by staying at partner's place. After some months of their relationship, he broke up and came back home. At the same time, he left the play group for personal problems. Right after leaving the play group, he got a job in an NGO which was working for MSM community. He got useful information from his work which prevented him from involving in risk behaviour. During that time, his family members pressurized him for marriage. He started realizing of his past mistakes. When he went for an organizational training programme, he met a girl and fell in love with her. After few days, they eloped and got married at the age of 33. His wife knew of his past life and his sexual behaviour.

After marriage, Sunil didn't think about MSM behavior anymore. His mind was totally focused on earning money and maintaining his family. At times his wife misunderstood his behaviour though she knew about it. He convinced her and acquired trust of his wife. He tried a lot to change his behavior, attitude and personality to impress his wife. Now, he is not mingling with his MSM friends anymore. Instead of spending time with his MSM friends, he preferred staying with his heterosexual friends. He is happily living with his wife and two children.

Case 9

Mani (name changed) is the middle child among eight siblings in the family. Mani's father was a daily earner and mother, a house wife. He belongs to poor family. His mother passed away when he was at young age and there was emptiness of motherly love in his life. Mani grew up with a mentality of a girl and always played with girls. He did not have interest playing with boys. His brother threatened him for his behaviour but he did not listen to them. Family members imposed lot of restrictions on him. At the age of 11, he had same sex experienced with his local friend. He did not share the incident to anyone. He did not express his sexual behaviour and identity due to fear of family members and society. However, when he was in class X, he met a friend who had similar behaviour with him. He made friendship with him and started expressing his sexual behaviour in public.

During those days, there was a play group in his locality. He participated and took female role in the play. His local elder people and friend appreciated of his roles in the play and encouraged him to join the play group. He got an offer from other play group and he joined the group. After joining the play, he came to know of same sex attraction. He became famous and people came to know of his performance and appreciated his role in the play. He got the Juri Award of Shumang Lila Competition in Manipur.

In order to make him stay in the group, his friend played a trick by engaging him in relationships with the secretary of the play group. They developed relationship for few months. Mani did not have sexual relationship with his partner for long time

but incidentally on the way to Assam his partner asked him for sex. He could not refuse and had sex with his partner for the first time.

Mani's brother came to know of their relationships and so he called him back at home. But he did not leave the play group. His brother got angry and restricted him from participating in the play. One day, his brother scolded his partner at his house and told him not to meet Mani. Mani got angry of his brother's attitude. He went straight to his partner's place and stayed with his partner. Later he returned back at home and started going for daily wages to support his father.

With his increasing age, his family members insisted him for marriage. At that time, he knew a girl. He proposed her and the girl accepted his proposal and got married at the age of 37 years. After getting married he was not happy with his wife as he wanted to have sexual relationships with partners. At the same time, his wife was not happy with him and complained of his roles and responsibilities. He is living in a compromise life with his wife.

Case 10

Thoiba (name changed) is 39 years old. He is the middle among the 6 siblings in the family. Thoiba's father was a bus driver and mother, a house wife. His family was comfortably running with his father's income. One of his younger sisters is lesbian. Thoiba grew up as a normal child. His parents did not find any strange behavior to him during childhood. He played with his friends and mingled with them and he did not show his behaviour in public. In very young age, he involved in business under his maternal aunty. He went to Moreh to take things and sold at nearby market. He reared

piggeries and earned money from it. One day, he went to Imphal for business purpose and met some MSM friends. He learnt some of the MSM nature and behaviour and he started behaving like MSM.

After returning home, he wanted to mingle with MSM friends. When he was in 16 years, one of his local brothers proposed him and had sex with him. After that incident, his behavior became totally changed, etc.

After class X, he got admission to a nearby college. In college, he was always with girls and spent time with them. His parents came to know of his behaviour and relationships through one of his local boys. His father got angry and restricted him from going out. He gathered his business money and headed for Dimapur for business. Unfortunately he lost everything in his business so, he returned back at home. Then he started running a local wine shop with his new partners but the shop was banned by local women organization (MeiraPaibi) and local club. Later, he became addicted to alcohol and found difficulty to live without wine. At present, he is having liver problems and doctors suggested him for rest.

Case 11

Thadoi (name changed) is from a Muslim family. He is youngest among eleven siblings in the family. He got married and divorced after two months of marriage. Thadoi's father was a daily wage earner and mother, a house wife. Thadoi's elder brothers and sisters helped his father so they have self-sufficient family income.

Thadoi was like a girl during his childhood and asked his parents for girls' clothes for him. Thadoi's parents brought girl clothes for him and he played wearing it.

His parents did not restrict and comment on his behaviour. He came to know of same sex attraction around class IV. He was attracted more to boys than girls. He learnt wearing make-up from his elder sister and he used to move in public with make up on his face. When he was in class VIII, he disclosed his sexual behaviour in public. His friends teased him because of his feminine behaviour but he avoided them. He also had sexual relationship with some of his classmates and even teacher caught during their acts. Often, he missed classes to escape abusing and threatening from teacher. He started having love affairs with a boy from his same class. Parents also came to know of their relationship and tried to separate them. He was separated from the boy after his X passed but he started having new relationship with another boy in new school. He was serious in his sexual relationship and had spent time with his boyfriend. Again, parents came to know of the relationship and tried to separate them. For three times, they tried to run away from home and finally they decided of staying together at a place. At the end, both the families could not separate them so; they allowed them to stay at boys' house.

Thadoi stayed at his partner's house like a newly married woman. He played the roles and responsibilities of wife and daughter-in-law in the family. He lived happily with his partner for two years. His partner was busy earning money and could not give time to him. So he felt bored staying at his partner's house. In absence of his partner he used to go outside and spent time with other partners. He even had sexual relationship with other partners.

