

CHAPTER II

REVIEW OF LITERATURE

This chapter highlights the review of literature of the present study. The main aim of the chapter is to deal with the available literatures related to psycho-social problems of MSM which will help to understand the different issues and problems encountered by MSM that affect their psycho-social well-being . It presents the literatures of available studies on sexual orientation and sexual identity, socio-economic and cultural factors, psychological aspects, risk and copying mechanisms of MSM. The study of psycho-social problems of MSM is an emerging area of interest as they are often perceived as sexual minority group due to association of double stigma of homosexual identity and HIV/AIDS. It is recently gaining interest even in Manipur. Thus, this chapter will help in understanding the different aspects of problems in relation with psycho-social problems of MSM. Literature has been collected from books, journals, reports, documents and newspapers to cover the different issues/ problems that are encountered by MSM at worldwide.

II.1 Reviews related to Global issues on MSM

This section tries to cover the different aspects of literature review related to MSM at global level. The outlook of MSM in relation to its different aspects has been discussed for better understanding of the issues /problems encountered by MSM.

II.1.1 Review related to sexual orientation and sexual identity of MSM

Sexual minorities are defined with reference to two distinct and complex characteristics: sexual orientation and gender identity. The American Psychological Association (2011) defines sexual orientation as “an enduring emotional, romantic, sexual, or affectional attraction toward others. It is easily distinguished from other components of sexuality including biological sex, gender identity (the psychological sense of being male or female), and the social gender role (adherence to cultural norms for feminine and masculine behavior.)” Further, “sexual orientation exists along a continuum that ranges from exclusive heterosexuality to exclusive homosexuality and includes various forms of bisexuality. Bisexual persons can experience sexual, emotional, and affectional attraction to both their own sex and the opposite sex. Persons with a homosexual orientation are sometimes referred as gay (both men and women) or as lesbian (women only)”.

The National Association of Social Workers (1999) identifies sexual orientation as "not merely a personal characteristic that can be defined in isolation. Rather, one's sexual orientation defines the universe of persons with whom one is likely to find the satisfying and fulfilling relationships." Sexual orientation refers to an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes. According to Kinsey et al. (1948, 1953) studies reported that 37% of adult men and 13% of adult women had at least one sexual experience resulting in orgasm with a person of the same sex and that 4% of adult men and 2% of adult women are exclusively homosexual in their behavior and fantasies. The

study of Seidman et al. (1994) found that various US studies also estimated that 2% of men are exclusively homosexual and 3% are bisexual. Data from the third wave of the National Longitudinal Survey of Adolescent Health (Add Health) collected in 2001–2002, similarly found that 3.2% of young adults aged 18–26 described themselves as mostly or exclusively homosexual or bisexual, with more females (3.6%) than males (2.6%) using these labeling (Silenzio, 2007). Thus, the studies showed that large numbers of adolescents had their sexual feelings, attraction, and sexual relationship with people of the same sex.

According to British Columbia Adolescent Health Survey (2003), among 2,89,767 student enrolled in public school, 1.5% of boys identified themselves as bisexual, mostly homosexual or 100% homosexual, while 6.4% said that they had had sex with someone of the same gender in past year (Saewyc, 2007). The above findings are similar to Remafedi et al. (1992) study that 1.1% of teens identified as gay or bisexual, but 4.5% stated that their main sexual attraction was to individual of the same sex. The same study conducted by Garofalo et al. (1999) revealed that about 3% of students in grades 9-12 identified themselves as gay, lesbian, or bisexual. Australian Study of Health and Relationship (2001) found that 19307 Australian aged 16-59 years which included 10173 men of whom 97.4% identified heterosexual, 1.6% as homosexual or gay, and 0.9% as bisexual, while 0.1% were undecided or “other”. 6.8% were reported to have sexual attraction with other men and 6.0% had sexual experienced and 2.7% had sex with at least one or other with man (Marian et al., 2006). The above studies indicated that there is always incongruent between sexual and affectional preferences in some people. Those who

are attracted primarily to opposite sex are heterosexual, those attracted primarily to the same sex are homosexual (gay or lesbian) and those who are attracted to both sexes are bisexual. So, there are different forms of sexual identity based on the roles taken during sexual act.

Often homosexual youth experienced of challenges especially those who come out without family or societal support. A study by Deuba (2012) found that 21% had experienced of verbal abuse, 10% reported of experiencing physical and sexual abuse, and 32% reported experienced of all three forms of abuse. He furthermore expressed that 38% reported of physical abuse by a spouse/sexual or partner/relative and 41% of sexual abuse by a spouse/sexual partner/relative. 61% respondents reported of depressions, 47% reported of having suicidal thoughts and 40% reported of suicidal plan. Ryan et al. (1998), studies have shown that almost one-half of gay men and one-fifth of lesbians were verbally or physically assaulted in high school and they were two to four times more likely to be threatened with weapons at school. Therefore, MSM had experienced of threatening by family members, peer group, partners, spouse and relatives because of their sexual orientation and behaviour leading to psychological problems such as depression, stress, tension, etc.

The teen who come out or express their sexual behaviour are able to adjust and live comfortably in society otherwise they may develop distress at later life. Remafedi (1991, 1998) found that high school students who say they are gay, lesbian or bisexual, or who say they are attracted to people of the same sex or have had sex with people of the same-sex are two to seven times more likely to attempt

suicide. According to Remafedi (1993) the risk appears to be highest when a teen acquires a gay identity at a young age; when there is a family conflict due to his sexual orientation; if the teen has run away or been thrown out of the house; if he or she is conflicted about his or her orientation; or if he or she has not been able to disclose his or her orientation to anyone. Parents often rejected of their sons' homosexual behaviour. Usually, homosexual oriented son may feel agonize about expressing their sexual behaviours to parents due to unexpected reactions from parents.

