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Perceived health concerns among sexual minority women in Mumbai, India: an exploratory qualitative study

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ABSTRACT

The experiences of sexual minority women (i.e., women who do not identify as 'heterosexual') in India have largely been absent in scientific literature. In partnership with India's oldest and largest sexual and gender minority-advocacy organisation, the Humsafar Trust, our study used community-based participatory research principles to explore the lived experiences and health concerns of sexual minority women in Mumbai. Study methodologies included interviews with key informants, a focus group comprised of six women, and an additional 12 in-person interviews with sexual minority women to identify important physical, mental, social and other health priorities from these women's perspectives. Thematic data are organised within the framework offered by the social ecological model, including individual, interpersonal, micro and macro levels. Findings from this study are important in providing the groundwork for future research and intervention involving sexual minority women in India, a dramatically underserved population.

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Introduction

Sexual minority women in India may be at elevated risk for adverse health outcomes as they face unique stressors including stigma, marginalisation, discrimination and violence (including the abhorrent practice of 'corrective rape' by men who believe they can change a woman's sexual orientation through forced heterosexual sex [Ghosh, Bandyopadhyay, and Biswas 2011]). These women not only face challenges due to criminalisation of same-sex sexual behaviours in India (Das 2013; Humsafar Trust 2011), but also have to navigate major gender inequities that constrict their expression of sexuality (Johnson and Johnson 2001) inherent in Indian society and to face marginalisation based on sexual orientation and identity (Vanita 2005).

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There has been relatively little previous research on the sexual practices, lived experiences and health concerns of sexual minority women in India. The few studies that do exist focus on same-sex marriage in India (Vanita 2005) and violence against sexual minority women (Fernandez and Gomathy 2005; Ghosh, Bandyopadhyay, and Biswas 2011; LABIA 2013) or provide historical overviews of lesbian and queer activism (Dave 2010; Mahn and Watt 2014). A much larger body of work has focused on men's same-sex practices and HIV-related risk (e.g., Banik 2008; Chakrapani et al. 2013; Hernandez et al. 2006; Logie et al. 2012; Thompson et al. 2013). The primary domain of the research has addressed male same-sex sexuality, although HIV-related research has benefited some sexual minority women through its attention to sexual minorities overall (Horton, Rydstrøm, and Tonini 2015) and, more recently, women in relationships with men who may be at risk (Closson et al. 2014; Sharma et al. 2015). Additionally, India's patriarchy prioritises men's needs (Johnson and Johnson 2001) and contributes to the neglect of women's concerns in research.

In emphasising the subjective experience of sexual minority women beyond risk behaviours, the current study includes 'non-heterosexually identified women'. As these women may not have the opportunity or desire to engage in sexual behaviours with other women at all times, this category is more encompassing than only 'women who have sex with other women' and more relevant for understanding the experiences of sexual minority women.

Using the Social Ecological Model (Centers for Disease Control and Prevention 2007), the present study aims to illustrate the complex relationships between sexual minority women and society, highlighting their effects on sexual minority women's health. Participants' perceived health concerns addressed various levels of social organisation. This model was applied after completed analyses to organise themes and show connections across levels (e.g., interpersonal and societal).

Methods

This project was conducted in partnership with Umang, a community-based support and advocacy group for sexual minority women within the Humsufar Trust (HST) in Mumbai.[1] HST is the oldest and largest non–governmental organisation in India focused on sexual and gender minority health. We used the elements of community-based participatory research identified by Israel et al. (1998) to strengthen our research partnership: namely, facilitating collaborative research, involving a cyclical and iterative process, addressing health from both positive and ecological perspectives and disseminating findings and knowledge gained to all partners. Protocols in English and Hindi were first edited by the HST ethics review board, then the study was submitted to and approved by the institutional review board of the lead author's affiliation.

