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Depression, human right abuses and sexual risk behaviour among men who have sex with men in Nepal: A cross-sectional study

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Abstract
Stigma towards men who have sex with men has resulted in a hidden population making them as high-risk group for HIV and AIDS and mental health problems. The objectives of the study were to assess human right abuses and correlates of depression and sexual risk behaviour to HIV infection among men who have sex with men in selected districts of Nepal. A descriptive cross-sectional study among 170 self indentified men who have sex with men in Kathmandu, Bhaktapur, Lalitpur, Makwanpur and Parsa was carried from 20th May 2010 to 25th September 2010. Both descriptive and inferential statistics were used for data analysis. Very high proportion of men who have sex with men had depression. Depression among them was found to be independent of their age and dependent of education and living status. A large percentage of them were found to be the victims of human right abuses like being raped (61%), sexually abused during childhood (59%), blackmailed (59%), beaten up by police official (60%), being teased by people (65.9%).They were found to be involved in high risk sexual behaviour. The proportion of respondent having consistent use of condom with the clients was 69.5% whereas only 14.6% were in good level of prevention and treatment. Condom use was found to be significantly associated with alcohol drinking, attitude towards condom use, accessibility and access to free condom supply and the reinforcing factors like support from the peers and clients. There was a positive significant correlation between the depression and sexual risk behavior among them. The first thing to be done is to bring positive change in attitudes and resultant behaviour towards them. Men facing problem due to having sex with men and condom use should be addressed comprehensively and synchronized in order to formulate appropriate programs for their proper care. Follow-up study is recommended along with further researches among them.

1. Introduction

Everyone have the right to recognition everywhere as a person not as according to their gender. Homosexuality is sexual attraction or behavior among members of the same sex. The concept of homosexual is still not well recognized in most part of the world especially in the developing countries like Nepal. They are not well accepted by them in the society [1].

AIDS is an extraordinary kind of a crisis among. It is unique in human history in terms of its rapid spread and extent, death and because of its impact on human lives. AIDS is a global burden, concern and a threat that exacerbates every other challenge to human

development. Tracing back the history, the first case was diagnosed among homosexual men twenty six years ago and since then the numbers have been mushrooming and grown to pandemic proportions, resulting in an estimated 65million infections and 25million deaths [2].

Asia is one continent in which the epidemic continues to expand making vulnerable population at greater risks. The HIV epidemics remains largely concentrated in injecting drug users, men having sex with men, sex workers, the clients and their immediate sex partners. Inadequate effective prevention programs coverage is one of the leading causes [2]. The practice of anal intercourse both in the homosexual and heterosexual couple has been associated with a high level of HIV infection. In particular, the receptive partner has been associated with higher risk of HIV infection [3].

Men who have sex with men (MSM) are considered to be one of the high-risk groups driving the epidemic of HIV/AIDS because of exposure of multiple partners and inconsistent use of condoms. Integrated Bio-Behavioral Survey (IBBS) revealed HIV prevalence among male sex workers as 5% in Kathmandu [4]. Nepal still remains unexplored in respect to these concerns. Men who have sex with men are generally a latent population in Nepal. There are indicators of high prevalence of unprotected anal sex, knowledge about HIV/AIDS, safer sex and sexual health issues. In spite of the ongoing investments to combat HIV/AIDS, as a high risk population and related to the background of the male sex workers in each low and middle income generating countries, it should be an effort to monitor their knowledge, attitude and practices of using condoms during the sexual activities. The response to HIV/AIDS has to be exceptional which requires leadership at both national and international levels transforming from an episodic, crisis management to an innovative strategic response that recognizes the need for long-term commitment and capacity-building. Besides, discrimination on the basis of sexual orientation exposes them more to violence and human rights abuses; this stigmatization also increase the climate of impunity, in which such violations frequently occur. Police officials frequently show prejudice towards minority people because of their sexual orientation and gender identity [5].

Stigma and discrimination towards them in Nepal has resulted in a "hidden population" trapped by misconceptions, myths and a lack of factual knowledge. As long as they remain hidden they do not hear the essential messages of HIV & AIDS prevention and this lack of knowledge places them at even higher risk. Due to this they are bound to keep their identity as a secret leading to minority stressor. This leads to stress, distress, depression and so many mental health outcomes. As a result of depression they are involved in high risk behavior towards HIV infection. Depression is an important diagnosis, in terms of both their high prevalence and high cost. Very few studies have been conducted in this field particularly on mental health and human right abuses among minority group who are at higher risk.