Cass (1983/1984) defines sexual identity as a cognitive construct that refers a person sees as definitely representing the self in a social setting or situation that may be imagined or real. Sexual identity becomes dormant when it removes from social environment. It is also defined as the set of characteristics where an individual perceives as definitely representing the self in relation to social environment that assume the form of attitudes and potentials for action towards self. He further described that there are two forms of sexual identity: private (personal) and public (social) identity. The process of declaring a homosexual identity is often referred as 'coming out'.

Hurlock (1983) expressed that during pre-school years, children find social contact with members of same sex as more pleasurable than with members of opposite sex. However, the significance lies in the fact that the individual interprets and construct sexual identity according to their earlier experiences in the form of homosexual, bisexual or heterosexual. Zhao et al. (2010) study found that suicidal behavior to be significantly higher in youth who identified as gay, lesbian or

bisexual, in compared to those who identified as heterosexual. Some of the research had also shown that individual identifies sexual orientation between middle childhood and early adolescence. For some of the people, declaration of sexual orientation is delayed due to fear of social norms, stigma, discrimination and prejudices. Most of the homosexual persons encounter extensive prejudices, discriminations, and violence due to their sexual orientation.

D' Augelli (2002) described that risk factors for gay men who attempted suicide include problems related to sexual orientation, parents reaction, a hostile environment, and victimization because of sexual orientation. He reported that more than three quarters of his participants had been verbally abused, 15 percent had been physically attacked, and more than third reported of losing friends because of their sexual orientation. Barret et al. (2002) found that hiding one's sexual orientation cause stress and anxiety, but when a gay man perceives discrimination, his work attitude is more negative, reduced number of accomplishments, fewer promotions, and a decreased level of status.

II.1.2 Review related to socio-cultural factors that affect psycho-social aspects of MSM

Social discrimination against gay men and other MSM has been well-documented in many regions around the world, regardless of cultural, social, political, economic or legal environment in which they live (Poon & Ho, 2008). In many cases, homophobia is condoned, and sometimes intentionally perpetuated, by policies that criminalize these individuals or neglect their basic human rights. Although civil society has made tremendous progress towards equality for all

people, regardless of sexual orientation, discrimination and violence targeting this population (Saewyc et al., 2006). The range of challenges faced by gay men and other MSM varied from everyday personal hardships to high-level structural factors that perpetuate adversity, including antipathy from civil society organizations, religious bodies, government and law enforcement agencies (Ottoosson, 2009). Many MSM hide their feelings, behaviours, and relationships because of harassment, ridicule, rejection, and violence.

Murray et al. (2000) expressed that societal attitudes towards homosexuality vary greatly in different cultures and different historical periods. All cultures have their own values regarding appropriate and inappropriate sexuality; some sanction same-sex love and sexuality, while others disapprove of such activities. Tsuneo et al. (1989) mentioned with heterosexual behaviour, different sets of prescriptions and proscriptions may be given to individuals according to their gender, age, social status and/or class. For example, among the Samurai class of pre-modern Japan, it was recommended for a teenage novice to enter into an erotic relationship with an older warrior, but sexual relations between the two became inappropriate once the boy became adult. Crompton et al. (2003) expressed many culture considered procreative sex within a recognized relationship to be a sexual norm. Some religions, especially those influenced by the Abrahamic traditions have traditionally censured homosexual acts and relationships in some cases implementing severe punishments for offenders.

The Pew Research Center's 2013, Global Attitudes Survey found broad acceptance of homosexuality in North America, the European Union, and much of

Latin America, but equally widespread rejection in predominantly Muslim nations and in Africa as well as in parts of Asia and Russia. The survey also found that acceptance of homosexuality is particularly widespread in countries where religion is less central in people's lives. These are also seen among the richest countries in the world. In contrast, in poorer countries with high levels of religiosity, few believe that homosexuality should be accepted by society.

Often cultural, social, and ideological systems deny and stigmatize any non-heterosexual forms of behavior, identity, relationship or community. Under this discourse, procreative heterosexuality becomes the normative process and homosexuality becomes 'abnormal'. Thus, MSM become victims of homophobia, heterosexism, and homocentrism. Walters & Hayes (1998) expressed that many homosexual people live in fear of disclosing of their sexual identity to their families, friends, employers, and co-workers. Stigma that included fear of social disapproval, a blemish on family identity, or loss of prestige in the community, were reasons given by family members for not disclosing of their sons' sexual orientation and sexual behaviour (Anderson, 1994). D'Augelli et al. (1998) revealed that lesbian, gay, and bisexual people who assume that their families would react negatively and thus hide their sexual orientation from them. Herek et al. (1998) also talked about the forms of social and cultural oppression that related with development of low self-esteem and mental health problems among MSM. In United States, the FBI reported that 15.6% of crimes reported to police in 2004 were based on perceived sexual orientation. Sixty-one percent of these attacks were against gay men. Thus, it can be said that homosexual people are not free to move in public place.