We conducted key informant (KI) interviews ($n = 2$), semi-structured interviews ($n = 12$) and a focus-group discussion (FGD) with sexual minority women ($n = 6$). The KI interviews were first conducted with two female lesbian, gay, bisexual and transgender activists in Mumbai (i.e., people involved with lesbian, gay, bisexual and transgender rights advocacy organisations). These facilitated individual interview recruitment through snowball sampling. The FGD participants were recruited from Umang's group. The FGD allowed for conversation and debate about issues between participants, eliciting counter-narratives from common responses. Questions in the FGD and participant interviews addressed, among other factors,

the sexual identity labels used to identify sexual minority women and their prioritised health concerns

The interview and FGD protocols were developed in collaboration with HST. We discussed findings from an initial literature review and HST's field experiences with their research administration and the US research team. Later, HST research administration reviewed drafts of the protocols. The initial KI interviews further shaped these protocols. Participants were recruited using purposive and snowball sampling techniques with the assistance of HST and Umang, through word-of-mouth and peer-group networks. One individual participated in both the interviews and the FGD, as she was a leader in the Umang group and her participation in the FGD encouraged others' involvement.

Participants were at least 18 years old, did not identify as 'heterosexual' but saw themselves as 'women' and reported living in Mumbai. Both the FGD and interviews were conducted in English, Hindi or both, in line with participants' preference. The FGD and the interviews were conducted by a female volunteer from HST as well as a female doctoral researcher from the USA (JB), both of whom were trained in qualitative methods. Both the FGD and interviews were audio recorded and transcribed verbatim. Pseudonyms were generated randomly using an online name generator. Participants were compensated US$5 (300 INR) for participation in the study, as recommended by HST.

Data analysis

The FGD and interviews were transcribed verbatim. Interviews predominantly in English were transcribed by JB with assistance from the HST volunteer. An India-based transcription and translation company transcribed the interviews conducted in Hindi into English. The transcripts were analysed using Nvivo software. Analysis involved the identification of related concepts, which were later grouped together to form themes. Open coding was used to identify groups of words and sentences that were related to form concepts, then, using axial coding, connected concepts were grouped together to form themes. Two researchers coded independently after establishing reliability by coding initial interviews separately and comparing the coding for agreement. Codes were verified by a third researcher. Identified themes were presented to HST's management to ensure their logic in context, through both informal and formal dialogues. The emerging themes from the FGD and interviews often coincided and are presented together unless separate trends were found.

Findings

Table 1 provides information on participant demographics. Participants were mostly college-educated women who ranged in age from 21–30 years old. Three of the participants were involved in lesbian, gay, bisexual and transgender community activism, such as working for HST or contributing to lesbian, gay, bisexual and transgender blogs. Major themes are organised using the social ecological model, a well-established conceptual framework in public health that acknowledges the importance of not only individual- but also interpersonal- and structural-level factors and their impacts on behaviour, as illustrated in Table 2.

Table 1. Participant demographics.

Pseudonym	Age	Sexual identity
Interviews (n = 12)		
Sima*	27	Bisexual
Riya*	30	Unlabelled
Lata*	28	Unlabelled/lesbian
Parnika	25	Bisexual
Yasiman	24	Lesbian
Darshana	24	Lesbian
Brinda	21	Lesbian
Pinga	26	Lesbian
Amita	28	Unlabelled/lesbian
Deepti	30	Unlabelled
Rachana	28	Lesbian
Maya	28	Unlabelled/lesbian
Focus group discussion (n = 6)		
Saloni	30	Bisexual
Priti	22	Lesbian
Harshita	24	Lesbian
Jaya	28	Lesbian
Shashi	30	Lesbian
Riya*	30	Unlabelled

*Participant reported significant involvement with lesbian, gay, bisexual and transgender community and activism efforts.

Table 2. Sexual minority women's health concerns: themes using the social ecological model framework.