Thadoi in-laws got angry with his behaviour. Most of the time there were conflicts in family because of his behaviour. So he discussed with his partner and asked

him to look for a girl. He was upset but he did not have any choice. With the help of Thadoi, his partner elope a girl but his partner's parents did not like the girl and thus all the blame had come to Thadoi. On this issue, there was a big fight in the family. Later, his partner got married with that girl. After their marriage he left them and came back home.

In order to come out from the pain of separation with partner, he started looking for new partner. He even started having sexual relationship with many partners. He started drinking and using intoxicated substances with other partners. After seeing his condition, family members pressurized him for marriage. Initially, he rejected but finally he decided for marriage. Thadoi's parents searched a girl for him and were married at the age of 32 years. After marriage he was unable to handle his responsibilities towards his wife. He was unable to maintain sexual relationship with his wife. After three months of their marriage, his wife left him.

Case 12

Thambal (name changed) is having three brothers and five sisters. His father passed away. Thambal father was a road mohori and mother, a house wife. His family is hardly run by with his father's pension. All the brothers and sisters got married and separated from them. He is living with his ailing mother and a mentally sick sister. He is looking after them.

During childhood, Thambal used to play with his local girls and spent time with them. Family members did not allow him in mingling with girls. Family members tried to change his behaviour by threatening, scolding with abusive words,

etc. But he could not change his behaviour. He ran away from home and stayed with relative to escape from family threatening. Till now his brothers do not like him because of his sexual orientation and behaviour.

Thambal came to know about same sex attraction at the age of 12 years. However, some of his local friends and local brothers teased him. He did not give much important to them. Around 18 years of age, he met a group of senior MSM who visited his neighbour. They came to know each another and spent time with them. The senior members of MSM shared about their experiences. Those interactions had influenced him to come out his sexual orientation and identity in public. He searched for friends who have similar behaviour and made friendships with them. Along with his friends, he put make up on their faces and went out for searching partners at night. He was good looking and famous among MSM friends that made him proud. One of his local brothers suggested him to join a play group and he joined the group. He was in play group for some years and had a serious relationship with a musician of the group. Many times, he had sexual relationship with the partner. After few months of their relationship, he came to know that his partner was HIV positive. After knowing of his condition, still he did not go for HIV test for long time. Suddenly, one day he got sick and was hospitalized. Doctor suggested him to undergo for HIV test and the results found to be HIV positive. He became depressed and regretted of his past life. He was upset to his partner as he cheated on him. Further whenever he thought of his weak mother and mentally ill sister he got the courage to live with double stigma.

Case 13

Raju (name changed) is at fifth members among seven siblings in family. He had one brother and five sisters. Raju's father is a business man and mother, a house wife. His mother passed away three years back. Since childhood, he preferred behaving like a girl. He never demanded of boy's things during his childhood. Members of family did not pay much attention towards his behaviour as they believed that he would change when he grew up. However, it did not happen according to the wishes of his family members. He built up better relationship with his sisters than his brothers. He was more attracted to his sister than his brothers in terms of behaviours. When he grew up, his family members recognized of his behaviour and tried to change his behaviour. But he was fully absorbed to girl's personalities and found difficult in changing his behaviour. Raju's locality members and school mates teased him for his behaviour. When he was in class III, a boy from his locality asked him for sex but he refused it. One day his locality brother gave him edible things, taught him about sex and also asked him for sex but he refused and escaped from the boy. When he was in class X, his mother came to know of his homosexual behaviour. She became upset but did not express to him. His mother called him and gave advice about the social norms. Later he became interested for make-up training course and took permission from his parents but they did not allow him to pursue the course. He did not inform parents but he managed to arrange everything with the help of his maternal aunty and went to Hyderabad for six months make-up training course. After the course, he came back to Imphal and wanted to open a parlour shop but he could not open it due to his poor financial conditions. He stayed at home for more than a year without doing anything.

Then he started going for hair cutting in his locality. Slowly, he gathered some money and took a rented room for opening a shop. He became famous in his area and started earning money. He even got make up order from Manipuri film artist, now he is financially sound and supporting his family. After having stable income, family members expressed their desires of his marriage but he refused for marriage as he had a serious relationship with a male partner. He loves his partner and does not have courage to leave him. Unfortunately, his brother do not have child. Now, he is the only hope in the family to bring a child and carry forward the generation. Now, he is in confused state whether he will marry for family or he will live as MSM for his own satisfaction.

Case 14

Ranjit is from Muslim family. He is eldest among two brothers in family. Ranjit's father was working as staff in Manipur State Transport Cooperation and mother, a house wife. He did not have girl's personalities in his childhood. He grew up like a normal boy. Because of his normal behaviour, parents did not recognize of his hidden behaviour. He grew up as a shy boy in family and society. In school, he could not have conversations with his friends and teachers. He knew of his weakness but could not come out from it. He was good in studies among the students. His shyness had become problems for him and affected on his academic performance. He met a girl friend from his same class who had helped him to overcome his shyness. They became close friends and spent time together. He was too closed to his girl friend that he even imitated her ways of walking, acting, talking, etc. His friend suggested him to participate in school

programme so that he could overcome from his shyness. Most of the time, he performed the girl's role in school functions or programme of locality. That made him developed confidence in his personality. He further went for singing training and performed in many school and local functions. Most of the time, he won prizes that boost his self-esteem. As most of the time he mingled with girls group, he had the tendency of developing girl's personality. But he was afraid to show his orientation in family and in public. He knew that his parents had lot of expectations from him because he was born after six years of marriage. Therefore, his parents had loved and cared for him. When he was at class VIII, he fell in love with a boy from class X in same school. The boy had developed emotional feelings for him so they became closed. However, their relationship became parted when the boy passed his class X exam. Meanwhile, his father was sick and was unable to go for work which hampered their family income. He could not complete his higher secondary due to his families' poor financial conditions. Then he started going for daily wages from one place to other. In due course, he had sexual relationship with close male partners whom he had confident of not disclosing his sexual behaviour. After all in Muslim community, there is strict restriction of homosexual activities. He was always afraid of his behaviour if someone came to know about it. In order to support family, he started teaching in a school. After working as an assistant teacher, he became worried of his sexual behaviour. Thus, he developed an internal conflict of living with private and public identity.