Today, nearly 80 countries worldwide criminalize same-sex acts between consenting adults, with penalties ranging from fines to imprisonment, and in seven nations with death (Ottoosson, 2009). In such situations, MSM cannot disclose their sexual behaviour in society. Even those organizations or staffs who are providing specific HIV prevention, information and services to MSM may be accused and subjected to fines, imprisonment, harassment or violence. Over 20 countries in Asia criminalize homosexuality, out of 20, 17 countries were reported for having higher HIV prevalence rates among MSM. Maximum of the African countries are still practicing of punishing of same-sex behaviour with criminal sanctions. Numbers of countries have recently taken renewed interest in same-sex criminalization laws, either by enacting existing laws, expanding their criminal penalties, or putting forward new criminalization initiatives for the first time. For example, in 2009, legislation was introduced in the Parliament of Uganda that would increase existing same-sex criminal penalties to include life imprisonment and, in some cases, the death penalty.

In many countries and cultures, a high social premium on heterosexual marriage and having children can also place enormous social pressure on gay men. Studies of MSM in China revealed that societal expectations of male gender roles contributed to higher levels of perceived stigma, which in turn correlated with higher rates of unprotected anal intercourse (Mutalemwa et al., 2008). It showed that gay men succumb to social pressure and enter into a heterosexual marriage, simultaneously; they often maintain sexual relationships with male partners.

Evidence demonstrated that there is a linkage between discrimination and poor mental health among gay men and MSM. It stressed that expectations of rejection and discrimination (stigma) and actual events of discrimination and violence (prejudice) each independently and collectively contribute to sub-optimal mental health (Meyer, 1995). Gay men and other sexual minorities in the United States who live in states with laws that discriminate against same-sex couples have been found to exhibit hopelessness, chronic worry, and hyper-vigilance, which are common psychological responses to discrimination (Hatzenbuehler et al., 2010). Social discrimination directed at gay, bisexual and transgender high school students has shown to elevated risk of self-harm, suicidal thoughts, risky sexual practices and excessive substance abuse (Almeida et al., 2009; Mcdermott et al., 2008).

Weinberg and Williams (1974) found that gays who were well adjusted with homosexuality identity, did not want to change their identity. They further did not support homosexuality as an illness. Hammersmith and Weinberg (1973) also found that positive commitment to homosexuality was related to psychological adjustment. The study by Jacobs and Tedford (1980) also found that membership in a gay group was positively related to self-esteem. Schmitt and Kurdek (1987) found that gay men living with a partner had more positive sense of self-esteem and also those gays who involved in long-term relationship suffered less depression and anxiety.

Muchmore et al. (1990) revealed that those who are not open about their sexual orientation may experience additional difficulties in their lives. When gay men tried to hide their sexual orientation from their co-workers and employers,

they often indicated of stress and anxiety, dissatisfaction, feeling misunderstood, pressured, detached, and alienated (Day et al., 1997). D'Augelli et al. (1987) expressed that the opportunity structure for gay development in rural settings is distinctly limited. Mayne et al. (1993) mentioned that persons closely associated with rural MSM, such as family members and personal friends, may also be at risk for social rejection if men's sexual orientation becomes publicly known. Lindhorst et al. (1997) found that rural MSM were having social isolation due to lack of networking opportunities with other MSM. They had experienced of more social stigma, rejection and social isolation in compared to urban MSM. MSM from urban area had more opportunities and connection with same community in compared to MSM of rural area. They were lacking from any kind of opportunities such as sharing with own community, education, vocational facilities, etc. The study of Smith (1997) also found that in rural areas, opportunities and support networking was not existed and many gay men travel long distances for social contact with other gay people. Moreover, MSM who were living in rural areas had high risk of rejection and ostracism from family, friends, and others in their communities, thus they did not disclose their sexual orientation as a means of survival. As a result of this, many rural MSM internalize feelings of social rejection, and internalized homophobia. D'Augelli et al. (2001) study found that the high prevalence of suicidal attempts among urban and rural gay youths ranges from 12% to 42% with up to 50% contemplating self-harm.

Hershberger et al. (1997) mentioned that there is evidence that rejection by peers and loss of friends due to sexual orientation is a predictor of suicidal attempts.

Parent-son/daughter relationship is also a factor which associated with adolescents' depression and suicidality among homosexual people. Floyd et al. (1998) study found that 50% of the respondents reported suffering from non-disclosure related stress and referred to their families' religious beliefs or cultural background as contributing to the family's non-acceptance and their own non-disclosure. The finding is indicated that those homosexual adolescent who had experienced of parental love, moral and emotional support had fewer psychological problems such as stress, depressive suicidal ideation, etc.

Mays et al. (2000) reported that data from National Survey of Midlife Development showed elevated anxiety, depression and other stress-related mental health problems in LGB adults aged 25–74 years who reported personal experiences with discrimination. D'Augelli et al. (2001) state that if a gay man is not able to be himself in public situations, he may develop feelings of loneliness, worthlessness, low self-esteem, and increased internalized homophobia.

Russel et al. (2003) expressed that homosexual people are having higher rates of depressive symptoms, suicidal ideation and suicidal attempts than their heterosexual peers. Thus, MSM had experienced of discrimination, victimization, and rejection leading to low self-esteem, depression, hopelessness, and social isolation which place them at risk for suicides. D'Augelli et al. (2005) also found that homosexual adolescent were at risk for conflicts with parent, parental criticism and parental rejection due to their non-disclosure related stress, sexual minority status and/or atypical gender role behavior. He furthermore expressed that family rejection and abuse related to sexual orientation have been associated with

depression and suicidality among LGB adolescents. The forms of abuses by family members are blatant, harsh rejection, cut off rejection, derogatory language, non-verbal manner (sadness and disappointment).