Individual (psychosocial)	Interpersonal (relationships)	Micro-level (communities)	Macro-level (society)
Identity labels and rejection	Parents' and family members' support/rejection	Neighbours/local community's policing of family relations	Section 377's de-legitimisation of same-sex identities
Internalised homo-negativity and bi-negativity	Partners' support/controlling behaviours	Connection with lesbian, gay, bisexual and transgender individuals and communities (in person, online)	Indian cultural patriarchy
Mental health pressures and supports	Social network support or ignorance of identity (friends, colleagues, etc.)		Homo-/bi-negativity

Intrapersonal/individual level

Mental health

Isolation linked to sexual identity hindered social support for some participants, which affected mental health: 'If there's a break up happening with a partner, they can't go and tell anyone' (Riya, 30, interview). Participants spoke about their own suicidal thoughts or those of other lesbian or bisexual women they knew. Maya experienced extreme anxiety when her parents moved her away from Mumbai upon finding out about her relationship with a classmate; she was heavily distracted at work and engaging in self-harm but had to hide it.

Participants reported that receiving mental health services was stigmatised, which resulted in a reduction in access to care. Participants also spoke about people avoiding receiving mental health care for fear of undesired consequences (e.g., hospitalisation or medication). Some participants spoke about their experiences of counselling. Some of these were positive and helped participants in realising fuller aspects of their identity. Conversely,

two participants described being forced into psychiatric care and medication. Maya (28, interview) was harassed by doctors with questions about her possible sexual attraction to men in presence of her father while she was under sedation.

There were counter examples of positive experiences in terms of mental health and resilience associated with being a sexual minority woman. Some participants were proud of their identity and strength: 'Whatever happens tomorrow, being a lesbian I can face whatever it is. I'm there standing for my family. I'm there standing for my friends' (Shashi, 30, FGD). Receiving and giving support to and from other sexual minority women allowed them to feel less alone while at the same time providing them with opportunities to express themselves through activities such as singing and dancing in dance groups or informally with other sexual minority women.

Physical health

Sexually transmitted infections were cited as a concern for sexual minority women by the KI interviews. Participants in the FGD also said sexual minority women had not been sensitised about the need for STI testing. Even if women wanted to be tested, identifying testing centres and lesbian, gay, bisexual and transgender-friendly providers were barriers keeping women from getting tested. Maya (28, interview) said that any kind of gynaecological examination was problematic: 'Going to a doctor and saying it, then opening and showing your vagina is a degree of torture.' Three individual interview participants reported that AIDS was a problem for sexual minority women, perhaps as the result of HIV awareness campaigns targeted at sexual and gender minorities.

Labels

The need to communicate their identity in their social network was important for many participants, and some used labels to facilitate this kind of communication. However, Sima (27, interview) also suggested that the main reason for employing labels was either to make a political statement or the need to identify in some online spaces. Participants reported generally learning about sexual identity labels through the Internet or through participation in lesbian, gay, bisexual and transgender advocacy groups.

While there are many different identities among sexual minority men in India (e.g., Asthana and Oostvogels 2001; Kumta et al. 2010), the only sexual identity labels for sexual minority women in Mumbai reported by participants were either 'lesbian' or, to a lesser degree, 'bisexual'.[2] The term lesbian, however, carries pornographic or sexual undertones with which some participants did not identify, while a bisexual woman was seen as one who was sexually available. Many participants rejected any label or identified as a lesbian but did not feel strongly aligned with this identity. By not identifying as 'lesbian' but rather simply as 'a woman' or 'a person', or even 'the girl who loves [name of partner]', participants created alternatives for themselves to more sexualised identities.

Participants frequently said that their sexual identity did not describe their whole self. Riya (30, interview) emphasised how her primary identity was that of a good human being rather than her gender or sexual identity. The salience of sexual identity was often subsumed by the daily life of participants: '[My sexual identity] doesn't really come out in my daily life. I'm too busy cooking or having a bath or making food, you know these normal things' (Sima, 27, interview). This was connected to the fact participants wanted to be seen as more than

their label: 'When I meet someone for the first time I don't want them to think of me, "Oh *that's* the dyke in the room"' (Lata, 28, interview).