Case 15

Suraj (name changed) is from Christian family. He is the second eldest among five siblings. He has three brothers and one sister. His father passed away and mother is running a small business. He completed graduation and diploma in computer. Suraj grew up as a normal boy and no one had recognized of his feminine personality in childhood. He developed feminine character but he did not express and expose of his behaviour to anyone. So, he did not face problems within family and society for his sexual orientation. He maintained his masculine character or behaviour in family and society. He had also taken male roles efficiently in family which did not doubt in his behaviour by others. In school, he had mingled with boys but had spent more time with girls than boys. But he was attracted towards men. However, he did not show his behaviour to friends or others. Suraj had first sexual attraction at the age of 16 years and had sexual relationship at the age of 22 years with a boy who was closed to him. He took long time in disclosing his sexual behaviour because of fear of family and society. Moreover, he did not meet any of his friends who had similar behaviour with him in school and locality. He always mingled with straight boys though he did not want them. He had pretended and acted like a straight man among his friends circle but he was not happy with his behaviour. In the meantime, his family's financial condition was not good and everyone was depending on his mother. So, after graduation he left study and went to Imphal for searching jobs. In Imphal, he got a job for shopkeeper so he stayed with his aunty. There, he met some MSM who had come to buy grocery from his shop. They became familiar and met them after his work. Slowly, his real behaviour came out; he was happy and comfortable with his new identity and

had spent time with his MSM friends. However, he did not expose his behaviour openly to family and public. When he was with MSM friends he showed the feminine character. Later he got information for a post vacancy in an NGO which was working for MSM community. He got the post and supported his family from his income. After working with MSM community, he started coming out of his homosexual character in public.

Discussion of Case studies

Due to non-acceptance of homosexual activities in traditions and cultures, MSM community has faced problems in family and society at large. The case studies of the study found that lack of proper socialization and bitter experiences during childhood that include child sexual abuse, nuclear family, no girl child, no father in the family can affect the individual's personal growth and development. Peer group also played a vital role in socialization to MSM culture. 'Coming out' with homosexual identity among MSM had created psychological distress to family members. Some family members do not accept their sexual identity that made them felt rejected and neglected. Some of them even left home to escape from family threatening. After leaving home, they stayed with their partners and peer groups that increase the risk behaviours such as use of intoxicated substance, having multiple sexual partners leading to HIV/AIDS. This further can influence their psycho-social well-being of MSM community.

PART III

IV.7 Services provided by Government and Non-government organizations for MSM

Part III of the chapter deals on the roles of Government organizations (GO) and Non-Government Organizations (NGO) in implementing services for MSM under the study area. It will further highlight the difficulties and challenges faced by service providers in providing services to MSM group. Following are the programs and services implemented by GOs and NGOs:

IV.7.1 Programmes and services provided by GOs

a) Manipur AIDS Control Society (MSACS)

- Background

AIDS was first come to know in the year 1982. The epidemic of this disease becomes a serious problem for the whole nation. The National AIDS Committee was set up in the year 1986 and launched National AIDS Control Programme in the year 1987. As per the guidance of National Government, Manipur Government immediately set up a Committee under the Chairman of Chief Minister. A cell has established in the State Health Directorate under the supervision of a Medical Officer. The State AIDS Policy was adopted by the State Government on 3rd October, 1996 and became the first state having AIDS Policy in India. The governing body of the society consisting of not more than 17 persons from various government and non-government organization with the Chief Minister of Manipur, the Minister, the Minister (Health) and the

Commission/Secretary (Health) as its Chairman, vice-Chairman and Member Secretary respectively. The management of the society is undertaken by an Executive Committee consisting of not more than 11 persons from different Government and Non-Government Organization with the Commissioner/Secretary (Health) and Project Director (MACS) and its President and Member Secretary respectively.

- Objectives

  - To arrest the pandemic of HIV/AIDS in the State

  - To give awareness to the people regarding the disease and care/support on the needs of HIV/AIDS affected people living in the State.

- Area of Operation

The services of the MACS is covered all the districts of Manipur i.e. Imphal East, Imphal West, Thoubal, Bisnupur, Chandel, Churachanpur, Senapati, Ukhrul and Tamenglong.

Figure4.16: Area under MACS

- Beneficiaries

The beneficiaries of the MACS are injecting drug user (IDU), MSM, People Living with HIV (PLHIV), truck drivers, children, and female sex workers (FSW).

- Organizational Structure and Infrastructure

The Governing Body of the Manipur State AIDS Control Society (MACS) shall consist of-

a) The Chief Minister, Chairman

b) The Minister in-charge of Health & FW, Vice-Chairman

c) The Chief Secretary, Government of Manipur, Member

d) The Administrative Secretary (Planning), Government of Manipur Member

e) The Administrative Secretary, Education (U), "Member"

f) The Administrative Secretary, Education(S) “Member”

g) The Administrative Secretary (Social Welfare) “Member”

h) The Administrative Secretary (Youth Affairs, “Member”

i) Director General of Police, “Member”

j) The Administrative Secretary (Finance), “Member”

k) The Project Director, MACS “Member”

l) The Administrative Secretary (H&FW) Government of Manipur Member-Secretary

Nominated Members are

a. One person who has rendered distinguished social member in the field of HIV/AIDS to be nominated by the Chairman for two years term.

b. Two persons (one Man and one women) representing member HIV-positive people, to be nominated by the Chairman for two years term.