II.1.4 Reviews related to risk behavior and coping mechanisms

a) Risk behaviour

In Asia, HIV prevalence among MSM are high and there are multiple factors such as misconceptions about risk factors, high levels of unprotected anal intercourse, high levels of transactional sex, high numbers of sex partners, and low perception of self-risk. Centers for Disease Control and Prevention (2002) expressed that in United States, MSM group are the largest proportion of HIV infections. Schechter et al. (1986) mentioned that the main sexual risk behavior for HIV infection among MSM has been unprotected anal intercourse. Some of the studies showed that those MSM who had experienced of higher levels of social discrimination were more likely to engage in risky sexual behavior leading to HIV infection. Therefore, both overt harassment and gender-role expectations had correlated with higher levels of sexual risk among MSM. Threatening by family members, partners and other sources have been associated with high risk behaviors such as unprotected anal sex (Konlin et al., 2006). A myriad of socially hostile behaviors directed against Latino gay men in the United States – including high levels of verbal harassment, perception of hurt and embarrassment within their families, and the need to pretend to be heterosexual – have also been linked with high-risk sexual behavior (Diaz et al., 2004).

Perceived sexual orientation is not the only factor that leads to social discrimination facing gay men and other MSM. Aside from their sexual orientations, MSM may be stigmatized on account of additional identities as migrants, sex workers, drug users, or people living with HIV, etc. This can add additional layers to the discrimination which they have already been facing. From a public health standpoint, these multiple stigmas exacerbate the challenges of disclosing risks or health status to sexual partners and health service providers, weakening one's ability to negotiate safer-sex practices and participate in health promoting behaviors (Padilla et al.,2008; Brown et al.,2010).

Paub et al. (1997) study of the sexual profile of 2583 homosexuals people found that 10.2 percent to 15.7% percent had between 501 and 1000 partners. In addition, 10.2 percent to 15.7% had more than 1000 lifetime sexual partners. The study also mentioned that 2% of U.S. population is gay and HIV infection prevalence rate is 61%. It is indicated that the unprotected sexual relationship with multiple sexual partners may be one of the reason that MSM remain the most heavily affected by HIV infections. Centre for Disease Control (2009) estimates that MSM represent only 2% of US population, they accounted for the majority i.e. 61% of all new HIV infected. Young MSM (ages 13 to 29) was most severely affected, representing more than one quarter of all new HIV infections nationally i.e. 27%. Paul et al. (2002) showed that among MSM, risk of HIV/AIDS elevated has been found to be associated with depression, substance abuse, suicidal behavior.

Some of the MSM have subculture of alcohol use, an injecting and other illegal drug use. Australian Study of health and Relationship reported that bisexual were

eight times more likely to report a history of injecting drug use and gay men were twice as likely as heterosexual. National Online Survey (2011) of health and well-being gay, lesbian, bisexual, transgender and intersex found that 38.3% of gay identifying men reported tobacco use on more than five occasions in the previous month in compared to 26% for Australian men in general. Stall et al. (2001) indicated that alcohol use among gay men ranges from 73.7% to 85%. Greenwood et al. (2001) found that recreational drug use is also highly prevalent among gay men. The study also found 8%-13.6% used alcohol and 12% reported of having alcohol related problems. Skinner (1994) study found that 37.5% of gay men admitted to smoking marijuana and 43% of participants engaged in multiple drug use. Thus the study highlighted that stigma and discrimination in society, partner problems may be factors to indulge in risk behaviour like use drug, multiple sexual partner, etc. among MSM.

Thus, homosexual people may experience of more stigma and harassment in public sphere. The result for such experience may engage in risk behaviours such as substance abuse. Garofalo (1998) found that gay youth were more likely to start using tobacco, alcohol, other substances and drug such as 3, 4-methylenedioxy-n-methylamphetamine (also known as ecstasy), crystal methamphetamine and ketamine at an earlier age. Self-medication for depression and low self-esteem, or increased tendency towards risk behaviour in response to rejection by family and peer may be reasons for homosexual oriented youth who engaged in risk behaviour.

Keshab Deuba (2011) study in Nepal found that 78% did not use condom at their last anal sex with another man, 35% did not use condoms in their last sex with

women, 70% had experienced of violence in the last 12 months, 61% complaints of depression and 47% with suicidal thoughts. Further, the study highlighted that 57% identified their sexual orientation as meti (receptive sex role), 13% as homosexuals/gay, 125 as bisexual, 9% as straight, 48% were reported as sex workers. 48% were involved in receptive anal sex followed by 27% in insertive anal, 17% in insertive and receptive and oral and 4% in receptive and oral. 46% of the total participants had sex with both men and female partner (wife and girlfriend) in past 12 months, 8% of the participants reported that they also had had sex with male, wives, girlfriends and female sex workers. Therefore, their nature of performances of sexual act and role during sex can lead them to become vulnerability of HIV infection.

b) Coping mechanism

The experiences of MSM of color with racism and homophobia are well documented in the academic literature (Bérubé, 2001; Chan, 1993; Han, 2007; Loiacano, 1993; Marín, 2003). Wilson & Yoshikawa (2004) examined both racial and sexual discrimination experienced by API MSM and found that API MSM used both confrontational and non-confrontational coping strategies to deal with racism and homophobia. Racism, discrimination, and sexual minority stigmatization have been previously identified as factors associated with elevated levels of sexual risk behavior for HIV transmission (Diaz, Ayala & Bein, 2004; Han, 2008; Jarama et al., 2005). Wilson & Miller (2002) conducted qualitative interviews to explore strategies employed by gay and bisexual Black men to manage heterosexism, “the institutionalized negative beliefs about and systematic discrimination against

people who are not heterosexual.” They found that gay and bisexual Black men cope with heterosexism by changing the image they present to others, relying on faith for emotional comfort, standing up for themselves, or attempting to change their sexual behavior and feelings.