Thus, the objectives of this study were to assess human right abuses and correlates of depression and sexual risk behaviour to HIV infection among men who have sex with men in selected districts of Nepal.

2. Methods

The research design selected for the study was cross-sectional descriptive design. A finite number of 170 MSM were recruited. The sample size was calculated by using the formula:

$$n_{srs} = \frac{Z^2_{1-\alpha/2} P\,(1-P)}{d^2}$$

$Z_{1-\alpha/2}$ = value from normal distribution with 95% confidence= 1.96

P = prevalence of condom use in the men having sex with men=52.3%

Ref: (*AIDS 2006 - XVI International AIDS Conference no. WEPE0610*)

d = degree of error allowance/maximum deviation from the true prevalence.

N = target population = 520

n = sample population = 170

In order to obtain the sample, the researcher had to access through organization centers of Blue Diamond Society in Kathmandu, Bhaktapur, Lalitpur, Makwanpur and Parsa where MSM usually spend time in the afternoon. The inclusion criteria included self identified men who have history of ever having anal or oral sex with other man, self identified men who have sex with men who were willing to participate in the study, and self identified men who have sex with men who were available during the data collection period in the study areas.

Study Duration: 20th May 2010 to 25th September 2010.

Instrument: Semi-structured interview schedule consisted of 4 parts as follows:

Part A: Socio-demographic profile.

Part B: Information regarding distress and depression. Distress and depression was measured with the Center for Epidemiological Studies Depression Scale (CES-D Scale) with a cutoff of 22 to define "depression", “euthymic” with scores of 15 and below; distressed with scores from 16 to 21.

Part C: Items to assess human right abuse.

Part D: This part was concerned with the information related to sexual risk behavior with 6 sub-parts as follows:

Knowledge about HIV/AIDS and condom use: These 19 questions measured modes of transmission, prevention and treatment of the disease and proper technique of condom use. The score was 1 for correct answer and 0 for incorrect answer. The range of score is 0-19. The score was divided into 2 levels: 80% and higher refers to good, whereas the other was needed to improve.

Attitude towards HIV/AIDS and condom use: There were 9 statements to measure the attitude toward HIV/AIDs and condom use. The sample had to address whether strongly disagree (1) to strongly agree (5) with each statement. The

range of score was 0 to 45. The score was divided into 2 levels: 80% and higher refers to positive, whereas the other was negative.

Enabling factors: This part included availability, accessibility of condoms and information about HIV/AIDS. The sample had to specify whether they have (1) or not have (0) to all these enable factors.

Reinforcing factors: This part included 6 questions measured perceived support condom use from peers and clients. Each individual had to specify whether they had (1) or had not (0) received support from all of these resources.

Condom use, lubricant use and number of partners: Regarding frequency of condom use with their client/partners either anal or oral sex; or items regarding number of sexual partners.

After receiving an approval from the ethical review committee of Nobel College, Pokhara University, Nepal and Blue Diamond Society, the principal investigator met MSM in the centers in order to summarize the purposes, requirements, and benefits of this study, emphasizing its' anonymous nature. They were allowed to make choice to participate in the study. Then MSMs willing to participate in the study were interviewed using the instrument by the investigator himself. Data analysis was done by using both descriptive and inferential statistics.

3. Results

3.1. Personal Profile

The findings revealed that most of the MSM (46.5%) were in the age group of 15 to 24 years which generally is supposed to be the most vulnerable group. They obtained secondary school or higher (64.9%), whereas some (8.4%) did not have formal education. About three-fourths (75.6%) were below 30 years with 67.9% of them were single. Their monthly income ranged from 1000NRs to 25,000NRs with an average of 5630.9 rupees. They drank alcohol (29%) prior to engaging in sexual activities with the clients. The result showed consistent use of condom with clients and partners was 69.5% among men who have sex with men. The main reasons for inconsistent use of condom were client refusal (17.6%), physical abuse (11.5%), and financial incentive (8.4%).

3.2. Depression

In the Urban Men's Health Study sample, 17% of MSM were depressed, 12% were distressed, and 71% were euthymic. The 7-day prevalence of depression in MSM was 17.2%, higher than in adult among the United States men in general in a study [6]. While in this study 77.1% of MSM were depressed, 8.2% were distressed, and 14.7% were euthymic. The finding of this higher level of depression may be due to lifetime and day-to-day experiences with discrimination in MSM which are also supported by various studies [7, 8, 9, 10, 11]. The levels of depression and anxiety in homosexual subjects, whether HIV positive or HIV negative, are substantially higher than those found in representative general population samples [12]. According to a study, HIV infection is not a cause of mental health problems among men who have sex with men but that stigmatization from society was likely the cause [13].

