CHAPTER V

SUMMARY AND CONCLUSION

The present chapter deals on summary and conclusion of the study. It summaries the findings of the study that include profile of respondents, problems encountered by respondents that affect their psycho-social well-being, focus group discussion, case studies. It discusses the important conclusion of the study, future research areas, social work theory and its implications towards MSM, recommendations and model of the study.

V.1 The Study in Retrospect

The present study is undertaken to understand the psycho-social problems of Men who have Sex with Men (MSM) in Imphal East and Imphal West districts of Manipur. In Indian society, sexuality is taken as secrecy. Society doesn't accept homosexual practice and it is regarded as social inferior or abnormal, or criminals, etc. In a predominant heterosexual society, MSM sexuality is always confronted with issues. They have encountered stigma and discriminations at various levels that include family, society, and institutions. Their life is not free from problems and issues like homophobia, heterosexism (prejudice), heterocentrism (bias), and compulsory heterosexuality (pressured or coerced for homosexual behaviour). Such situations affect their psycho-social well-being leading to depression, anxiety, feeling of guilty, suicidal thoughts and low self-esteem. Besides of facing social stigma and discrimination, there are also laws such as Section 377 of Indian Penal

Code which are against homosexuality in India. Such laws made them more insecure which often offended to come out openly in society and enjoy their rights like other straight man. This further hampers their status socially, economically and politically at various forms. The available services provided by GO and NGOs are focused only on HIV/AIDS related problems which does not touch upon the psycho-social well-being of MSM. As such, there are no particular programs and services for MSM apart from HIV/AIDS under the study area. Review of literature has revealed that there are little studies done on psycho-social issues of MSM under the study area of Imphal East and Imphal West districts of Manipur. Thus, in the present study, researcher has tried to describe the psycho-social problems and related issues that affect MSM under the study area. The study also made afford to understand the available GOs and NGOs services for MSM population.

As justified in methodology chapter, a descriptive research design is used in the present study. The present study was conducted in four phases. In the first phase, secondary data was gathered to understand the different factors that impact on psycho-social problems of MSM such as sexual orientation, sexual identity, socio-cultural factors, risk behavior, coping mechanism; and available services of MSM provided by GOs and NGOs. In the second phase, pilot study was done in two districts of the study area i.e. Imphal East and Imphal West districts of Manipur. Testing of interview schedules were done through pilot study. The data were collected from respondents and key informants through snowball sampling and purposive sampling. In the third phase, interviews were conducted from 150 MSMs and 50 family members with the help of interview schedule. The researcher

conducted and studied four focus group discussions and 15 cases. In the fourth phase, stakeholders/ key informants were interviewed from Awaken Artisan Shelter Association (AASHA) and Social Awareness Service Organization (SASO) and Manipur AIDS Control Society (MACS).

V.2 Major findings of the study

V.2.1 Profile of MSM under the study area

The profile of the respondents showed that majority with 42.7 percent of respondents belong to the age group of 21-30 followed by 26.7 percent in 11-20 and only 4.0 percent are above 50 years. The study found that majority of respondents expressed their MSM behavior during the stage of young adulthood. It is further seen that majority with 58 percent of respondents belong to Hindu religion followed by Meitei religion (one of the indigenous religion of Manipur) with 28 percent, Muslim with 9.3 percent and Christian with 4.7 percent respectively. Thus, the maximum of respondents are from Hindu religion. 33.3 percent of the respondents attained higher secondary followed by 32 percent at secondary level and 20.7 percent with graduation and only 5.3 percent were found to be illiterate. 45.3 percent of respondents fell under the categories of daily wages. Out of these 45.3 percent, 20.7 percent of respondents were having income between Rs.1001 to 5000. The finding revealed that their occupations were limited and unstable. Further, 40.7 percent of respondents engaged in self-employed where 18.7 percent of them were having income between Rs.5001-10000. It is also seen that only few with 2 percent of respondents engaged in government jobs. The data further indicated that very few MSM were engaged in white collar job in Manipur. 61.3 percent of respondents

were from nuclear family followed by joint family with 22percent. The finding suggested that the family structure and character of parents may make difference in child socialization. It is also seen that 6 percent of respondents got married and the remaining 94 percent were unmarried at the time of the study. It further revealed that out of (9)6 percent of married MSM, (5) 3.3 percent of respondents were living with spouses and (3) 2 percent were separated and (1) 0.7 percent was divorced at the time of the study. Further, the finding revealed that respondents got married at late adulthood (34-42 age group) which indicated that respondents might not consider marriage as important aspects of their life.

V.2.2. Sexual orientation and sexual identity of MSM that affects their psycho-social aspects well-being of MSM

a. Sexual orientation and sexual identity domain

The finding of the study revealed that 93.3 percent of respondents were having sexual relationship with only male partners where 6.7 percent were with both male and female. Further, 92.7 percent of respondents expressed of having more emotional attachment with male. 83.3 percent of them felt more comfortable in spending time with male than female. The study found that the respondents had their fantasies and sexual attraction towards male than female. Majority of respondents with 68 percent were regarded as MSM B followed by 26.7 percent as Transgender (TG) and 5.3percent, 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. 68 percent of respondents were aware of their same sex attraction at the age of 11-20 years i.e., during the

adolescence period, followed by 32 percent, below 10 years of age. Maximum with 71.3 percent of them had experienced of first time sex as sexual abused. Out of 71.3 percent, they revealed that 35.3 percent of abusers were from their friend circles and partners, and 26 percent were local goonda/ local elder/ relatives. The finding noticed that sexual abused is done by near and dear ones whom they were well acquainted with the client. Ninety two percent of respondents had disclosed their sexual orientation and identity at the age of 11-20 years followed by 1.3 percent at the age group of 31-40 years. The study found that majority of the respondents came out during adolescent periods. It is seen that 40.7 percent of respondents disclosed of their sexual orientation and identity to their mothers, 28 percent to peer groups followed by 20 percent to MSM community, 8.7 percent to relatives and 4.6 percent to siblings respectively. The study found that majority of respondents expressed their sexual identity and behaviour to their mothers.

b. **Problems encountered in living with MSM identity**

The finding of the study showed that 85.3 percent of respondents faced problems in living with MSM identity whereas14.7 percent of them did not face problems. It is also seen that 42.6 percent of respondents had experienced of verbal abuse, 36 percent physical abuse followed by 6.7 percent with sexual abuse, 10 percent with physical and sexual abuse, 10.7 percent with physical and verbal abuse and 8.7 percent with physical, verbal and sexual abuse. The finding revealed that the problems faced by MSM are because of their sexual orientation and sexual behaviour.

- Problems encountered at Individual level

The study found that 59.3 percent of respondents did not agree that there were certain gender roles in accordance with gender identities whereas 24 percent of them agreed to it but 8.7 percent were neither agree or disagree with the statement. The findings revealed that majority of respondents were in favour of taking roles of female identity. 87 percent 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 percent of parents did not reveal their expectations of their sons' behaviours. It may indicate that parents are not aware of their sons' sexual behavior and identity as most of MSM have kept hidden of their sexual identity from family members. 80 percent of respondents had reported of having gender role conflicts and 20 percent 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. Maximum of respondents with 76.7 percent expressed that family members did not allow them to do household work at home. The finding of the study suggested that the concept of masculinity in gender role affects effeminate MSM in various forms. 80 percent of respondents had experienced of harassment and blackmail whereas 20 percent did not experience of it. 62 percent of respondents expressed of not feeling comfortable in meeting police, local goonda and sometimes insurgency group. The respondents revealed that there were physically and sexually abused by police and local goonda.

- <u>At family level</u>

The study found that 84 percent of respondents had experienced of threatening by family members. Out of 84 percent, 69.3 percent 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. 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. Majority with 62.7 percent of respondents' family members wanted their sons to get married whereas 37.3 percent 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' behavour.

- <u>Society level</u>

The finding showed that 80 percent of respondents faced negative attitudes from neighbours whereas 20 percent of them did not experience of it. The finding revealed that MSM experienced of some form of negative attitudes from neighbours such as teasing, putting down, prejudice, angry, verbal abuse, disconnect communication, etc. 86 percent 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.