Interpersonal level

Family support or rejection

Family support was a critical factor to participants, especially from parents. This is linked to the central nature of the family unit in India. Due to the continued importance of the natal family, few participants described having a family of choice (e.g., friends as family). Siblings and cousins were often seen as supportive, and the process of 'coming out' with them was said to be brief and easier than with parents. For some participants, discussing their identity with their family was seen as necessary and an act of activism in and of itself. Disclosure to family members might also be to avoid an 'arranged' marriage by the family. An alternative common coping mechanism was for women to conceal their sexual identity from their parents, particularly their father, although at the same time participants expressed a strong desire to communicate their sexuality to family members.

The threat of being asked to leave the parents' home was identified by most participants as a problem due to safety concerns. Even if their parents did not ask them to leave, an uncomfortable home environment felt untenable for some participants. Maya's parents hacked into her email and reduced her access to the phone and Internet after finding out about her girlfriend. Participants stated they would be content if their parents wanted to censor discussion of same-sex relationships to others outside the home, but sought parental acknowledgement of their relationship at some level within the privacy of their home: 'But at least [parents] can tell us, "OK fine I agree but at least outside don't behave as you are, be as a friend. Inside it's OK, fine. I accept you guys"' (Riya, 30, interview).

All participants mentioned parental pressure to get married to a man. As women get older, parents may either reduce the pressure or change tactics. Maya's father pressured her to get married but said she could enact her sexual identity within that marriage: 'He said, "you get married to any man and you can tell any man that you are a lesbian. You both can do whatever you want"' (Maya, 28, interview). Although participants acknowledged the pressure of marriage, if women from the LBT community were to marry to a man, they were no longer considered a part of the community.

Several participants mentioned their identity not being taken seriously by their family or being turned into a joke. The idea of an interest in women as being 'just a phase' was reported by participants. Some family members attributed sexual abuse as the cause for an attraction to women and this diminished the validity of the attraction: 'They asked me if I was ever molested in my past. Maybe that would become a reason that I would hate men or not want to be with any guy in the future' (Yasiman, 24, interview).

Friends

The level of support from friends varied for participants: 'Making friends becomes difficult after you come out. And because I am a girl, I like to hang out with girls and not necessarily because I'm bisexual' (Parnika, 25, interview). Priti's (22, FGD) friends encouraged her to do yoga and meditate to correct her 'hormonal imbalance', which they claimed was causing her attraction to women. Participants also voiced their friendship with heterosexual friends as a form of activism by helping them learn about sexual minority women.

Friends were seen as critical mental health supports, but were limited in their ability to provide financial support: 'If today my parents threw me out of the house, where I'm going to go? I'm not going to ask the queer people to take care of me. They'll take care of me for what? One month? Two months?' (Darshana, 24, interview). Because of the resource instability that many sexual minority individuals face, they are unlikely to be able to financially support another person.

Relationship partners

Most participants reported currently being in relationships. Although a few lesbian participants spoke about having had sex with men in the past, there was general negativity toward women who were perceived to be heterosexual but who simply wanted to 'experiment' sexually with other women. One strategy for dealing with the perceived hypersexualisation (i.e., in the form of being sexually available) of bisexual individuals was hiding their sexual identity from male partners.