Although the pervasiveness of heterosexism in the lives of gay and bisexual youths is well established, little is known about the strategies they use to cope with stigma and discrimination based on their sexual minority status (Bryce et al. 2008). One of the most daunting stressors gay and bisexual youth face is heterosexism, the ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community (Herek, 1990). The experience of being stigmatized is at the root of a range of psychosocial health problems faced by sexual minority adolescents (American Academy of Pediatrics, 1993; Rotheram-Borus & Fernandez, 1995), including increased depression, suicidality, and other mental health disorders (Meyer, 2003). Few researchers have examined the emotional consequences of day-to-day encounters with heterosexism, but many have noted the challenge of maintaining a positive sense of self in the face of chronic negative feedback based in heterosexist attitudes (Dean et al., 2000; Williamson, 2000). Goffman (1963) emphasized choices around disclosure by developing the concepts of “passing,” or hiding a stigmatized characteristic, and “covering,” or minimizing its outward signs. More recent qualitative studies have begun to describe the range of strategies used by individuals to cope with heterosexism in a variety of contexts. Decisions regarding disclosure (e.g. when or how to come out) have continued to be important themes (Adams, Cahill, &

Ackerlind, 2005; Wilson & Miller, 2002). However, additional dimensions of coping have also emerged, such as seeking support or challenging heterosexist assumptions (Wilson & Miller, 2002). Other studies have focused on the experiential aspects of facing heterosexism, such as feelings of alienation or isolation, and states of self-reflection or inner conflict (Flowers & Buston, 2001). Such feelings may be particularly relevant to coping with heterosexism, since, unlike racism and many other types of stigma, heterosexism is often overtly reinforced by the stigmatized person's own family members (D'Augelli & Hershberger, 1993; Savin-Williams, 1989). Thus, while victims of racism can sometimes turn to family members for anti-racist support, sexual minorities often lack such support. Heterosexism, like infertility stigma and other types of stigma that are often reinforced by family members, may therefore increase distance in relationships with key members of an individual's familial social support network and create further isolation (LaSala, 1998; Remennick, 2000).

Bontempo & D'Augulli (2002) expressed that school victimization was found to be moderate and perhaps mediates the association between LGB status and depressive symptoms and suicidality. Many studies also suggested that there is a significant proportion of MSM communities consume intoxicating substance to forget stress and depression that they face in their daily life. They justified the reasons for consuming intoxicated substances as to forget worries and to manage rough clients in their sex work life. Consumption of alcohol and drug made them inability to control and use condoms or insist their clients to use condoms during sex. Such activities gave more chances of increasing HIV infection among MSM.

II.1.5 Reviews related to available services of MSM

According to Bill and Melinda Gates Foundation and Kaiser Family Foundation, the Global HIV Prevention Working Group estimates that HIV prevention services reach only 9% of MSM worldwide. The Global Forum on MSM & HIV (MSMGF) is dedicated to advocating for equitable access to effective HIV prevention, care, and treatment services tailored to the needs of gay men and other (MSM), while promoting their health and human rights worldwide. In 2006, a group of concerned activists, academics and program implementers with a shared concern for the lack of attention to the expanding HIV epidemic among MSM globally which identified five key strategic areas to halt and reverse the spread of HIV among MSM by increasing investments in programs for MSM, expanding coverage of quality HIV-related services for MSM, increased knowledge and research on MSM and HIV, decreased stigma, discrimination, and violence against MSM, strengthened international, regional, sub-regional, and national networks of MSM.

MSM HIV prevention and care programs and services are funded in several countries in the region through a range of mechanisms. USAID-funded agencies such as FHI and others support programs in several countries. Some MSM groups receive, or are about to receive funds from principal recipients of Global Fund grants. Others are funded as part of donor country allocations to recipient countries under national AIDS strategies (amFAR, 2009).

A recent UNAIDS report documents described that many successes of the heightened AIDS response, such as increase in ART coverage from 7% in 2003 to 42% in 2008 among children and adults, and in one year, a 35% increase in the

number of health facilities providing HIV testing and counseling in low and middle income countries from 2007 to 2008. However, while UNAIDS estimates that sex between men accounts between 5% and 10% of HIV infections worldwide, only 1.2% of all HIV prevention funding is targeted towards MSM (Saavedra et al., 2008). Thus, HIV prevention related information are focusing exclusively on heterosexual transmission leading to misconceptions among MSM in various parts of the world that sex between men carry no risk of HIV transmission.

In some countries, gay bars and other known meeting places for MSM, such as bathhouses were provided and promoted condoms and lubricants. Successful prevention work has also been carried out by outreach workers and peer educators for MSM by providing them with condoms, lubricants, and information. The World Health Organization (WHO) (2003) provides guidelines for prevention and treatment of STIs including symptomatic management. The Centers for Disease Control and Prevention (CDC) USA, (2011), provides updated and basic guidelines for health promotion and prevention of STIs among MSM.