- Experience at work place/school/college

74 percent of respondents had experienced of unfairly treatment at school/college and 26 percent 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. 75.3 percent of respondents experienced of negative treatment at work place whereas 24.7 percent of them did not face of such experiences. The finding revealed that MSM had encountered stigma and discrimination at work place.

V.2.3 Risk behavior and coping mechanism of MSM

a) Sexual partner's domain

The finding of the study showed that 98 percent of respondents had male sexual partners and 2 percent did not have at the time of the study. The finding revealed that the culture of keeping male partner relationship is prevalent among MSM community. 62 percent of respondents were having multiple sexual partners followed by 24.7 percent with monogamous and 13.3 percent with bigamous sexual partners during the last three months. The finding noticed that the main reasons for keeping multiple sexual partners were due to unsteady partner-relationship. It is seen that 62.6 percent of respondents regretted after having sexual act with partners. Out of these 62.6 percent, 42 percent 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. It is further seen that bigamous relationship is a serious threat as it spreads sexually transmitted disease to general population.

Majority with 59.3 percent of respondents were able to keep relationship for more than a week but less than a month and 15.3 percent 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 relationship. Thus, the finding highlighted that the nature of partnership pattern among MSM is unstable and unsteady in nature. It is seen that 72.7 percent of respondents did not feel their partners as faithful whereas 27.3 percent 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. 71.3 percent 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. 83.3 percent of respondents did not receive money or gift for sex whereas 16.7 percent 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. 36 percent of respondents did not use condom during last three months and majority with 64 percent use condoms for at least 0-10 times (16 percent), 11-20 times (21 percent), 21-30 times (10.7 percent), 31-40 times (7.3 percent) 41-50 times (8 percent) and Above 50 (0.7 percent). It further seen that out of these 36 percent who did not use condom, 24 percent 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 the 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. 86 percent of respondents did not face problems of searching place for sexual act whereas 14 percent had experienced of it. The finding revealed that respondents were aware of places where they can get partners. Thus, the easy availability of place for sexual act may lead them to engage more in risk behaviour. Further, 39.3 percent of respondents had sexual act at hotels/venders, 28 percent of them had sex at public places such as parks, woods, streets or car, 20.7 percent at their own house or partner's house and 12 percent 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.

b. Intoxicated Substance abuse

The finding of the study found that 84 percent of respondents used intoxicated substances. Out of these 84 percent, 57.4 percent 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 percent. Thus, the study found that there is prevalence of used of intoxicated substances among adolescent and young

adulthood. 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. Majority of respondents with 84 percent 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 percent, 46.7 percent of respondents used more than one substances (tobacco, alcohol, drug etc.) followed by 23.3 percent with only tobacco and 7.3 percent with alcohol. Very few respondents with 0.7 percent consume others that include beri, cigarette, ganja, etc. The finding revealed that used of multiple substances is prevalent among MSM in Manipur. 46 percent of respondents used substances to cope up from depression/stress followed by 20 percent and 8 percent of the respondents used substance due to peer group pressure and for enjoyment and fun respectively. Thus, the finding indicated that psychological disturbances and pressure from peer group made MSM used of intoxicated substances. They used substances as a means of coping mechanism from stress, depression, painful relations, family threatening, societal stigma and discrimination, homophobia, prejudices, etc. 54 percent of respondents were having habits of drinking before/after sex with partners while 46 percent of respondents did not have such habits. It is noted that such situations may lead to increase risk behaviour such as sex without condom, substance use, gift sex, etc.

c. HIV/AIDS

The study found that 100 percent 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. The finding indicated that GOs and NGOs who are working for MSM and mass media have taken the vital roles in prevention and control of HIV/AIDS by spreading information and knowledge especially among MSM community in Manipur. 82.7 percent of respondents did HIV test during last six months whereby 17.3 percent 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. It is seen that 75.3 percent of respondents conducted HIV test through NGOs followed by 6 percent in private hospital and 0.7 percent in public hospital whereby 17.3 percent 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. 80 percent of respondents found to be HIV negative whereas 2 percent reported of HIV positive. The study noticed that 2 percent of MSM were infected by HIV against 11.6percentof total HIV infection person 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. Majority of respondents with 95.3 percent did not have sexually transmitted diseases whereas 4.7 percent of them had revealed of suffering from STDs. It can be noted that they may have not revealed at the time of data

collection due to ashamed of, fear of stigma and discrimination or did not visit to STD clinic for diagnosing the disease.

V.2.4 Perceptions of MSM towards the available services of NGOs and GOs

The study found that 100 percent of respondents had heard of HIV/AIDS programme and policy where 61.3 percent of respondents did not satisfy of services of GOs and NGOs while 22.7 percent found satisfied, 8.7 percent were slightly unsatisfied and 7.3 percent 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. The respondents reported that they had accessed to NGO's services such as condoms and lube, health checkup, free HIV test, medicines, etc. It is seen that 90 percent of respondents had heard of fundamental rights while 10 percent did not. It is also seen that 68 percent of respondents were not able to enjoy their rights whereas 24 percent 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. 58.7 percent of respondents heard of Section 377 Indian Penal Code while 41.3 percent of respondents did not hear of it. Out of 58.7 percent respondents, 41.3 percent of respondents wanted to withdraw the Section from the IPC and 17.3 percent of them expressed of amending the Section because they perceived that the said Section is one of the reasons of hiding their identities. 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. 98 percent 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. 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.

V.3 Important Conclusion of the Study

1. Sexual orientation of an individual can influence one's sexual identity.
2. Childhood socialization played a vital role in shaping one's sexual identity in later life.
3. Childhood negative experience can have negative effects such as depression, stress, anxiety and low self-esteem, feeling of worthlessness, etc.
4. Adolescent period is the important stage to develop one's sexual orientation and sexual identity. In this period, the sexual information sought from peer, books, magazines, internets, mass media, etc. are culminating in sexual maturity.
5. MSM had experienced of role conflicts because of their sexual orientation. Such situations made victims of abuse, harassment, hostility that may affect their psycho-social well-being by experiencing of distress, low self-esteem, and internalized homophobia, guilty, loss of interest, irritable, loss of attentions, upset, etc.

6. Disclose or coming out of one's homosexual identity is a crucial and big challenge. Those MSM who had come out might have unique consequence in later life in compared to those who had not disclosed of their sexual identity. Therefore, 'coming out' on time in family and society helps in psychological well-being of MSM people.
7. 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.
8. MSM people feel comfortable in expressing their feelings to mother. At the time of coming out MSM people needed adequate social and emotional support about their sexual orientation. Those who do not receive such social and emotional support felt upset, guilty, isolation, etc.
9. Physical, verbal and sexual abuses are the common experiences encountered by MSM people after coming out as homosexual identity. Those MSM with effeminate behaviour have more chances of encountering sexual abuse from friends, partners, local goonda, local elders and relatives. Mainly sexual abuse is done by near and dear ones whom they were well acquainted. Such situations made them more vulnerable in society leading to develop low self-esteem and low self-confidence.
10. The concept of ideal traditional masculine man made married MSM in fear of expressing their sexual identity and orientation. Such negative societal attitudes affect their self-image and make insecure, inadequacy and inferiority.

11. MSM people had experienced of threatening by family members due to their role conflicts. Within family level, they were humiliated, isolated, threatened, intimidated, denied and blamed, discriminated in education, property, etc. Such conditions made MSM involved in risk behaviours like suicidal ideation and suicidal attempt, leaving home, engaging in sex work, use of intoxicate substances, etc.
12. Family members of MSM believed that their sons' sexual behaviour might change after marriage. Therefore, they pressurized their sons to get married. Those who cannot escape from parents' pressure are living with stress which affects their psycho-social well-being.
13. It is evident that family is a place where an individual can get care, support and security. Negative attitudes of family members made them developed psychological disturbance in their daily life.
14. MSM people had experienced of some form of negative attitudes from neighbours such as teasing, verbal abuse, prejudices, angry, disconnect of communications, etc. Such negative attitude made them sad, guilty, upset, feelings of different and shy in front of others.
15. They had experienced 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. Such negative attitudes of people affected MSM and led to develop psychological problems such as feeling of guilty, shame, self-

loathing, low self-esteem, self-hatred, feeling of worthlessness and feeling of being abnormal.