Table 1 shows that obtained χ^2value between the depression score of the MSMs and age (1.86) was not found to be significant while education (62.85) and living status (6.04) at 0.05 level were found to be significant. Hence there was no association of depression with age while there was significant association of depression with education and living status among men who have sex with men.

Table 1. *Association between the between the distress and depression of MSM and selected factor, N=170*

Selected factors	Distress and depression Score		Chi square value (χ^2)	Degree of freedom
	Frequency Below median	Frequency Above median		
Age				
15-24 years	37	42		
25-34 years	34	32	1.86	3
35-44 years	08	10		
45 and above	05	02		
Education				
illiterate	06	10		
Read and write but no schooling	02	14		
Primary	11	12	62.85*	4
Secondary	35	28		
Higher secondary and above	28	24		
Living status				
alone	37	28		
male partner	15	30	6.04*	2
family	30	30		

*= significant at 0.05 level of

3.3. Human Right Abuses

In Urban Men's Health Study depression among MSM were associated with lack of a domestic partner; not identifying as gay, queer, or homosexual; experiencing multiple episodes of antigay violence in the previous 5 years; and very high levels of community alienation. Distress was also associated with experiencing early antigay harassment. Depression was also associated with histories of attempted suicide, child abuse, and recent sexual dysfunction [6].

In the present study 59.4% of the samples of MSM were found to be the victims of child sex abuse. A significantly higher proportion of Latino MSM reported child sexual abuse 22% [14]. Gay/bisexual men suffer higher rates of childhood sexual abuse [13]. Child sexual abuse experienced by such men is more likely than never-coerced men to engage in high risk sex [16].

In the present study also, most of MSM (60.6%) were found to be the victims of rape (forced sex). The rapist included own friend, relative, teacher, unknown person, own sexual clients, and even own family members and police officials. Similarly, 17.6% of the samples had their first sex by force. Among them 33.3% of the victimized samples were forced for sex by their own friend, 23.3% by their relative, and 6.7% by their own family member who are supposed to be their care taker and 6.7% by their teacher who are supposed to be their educator. This shows how miserable their life is.

Similarly, 60% of the samples were found to have physically abused (beaten up) by police official who are meant for securing peace and giving protection to our lives. 47.1% were afraid to seek health service because of own sexuality. 28.8% were found to have been denied from health care services. 61.2% were afraid to walk in the streets of their own community. 59.4% were found to have ever faced from blackmail based on sexuality. Even some responded that the blackmailer were doctors when they had gone for seeking health care. 61.2% were found to have been forced for heterosexual marriage against their will which is against human right and law. 65.9% responded that they are being teased by the community people with the offensive words like *hijada* and *chakka*. So see what sort of life they might be living in the same society where heterosexual people enjoy all benefits and such MSM live their life with fear and afraid as if their sexuality will be disclosed among of all leading them to more discrimination, more victimization and more pathetic life. So see where is the human right for this group of people? Are not they human being?

Human rights abuses among MSM were across all three countries Malawi, Namibia, and Botswana. Between 5-10%, they had been denied housing in the past for reasons other than the ability to pay. Being afraid to seek health services because of sexual orientation was reported 17.6% in Malawi, 18.3% in Namibia and 20.5% in Botswana. 5.1% were found to deny seeking health care because of their sexuality. MSM reported being afraid to walk down streets in their own community most commonly in Botswana (29.1%), but also to a lesser extent in Malawi (15.5%) and in Namibia (16.7%). Overall 12.2% of MSM indicated that they were physically abused by a government or police official. 11.4% reported ever having been raped by another man. 21.2% were blackmailed or extorted due to their sexual behavior or orientation [17].

It was found that MSM were 6.5 times as likely as their co-twins to have attempted suicide. 24.1% of the samples MSM were found to have attempted suicide in this study. Majority responded that the reason of suicidal attempt as disregard from own family, lack of domestic same-sex partner, betray from sexual partner, loneliness and few responded due to sexual abuse and lack of understanding of own sexual orientation, finding it different from other individual of same gender identity. Suicide attempts among homosexual were six times greater than the average [13, 18].