Emotional connections with partners were perceived as more important than the physical aspects of sex. Riya (30, FGD) explained: 'I saw a lot of cases — actually they are people not attracted for the sex. They're connected emotionally and mentally.' As Jaya (28, FGD) put it: 'It's hard for me. It's more of an emotional thing. Emotional attachment is more than physical.' Physical and emotional connections were perceived as different between men and women by some bisexual participants:

> I'm more attracted to girls physically … but from getting involved with a guy you know I need to be friends with him, get emotionally involved in them and then only I feel an urge to you know be physical with them. But with girls that is not the case. (Saloni, 30, FGD)

Intimate partner violence

Intimate partner violence was identified as an issue in same-sex partnerships in the KI interviews. Same-sex relationship stigma enforces silence, which amplifies intimate partner violence. Although few participants felt that physical intimate partner violence was an issue for sexual minority women, Brinda (21, interview) felt the perceived equal strength between two women might lead to more violent acts. Participants identified the commonality of emotional abuse and stalking or controlling behaviours in same-sex relationships. Stalking, in which (ex)partners may appear when uninvited, or, more often, in the form of inappropriate or frequent electronic contact (via social media or text message), was seen as common in all types of relationships regardless of the gender of partners.

Some said that it was more common for women who were just starting to accept their identity to try to emulate masculine gender norms of control over women. This may be learned from their parents: '[Sexual minority women] see their father beating up their mother, the mother not saying anything. So even in their relationships they will beat or be beaten up' (Sima, 27, interview). But after women become more comfortable with their sexual identity, participants said sexual minority women may enact more flexible modes of gender expression.

Many participants, including bisexual women, reported distrust or dislike of men. Compared to women, men were seen as less intelligent, pushy and more likely to engage in stalking-type practices: 'Men are really pigs but I can make exceptions for a few' (Parnika, 25, interview). Communicating with men was seen as different than with women: 'We have to be very clear with [men]. Because if you are talking about sexuality, it's implied that you have

to have sex with them' (Sima, 27, interview). There was a perceived difference between how lesbians and bisexual women related to men: 'I am okay with having men around, because I've been with a man before but for lesbians who haven't been with a man, they get a little uncomfortable when men are around … bisexuals are okay with anything around them' (Pinga, 26, interview).

Employment

Many of the participants prioritised their professional development or job as an important part of their identity and lives. In negotiating identity disclosure to co-workers, participants took into consideration general attitudes in the workplace, their position in the organisation and relationships with co-workers in deciding whether to reveal their identity. Yasiman (24, interview) spoke about working in the legal field, and although she expected her colleagues to be rational-thinking people, she had not had enough time to gauge the workplace climate to disclose her identity.

Micro level

Local communities

The local neighbourhood community was perceived as playing a role in enforcing parental/social pressures to marry a man: 'In India it's like the neighbours are always worried about what the other people [are] doing' (Deepti, 30, interview). This monitoring extends beyond just neighbours. Maya's (28, interview) classmate told the hostel warden about Maya's relationship with another woman, who then called her parents. This resulted in a loss of partner and community when her parents moved her out of the country with them.

Connection with lesbian, gay, bisexual and transgender individuals and communities

The importance of finding other sexual minority women was paramount for some participants. One participant spoke about meeting other sexual minority women for the first time: 'They're just normal people. They don't have kidney problem or they don't have jaundice or they don't have cholera. Because that's how people see us. They think that we have a disease' (Yasiman, 24, lesbian). Rachana's (28, interview) future dreams included having a network of other sexual minority individuals: 'I want a house, car, good secured job and many friends who are like me.' The Internet offered an important source for participants to connect with people and resources in India and to learn about sexual minority identity labels.

Macro level

Re-criminalisation of homosexuality

All participants were aware of the re-criminalisation of sexual acts between people of the same sex and wanted decriminalisation.[3] The illegality of same-sex relations hindered participants' disclosure of identity and activism efforts but did not cause legal problems for them. It also reduced participants' feelings of safety: 'If you want to even pull away from your family and you want to build your own life independently, that should at least be an option. With this law being upheld that seems very risky and terrible' (Maya, 28, interview). The news coverage of the re-criminalisation sparked conversations with family members and between friends:

Riya (30): I saw that news on TV, I [was at Shashi's] house …

Shashi (30): On that night I came out to you. (FGD)