16. Experienced of common negative attitudes at educational places such as bullying, teasing, stigma, discrimination and homophobic, physical, emotional and sexual assault in school/college by class mates and even by staffs affect the psycho-social well-being of MSM.
17. Experienced of stigma and discrimination at work place lead to frustration, dissatisfaction, poor mental and physical health.
18. Experienced of physical and sexual abused by police and local goonda made them more insecure. Living in such stressful and anxiety might lead to affect psychological well-being among MSM community.
19. The culture of having partnership (male partner) is prevalent among MSM community. Those who have partners (MSM B – MSM A) played a positive and an important role in psychological well-being of MSM.
20. Keeping of multiple sexual partners due to unsteady partner-relationship can affect the psycho-social well-being of MSM. Therefore, they had mixed-feelings of emotions like anger, hurt, hatred, frustrated, guilty, regret, tension, anxiety and revenge.
21. The rates of condom used among the respondents who have multiple sexual partners were very low because of refusal by partners, lack of condom availability, unable to access condom, sub-standard and lack of awareness, etc. Involving in unsafe sexual relationship made them worried and anxiety which directly and indirectly affect the psycho-social well being of MSM.

22. Involving in risk behaviours such as used of multiple intoxicated substances among adolescent and young adulthood MSM, having multiple sexual partners due to partner problems, family and societal problems, tensions for their career, lack of opportunities and problems of employment have affected the psycho-social well-being of MSM.
23. Psychological disturbances and pressure from peer group made MSM used of intoxicated substances. They used substances as a means of coping mechanism from stress, depression, painful relations, family threatening, societal stigma and discrimination, homophobia, prejudices, etc.
24. The high rates of HIV test among MSM are due to high awareness level of HIV/AIDS and also for fear of having HIV/AIDS infection because of their sexual acts with multiple unknown partners. Such situation made them more tensed, worried, anxious, upset, guilty etc.
25. Attitudes of health care providers play an important role among MSM in accessing health care treatment both in private and public hospitals that may affect their psycho-social well-being.
26. The law enforcement of IPC Section 377 made MSM people hide their sexual orientation and identity that lead to affect their psycho-social well-being.
27. There are no specific programmes and services available for MSM community from government and NGOs except HIV/AIDS programme. This double standard of the policy may affect the psycho-social well-being of MSM.

28. The status of homosexual identity and HIV/AIDS leveled MSM with double stigma by society at large. This double stigma made MSM suffer from psycho-social problems under the study area.
29. There are 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 which will help in reducing stigma and discrimination against MSM that may bring a positive well-being of MSM community.

V.4 Suggested recommendation of the study

- Ensure greater involvement of vulnerable communities including MSM in policy formulation and program development.
- Adopt a human rights based approach in tackling social discrimination.
- Repeal of criminalization of same sex acts i.e. Section 377 of Indian Penal Code.
- National government, policy makers and civil society to create enabling environment and advocate for safe spaces of MSM.
- Update of code of conduct related to sexual minority and make free from discrimination in family, society, institutional setting, and healthcare setting.
- Inclusion of income source programs for MSM
- Expand public and private fund and increase investment in MSM and HIV-related and anti-stigma activities.
- Extend services to sexual partner and promotion of mental health services of MSM and family.

- Open rehabilitation centre and short stay home for homeless MSM and substance abuse.
- Encourage education among MSM and introduce topics of sexuality in academic syllabus and formulation of anti-bullying and safe school legislation.
- Selection of professional and knowledgeable person who have knowledge of MSM for service delivery.
- Provide education and sensitization programme for service providers in accessing the services among MSM at regular basis with care, seek information and obtain treatment without fear of discrimination or harassment.
- Encourage for formation of self-help group among MSM.
- Well evaluation of intervention programme and transparency of funds for MSM programs.

V.5 Suggested recommendation for further research from the study

Further research can be done on the following:

1. Role of GO and NGO/CBO partnership in providing services for the welfare of MSM.
2. Issues of human development and social security of MSM.
3. Role of MSM A in the midst of lifestyle of MSM B and HIV/AIDS.
4. Shumang Lila (Courtyard play) and its influence to MSM identity in Manipur.

V.6 Social work theory and interventions

V.6.1 Social work theory

The finding and observation of the present study reflects a need to apply for "Structural Social Work" for the well-being of MSM people. The life of MSM can only be enhanced when structural exploitation are reduced and applied for equal opportunities to everyone.

The findings of the study suggested a holistic approach of social work. The study showed that MSM are a group of people who are deprived in every aspects of life due to their sexual orientation and sexual behaviour. They are oppressed or suppressed within or outside the family. In family, family members neglected and rejected due to their sexual behaviour and identity and often underestimated their capacities and potentials leading to deprivation. In society, people don't look them in positive ways. They suffered from social stigma, discrimination, prejudice, homophobia, heterocentrism and heterosexism in society. Therefore, structural social work is important to empower and enhance the quality of MSM life. Structural social work talks from two perspectives. First, it discussed about the negative consequence of structural exploitation of people. The inequalities which are expressed through a social order in terms of different class, gender, race, sexual orientation, age, disability and geographical region that allow people with economic and social power to define one aspect of these features of society as valid and to oppress those who do not possess this features. Those people who oppressed are excluded from opportunities, participation and a good quality of life. Secondly, it discussed the transformation through social reform and social change. Thus, it seeks

changes in the society, rather than simply dealing with the consequences of it. This approach will move from social relations based on inequality to social relations based on equality with a collective, participatory ideology and support from social institutions.

Thus, successful application of Structural Social Work at family, society and institutional places will help in empowering and developing the life of MSM people. Structural Social Work will help social workers and civil society to inspire in taking up strategies for reducing stigma and discrimination against MSM community. It will help in solving the problems by highlighting the issues of injustice and also by developing a specific programme and policies for MSM. So, Structural Social Work becomes one of the important areas to discuss in social work education. The following are the area of interventions that suggested from the study:

V.6.2. Social Work Interventions

Some social workers have noted that the profession has not been at the forefront of advocacy for gay and lesbian rights even in the United states in the earlier period (Di Nitoo and McNeece, 1990;343) but in the last two to three decades, social workers has clearly moved towards a position in support of their rights. Social worker has taken up many actions to commit towards homosexual individuals. The council of Social Work Education (CSWE) recognized the need of putting homosexual issues in Social Work Education which will help in changing the relationships between social values and homosexuals. Thus, there was an evolution of anti-discriminatory social work practice with homosexuals.

There are difference levels of social work intervention for homosexual people. Michael Shernoff (1998) explains the different aspects of individual practice with gays that include issues of identity development, substance abuse, domestic violence, anti-gay violence, ageing, living with HIV and AIDS and death and dying. Homosexual people encounter vast issues in compared to other groups of people. In order to deal with the issues of homosexual people, social worker need to have skills in various field such as case work, counseling, group work, community mobilization, and crisis situation and existential conditions as they are part of an array of much needed social work services that aim at fuller integration of gays into the society. According to Prasad (1979), psychiatric social worker can foster social action for the rights of the clients, and as a therapy to solve the problems of patients with reference to their needs to achieve self-actualization, a sense of identity and interdependence and as a means to correct the social system that causes maladjustment.

Following are the some of the areas where a social work can intervene:

a) <u>Individual level interventions</u>

- Counseling can be given at the time of coming out from family members. Usually at the time of coming out, family feel shock and sad.
- Social worker can help MSM to control and handle internalized homophobia.
- Social worker can become negotiator and mediator to re-emergence of feeling of attachment.
- Social worker can give assistant to those MSM who are facing violence.