Despite the vulnerability of MSM to HIV/AIDS, until recently little attention has been focused on these communities in Asia. Stigma and discrimination have marginalized MSM, and the result is that the unique prevention and treatment needs of these populations have largely been ignored (amfAR, 2006). Thus, it is not surprising when you consider that most countries in Asia spend less than 1% of their HIV budgets on MSM, despite 5% to 20% of new infections occurring among them. Thus, there is no related services and programme for MSM apart from HIV/AIDS. Therefore, this can lead to misinformed policies which in turn can result

in sub-optimal services, self-segregation and consequently poorer health outcomes for MSM. The double stigma associated with MSM made MSM driving away from health care settings due to lack of openness towards their sexuality by service providers.

The Global Network of People Living with HIV (GNP+), along with the International Community of Women Living with HIV, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Planned Parenthood Federation are currently implementing a mechanism – the HIV stigma index – to document the way in which people living with HIV (including MSM and other key populations) experience and are affected by stigma and discrimination. The aim is to inform and improve policies and programmes in countries, including decriminalization of homosexuality and HIV transmission. In spite of this, it is evident that decriminalization alone will not necessarily lead to reduced discrimination. In South Africa, where MSM are protected by the most robust constitution in the world where same-sex couples have the same rights and freedoms – including marriage – as anyone else. A study showed that perceptions of MSM are still negative, even more than 10 years after the adoption of the current constitution. Changing laws is the first step. Changing minds will take much longer (Robert et al., 2008).

II.2 Reviews related to National and local issues on MSM

This section attempted to highlight literatures on the issues of MSM in India to cover up broad areas i.e., sexual orientation and sexual identity, socio-cultural

factors that affect the psycho-social problems of MSM, risk behavior and coping mechanism and available services of MSM.

II.2.1 Reviews related to Sexual orientation and Sexual identity of MSM

Very little is known about male homosexuality in India (Nag, 1994). In a study of 966 lower income college students in metropolitan Mumbai, about 18 percent of young men reported having same-sex experienced (Abraham and Kumar, 1999). Data from a survey on MSM and HIV, conducted by London-based Panes Institute in 1996, estimated that more than 50 percent of men in India have had encountered same-sex in their lifetime (Purkayastha et al., 1997). In a survey conducted among middle-class men and women in Mumbai, Kolkata and Chennai, 5 percent of the men reported of having homosexual orientation (Basu, 1994). Another study conducted on a sample of 464 male college students in Chennai revealed that 11 percent of the students had experienced of homosexuality (Reddy et al., 1983). In 1991, Debonair survey of middle-class and upper-class men, out of 1,158 respondents who ever had sexual intercourse, 37 percent reported of homosexual experienced where twelve percent were unmarried and 8 percent of married men reported of first sexual experienced with men. The homosexual experienced was limited to one or two partners; it extended to six partners or more for about 25 percent (Savara and Sridhar, 1992). In Hyderabad, male college students talked about homosexual experienced of their friends, but none of them reported of their own experienced, while others wondered how two men could have sex (Goparaju, 1994).

II.2.2 Reviews related to socio-cultural factors that affect psychological aspects of MSM

According to Gregory Pappas (2001), Indian society has numerous linguistic, religious, socio-economic and cultural groups. Each group is bounded by certain social taboos and some societal norms and values. Homophilic and gender segregation is common in each society in South Asia. Such societal norms have given an opportunity to men to have relation with men. For instances, sharing of place in hostels, guest house, teashops, sleeping quarters, walk hand in hand and sharing bed. For women such behavior is restricted by society. In India, MSM population is facing hatred by society and religious places and which has resulted from homophobia and stigma.

In India, diversity of religious belief has been another dimension to create MSM problems more complexity. India is a conservative society, a ban or shun of homosexuality. Muslims have specific dictums and punishments for male homosexuality. According to Shariat law, sodomy is a severely punishable offence. On the basis of religious law in Islam; depending on the setting and interpretation, sodomy can be considered punishable by decapitation, by throwing the guilty off a cliff, or by pushing a brick wall on top of the offender. While Shariat law has no formal legal status in India, it sets a cultural norm for 120 million Muslims living in India. With respect to Hinduism, the status of homosexuality is less clear-cut: Hinduism offers many models for homosexual love in the extensive set of stories about gods, goddesses, and demons; however, in terms of contemporary norms, the overall conservatism does not tolerate homosexuality, as evidenced by recent

backlash against homosexuals. Christianity, as practiced on the Indian subcontinent, follows European and American trends, which interpret Biblical references as prohibition.

MSM and hijras/aravani (transgendered women or male-to-female transgendered persons) have existed in India for thousands of years. This is evident from the temple carvings in Konark and Khajuraho (950- 1050 AD) that depict homosexuality and various treatises existing from ancient times. Pradhan et al. (1982) noted that 'Homosexuality was not a condemned mode of sexual gratification when the temple sculptors of Konark and Khajuraho were depicting it in stone for all posterity to see. Even though historical evidences of homosexuality existed in many of these countries were socially and/or legally not accepted. In other period and places, where homosexual love has been punished and those who practiced it have been humiliated as unnatural and abnormal. MSM in India, therefore, experience multiple forms of social and legal discrimination (Chakrapani et al. 2002). It is this pervasive social intolerance along with the cultural pressure for men to engage in heterosexual marital relations that have led many MSM to marry women and have children (Dandona et al. 2005; Go et al., 2004).

Pandya (2011) mentioned that most of MSM stayed in joint family. Marriage has become an unavoidable pressure which they have faced in their life time. Unwillingly they got married with women and live between the two identities i.e. private and public. They undergo marriage as to protect their social prestige. Living between public and private identities creates various psychological and mental health concerns such as dual sexual identities, intra- psychic conflicts such as

confusion related to gender and sexual identity, anxiety related to same-sex attraction and guilt for practicing socially prohibited sexual practice. He furthermore expressed that society expected that all people should get married heterosexually and start a family in order to be considered as “complete adults”. The assumption is that all people are heterosexual and that marriage and family life will fulfill all personal, social and sexual needs. Hence, most of the homosexual men are heterosexually married. His study also revealed that they wish to marry heterosexually because they want to be accepted within society and in family.