Patriarchy

Participants often cited gender oppression as more salient than discrimination based on sexual identity. Sima's words below describe how her position as a woman influenced her self-esteem and her relationships with others:

> So there is a deep set insecurity about being female. You have issues with your body, you're fat. You don't feel comfortable approaching women …. Feeling bad about your body. Or feeling that what you have to say is not good enough. Or not witty enough. Wanting to stay in your own space, not really wanting to be outspoken. Not to be showing you're a sexual person and you have sexual needs. And wanting to – in the name of respecting your family, being OK with going into a marriage. And we have this always concept that even elders are right. Even though in your heart you know that they are not …. And it being OK for your family to make choices for you. (Sima, 27, interview)

This affected participants' lives because women are less physically safe and have fewer rights than men in India:

> Women are really difficult to get out of a closet. And not just that. Just out in numbers and share themselves. I think the stigma of society and secondly just honestly being a woman in India you're already a second-class citizen. (Lata, 28, interview)

Maya felt like she was valued as an object within her family, comparing her treatment to a chair or to cattle: 'I felt like an object, how you push a chair to the corner of the room and it stays there' (Maya, 28, interview). Gender discrimination was connected to their financial instability as well. Participants referenced women's inability to be safe on the streets. For example, in response to the threat of being turned out of the home, Riya (30, interview) reported that men would be safe sleeping in the railway station, while women would not.

Women's subjugation and prescribed role in society may also provide them some protection: 'Yeah for me, being a lesbian, it's a kind of advantage for me. In India they trust girls a lot. Even if they are making out' (Priti, 22, FGD). However, this trust may only be for assumed heterosexual girls and women:

> You can stay with your girlfriend or partner very easily. If you've not come out, that is very important. But if you're out, even if you're just friends, people will think you're making out somewhere. If you've not come out, it's good to be [in Mumbai]. (Saloni, 30, FGD)

Homo- and bi-negativity[4]

Participants primarily referenced homo-negativity from others in advocating for others' acceptance of their identities and relationships, especially for older generations. In matters of sexual identity, Yasiman (24, interview) claimed distrust of anyone over 30 years of age. Participants spoke of hope for the younger generation's acceptance of sexual minority identities. The ways in which internalised homo- and bi-negativity were discussed included difficulty accepting themselves as attracted to women, and thus attempting to be in relationships with men.

When asked about issues specifically faced by bisexual women, Amita (28, interview) said: 'Bisexual? I don't think so. They don't face any issues. They'll adjust to both [men and women] so [they have] all the options.' Many lesbian or non-identified participants either outright expressed dislike and intolerance of bisexual women, or said they did not know any of them.

Another factor contributing to bi-negativity was the perception that most bisexual women would eventually marry a man. Yasiman (24, lesbian) called it 'pathetic' that her ex-girlfriend had married a man. Harshita (24, FGD) said she is wary of dating a bisexual woman and asks a prospective partner upfront to decide if she's a risk: 'If I like you, I'll ask first "are you lesbian or bisexual?"' However, there may be more fear about women's sexuality as impermanent in general. Brinda (21, interview) said that in her relationship, both partners worried that the other one would 'go back to being straight' although they both identified as lesbian.

Being bisexual isolated individuals from social networks, and the invisibility of bisexual women was problematic for participants. Bisexual participants often reported that they felt either in 'the community' (of lesbian, gay, bisexual and transgender individuals) or not, depending on the gender of their partner. Relationships with male partners were sometimes beneficial; one participant felt her relationship with a man may have been less of a threat to social norms and thus her mother might have been more accepting of her bisexual identity. Far from being privileged, however, this separation of women in relationships with male partners from the lesbian community contributes to bisexual women's invisibility.

Discussion

This study contributes to the relatively small body of research on sexual minority women in India by identifying perceived psychosocial factors that affect health among a sample of sexual minority women. In examining these issues through the lens of social ecological theory, it appears that such factors are prevalent across all levels of these women's experience from the individual to the societal.