The Manipur State AIDS Control Society (MACS) shall have an Executive Committee consisting of:

a. The Administrative Secretary (H&FW) Chairman/ President

b. The Project Director (MACS), Member Secretary

c. The Director, Health Services, Manipur, Member

d. The Director, Family Welfare Services, Manipur, Member

e. The State Mission Director, NRHM, Manipur, Member

f. The Director, Social Welfare, Manipur, Member

g. The Director, Youth Affairs & Sports, Manipur, Member

h. The Director, Planning, Manipur, Member

i. The Director, Education(S), Manipur Member

j. The Director, Education (U), Manipur Member

k. The Medical Superintendent, RIMS, Member

l. The Medical Superintendent JNIMS, Member

m. The Administrative Secretary (Finance)/depute one on his behalf from the department, member

n. Two representatives (one male & one female) from HIV Member positive people to be nominated by the Chairman for two years term

o. Two representatives from NGOs (One man & one women) working in the field of HIV/AIDS to be nominated by the chairman

The services of the organization are provided according to various sections such as ICTC, ART, Mobile ICTC and Blood bank.

- Progamme

i. *Targeted Intervention Project*: The basic message for prevention of HIV infection among the injection drug users are total abstinence from drugs, injection is more dangerous than oral used, do not share needles and syringes with other in all situations, and sterilize needle and syringes with 5 % Bleach with the standard sterilization procedure of 2X2X2 before injecting drug. The strategy is based on "Harm Reduction" or "Harm Minimization ". In order to ensure effective implementation of the Harm Reduction Program in Manipur, the program is integrated with care component and it is called Rapid Intervention and Care (RIAC) project. Manipur is the first state in India to have adopted Harm Reduction program.

ii. *Rapid Intervention and Care (RIAC) Injecting Drug Users:* The main objectives of the RIAC are to reduce further spread of HIV infection among IDUs and their sexual partners, to monitor and evaluate behaviour change of IDUs, to achieve complete abstinence from drugs in the long run, to minimize spread of HIV infection to the female spouse of IDUs. The major services/activities of the programme are community sensitization and mobilization, risk reduction education, outreach work, voluntary counselling and HIV testing, STD treatment, condom promotion and social marketing, needle syringe exchange programme, drug substitution programme, bleach and teach programme, home detoxification, home care supportive and conductive social environment, creation of helpful, referral services and formation of self-help group.

iii. *STD Clinics and Condom Promotion:* There are nine STD Clinics functioning in Manipur under MACS. There are STD Specialist, Medical Officers, Nurses, and Technicians. In all district hospitals, CHCS, PHCS have trained STD Syndrome management. IEC and condom, and STD drug are freely available in the entire STD clinics. STD drugs available in the clinic are Tablet Ciprofloxacin, Tablet Norfloxacin, Tablet Cotrimoxacin, Tablet Erythromicin, Pedophyllum, Co-trimoxazole Vaginal tablets/cream, Capsule Doxycycline, Bezyl Benzoatr and Capsule Tetracycline. Now, 19 Condom Outlets are functioning in Imphal town.

iv. *Blood Safety Programme :* There are three licensed blood banks at the Regional Institute of Medical Sciences (RIMS), the J.N. hospital, Imphal and the District Hospital, Churachandpur.

v. *Information, Education and Communication (IEC) and Social Advocacy:* There are regular IEC campaigns and social advocacy programme for effective and implementation of AIDS Control Programme. IEC is being used in various forms such as print media including newspapers and journals, electronic media like TV, Radio, Films, Video and Audio Cassettes and traditional media like Shumang Lila, Dramas, Folk Plays, and Music Ensemble, etc. It is produced in English, Manipur and major tribal dialects so that widespread of people can understand suitability, and acceptability. The basic messages of spreading of IEC are how does HIV spread, the mode of transmission, prevention and control of HIV/AIDS, the importance of voluntary participation of people with high risk behaviors, facilities available for voluntary HIV antibody testing, the services available, the importance of non-discrimination, respect for privacy, human rights and human dignity of patients with HIV/AIDS, the influencing patterns of behaviours which may put an individual at risk, rehabilitation of recovering drug users, people with HIV/AIDS and various aspects of the Manipur State AIDS Policy. The targeted groups of spreading IEC are Injecting Drug Users (IDUs), Commercial Sex workers (CSWs), MSMs, Migrant Workers.

vi. *School Education :* The programme of school education is implementing under the NACO guideline. There are 523 schools, 1050 teachers and 1050 Peer Educators have been trained under this programme. MACS has selected a state level NGO called Indian AIDS Consortium (IAC) which having about 20 members NGO for the concern programme.

vii. *Shumang Lila*: The spreading of information is also taking in the form of play. There are training programmes for Shumang Lila (Court yard play) actors and actress. The campaign is conducting in all the districts of Manipur. In addition, there is poster, slogan, and essay, debating competitions organized at state, district and institution levels.

viii. *Voluntary Counseling and Testing Centres (VCTCs):*Two Counselling Centres are functioning at present, one at the VCTC (Blood Testing Centre), RIMS and the J.N. Hospital, Imphal. These two Centres are operated entirely by one NGO namely the SASO, RIMS Road, Imphal.

ix. *Telephone counseling Centre:* On the recommendation of the Executive Committee, one Telephone Counselling Centre has been approved on the NGO sector namely the Meitei Leimarol Shinnaishang. The electronic telephone counselling machine (Voice Response Computerized System) has been procured. The centre starts functioning by 1st week of June, 2002.