- Social worker can channelize the local available resources such as support group and network, policies and programme for MSM and to show the direction for accessing it.

b. <u>Group level interventions</u>

- Social worker can help in forming support groups/collectives for MSM. Support group will help MSM for mutual aid and assistance among each other.
- Social worker can foster a group cohesion and interdependence among the group members of MSM.
- Social worker can provide psycho-educational counseling to MSM at the time of crisis such as family, partner , friends and society

c. <u>Community level interventions</u>

Social worker can intervene in community from two dimensions:

i. Within the MSM community

- Social worker can sensitize the MSM community member to acknowledge the diversity among them. He can develop a sense of mutual respects among community members.
- Social worker can motivate community members to fight against discrimination, prejudice and disempowerment.
- Social worker also intervenes in project planning to design programs for addressing the issues of MSM.

- Social worker can educate peer educator and Outreach worker for effective and collaborative work with community members.

ii. With the dominant heterosexual community

- Social worker can create awareness on the nature of homosexuality to change the perception by public on same sex behavior, identities and lifestyles.
- He/she can advocate regarding the rights of MSM to access power for them.
- He/she can sensitize and mobilize other human rights and civil rights organizations to include the homosexual issues in their work.
- Advocate to the police station and court of justice.

d. As service Provider

- Awareness program on the issues of MSM/same sex relationship through mass media.
- Government needs to focus on human rights of MSM community.
- NGO needs to do advocacy and sensitization progamme on MSM issues.
- Government needs to develop welfare schemes for MSM community.

V.7 Suggested Model by the Researcher

From the finding of the study researcher has developed a model of psychosocial problems of MSM. Stigma is a dynamic process of devaluation that significantly discredits an individual in the eyes of others (Goffman, 1963). Social discrimination is a mean, unfair, or unequal treatment (including acts of verbal or physical violence) intended to marginalize or subordinate individuals or

communities based on their real or perceived affiliation with socially constructed stigmatized attributes (Ayala, 2010).

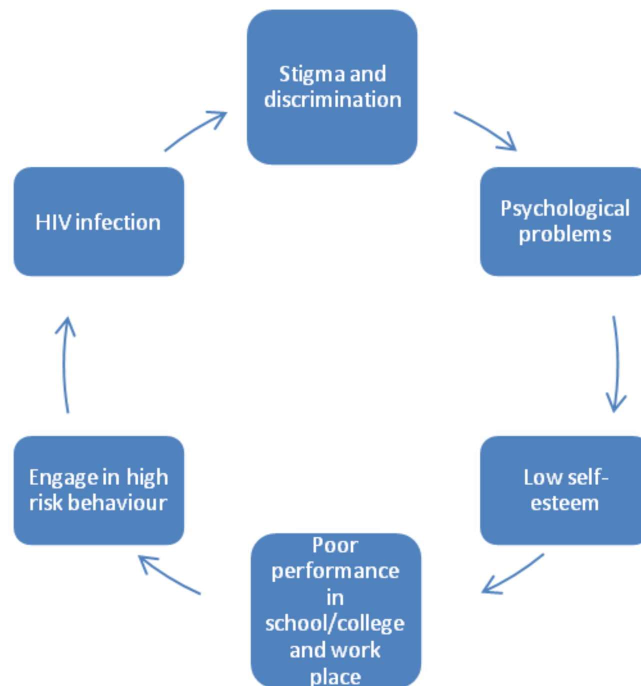

Figure 5.1 Psycho-social Model of MSM

Stigma and discrimination can lead to have psychological problems which affect the mental well-being of MSM. MSM is one of the sexual minority groups in society due to their sexual orientation and behaviour. Stigma and discrimination exhibit hopelessness, chronic worry, and hyper-vigilance. Moreover, it is also leading to elevate risk behaviour such as self-harm, suicidal thoughts, risky sexual practices and excessive substance abuse among MSM. Some of the mental health problems of MSM people are depression, suicidal tendencies, isolation, etc. such condition made them to loss self-image, self- respect, competency and worthlessness. Thus, the consequence of poor mental health leads MSM to have low self-esteem.

Self-esteem is the overall emotional evaluation of his or her own worth. It is a judgment of oneself as well as an attitude towards the self. Self-esteem encompasses beliefs and emotions such as triumph, despair, pride and shame. It is also one of the evaluative dimensions of the self that includes feelings of worthiness, pride and discouragement. It exists as a consequence of the implicit judgment that every person has the ability to face life's challenges, to understand and solve problems, and their right to achieve happiness and be given respect (Nathaniel, 1987). Life experience is the major source of self-esteem development. The negative and positive life experience will show the person of positive feeling of self-worth or negative feeling of self-worth. Most of the MSM people have experienced of unfavourable environment inside or outside since their childhood. Those who had negative experienced during their childhood will impact on later life. Lack of parental and societal emotional support, love and care can lead to develop low self-esteem in later life.

Self-esteem plays a vital role in performing one's role and responsibilities in family and society. It gives significant contribution to academic performance and work achievement. An individual's consistent achievement and success or failures are strongly affected by their self-esteem. MSM had experienced of unfair treatment in school/ college and at work place. They did not feel free and safe at the place where they can get knowledge, skill and personal development. They did not feel free to express their ability in any field. They were insecure in compared to others. Their performances and achievements were comparatively low in school/college or work place due to lack of knowledge and opportunities, etc. The consequences of

such problems are due to lack of proper socialization, self-stigmatization, loss of family and social support, loss of employment, etc. Such conditions made them deprive from their opportunities in family and society as their involvement in decision making are less, and often neglected in family. They are discriminated and neglected from educational institutions, work place, public places and health care setting due to their sexual orientation and behaviour. They are often denied from their rights like Right to equality and Right to life, etc. Such conditions made them suffer from psychological problems such as tension, stress, upset, isolation, worthlessness, lack of self-respect and self-image, etc. In order to cope up from the situation, they engaged in high risk behaviour such as substance abuse, multiple sexual partners, engage sex without safer ways, sex work, gift sex etc. Finally, they are infected by HIV/AIDS leading them to face double stigma of HIV positive and living with MSM identity. Double-stigma against MSM who are living with HIV can hamper in involvement of preventive efforts, decrease opportunities for early intervention, and potentially reduce overall quality of life (Mahalingam et al., 2004).

V.8 Conclusion

MSM are always looked down upon and oppressed them by other sections of people. Their sexuality made them more vulnerable and has a little space in society. Stigma and discrimination diminish their efficiency of being human and made them psychologically impaired. With the advancement of science and technology, society needs to see them as an individual rather than their sexual behaviour. Such group of people requires empowerment and moral support so that they can contribute their

roles to family and society. It is expected that the major findings of the present study will help MSM to get social and family acceptance which is much needed for improving the living conditions of MSM and also for enhancing their quality of life. GO and NGOs in collaboration with family and society at large need to provide special attention, supports, care and love to protect and prevent MSM community from risk behaviours which will further help in reducing HIV/AIDS, STIs, STDs, and other psycho-social problems.

References

Ayala, G. (2010). MSM guide to the guidance package [in press]. Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV. GNP+ and MSMGF.

Branden, N. (1987). *How to Raise Your Self-Esteem.* New York: Bantam Books.

CSWE (1982). Curriculum Policy for the Master's Degree and the Baccalaureate Degree Programs in social Work Education. Council on Social Work Education, New York.

Di Nittoo, D. M. and Mc Neece, C.A., (1990). *Social Work-Issues and Opportunities in a Challenging Profession.* New Jersey: Prentice –Hall.

Goffman, E. (1963). *Stigma: notes on the management of a spoiled identity*. New York: Prentice-Hall; 1963

Michael, S., (1998). Individual Practice with Gay Men' in P.G.Mallon (ed.), Foundations of Social Work Practice with Lesbian and Gay Persons. New York: The Harrington Park Press.

National Association of Social Workers (1977). NASW Public Social Policy Statement on gay Issues, Washington.

Payne, M. (1997). *Modern Social Work Theory*. New York: PALGRAVE.

Prashad, R. (1979). Psychiatric Social Work-Past Vestige and Future Challenges. Presidential address at the 6th Annual Conference of IPSW (mimeo),(cf. Verma, 1991).