3.4. Knowledge about HIV/AIDS and Condom Use

Almost all (91.5%) were well-versed about the disease and modes of transmission. Probing into the matter, only about three- fourths (80.2%) comprehended the fact the symptoms of HIV does not appear immediately after the entry of the causal agent. Regarding the prevention and treatment of the disease, only 14.6% respondent's knowledge was in good level. Majority of the respondents were not sure of the correct response refraining them from benefiting the positive score. Less than half (48.1%) of them well understanding were well understood that HIV can be prevented by using sterile/disposable needles. Three fourth (72.5%) thought that withdrawal/ejaculation is one way to prevent HIV/AIDs. Only 67.2% and 64.9% believed that HIV/AIDs can prevent by vaccination and drugs respectively. Regarding condom use, 35.9 % needs to improve their understanding on how to use a condom effectively. 28.2% and 26.7% did not know that they need to press the tip of the condom to release the air out and avoid the nail to tear the condom when tearing package, respectively.

3.5. Attitude towards HIV/AIDS and Condom Use

More than three fourths (80.9%) of MSM had positive attitude towards HIV/AIDS. They strongly agreed that AIDs is a global threat (84.7%) but it preventable (49.6%). Only 9.1% strongly agreed that people living with AIDS are worthless. More than half of the respondents (59.5%) had positive attitude towards condom use. They felt that condoms create a sense of security (77.1%) and hygienic (74.0%). However, 23.6% of them strongly agreed that using condom interrupts sexual pleasure, and 19.0% felt reluctance to use a condom with those they had strong sexual desire.

3.6. Enabling Factors

About half (42%) of MSM obtained condoms from non-

governmental organizations (NGOs). Three-fourths (77.9%) got access to condoms easily and more than three-fourths (87.7%) did not get access to free condoms supply whenever needed. Concerning with the accessibility of information about condoms and HIV/AIDS, majority had access via media like television and radio (98.5%). Less than half (38.2%) gained information from their family.

3.7. Reinforcing Factors

Majority had friends support for condom use (90.8%) and role modeling for practice safe sex (89.3%). About 86% had friends who demonstrated how to use condom properly. One third (22.9%) avoided using condom when swept away in a moment and 20% used condom on demand of clients.

3.8. Condom Use

The result showed 69.5% consistent use of condoms with clients/partners among MSM. The reasons behind inconsistent use of condoms with clients revealed prime/ primary cause as a client refusal (17.6%) with abuse/threat(11.5%),financial incentives(8.4%), condom was not available(7.6%), acquaintances (5.3%), others(1.5%) respectively. (See Table 2)

Table 2. *Always using condom with clients*

Practice	Number	Percentage (%)
Always use condoms with your clients.	118	69.5
Reasons for not using condoms (multiple choice)		
Client refusal	30	17.6
Physical abuse/threat	20	11.5
Financial incentives	14	8.4
Condom was not available	13	7.6
Acquaintances	9	5.3
Others	2	1.2

3.9. Associated Factors of Condom Use

Table 2 shows that there was a significant association between alcohol drinking prior to sexual activities and condom use among Commercial Male Sex Workers (CMSWs) (p = 0.024). The result showed that among MSM who drank alcohol prior to sex were found to have less consistency in the use of condom. There was no significant association between knowledge about HIV/AIDs & its prevention and proper way of using condom. There was a significant association between attitude towards condom use and practice of using condom (p-value = 0.003). MSM who consistently use condom had positive attitude (79.5%) towards the use of condom rather than the negative attitude (54.7%) towards its use.

Table 3 shows that enabling factors such as available places like NGOs and pharmacy had significant association with condom use (p-value = 0.012 and 0.037, respectively). Easy access to condom also had significant association with condom use. MSM who have easy access to condom (78.4%) were more likely to use condom when having sex. The accessibility to free condom supply is significantly associated with condom use (p-value < 0.001). The more accessibility to free condom, the more frequently MSM use a condom (75.4%). Regarding reinforcing factors, there were significant associations between support from peers, regular client, and client incentive with condom use among MSM (p-value < 0.05). When the MSM had encouragement, modeling, and demonstration to use condom from friends, they are more likely to use a condom (72.3%, 73.5, and 75.9%, respectively). One of the important reinforcing factor was client incentive (p-value = 0.001). When MSM were asked for not using condom by providing money incentive, they were less likely to use a condom (76.2%).