- People's participation

People participate in spreading information on HIV/AIDS to mass. Public come up in public arena and took part in various programme and services of the organization.

- Staff Related Information

MACS have a Commissioner (Health &F.W.), Project Manager, Finance Officer, 5 Deputy Directors (M&E/DAPCU, BS/TI, CST/Surveillance, ICTC/STI/Targeted IEC), Join Director, M&E Officer, Consultant VBD, Consultant Youth Affairs, Consultant CSM, GIPA Coordinator, Data Analysist, 18 Divisional Assistant, Office Assistant, 2 Computer Literate Steno, 5 Finance Assistant, 7 Drivers, Grade IV/ Messenger, 3 Grade IV and attendant in Head Office. The organization is also having 9 District Supervisors, 4 each DAPCU in all the 8 districts of except 3 in Senapati district. 4 each staffs of Mobile ICTC staff in Chandel, ukhrul, Churachandpur, Senapati and Tamenglong districts of Manipur. There are 13 staffs in Blood Bank Centre. So, all together there are 290 staffs in MACS.

- Financial Information

The financial source of the MACS is wholly from National AIDS Control Society (NACO). In respect of fund, there is no relationship between MACS and State Government. Fund is directly credited to the MACS account instead of State Government account. The main region is to avoid controversy and interference of State Government to society activities because MSACS is following the rules and regulations of NACO not for State Government. Then the funds are disbursed to respective projects through concerned NGOs. Though MACS is following the norms

of NACO but the staffs are getting salary according to the State Government contractual salary norms.

IV.7.2 MSM program implemented by NGOs

a) Social Awareness Service Organization (SASO), Wahengbam Leikai, Imphal West, 795001

- Background

Social Awareness Service Organization (SASO) was established in the year 1st January 1991 and got registration in 18th Feb. 1992. The organization is located at the centre of the Imphal town. It was form by a group of people who had experienced of drug, agony, pain, stigma, discrimination and chaotic lives because of drug use. Since its inception, Social Awareness Service Organization (SASO) has been working in the area of intervention and prevention of HIV among the drug users and slowly expanded its activities to cover other vulnerable groups with care and support program of the people living with HIV/AIDS (PLHIV) and issues affecting the lives of women and children across the state of Manipur. SASO also established meaningful linkages and is collaborating with different local, regional, national and international agencies.

In the year 1991, SASO initiated community based outreach intervention on drug use prevention and HIV/AIDS in Manipur. In the next year, the organization organized drug user & HIV/AIDS awareness program in different localities with the help of State Social Welfare Department of Manipur and initiated of pilot study & home-based care service to PLHIVs with the help of Indian Council on Medical Research (ICMR) and individual doctors. In 1994, SASO started First Telephone

Helpline (counseling) on drug use prevention HIV/AIDS and also health care activities through home based care with the support from OXFAM, UK. SASO was participated the first Asia-Pacific Conference on AIDS at Changmai, Thailand in 1995. In 1997, University of California and Los Angeles and SASO conducted a study on (HIV infection) among the spouse of positive IDUs. In 1998 & 1999, taking into the accounts of SASO, MACS gave the responsibility for handling voluntary HIV test counseling in the two existing testing facilities of Imphal. In the same years, SASO involved in the program designing of Rapid Intervention and Care (RIAC) and implementation of RAIC project among the IDUs and MSM sexual partners in four districts of Manipur. The organization initiated first Oral Substitution Therapy (OST) among the IDUs in Manipur supported by SHARAN and European Commission (EC) in the year 1999. In the next year, developed training manual on Drug Substitution Program and submitted to MACS. In 2001, there was publication of 'Consumption and availability of drug in border area at Moreh'- a study sponsored by UNDCP-ROSA. In the same year, SASO Home Based Care activities was documented as one of the UNAIDS Best Practice document in South East Asia. In the next year, organization has initiated HIV/AIDS intervention and Prevention among the IDUs and their Sexual partners in Imphal supported by Family Health International (FHI). In 2004-2005, SASO has initiated Home based Care program, Care and Support, Care and support program among the IDUs and PLHIV, Oral Substitution Research Study, Implementation of Oral substitution program, Nutritional support for PLHIV windows, Medicinal support for PLHIV, HIV/AIDS intervention and prevention among the IDUs, MSM, SW and their sexual partners in four districts of Manipur

(ORCHID Project) supported by Project Concern International (PCI) through Center for Disease Control (CDC), Catholic Relief Service (CRS), International HIV/AIDS Alliance, UNODC, DFID, EJAF, PLAN AID and Emanuel Hospital Association (EHA) respectively. In the same year, organization has conducted various research studies on psychological implications on PLHIV women, gap and challenges on PPTCT program and access to ARV treatment, sexual behavior among IDUs in partnership with Population Foundation of India through UNICEF. HIV Prevention and Intervention among the Female IDUs supported by International HIV/AIDS Alliance was initiated in 2007. The organization also received support from India HIV/AIDS Alliance through Global Fund Round-6 and Clinton Foundation for the Implementation of Care and Support program for children affected and infected by HIV in six districts of Manipur and Care and support program children infected by HIV. The ongoing programs of the organization are:

- HIV Prevention and Intervention among the Female IDIs supported by International HIV/AIDS Alliance
- Care and support program for children affected and infected by HIV in six districts of Manipur with the support from India HIV/AIDS Alliance
- Care and support program for children affected and infected by HIV in six districts of Manipur with the support from India HIV/AIDS alliance through Global Fund Round-6
- Community Care Centre for Children (Hospital set up) supported by NACO
- Home based care at Sagolband constituency with the support from PCI through CDC Atlanta

- Care and support program in Imphal West by CRS
- Care and support program among the female IDUs in Imphal supported by International HIV/AIDS Alliance.
- HIV/AIDS intervention and prevention among the IDUS, MSM, SW and sexual partners in four districts of Manipur under the support from Emanuel Hospital Association (EHA)

➢ Vision and Mission of the Organization

Vision: The vision of the organization is to become a lead and reference organization in the area of prevention of drug use, HIV and its related diseases, universal access to treatment and provision of care & support, and creating productive, healthy and supportive environment among people who used drug, PLHA and their families.