Chakrapani (2007) studies in Chennai found that interlocking subsystems of discrimination and victimization of kothi (identified MSM) including police, community members, family members and health care providers that are embedded in structural factors. Further he found that rowdies are able to extort money from kothis because of kothis’ reality based on fears of rejection from family if their sexual orientation and/or HIV status became to be known. Rowdies can engage in unmitigated exploitation and violence against kothi in the form of rape, harassment, and blackmail of MSM. Disclosure of one’s sexual orientation to family is tantamount to family and community rejection that enables the threat of blackmail and extortion. Further his study revealed that many kothis are reluctant to bring shame to their families by revealing their HIV status, in addition to fears of being rejected by their families, which obviates even the possibility of disclosure and family support. Families as perpetrators of both indirect and direct discrimination and violence on a personal level also form part of the super ordinate system of structural violence in enacting oppressive social codes that disenfranchise and victimize MSM

(Chakrapani et al. 2007). Such societal negative reactions are affecting to their psychological well-being.

Pandya (2011) revealed that 72% of the respondents have been sexually abused in childhood. There were significant levels of sexual abuse of Koti (feminized male) from childhood to adulthood. Study shows that 35% of the respondents were physically abused by relatives, 25% were abused by friends and 12% by police. They were sexually abused because of their effeminate character. Therefore, childhood sexual abuse can lead them to develop homosexual associated with psychological problems such as upset, tension, stress, etc.

The implications of homophobia at a personal level on a homosexual individual have serious implications. A homosexual individual, like others, has also grown up in an environment that devalues homosexuality. These internalized negative beliefs and attitudes affect the self-esteem and identity development of a homosexual individual. Homosexuals may devalue themselves by considering their same-sex fantasies and behaviour as 'wrong', 'unnatural', 'immoral' or 'sin' and involve themselves in self-destructive behaviour like substance abuse, leaving their studies and professional concern incomplete (Seabrook, 1999 and Kala, 1992).

II.2.4 Reviews related to risk behaviors and coping mechanisms

a) Risk behaviour

Global data shows that India has the second highest HIV positive people living in the world. Evidence has found that the main route for transmission of HIV is sexual intercourse. The estimated size of MSM and male sex worker populations in India (latter presumably includes Hijras/TG communities) is 2,352,133 and

235,213, respectively. No reliable estimates are available for Hijras/TG women. HIV prevalence among MSM populations was 7.4% as against the overall adult HIV prevalence of 0.36%. Until recently, Hijras/transgender people were included under the category of MSM in HIV Sentinel Sero Surveillance. Recent studies among hijras/transgender (TG) women have indicated a very high HIV prevalence (17.5% to 41%) among them.

Network of Male Indian Sex Workers, (2005); Khan & Bondyopadhyay, (2005) reported that the reasons for continued sexual risk taking among MSM in India include (i) perceptions that HIV is transmitted through vaginal sex and via sex workers, resulting in individuals engaging in alternate anal and oral sexual practices as a way to avoid infection, (ii) stigma and denial of same sex behaviour resulting in anonymous, single-encounter sexual relationships, and (iii) inequalities in power dynamics that arise from Indian notions of masculinity (e.g., discriminatory attitudes and exploitation of effeminate males). It further seen in a study by Kumta et al. (2010), found that almost half of all men (49%) who requested an HIV test did not perceive themselves to be at any risk for HIV infection and 26 per cent indicated that they did not know if they were at risk for HIV acquisition.

There are very limited data on the prevalence of depression among MSM in India. Safren et al. (2009) study found that 55 per cent of 210 participants who screened for clinical depression were found to be suffering from depression. It was highlighted that depression was associated with unprotected anal sex, and higher numbers of male partners, not being married, not having a child, family not knowing about MSM identity, having been paid for sex. A study from Chennai reported that

significant predictors of unprotected anal intercourse were being less educated, not having previously participated in an HIV prevention programme, having clinically significant depression symptoms and lower self-efficacy (Thomas et al.,2009). Such condition made MSM to take up wrong coping mechanism and involved in risk behaviour. Dandona et al., (2005) study in Andhra Pradesh expressed that MSM reported high rates of unprotected anal sex with other men and women. Dandona et al., (2005); Gangakhedkar et al., (1997); Neumann et al., (2000) expressed that behaviorally bisexual men preferred insertive during anal vaginal sex with their partners. These men may form a major bridge population between other high-risk MSM and transgender people and their regular female partners or spouses. Verma et al., (2004) study also found among rural men from 5 different states in India reported that 9.5 per cent of single and 3.1 per cent of married men had anal sex with other men and had greater number of male sexual partners, and found high rates of unprotected anal sex with male partners. Kumar et al., (1991) study revealed that a study in Bangalore, 357 men were reported for same sex behaviour out of that 41 per cent also reported sex with a woman in the past years and 14 per cent were currently married. Condom use was very inconsistent with all male partners, while 98 per cent reported unprotected vaginal sex with their wives. Phillips et al. (2010) expressed that the frequency of bisexual behaviour among MSM, coupled with low condom use, high HIV prevalence and increased transmission efficiency of anal sex, means that the contribution of MSM to the HIV epidemic, through transmission to their female partners, could be substantial.