Table 3. *Associated factors of condom use*

Factors	Total	Condom use				p-value
		Not always		Always		
		Number	%	Number	%	
Drink alcohol before engaging in sexual activities						
Yes	49	22	44.7	27	55.3	0.024
No	121	30	24.7	91	75.3	
Attitude towards condom use						
Negative	69	31	45.3	38	54.7	0.003
Positive	101	21	20.5	80	79.5	
Enabling factors						
Place to get condom						
NGOs						
Yes	71	13	18.2	58	81.8	0.012
No	99	38	38.7	61	61.3	
Pharmacy						
Yes	59	24	41.3	35	58.7	0.037
No	111	26	23.8	85	76.2	
Accessibility of condom						
Yes	132	29	21.6	103	78.4	<0.001
No	38	24	62.1	14	37.9	
Access to free condoms supply						
Yes	148	36	24.6	86	75.4	<0.001*
No	22	16	73.0	6	27.0	
Reinforcing factors						
Having friend encourage to use condom						

Factors	Total	Condom use				p-value
		Not always		Always		
		Number	%	Number	%	
Yes	154	43	27.7	111	72.3	0.045*
No	16	9	58.3	7	41.7	
Having friend as role model						
Yes	154	41	26.6	113	73.4	0.011*
No	16	10	63	6	37	
Having friend demonstrate using condom						
Yes	145	35	24.1	105	75.9	<0.001
No	25	17	68.4	8	31.6	
Regular client or lover request						
Yes	140	30	21.3	110	78.7	<0.001
No	30	23	77.3	7	22.7	
Long time to negotiation with client						
Yes	39	21	53.3	18	46.7	0.002
No	131	31	23.8	100	76.2	
Client incentive						
Yes	34	20	57.7	14	42.3	0.001
No	136	32	23.8	104	76.2	

* Application of Fisher's exact test

3.10. Sexual Risk Behaviour

More than halve of the MSM (51.8%) were found to have multiple male partners and 34.1% were found to have multiple male along with female (wife) partner as well. Only 14.1% were found to have single male partner. Similarly within a period of one month, 27% were found to have sexual intercourse always with a partner of unknown HIV status and 36.5% had sometimes. The result showed always use condoms with male partners was 69.5% among MSMs. The main reasons for not using a condom were client refusal (17.6%), physical abuse (11.5%), and financial incentive (8.4%). In terms of sexual intercourse with their wife, 21.8% responded they never use condom. Similarly, regarding use of lubricant, 52.9% responded not always and 44.7% responded sometimes. These data illustrates how much MSM and their wives are in sexual risk behavior.

The use of condoms with the clients was higher among those of above 30 years of age. Concerning the age there are studies of Campbell in Africa who found that the younger age group showed tendency towards intention to use condoms compared with the older age group [19]. The percentage of condom use with the clients was seen more in MSM who attained secondary school or higher. The practice of condom use is higher with awareness and increase knowledge. One study in Vietnam showed that education is related with the practice of condom use, it is a positive factor towards condom use [20]. Educational programs and materials provided need to be culturally sensitive and developed specifically for MSM. Information can be disseminated in the right manner to bring about awareness and mitigate stigma. Regarding income status, the MSM making lower monthly income used condoms lower as compared to MSM making an income of 4000 rupees and above. As a matter of fact when some of the MSM are low-paid and work at a cheaper rate, they are entitled to having more hurried negotiations and higher number of partners eventually leading to the inconsistency in condom use.

The percentage of always condom use with clients who did not drink alcohol was higher than those who drank alcohol. This result supported the findings of Syracuse University, New York which revealed that the men who consumed alcohol demonstrated lower skill in negotiating condom, and were more likely to consent to sex without a condom [21]. Issue of alcohol drinking prior having sex is of special concern among MSM and clients because alcohol relates to reckless decision making and consent to use condom. Warning messages about disadvantages and risks involved in alcohol drinking should be dispersed through public media (i.e., TV and radio).

Regarding the knowledge, although the MSM in this study were aware of the disease and the modes of transmission and condom use, they were not knowledgeable in prevention and treatment of the disease. These findings were consistent with the findings of the study done in Nepal among the adolescents [22].

The significant association of attitude towards condom use and condom use among MSM does support feeling about condoms as a sense of security and cleanliness [23]. These findings are supported by the findings of Browne and Minichiello that for workers 'sex at work' is different to 'personal sex'. This result also addressed issue about using condom interrupts sexual pleasure which consistent with the study done in Australia [23]. Changes in the attitude towards condom use can create awareness, and enhancing condom use with the clients more consistently.