Mission: The mission of the organization is to build sustainable models for prevention of drug use, HIV and its related diseases and to provide care and support for PLHA and their families adopting a rights based approach using multi-pronged and multi sector involvement through advocacy, partnership, networking and capacity building for an increased level of activity in the North East India.

➢ Objectives of the organization

- To encourage 'humility' in order to create a more accommodating society
- To bestow 'courage' in people who have lost their hopes for a normal life
- To spread 'wisdom' for liberating our society from drug abuse and HIV/AIDS

- Areas of Operations

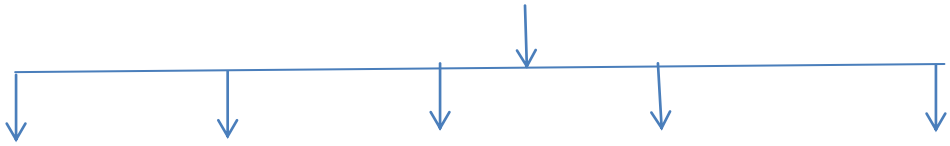
The program of the organization is covered all the nine districts of Manipur i.e. Imphal West, Imphal East, Thoubal, Bishnupur, Chandel, Senapati, Churachandpur, Ukhrul, and Tamenglong. All the block and villages of the said district are included.

- Beneficiaries

The beneficiaries of the organization are Injected Drug User (IDU), Men who have Sex with Men (MSM), People Living with HIV/AIDS (PLHIV), and Children.

- Organizational structure and infrastructure

Governing Body (It includes president, vice president, General Secretary and executive members)



Finance Section Project section M&E Section Research Section Subordinate Staff

- Programs of the Organization

i. *Injected Drug Users (IDUs) intervention & Prevention in four districts of Manipur:* The program was started in the year 2002 collaborating with the program of sexual partner in Imphal. It was conducted with the support of Family Health International (FHI). The main objectives of the program are to help IDU from recovering by motivating behavior change, to support to avoid relapse to drug use, motivating to use condom, make them to access to quality medical care and STD treatment and to promote safer sex.

ii. *MSM intervention programme in Imphal West and Imphal East districts of Manipur:* This program was started in the year 2004 in four districts of Manipur with the support of Emanuel Hospital Association (EHA) through Orchid Project. The objective of the program is to reduce the rate of HIV transmission among MSM population by using multi-pronged strategies, behaviour change communication, counselling, providing health care support, treatment for STD, and creating an enabling environment.

iii. *Four Key Elements / Components of the program:* Behavior Change Communication including peer educator that focus on providing information on a one to one basis often through peers or those who have close affinity to the populations being addressed.

iv. *Condom Programming*: Increasing the accessibility, acceptability, skills in and consistent use of condoms as means of prevention of STIs.

v. *STI Care and Counselling*: Addressing the technical and attitudes of providers and ensuring quality care (partner notification, drug, counseling and provision of condoms).

vi. *Creating of an enabling environment:* Through addressing the macro environment in which risk behavior takes place and facilitating legal and policy changes that will facilitate preventive behavior.

vii. *Female Injecting Drug Users (FIDUs) intervention in Imphal:* The program was started in the year 2007 with the support of International HIV/AIDS Alliance.

viii. *Sexual and Reproductive Health Right (SRHR) among the youth in Imphal:* The program was launched in Manipur in February 2010. The program is supported from European Commission (EC) through India, HIV/AIDS Alliance and implemented by SASO in Imphal West and East. In Imphal West, the program is implemented by Futures Development Drug Users Organization (FIDDUO) and in Imphal East Awaken Artisan Shelter Association (AASHA). The goal of the program is to improve the sexual and reproductive health and rights among adolescents and young people especially those from the most vulnerable and marginalized groups. The project aims to improve the sexual and reproductive health and rights among adolescents and young people, especially those who are from vulnerable and marginalized groups. The specific objectives of the program are to strengthen and empower youth groups/networks to advocate for young people's participation in sexual and reproductive health programming and policy process. The primary target groups of the program are CSOs, youth networks and other networks of vulnerable and marginalized groups such as sex workers, MSMs and IDUs. Secondary target group are policy makers, health care providers, teachers, parents, religious leader and other individual whose action impact on adolescent's sexual and reproductive health and final target is adolescents girls and boys whose access to sexual and reproductive health and related service.