BIBLIOGRAPHY

Abraham, L. and Kumar, K.A. (1999). Sexual Experiences and Their Correlates among Colleges Students in Mumbai City, India. *International Family Planning Perspectives*, 25 (3).

Adam, P., Wit, J., Toskin, I. et al. (2009). Estimating levels of HIV testing, HIV prevention coverage, HIV knowledge, and condom use among men who have sex with men (MSM) in low-income and middle-income countries. *Journal Acquire Immune Deficiency Syndrome*, 52(S2).

Adimora, A. A., Schoenbach, V. J., Doherty, I. A. (2007). Concurrent Sexual Partnerships Among Men in the United States. *American Journal Public Health*, 97(12).

Almeida, J, Johnson, R. M., Corliss, H. L., Molnar, B. E., Azrael, D. (2009). Emotional Distress Among LGBT Youth: The Influence of Perceived Discrimination Based on Sexual Orientation. *Journal Youth Adolescent*, 38(7).

Alston et al. (2003). *Research for Social Workers: An Introduction to Methods*. New Delhi: Rawat Publication.

ABVA (1991). Less than Gay-*A Citizens Report on the Status of Homosexuality*. New Delhi: AIDS Bhedbhav Virodhi Andolan.

Alsop, R., Fitzsimmons, A., & Lennon, K. (2002). *Theorizing Gender.* Polity Press, pp. (64-93).

American Psychological Association (2013). Sexual orientation, homosexuality and bisexuality.

amfAR (2006). *MSM and HIV/AIDS Risk in Asia: What Is Fueling the Epidemic Among MSM and How Can it Be Stopped?* New York: amfAR.

APA Online. Answers to Your Questions About Sexual Orientation and Homosexuality. Retrieved on September 6, 2012 from http://www.apa.org/pubinfo/answers.html.

Ayala, G. (2010). MSM guide to the guidance package [in press]. Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV. GNP+ and MSMGF.

Bailey, C.A. (2007). *A Guide to Qualitative Field Research*. New Delhi: Pine Forge Press.

Bell, A. P., Weinberg, M. S. (1978). *Homosexualities: A Study of Diversity Among Men And Women*. South Melbourne: The Macmillan Company, ISBN 0-333-25180-6.

Barrett, D.C., Pollack, L.M., &Tilden, M.L. (2002). Teenage sexual orientation, adult openness and status attainment in gay males. *Sociological Perspectives*, 45 (2), 163-182.

Basu, D.P. (1994). Appropriate Methodologies for Studying Sexual Behaviour in India. *Indian Journal of Social Work*, LV (4).

Branden, N. (1987). *How to Raise Your Self-Esteem*. New York: Bantam Books.

Brown, L., Trujillo, L., Macintyre, K. (2001). Interventions to reduce HIV stigma: What have we learned? Retrieved on March 19, 2012 http://www.popcouncil.org/pdfs/horizons/litrvwstigdisc.pdf.

Cass, V. C. (1984). Homosexual Identity Formation: Testing a Theoretical Model. *Journal of Sex Research*, 20, 143–167.

Centers for Disease Control and Prevention (2002). Unrecognized HIV infection, risk behaviors, and perceptions of risk among young Black men who have sex with men: Six U.S. cities, 1994–1998. Morbidity and Mortality Weekly Report. 2002. pp. 733–736. Retrieved on May 20, 2012 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5133a1.htm.

Centers for Disease Control and Prevention (2008). Sexually Transmitted Disease Surveillance. Atlanta, GA: U.S. Department of Health and Human Services; November 2009.

Chakrapani, V., Kavi, A. R., Ramakrishnan, L.R., Gupta, R., Rappoport, C., Raghavan, S.S. (2002). HIV prevention among men who have sex with men (MSM) in India: review of current scenario and recommendations: SAATHI (Solidarity and Action Against The HIV Infection in India) Working Group on HIV Prevention and Care among Indian GLBT/Sexuality Minority Communities.

Chakrapani, V., Newman, P. A., Shunmugam, M., McLuckie, A., & Melwin, F. (2007). Structural violence against kothi-identified men who have sex with men in Chennai, India: A qualitative investigation. *AIDS Education & Prevention*, 19,346–364.

Cochran, S. D., Mays, V. M., Sullivan, J. G. (2003). Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United State. *Journal of Consulting and Clinical Psychology*, 71(1):53–61.

Cochran, S. D., & Mays, V. M. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California Quality of Life Survey. *Journal of abnormal Psychology*, 118, 647-658.

Cohen, L. (1995). *The pleasures of castration. In: P Abramson, S Pinkerton, editors. Sexual Nature, Sexual Culture*. Chicago: University of Chicago Press, pp. 276–304.

Conner, R.P., Sparks DH, Sparks M. (1997). *Cassell Encyclopaedia of Queer Myth, Symbol and Spirit*. London: Bath Press, p. 342.

Crosby, G.M., & Grofe, M. (2001). Study of HIV sexual risk among disenfranchised African American MSM (In Science to Community, No. 8). San Francisco, CA: UCSF CAPS and AIDS Research Institute.

D'Augelli, A.R. (2006). Developmental and contextual factors and mental health among lesbian, gay, and bisexual youths, Sexual orientation and mental health: Examining

identity and development in lesbian, gay, and bisexual people Omoto AM, Kurtzman HS, editors. Washington, DC: American. *Psychological Association*, pp. 37–53.

CSWE (1982). Curriculum Policy for the Master's Degree and the Baccalaureate Degree Programs in social Work Education. Council on Social Work Education, New York.Crompton, L. (2003). Homosexuality and Civilization. Cambridge: Harvard University Press.

Dandona, L., Dandona, R., Gutierrez, J. P., Kumar, G. A., McPherson, S., & Bertozzi, S. M. (2005). Sex behaviour of men who have sex with men and risk of HIV in Andhra Pradesh, India. *AIDS*, 19, 611–619.

Deuba, K., Karki, D. K., Shrestha, R., Aryal, U. R.., Bhatta, L., et al. (2012). Risk of HIV Infection mmong men having sex with men in Kathmandu Valley, Nepal. *Asia Pac J Public Health*, DOI: 10.1177/1010539512441491.

Day, N. & Schoenrade, P. (1997). Staying in the closet versus coming out: Relationships between communication about sexual orientation and work attitude. *Personnel Psychology*, 50, 147-163.

D'Augelli, A.R. & Hart, M.M. (1987). Gay women, men, and families in rural communities: Towards the development of helping communities. *American Journal of Community Psychology*, 13, 79-93.

D'Augelli, A.R., Hershberger, S. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology*, 21(4):421–448.

D'Augelli, A.R., Hershberger, S. L., Pilkington, N. W. (1998). Lesbian, gay, and bisexual youth and their families: Disclosure of sexual orientation and its consequences. *American Journal of Orthopsychiatry*, 68(3):361–371.

D'Augelli, A.R., & Grossman, A.H. (2001). Disclosure of sexual orientation, victimization, and mental health among lesbian, gay, and bisexual older adults. *Journal of Interpersonal Violence*, 16 (10), 1008-1027.

D'Augelli, A. R., Pilkington, N. W., & Hershberger, S. L. (2002). Incidence and mental health impact of sexual orientation victimization of lesbian, gay, and bisexual youths in high school. *School Psychology Quarterly*, 17, 148–167.

Díaz, R. M., Ayala, G., Bein, E. (2004). Sexual risk as an outcome of social oppression: data from a probability sample of Latino gay men in three U.S. cities. *Cultur Divers Ethnic Minor Psychol*, 10(3):255-67.

Dinesh, C.S. (2014). Changing landscape for sexual minorities in India. *The Lancet* (2199-2200).

Di Nittoo, D. M. and Mc Neece, C.A., (1990). *Social Work-Issues and Opportunities in a Challenging Profession*. New Jersey: Prentice –Hall.

Ellen, I.G., Mijanovich, T., & Dillman, K. (2001). Neighborhood effects on health: Exploring the links and assessing the evidence. *Journal of Urban Affairs*, 23(3-4), 391-408.