The findings of easy access and free access both show a statistically significant association. MSM that have free access to condoms had higher percentage of condom use when compared to those who do not have free access. This supported an idea of increasing free access encouraging always using condom. However, regarding the association between the availability places and condom use with clients, there was significant association between pharmacy and non-governmental organizations and condom use. It is consistent with a study which found that availability of condoms and

cost of condom was associated with condom use among Vocational education male students in Bangkok [24]. Condoms should be freely distributed in order to promote safe sex resulting in combat HIV/AIDs and 100% condom use policy could be implemented. The MSM must be acknowledged about access to free condom supply or make easily accessibility in the proper areas of reach at a subsidized cost.

Interesting findings are only one third of MSM receive information from families. This might be possible result from cultural context. Talking about safe sex and condoms is not an easy task in Nepal where it is bonded with cultures and orthodox traditions which still exists today. Furthermore, most Nepalese people believe that their children are not sexually active, and also believe that teaching them about safe sexual practices will promote sexual activity among adolescents. Stigma still exists and young adolescents and the sex workers still feel such issues still cannot be openly discussed with in families. This result was consistent to a study which founded that there was no significant association between source of information and condom use [25].

There was significant association between reinforcement from peers and clients and condom use among MSM. Discussing about HIV/AIDs with partners, friends or teachers, and perceived support were important predictors of the acceptability of condom [26]. In addition, perceiving of informal networks among friends encourage condom use as a mean of maintaining safety from sexually transmitted disease including HIV [27]. More comprehensive and innovative training session about condom use should be held for peer educators to increase their knowledge and skills. After that they can disseminate all information to their MSM's friend.

3.11. Depression and Sexual Risk Behaviour

Table 4 shows that there was a positive significant correlation between the depression and sexual risk behavior among MSM. This suggests that the MSM having more depression are also involved in sexual risk behavior. Hence it was found that there was a significant relationship between depression and sexual risk behavior among men who have sex with men.

Table 4. *Correlation between depression and sexual risk behavior among MSM, N=170*

Variables	Mean	Median	S.D.	'r'
Depression	28.58	29	11.32	.63*
Sexual risk behavior	12.22	12	3.63	

*significant at 0.05 level

The effect of childhood sexual coercion on sexual risk is mediated by substance use, patterns of sexual contacts, and partner violence, but not by adult sexual re-victimization or by depression [16]. Among MSM, CES-D scores > or = 16 were related to reporting 3 or more sex partners in the last month but not to other sexual risk behavior. The analysis suggested that psychological depression may influence certain HIV risk behavior in MSM, and that interventions addressing depression may be indicated [28].

In a study neither the number of sexual partners nor the history of unsafe sex in the prior year was associated with distress or depression. According to various studies psychological distress is an important predictor of high risk sexual behavior among gay/bisexual men and reductions in symptoms of depression are associated with reduced sexual risks. Sexual sensation seeking is another aspect of mental health that appears to impact homosexual men and is associated with sexual risks [15].

Limited resources and the constraints of working with blue diamond society is the major limitation of this study as the constrained environments limited the scale and scope of these probe studies.

4. Conclusions

This study perhaps bears stating openly: MSM exist in various parts of Nepal, and were at higher risk of depression. Similarly, depression among MSM was found to be significantly associated with education and their living status i.e. higher level of depression among low educational status and among those who have been disregarded from family and living outside with their partner. MSM were found to suffer from various human right abuses including physical, mental and sexual abuse and the abusers were the people from our society only whom we refer as social animal. So, the first and the most important thing to be done are to bring positive change in attitudes and resultant behavior towards them. Another important fact found in this study was that MSM were at high sexual risk for HIV infection and there was significant relationship between depression and sexual risk behavior among them.

All these facts indicate that the separate budget for sexual minorities should be used in educating and creating awareness among general population regarding sexual minorities. Especial policy and program should be adopted by the government for prevention and care of both mental and sexual health of MSM. They need equal care and support from family and community, equal opportunities in all aspects including education, employment, and access to health care and even at policy level. They need a life with equal human rights as the rest of the population, not only on paper but in practice; a life without discrimination. Sensitization and training of police on the human rights of MSM and their roles in protecting those human rights should be done. The study indicates the need for further research into the issues and how they may be handled.

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