The major purpose of the program is to address the barriers to adolescent's sexual health and well-being at the level of Regional and National, Local and

State policy and Programme & service delivery and to facilitate the voice of marginalized adolescents in these actions. The three themes of the program are is to empower CSOs, CBOs and the implementing partners to become more effective policy advocacy partners to government in development and planning process. It is also emphasizing on raising the profile of funding integrated SRHR-HIV programs for youth including vulnerable groups and empowered and capacity building of youth groups and networks to increase their knowledge, advocacy on adolescent's sexual and reproductive health rights. The main activities of the program are Engagement of external stakeholders (government, CSOs, etc.), advocacy and dialogue on inclusion of youths SRHR components, participatory community assessment and youth group activities, conduct training for youths groups with focus on SRHR advocacy, organize community based advocacy activities through connecting people, youth leadership training for selected youth group members, develop and roll-out YPP model at State level youth led stakeholder meeting for dissemination and lesson learning from activities and participation of youth in global and regional SRH and HIV Conference.

viii.*Care & support program for affected & injected children in six districts:* The program was started in the year 2007 with the support of International HIV/AIDS Alliance.

- Financial Information

The organization is getting funds from

1. Indian HIV/AIDS
2. Global fund
3. European Commission
4. Elton John AIDS Foundation
5. Catholic Relief Service
6. Project Concern International
7. Bill & Melinda Gates Foundation
8. National AIDS Control Organization (NACO)
9. Manipur AIDS Control Society (MSACS)

- Nature of people's participation

Civil society organisations and common people supported and participated to the programs organised by organization. In SRHR project, the organization is taking the leading role in developing advocacy plans for district-and state-level advocacy. The organization is supporting the formation and functioning of 360 youth groups. Youth groups are supported to engage in community and district-level advocacy. Youth leaders take the leading role in establishing state/districts-level advocacy coalitions. There is also positive support from people to the program related to HIV/AIDS. There is active participation from populations in any programs and services of the organization.

- Regular monitoring

Regular evaluation and monitoring is done by concern funders. Organization is submitting monthly and quarterly report to concern funder organization.

b) Awaken Artisan Shelter Association (AASHA), Sagolband Salam Leikai, Imphal West, 795001

- Background

In Manipur, MSM have been affected by HIV epidemic. HIV infection rate among MSM are often higher than the general population due to multiple sexual partners, unprotected sex and the hidden nature that contribute to the prevalence of HIV among MSM. The intervention to such community has been difficult because of gender issues, sexual role, stigma and discrimination and homophobia. In another way, they become victim of sexual, physical abuse, harassment. Most of them are discriminated by families. Keeping such things in front, a group of MSM people joint hand in hand and form an organization called Awaken Artisan Shelter Association (AASHA) in 1997 under the mother NGO Social Awareness Service Organization (SASO). The organization got registration in the same year 1997.

- Vision and Mission

The vision and mission of the organization is to develop inner strength and unification towards the betterment of health among MSM and TG in Manipur.

- Objectives

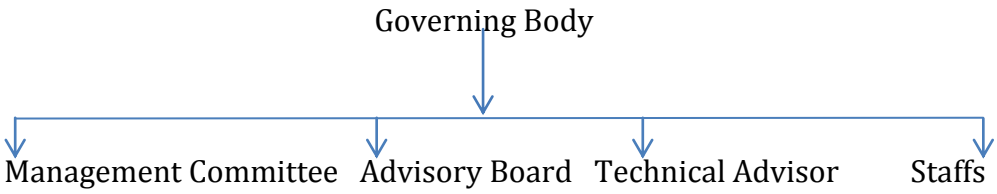
Objectives of the organization are:

- To access care and support for MSM and TG community
- To reduce the risks of HIV and STI among MSM and TG
- To sensitize the local governing body and stakeholders
- To fight for stigma and discrimination against MSM/TG

- Area of operation

The organization is working in four districts i.e. Imphal East, Imphal West, Bishenpur and Thoubal districts of Manipur. From these four districts, eight blocks are taken for the program implementation.

- Organizational structure



- Beneficiaries

Beneficiaries of the organization are MSM, TG.

- Programme

i. *Pehchan Project:* Pehchan Project was launched in the year 2010 under Solidarity and Action against the HIV Infection in India (SAATHII) through Global Fund to Fight AIDS, Tuberculosis and Malaria. It is the largest Global Fund grant to date to strengthen HIV prevention that programmed for marginalized group. The duration of the project is for five years. The main objective of the project is to halt and reverse the HIV epidemic among MSM, TG, Hijra; to make MSM, TG and Hijra enable to access key sexual and reproductive health (SRH) and HIV services. The project is mainly focused on advocacy and policy activities to create an enabling environment so that MSM, TG and Hijra can easily access to services. The services of the project are based on two packages:

- Pre TI package - to be implemented in those areas / districts where there are no MTH TI projects (reaching out to new MTH clients)
- TI Plus package - to be implemented in those areas / districts where MTH TI projects are running (offering additional SRH services to TI clients and also reaching out to new clients)

ii. *Sexual Reproductive and Health Right (SRHR):* The program was started in the year 2010. The project is implementing in different 8 areas (localities) under Imphal East and West District of Manipur. The program is funded by HIV/AIDS Indian Alliance. The main purpose of the program is to advocate for sexual and reproductive health and rights which is needed for all young people. It is addressing the barriers to adolescents' sexual health and well-being through different levels are Regional and national level, Local and state level policy, Programming & service delivery and by facilitating the voice of marginalized adolescents in these actions. The overall objectives of the program are to improve reproductive and sexual health and rights among adolescents especially those from vulnerable groups.

iii. *Community Mobilization:* The program is an ongoing program for the organization. It is the mobilization of MSM and TG community by conducting group meetings, awareness programs, seminars and workshops. The source of fund is mainly from contribution, donation and organization fund.

iv. *Access care and support:* The program is also an ongoing program for the organization. The sources of fund are donation and contribution. The activities of the program are mainly providing home based care.

- Staff related Information

There are 8 full time paid staffs in the organization. There are also volunteer members of the organization.