Given the stressors in the context of India for sexual minority women, mental health is a real concern for this population. The depression and anxiety that multiple studies have documented in men who have sex with men in India (e.g., Logie et al. 2012; Mimiaga et al. 2013; Sivasubramanian et al. 2011) point to a need for research on sexual minority women's mental health. Many participants reported that accessing mental health resources is highly stigmatised, and also that women who *do* access services often have negative experiences (e.g., forced medication). Ranade and Hastak (2015) called for more sexual minority-affirming mental health providers in India, as many providers continue to try to 'cure' homosexuality.

Participants mentioned alcohol, tobacco and marijuana as the drugs of choice among those sexual minority women who use them. Women of both low- and higher-SES levels in India have been found to have increased odds of alcohol use (Subramanian et al. 2005), although the rates are still low, with a peak of 1.6% in the 50–59 age group for women (Neufeld et al. 2005). Smoking and chewing tobacco rates for women aged under 40 in India range between 3-10% (Neufeld et al. 2005). Marijuana estimates for India are difficult to obtain, especially for women, but national surveys have found 3.0% of men use marijuana across India (Ray 2004). As participants did not feel that sexual minority women were more likely than other women to use substances, more research is needed to determine the prevalence of use for sexual minority women.

Our findings align with existing research on sexual minorities in India that have identified the threat of family rejection and pressure into heterosexual marriage (Dodge et al. forthcoming; Joseph 2005; LABIA 2013; Ranade and Hastak 2015). India's cultural emphasis on collectivism and family lineage leaves little room for women in same-sex relationships

in a context where same-sex marriage is illegal. In advocating for themselves with parents or in their self-concept, a few participants framed their relationship with another woman within this cultural framework (i.e., committed and with dreams of having children). It also may limit the ways sexual minority women conceive of friends as family and their ability to rely on them for support.

At the societal level, legal criminalisation of same-sex sexual relations, homo-negativity and, in particular, bi-negativity and subjugation of women were important factors. Section 377 has become nearly a household name in Indian society at large (Corrêa et al. 2014). The effects of this law on the lives of sexual minority women, specifically, are not yet documented in academic research. Participants in our study highlighted the increased difficulties in talking about a lesbian or bisexual identity because of Section 377, but it may also have fostered more political advocacy in sexual minority women who were previously less involved. More research into the ways this law affects sexual minority women is needed to inform policy change.

Stigma and bi-negativity from other sexual minority women and the larger society was discussed in ways that echo the experiences of bisexual individuals in other contexts (Friedman et al. 2014). For example, the social invisibility of bisexual individuals, misconceptions regarding impermanence of identity, hypersexuality and incapability of monogamy (including the stereotype of bisexual women leaving their female partners for male partners) that participants discussed have been documented with bisexual men and women in the USA and the UK (e.g., Barker et al. 2012; Dodge et al. 2012; Hayfield, Clarke, and Halliwell 2014; Ochs 1996).

Recent research on the social position of girls and women in India has found associations with negative mental health symptoms (Rao, Horton, and Raguram 2012), sexual violence (Karandikar, Frost, and Gezinski 2014), substance use (Chari et al. 2012), female foeticide (Patel 2013) and unequal resource provision in childhood (Barcellos, Carvalho, and Lleras-Muney 2014). The participants in this study described the ubiquity of gender oppression. However, they also used the power of patriarchy to subvert expectations and to be physically intimate with other women. These findings are in agreement with previous research concerning the indirect nature of discussing and performing sexuality in India (e.g., Lambert 2001; McDougall, Edmeades, and Krishnan 2011). There may be consequences in subversion of this control; future research might usefully examine the ways in which these women feel they undermine patriarchy, how they are perceived and whether there are positive/negative consequences.