Erikson, E. (1950). *Childhood and Society*. New York: Norton.

Foucault, M. (1979). *The History of Sexuality-An introduction, Vol. I.* Allen Lane, London: Hurley Roberts (trans.).

Gangakhedkar, R., Bentley, M., Divekar, A. (1997). Spread of HIV infection in married monogamous women in India. *J Am Med Assoc*, 273: 2090-2.

Garofalo, R, Wolf, R. C., Wissow, L. S., Woods, E. R., Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med*., 153:487– 493.

Goparaju, L. 1994. Disclosure and Practice, Rural-urban Differences in Mlae Students' Sexual Behaviour in India. Paper prepared for the IUSSP seminar on sexual subculture, migration and AIDS, 27 February-3 March, Thailand.

Goffman, E. (1963). *Stigma: notes on the management of a spoiled identity*. New York: Prentice-Hall; 1963.

Goode, W.J. and Hatt, P.K. (1981). *Methods in Social Research*. Singapore: Mc Graw Hill Book.

Go, V. F., Srikrishnan, A. K., Sivaram, S., Murugavel, G. K., Galai, N., Johnson, S. C., Celentano, D. D. (2004). High HIV prevalence and risk behaviors in men who have sex with men in Chennai, India. *Journal of Acquired Immune Deficiency Syndromes*, 35, 314–319.

Government of India, NACO, (2011). Annual Report 2010-2011.

Greenwood, G.L., White, E. W., White, E.W., & Page-Shafer, K. (2001). Corretes of heavy substance use among young gay abd bisexual men: The San Francisco Young Men's Health Study. *Drug & Alcohol Dependence*, 61 (2), 105-112.

Griensven, F, Wijngaarden, L.H. (2010). A review of the epidemiology of HIV infection and prevention responses among MSM in Asia. *AIDS*, 24(Suppl 3):S30–

Halperin, M. D. (1989). *One Hundred Years of Homosexuality and Others Essays on Greek Love.* New York: Roultledge.

Gupta, S. (2008). Portrayal of homosexuality in India arts. Presented at ANCIPS, Kolkata.

Hammersmith, S.K. and Weinberg, M.S. (1973). Homosexual Identity-Commitment, Adjustment and Significant Others. *Sociometry*, 36.

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., Hasin, D. S (2010). The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study. *Am J Public Health*, 100(3):452-9.

Herek, M. Gregory, P. (1990). Homophobia. In W.R. Dynes (ed.), *Encyclopedia of Homosexuality*, New York: Garland.

Herek, M. Gregory, P. (1993). The Context of Antigay Violence-Notes on Cultural and Psychological Heterosexism. In D. L. Garnets and C. D. Kimmel (eds), *Psychological Perspective on Lesbian and Gay Male Experience*, Columbia: Columbia University Press.

Herek, G. M., Capitanio, J. P. (1998). AIDS stigma and HIV-related beliefs in the United States: Results from a national telephone survey. Paper presented at 12th International Conference on AIDS, Geneva, Switzerland.

Hershberger, S. L., Pilkington, N. W., & D'Augelli, A.R. (1997). Predictors of suicide attepts among gay, lesbian, and bisexual youth. *Journal of adolescent research*, 12 (4), 477-497.

Hudson, W.W. and Ricketts, W.A. (1980). A Strategy for Measurement of Homophobia. *Journal of Homosexuality*, 5.

Humsafar Trust. (2000), Mumbai. 'A Baseline Study of Knowledge, Attitude, Behavior and Practices Among Men Who have Sex with Men in Selected Sites of Mumbai. Humsafar Trust, Mumbai.

Hurlock, B. E. (1983). Developmental Psychology- A Life Span Approach (5th edition, 2nd reprint. New Delhi: Tata McGraw-Hill.

Jacob, J. A. and Tedford, W.H. (1980). Factors Affecting Self-esteem of the Homosexual Individual. *Journal of homosexuality*, 5.

Jafar, A. (2000). Youth who are MSM—young males who are having sex with men: Accessing sexual health information and modifying sexual practices. *Pukaar*, 29, 14-1

Joint United Nations Programme on HIV/AIDS, (2010). India MSM Country Snapshots – Country Specific Information on HIV, men who have sex with men (MSM) and transgender people (TG).

Joseph, S. (2005). *Social Work Practice and Men who have Sex with Men*. New Delhi: Sage Publication.

Joseph, S. (2004). *Social work practice and men who have sex with men*. New Delhi: Sage publication.

Kalra, G., Gupta, S., Bhugra, D. (2010). Sexual variation in India: A view from the west. *Indian J Psychiatry*, 52:S264–8.

Kala, A. (1992). *Invisible Minority-The Unknown World of the Indian Homosexual*. New Delhi, Dynamics Books.

Kavi, A. R. (1993). 'HIV/AIDS Awareness in the Self-identified Gay Community and its Implications', paper presented in the Workshop on Sexual Aspects of AIDS/STD Prevention in India, 23-26 November, Mumbai.

Khan, S. (1994). Cultural Contexts of Sexual Behaviours and Identities and their Impact Upon HIV Prevention Models: An Overview of South Asian Men Who have Sex With Men. *Indian Journal of Social Work*, LV (4).

Khan, S. (1995). 'Cultural Construction of Male Sexualities in India', paper presented in the 12th World congress of Sexology, Yokahama, 12-16 August, Japan.

Khan, S. and Bondyophadhyay, A. (2005). From the front line: The impact of social, legal and judicial impediments to sexual health promotion, and HIV and AIDS related care and support for males who have sex with males in Bangladesh and India. A study report: NAZ Foundation International.

Kinsey, A. C, Pomeroy, W. B., Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia, PA. W.B. Saunders.

Konlin, B.A., Torian, L., Xu, G. et al. (2006). Violence and HIV-related risk among young men who have sex with men. *AIDS Care*, 18(8):961-7.

Kumar, B., Ross, M. (1991). Sexual behaviour and HIV infection risks in Indian homosexual men: a cross-cultural comparison. *Int J STD AIDS*, 2: 442-4.

Kumta, S., Lurie, M., Weitzen, S., Jerajani, H., Gogate, A., Kavi, R. A, et al (2006). Socio-demographics, sexual risk behaviour and HIV among men who have sex with men attending voluntary counseling and testing services in Mumbai, India. 16th International AIDS Conference. Toronto, Canada; 13th-16th August 2006.

LaFrance, M., Paluck, E. L., & Bescoll, V. (2004). Sex changes: A Current perspective on the psychology of gender. In (Eds.) A. H Eagly, A. E. Beall, & R. J. Sternberg, *The psychology of gender* (328 – 344). New York: Guilford Press.

Lakshya Trust (2005), Vadodara. A Baseline Study of Knowledge, Attitude, Behavior and Practices Among Men Who have Sex with Men in Vadodara City, Gujarat. Lakshya, Trust Vadodara.

Lampinen, T. M., McGhee, D., Martin, I. (2006). Increased risk of "club" drug use among gay and bisexual high school students in British Columbia. *J Adolesc Health*, 38:458-61.

Link, B., & Phelan, J. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363.

Lindhorst, T. (1997). Lesbian and gay men in the country: Practice implications for rural social workers. In J.D. Smith & T. J. Mancoske (Eds.), *Rural gays and lesbians: Building on the strengths of communities* (pp. 1-11), New York: Haworth Press.

Lytle, C., et al. (1997). 'An in vitro evaluation of condoms as barriers to a small virus', *Sexually Transmitted Diseases*, 24, 161-164.

Marecek, J., Crawford, M., & Popp, D. (2004). On the Construction of Gender, Sex, and Sexualities. In A.H. Eagly, A.E. Beall, & R.J. Sternberg (Eds.), *The Psychology of Gender* (pp. 192-216), New York: Guilford Press.

Martinez, D. G. & Sullivan, S. C. (1998). African American men and lesbians: Examining the complexity of gay identity development. *Human Behavior in the Social Environment*, vol.1, 243-264.