- Financial Information

The main financial source of the organization is HIV Indian Alliance and SAATHII, Kolkata through Global Fund for AIDS, Tuberculosis and Malaria. The turn over budget for the program is as followed:

a. Pehchan Project- 1, 87,700
b. Sexual Reproductive Health Right (SRHR)- 10,000
c. Community mobilization- 4000
d. Access care and support-3000
e. Through donation and contribution. Sometimes they faced deficits of finance in organizing the activities of the program.

- Nature of people's participation

People have become aware of MSM, however, in deep concern, the stigma and discrimination against MSM still exists in family and society levels. There is cooperation and support from public in most of the programs conducted by the organization. Sensitization programs for key stakeholders are conducted regularly. There is positive response from community people in awareness

programs and community events such as fashion period, thabal chongba, dance and song competitions and sports, etc. In some of the programs, community people especially youth took responsibility for the programs.

- Regular monitoring

There is regular monitoring of program activities and financial statement for every quarter by concern funder. Weekly staff meeting is held in every Saturday. Monthly reports are submitted to Sub-Recipient (SR) organization. Disbursement of money is depending upon the satisfaction of their activities.

IV.8 Difficulties and Challenges faced by government and Non-Government Organisations in providing services for MSM

Organisations expressed that as MSM are hidden population, they do not come easily for the services. It is difficult for organisation to reach out the services and make MSM people accessible to available services. So they need to track MSM community through peer educators and sometimes they need to provide recreational facilities for attracting MSM for the services.

The counsellors of SASO and SODO have also faced the same issues while working with MSM community. These two organizations work under Manipur AIDS Control Society project i.e. Targeted Intervention Program. The main responsibilities of the counsellor are psychosocial counselling, client referral, established network and linkage, handling of crisis intervention, etc. They expressed that providing counselling to MSM community is difficult as they don't accept the services very easily till they face crisis or health problems. They often hide their

sexual behaviour and identity and their personal and health problems to family and society. They further expressed that most of the MSM families do not accept their sons' sexual identity so family members do not want any service providers visiting their houses without taking prior permission. They also faced challenges like lack of openness, lack of facilities as no separate room for counselling to maintain confidentiality, and poor referral services, etc.

The Outreach Workers (ORW) of the two organizations are also having almost same views towards the issues and problems of MSM. The main responsibilities of the Outreach Workers are monitoring in distribution of condoms; performance of peer educators; conducting meeting at hot spot; giving training to peer educators; preparation of weekly plan, etc. They work both in office and at the field. They are the key persons who conduct programs for organization at field level. The main work of ORW is to contact with key population, community members, and deliver services to MSM and liaison with other organizations. They expressed that it was difficult in finding MSM as some MSM gave wrong addresses and fixed timings for meeting but they would not be available at the given time. So ORW tried to find out MSM's peer groups so that peer group can motivate the other MSM and fix a meeting accordingly. It is also seen that most of MSM don't show interest in discussing on HIV/AIDS. So they started showing negative attitudes towards service providers of NGOs.

Conducting awareness program in society is one of the challenges for NGOs as social acceptance of MSM behaviour is still low in society. Some sections of the

population do not have positive attitudes to NGO's service providers as people felt that their work is to raise funds from funding organizations.

IV.9 Discussion

The finding of the present section is based on the background of main services provided by concern post of the staffs, strategies which they used in rendering services, challenges faced in providing services for MSM. In India, program for MSM is very limited despite of categorizing them as marginalized group. According to Manipur AIDS Control Society (MACS) Epidemiological analysis of HIV/AIDS (March 2008) found that there were 29,000 HIV positive in Manipur. However, the figure of HIV infection may be increased because there may be many unreported cases. It is also found that the main route of HIV transmission is sharing of infected needles among intravenous drug users (IDU). However, after implementing programs and services of HIV prevention and treatment, the prevalence rate of HIV transmission is reducing from 1998 (72.78%) to 2004 (21%). Unfortunately, the finding revealed that the HIV transmission is not restricted only to IDUs. There are also a group of people who played main roles in spreading HIV infection in public i.e. MSM. According to Sentinel Surveillance Report 2006, HIV prevalence among the IDUs is 19.8% while among the MSMs and Female Sex Worker (FSWs) is 11.6% and 12.4% respectively. The above data showed that MSM people become one of the target groups to hold HIV infection in public because they played both penetrative and receptive roles during sexual intercourse. The finding of the study showed that MSM are hidden population who are hard to see in public places. Most of them preferred to live with their own community and were visible in

group. The finding also revealed that coming out stage is the most crucial stage in the life of MSM. They found difficult or hesitated to express their sexual behaviour and identity in family and society. The finding also highlighted that most of them had experienced of threatening by family members in the form of physical and verbal abuse. Maximum of the key informants expressed that service providers found difficulties in approaching or meeting family members due to MSM's hidden identities in family. Members of family did not know about MSM's sexual identity as long as MSM did not reveal their health and other related problems. Members of family perceived that meeting of service providers may expose their sons' sexual behaviour and identity in society. Moreover, MSM client do not want service providers to reach their family members as they are afraid of exposing their sexual behaviours and identity in front of family members.

Apart from having less support by service providers i.e. GOs and NGOs, MSM are not free from social ostracism such as homophobia, social stigma and discrimination in society. Society does not accept MSM's sexual behaviour and identity due to myth and misinformation of homosexuality. The informants reported that MSM were having experienced of physical and sexual harassment by polices, local goonda, friends, local elders and partners. Such situations made them faced of stress and depression in their daily life. Thus, the existing scenarios of MSM suggested that there is need of extra care, love, affection and support for this group of people so that they can come up in society. The government and NGOs need to work on different programmes beyond HIV/AIDS like livelihood and sustainable development programmes for MSM.

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