In summary, some of the issues identified by sexual minority women are similar to the experiences of sexual minority men, such as mental health stressors (Prajapati, Parikh, and Bala 2014), marriage pressures (Pandya 2011) and restricted expression of sexuality (Pandya 2011). We have chosen to use the terminology of 'sexual minority women' to situate our work within a larger body of research on and with sexual and gender minority individuals. However, it may be more reflective of women's experiences to use phrases such as 'women in same-sex relationships' (Swarr and Nagar 2004) or 'women who love women', which stress emotional connections with women, rather than 'women who have sex with women' in which sexual practices are emphasised. Additionally, bisexual participants might be more accurately described as 'women who love women and men.'

Strengths and limitations

This study is exploratory in nature and, as such, has limitations. The sample was relatively small and selected using convenience sampling. Although the number of participants was not large, the degree of consensus on the issues discussed lends support to these being shared issues for the health of sexual minority women in Mumbai. Participants were relatively connected to a socially active lesbian, gay, bisexual and transgender community; thus, findings from our study are not generalisable to sexual minority women who are not connected to such networks or who are in more isolated areas of India. This study was conducted in Mumbai, which may differ from other urban and rural areas of India. The urban context of our findings implies possibly different stressors for sexual minority women in other areas. Additionally, participants were relatively similar in age and the attitudes and issues may be different for other generations. Although participants were connected to other sexual minority women, they ranged in their degree of involvement with the lesbian, gay, bisexual and transgender community, from activists to newly connected women with only a few people aware of their identity. Within the FGD, participants having previous connections to each other strengthened their comfort level in the group but it also may have increased the social desirability bias of their responses

Although the lead researcher did not speak fluent Hindi, the lingua franca of the area, collaboration with a trained, bilingual research assistant mitigated some language and cultural issues. Using NVivo qualitative software to organise and analyse the data strengthened the validity of thematic findings. The partnership with local researchers and community partners strengthened the quality of the findings through their involvement in design, recruitment and interpretation phases. The fact that both interviewers were women may have affected participants' comfort in discussing their experiences.

Conclusion

This study has implications for future public health research and programmes targeting sexual minority women in India. To date, the focus of much health research with sexual minorities in India has been predominantly been on HIV/STIs, and also primarily on men. Sexual minority women have not been considered at great risk for these health issues and are thus excluded from health research and programming; this further contributes to their social marginalisation. The rejection of labels for some sexual minority women in Mumbai may lead to their lack of identification with a broader sexual minority community. It may also reflect the prominent finding that sexual identity may not be a critical part of sexual minority women's conceptualisation of their selves. To address the consequences of family rejection, increasing the number and accessibility of mental health counsellors trained to work with issues faced by sexual minority women may help to mitigate this among these women. Another stigma reduction strategy is fostering dialogue between family members of varying acceptance levels of sexual minority women. As many women relate to their sexual identity and connect to others through Internet resources based in India and globally, increasing virtual support services may be congruent with the needs of sexual minority women, particularly those who are isolated. Future larger-scale empirical research is also needed to assess the prevalence of health behaviours, as well as risk and protective factors,

to inform future interventions that may improve health and wellbeing in this understudied and underserved population.

Notes

1. HST's activities include prevention, care, support and treatment of HIV and people living with HIV, research, awareness and advocacy, and mental health counselling for sexual minority individuals. Similarly, Umang provides social support and advocacy for sexual minority women.
2. According to participants, the only Hindi word to reference sexual minority women was *bhai*, which translates as brother or boss. This was not used as an identity label but in reference to, or when speaking with, a masculine-presenting sexual minority woman.
3. Section 377 of the Indian Penal Code, which criminalised same-sex sexual relations, was read down in 2009 to strictly limit the interpretation of the law (Das 2013; Humsafar Trust 2011). In December 2013, this decision was overturned so as to re-criminalise same-sex relations.
4. Homo-negativity and bi-negativity refer to negative attitudes and associated stigma against homosexual and bisexual individuals, respectively (Yost and Thomas 2012).

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