Mays, V.M., Cochran, S.D., Zamudio, A. (2004). HIV prevention research: are we meeting the needs of African American men who have sex with men?' *J Black Psychol*. 30:78–103.

Mays, V.M., Chatters, L.M., Cochran, S.D., & Mackness, J. (1998). African American families in diversity: Gay men and lesbians as participants in family networks. *Journal of Comparative Literature*, 29, 73-87.

Mays, V.M., Nardi, P.M., Cochran, S.D., Taylor, R.J. (2000). The importance of friendship networks in HIV prevention among African American gay men. Proceedings of the Thirteenth International Conference on AIDS; Durban, South Africa. Available at http://www.iac2000.org/abdetail.asp?ID=WePpD1338.

Mayne, T. J., & O'Leary, A. (1993). Family support is more important than friend or partner support in reducing distress among suburban and rural gay men. Proceedings of the International Conference on AIDS, 9, 120.

Mashall, et al. (2006). *Designing Qualitative Research*. New Delhi: Sage Publication.

Mcdermott, E., Roen K., Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. Cult Health Sex, 10(8):815–29.

Meyer, I.H. (1995). Minority stress and mental health in gay men. *J Health Soc Behav*, 36(1):38-56.

Meyer, I.H., Dean, L. (1998), Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In: Herek G. M, (ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals.* Thousand Oaks, CA: Sage Publications.

Michael, S., (1998). Individual Practice with Gay Men. In P.G.Mallon (eds.), *Foundations of Social Work Practice with Lesbian and Gay Persons*. New York: The Harrington Park Press.

Muchmore, W. & Hanson, W. (1990). *Coming out right: A handbook for the gay male*. Los Angeles, CA: Alyson Publication Inc.

Morin, S.F. and Garfinkle, E.M. (1978). Male Homophobia'. *Journal of Social Issues*, 34.

Mutalemwa, P., Kisoka, W., Nyigo, V., Barongo, V., Malecela, M.N., Kisinza, W.N. (2008). Manifestations and reduction strategies of stigma and discrimination on people living with HIV/AIDS in Tarnzania. *Tanzan J Health Res.*, 10(4):220-5.

Murray, S. O. (2000). *Homosexualities*. Chicago: University of Chicago.

Nag, M. (1996). Sexual Behaviour and AIDS in India-State-of-the-art. *Indian Journal of Social Work*, vol. LV (4).

Nandi, J., Kamat, H., Bhavalkar, V., Banerjee, K. (1994). Detection of human immunodeficiency virus antibody among homosexual men from Bombay. *Sex Transm Dis* 21: 235-6.

National AIDS Control Organisation (2006). HIV sentinel surveillance and HIV estimation. Retrieved on March 21, 2012 from http://www.nacoonline.org/NACO.

National Association of Social Workers (1977). NASW Public Social Policy Statement on gay Issues, Washington.

National AIDS Control Organization/Ministry of Health and Family Welfare, New Delhi, India (2010). Annual report 2009–2010.

National AIDS Control Organization (2010). United Nations General Assembly Special Session on HIV/AIDS, India, 2010. New Delhi.

Neumann, S., Sarin, P., Kumarasamy, N. (2000). Marriage, monogamy and HIV: a profile of HIV infected women in South India. *Int J STD AIDS*, 11: 250-3.

Newman & Graeme (1976). *Comparative Deviance: Perceptions and Law in six Cultures.* New York: Elsevier.

Nina, T., Harawa, John, K. W., Hema, C. R. and Trista, A. B. (2006). Perceptions Towards Condom Use, Sexual Activity, and HIV Disclosure among HIV-Positive African American Men Who Have Sex with Men: Implications for Heterosexual Transmission. *Journal of Urban Health*, 83(4): 682–694.

O'Neil, J. M. (2008a). Summarizing 25 years of research on men's gender role confl ict using the gender role conflict scale: New research paradigms and clinical implications. *The Counseling Psychologist*, 36 (3), 358–445.

Ottosson, D. (2009). State sponsored homophobia: a world survey of laws prohibiting same-sex activity between consenting adults. Retrieved on September 21, 2013 from http://ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2009.pdf.

Pandya, A. (2010), Voices of invisible: Coping responses of Men Who Have Sex With Men. In Chris Blazina & David S. Shen-Miller (Eds). *An International Psychology of Men-Theoretical Advances, Case Studies, and Clinical Innovations* (pp.233-258). New York: Rutledge Publications.

Pandya, A. (2011). Psycho-social cultural Issues of Men who have Sex with men Gujarat, India. *International journal of Psychology and Behavioural Science*, 1(1): 18-23 DOI: 10.5923/j.ijpbs.20110101.03

Padilla, M., Castellanos, D., Guilamo-Ramos, V., Reyes, A.M., Marte, L.E., Soriano, M.A. (2008). Stigma, social inequality, and HIV risk disclosure among Dominican male sex workers. *Soc Sci Med*, 67(3):380-8.

Pattanaik, D. (2001). *The man who was a woman and other queer tales of Hindu lore.* New York: Routledge.

Paul, J. P., Catania, J. & Pollack, L. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. *American Journal of Public Health*, 92 (8), 1338-1345.

Paul, J.P., Catania, J., et al. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: the Urban Men's Health Study. *Child Abuse and Neglect*, 25:557–584.

Payne, M. (1997). *Modern Social Work Theory*. New York: PALGRAVE.

Phillip, A.E., Boily, M.C., Lowndes, C.M., Garnett, G.P., Gurav, K., Ramesh, B.M., et al. (2008). Sexual identity and its contribution to MSM risk behavior in Bagaluri (Bangalore), India: the results of a two-stage cluster sampling survey. *J LGBT Health Res*, 4 : 11-126.

Poon, M.K., Ho, P.T. (2008). Negotiating social stigma among gay Asian men. *Sexualities*, 11(1-2):245-268.

Pradhan, P.V. et al. (1982). Male Homosexuality: A Psychiatric study of thirteen cases. *Indian J. of Clinical Psychiatry*, 24(2), 182-186.

Prashad, R. (1979). Psychiatric Social Work-Past Vestige and Future Challenges. Presidential address at the 6th Annual Conference of IPSW (mimeo),(cf. Verma, 1991).

Purkayastha, D. et al. (1997). Male to Male Sexual Behaviour in Kolkata and its Suburbs. Paper presented at the 4th International Congress on AIDs in the Asia and Pacific, 25-29, October, Manila.

Purkayastha, D. (1999). 'Networks of Men Who Have Sex With Men: Identity Categories Versus Identity Continnum', Kolkata: Praajak Development Society (mimeograph).

Reddy, D. N. et al. 1983. A Report on Urban (Madras) College Students' Attitude Towards Sex. Antiseptic, 1-5 September.

Remafedi, G., Farrow, J.A., Deisher, R.W. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics*, 87:869– 875.

Remafedi, G. (1993). The impact of training on school professionals ' knowledge, beliefs, and behavior regarding HIV/AIDS and adolescent homosexuality. *Journal of School Health*, 63, 153 – 157.

Remafedi, G., French S., Story M., Resnick M.D., Blum R. (1998). The relationship between suicide risk and sexual orientation: results of a population-based study. *Am J Public Health*, 88:57– 60.

Remafedi, G. (2002). Suicidality in a venue -based sample of young men who have sex with men. *Journal of Adolescent Health*, 31 (4), 305 -310

Roberts, B., Reddy, V. (2008). Pride and prejudice: Public attitudes toward homosexuality. Retrieved on November 20, 2012 from http://www.hsrc.ac.za/index.php?module=pagesetter&type=file&func=get&tid=25&fid=pdf&pid=26

Rosario, M., Schrimshaw, E. W., Hunter, J., Gwadz, M. (2002). Gay-related stress and emotional distress among gay, lesbian, and bisexual youths: A longitudinal examination. *Journal of Consulting and Clinical Psychology*, 70(4):967–975.

Rosario, M., Meyer, B., Hunter, J., Exner, T.M., Gwadz, M., Keller, A.M. (1996). The psychosexual development of urban lesbian, gay, and bisexual youths. *Journal of Sex Research*, 1996; 33(2):113–126.

Rothman, E. F., Sullivan, M., Keyes, S., & Boehmer, U. (2012). Parents Supportive Reactions to Sexual Orientation Disclosure Associated With Better Health: Results From a Population-Based Survey of LGB Adults in Massachusetts. *Journal of Homosexuality*, 59(2): 186–200.

Rubin, J., Provenzano, R., & Luria, Z. (1974). The eye of the beholder: Parents' views on sex of newborns. *American Journal of orthopsychiatry*, 44, 512-519.

Russell, S.T., Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 2001; 91(8):1276–1281.

Russell, S. T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist*, 46 (9), 1241 -1257.

Ryan, C., Donna, F. (1998). *Lasbian and Gay Youth*. New York: Columbia University Press.

Rowland, D. L., Inrcrocci, L. (2008). *Handbook of Sexual and Gender Identity Disorders*. NJ: John Wiley and Sons.

Russell, S.T., Franz, B.T., Driscoll, A.K. (2001). Same-sex romantic attraction and experiences of violence in adolescence. *Am J Public Health,* 91:903– 906.

Saewyc, E. M., Poon, C., Wang, N., Homma, Y., Smith, A. (2007). Not Yet Equal: The Health of Lesbian, Gay, & Bisexual Youth in BC. Vancouver: McCreary Centre Society.

Saewyc, E.M., Skay, C.L., Bearinger, L.H., Blum, R.W., Resnick, M.D. (1998). Sexual orientation, sexual behaviors, and pregnancy among American Indian adolescents. *Journal of Adolescent Health*, 23(4):238–247.

Safren, S.A., Thomas, B.E., Mimiaga, M.J., Chandrasekaran, V., Menon, S., Swaminathan, S., et al. (2009). Depressive symptoms and human immunodeficiency virus risk behavior among men who have sex with men in Chennai, India. *Psychol Health Med*, 14: 709-15.

Safren, S.A., Reisner, S.L., Herrick, A., Mimiaga, M.J., Stall, R.D. (2010). Mental health and HIV risk in men who have sex with men. *J Acquir Immune Defic Syndr*, 55: S74-S77.

Sarvari ,A.Q. (ed) (1998). Kulliyat-i-Siraj. Delhi: Qaumi Council Barai farosh-i Urdu Zaban.

Seabrook, J. (1999). *Love in Different Climate-Men Who Have Sex with Men in India*. London: Verso.

Savara, M. and Sridhar, C.R. (1992). Sexual Behaviour of Urban educated Indian Men-Results of Survey. *Journal of family Welfare*, 38 (1).

Schechter, M.T., Boyko, W.J., Douglas, B., Willoughby, B., McLeod, A., Maynard, M., et al. (1986). The Vancouver Lymphadenopathy -AIDS Study: 6. HIV seroconversion in a cohort of homosexual men. *CMAJ*, 135(12):1355-60.

Schneider, J.A., Saluja, G.S., Oruganti, G., Dass, S., Tolentino, J., Laumann, E.O., et al. (2007). HIV infection dynamics in rural Andhra Pradesh south India: A sexual network analysis exploratory study. *AIDS Care*, 19: 1171-6.

Schmitt, J., & Kurdek, L. (1987). Personality correlates of positive identity and relationship involvement in gay men. *Journal of Homosexuality*, 13, 101-109.

Seidman, S.N., Reider R.O. (1994). A review of sexual behavior in the United States. *Am J Psychiatry*, 151:330–341

Setia, M.S., Lindan, C., Jerajani, H.R., Kumta, S., Ekstrand, M., Mathur, M., et al (2006). Men who have sex with men and transgenders in Mumbai, India: an emerging risk group for STIs and HIV. *Indian J Dermatol Venereol Leprol*, 72: 425-31.

Shafer, K.P., Hahn, J.A., Lum, P.J., Ochoa, K., Graves, A., & Moss, A. (2002). Prevalence and correlated of HIV infection among young injection drug users in San Francisco. *Journal of Acquired Immune Deficiency Syndromes*, 31, 422-431.

Shively, M. G., & De Cecco, J.P. (1977). Components of sexual identity. *Journal of Homosexuality*, 3(1), 41-48.

Silenzio, V. M., Pena, J. B., Duberstein, P. R., Cerel, J., Knox, K. L. (2007). Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *American Journal of Public Health*, 97(11):2017–2019.

Singh, S. N. (2009). 'MSM and HIV/AIDS in Manipur. Retrieved on April 23, 2012 from http://e-

pao.net/epSubPageExtractor.asp?src=education.Health_Issue.Drug_Awareness_Education.MSM. (2012, 10 July)

Smart, L.S. & Smart, M. S. (1980). *Families: Developing relationships* (2nd ed.) New York: Macmillan.

Smith, J. D. (1997), Working with larger systems: Rural lesbians and gays. In J. D. Smith & R. J. Mancoske (Eds.), *Rural gays and lesbians: Building on the strengths of communities* (pp. 37–52), New York, Haworth Press.

Stall, R., Paul, J.P., & Greenwood, G. (2001). Alcohol use, drug use, and alcohol-related problems among men who have sex with men. The Urban Men's Health Study, *Addiction*, 96 (11), 1589-1601.

Stall, R., Mills, T.C., Williamson, J., Hart, T., Greenwood, G., Paul, J., et al. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *Am J Public Health*, 93: 939-42.

Thadani, G. (1996). *Sakhiyani-Lesbian Desire in Ancient and Modern India.* London: Cassell.

Thomas, B., Mimiaga, M.J., Menon, S., Chandrasekaran, V., Murugesan, P., Swaminathan, S., et al. (2009). Unseen and unheard: Predictors of sexual risk behaviour and HIV infection among men who have sex with men in Chennai, India. *AIDS Educ Prev*, 21: 372-83.

Thomdson and Devine (2003). Homosexuality: Biologically or Environment Constructed. Retrieved on March 12, 2013 from http://jrscience.wcp.muohio.edu/Research/HNatureProposalArticle (2012, July 30).

Troiden, R.R. (1993). *The Formation of Homosexual Identities.* In L.D. Garnets and D.C. Kimmal (ads), *With Respect to Sex: Negotiating Hijra Identity in South India.* Chicago: University of Chicago Press.

Truong, K.D., & Ma, S. (2006). A systematic review of relations between neighborhoods and mental health. *Journal of Mental Health Policy and Economics*, 9, 137-154.

Tsuneo, W. & Jun'ichi, I. (1989). *The Love of the Samurai: A Thousand Years of Japanese Homosexuality*. London: GMP Publishers Ltd.

UNAIDS (2011). A new investment framework for the global HIV response, UNAIDS issues brief.

Vanita, R., Kidwai S. (2002). *Same Sex Love in India.* New Delhi: Macmillan India.

Vanita, R. (2002). *'Queering India'*, New York: Routledge.

Verma ,R.K., Collumbien M. (2004). Homosexual activity among rural Indian men: Implications for HIV interventions. *AIDS Educ Prev*, 18: 1834-7.

Walters, A.S. & Hayes, D.M. (1998). Homophobia within schools: challenging the culturally sanctioned dismissal of gay students and colleagues', *Journal of Homosexuality*, 35, 1 - 23.

Weinberg, G. (1972). *Society and the healthy homosexual.* New York: St. Martin's Press.

West, C. & Zimmerman, D. H. (1987). Doing gender. *Gender and Society*, 125-151; p. 127.

Wiberg, B. (1988), Barnets forsta levnadstimme – En beskrivande studie av interaktionen mellan det nyfodda barn et och dess foraldrar. *Nordisk Psykiatrisk Tidsskrift*, 42, 17-20.

Zeelenberg, M. (1999). Anticipated regret, expected feedback and behavioral decision making. *Journal of Behavioral Decision Making*, 12(2):93–106.

Zhao, Y., Montoro, R., Igartua, K., Thombs, B. D. (2010). Suicidal ideation and attempt among adolescents reporting "unsure" sexual identity or heterosexual identity plus same-sex attraction or behavior: Forgotten groups? *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(2):104–113.