Schneider et al. (2007) expressed that condom used by MSM with spouses tends to be low, which suggests that through bisexual behaviour, men could link circuits of high risk male-with-male activity with the general female population. Meyer et al., (1998) also mentioned that the number of cases of women infected with HIV through heterosexual transmission within marriage is increasing in India, and that the behaviour reported by the husband was an important risk factor for infection among many of these women. Many MSM engage in unprotected anal and vaginal sex with male and female sexual partners (Nandi et al., 1994; Setia et al., 2006; Chakrapani et al. 2002; Verma et al., 2004). Thus, MSM played a “bridge” role in spreading HIV to the general public.

Phillip et al. (2008) study in Bangalore found that 15 per cent of MSM were full time commercial sex workers and 63 per cent reported of sex for pleasure. Further the study also revealed that there was association of high risk factors amongst MSM who were engaged in commercial sex. Other risk factors were concurrent multiple sexual partners, low condom use during last sexual act and poor health seeking behaviour. A study by Thomas et al., (2009) in Chennai also found that 22 per cent of MSM respondents had unprotected anal exposure and 35.9 per cent had ever paid another man for sex.

Gregory Pappas (2001) article “Male who have sex with male (MSM) and HIV/AIDS in India: The hidden epidemic” discussed about social and cultural context in which males have sex with other males includes sexual behavior patterns, religion, socio-cultural factors and legal consideration. The prevalence risk groups are truck driver ranges with 4.98% to 8.2% and pregnant women at between 0.69%

and 3.4%. Further the study also found that sexual act, anal sex, oral sex, frottage and mutual masturbation are common among MSM. There is less used of condom. MSM do not have much knowledge about condom as a means of protective method. They use hair oil; cooking oil and spit are the mean of lubricants. They exchange sex for money and adopted as a means of livelihood. Joint United Nations Programme on HIV/AIDS (2010) found that 57.6% of MSM were reported for condom use at the last occasion of anal sex in Manipur and 48.9 per cent in Tamil Nadu. Further, it is also found that over half of men with female partners (53%) reported never using condoms with female spouses during vaginal sex and 38 per cent never using condoms with regular male partners during anal sex except for Karnataka. Consistent condom used with paid male partners was low in Karnataka with 35 per cent; it was reported with 54 per cent in Tamil Nadu (NACO, 2010). A study from Chennai reported that 22% of MSM respondents had unprotected anal exposure and 35.9% had ever paid another man for sex. A study among rural men from 5 difficult states in India reported 9.5% of single and 3.1% of married men had anal sex with other man had greater number of male sexual partners and found high rates of unprotected anal sex with male partner. A study in Manipur and Tamil Nadu in 2010 reported that 57.65 and 48.9% used condom at the last occasion of anal sex respectively. 53% reported of not using condoms with female spouses during vaginal sex. 38% reported for never using condoms with regular male partners during anal sex except in Karnataka. Thus, the lack of safer sex knowledge can enhance the risk of HIV infection among MSM in India.

NACO (2009) survey found that there was low levels of comprehensive knowledge about HIV among MSM which were 21 percent in UP; 30 percent in Manipur; 32 percent in Tamil Nadu; 22 per cent in Karnataka; and 57 per cent in Andhra Pradesh. In 2009, 46.3 per cent of MSM in Tamil Nadu had been tested for HIV in the last 12 months and knew their results. Kumta et al. (2010) also revealed that HIV prevalence in Mumbai was 12.5 per cent, 14 per cent of the men reported for having STD symptoms. Setia et al. (2000) mentioned that only limited data are available about STI prevalence among MSM in India. A preliminary analysis of STIs among 85 MSM attending STI clinic in Mumbai provides the following information: 4 had clinical rectal gonorrhoea (among these 2 were culture-positive and remaining 2 were smear-positive), 4 had perennial warts, 3 had gonococcal urethritis, one case each of secondary syphilis, genital molluscum contagiosum and genital scabies. The prevalence of HIV in this population was 15 per cent and VDRL reactivity was 16 per cent. A study by Verma (2004) in Chennai revealed that out of 51 MSM who attended community-based clinic over the period of three months, 13 (26%) MSM were clinically diagnosed to have one or more STIs. Gurung et al. (2010) also indicated that the overall prevalence of gonorrhoea and/or Chlamydia amongst 513 MSM during 2008-2009, recruited from four clinics at two cities of Mumbai and Hyderabad MSM was 16.6 per cent (13.8% had gonorrhoea and 2.8% Chlamydia). A study from Chennai reported that 28 per cent of MSM who use alcohol weekly was associated with older age, being married to a woman, tobacco use and unprotected vaginal and anal sex (Thomas et al., 2009). Therefore, low rate of HIV /STD test can lead them in engaging more in risk behaviour due to unaware of their health status.

Safren et al., (2010) expressed that the behavioural mechanism and psychosocial problems such as depression, substance use, and violence frequently co-occur for many MSM (e.g., as syndemic conditions) elevated risk for HIV. Meyer et al (1998) study revealed that stigma has been shown to contribute to negative self-images and low self-esteem, depression, which increased sexual risk behaviours and decreased of accessing HIV preventive services. Mann et al. (1987); Mawar et al. (2005) studies also found that engaging in unprotected sex perhaps is related to low self-esteem due to marginalization and stigma. The silence and secrecy associated with institutional stigma and discrimination may provide ideal conditions for escalation of AIDS epidemic. This included stigma from health providers, employers and other service providers.

b) Coping response

Stress is a cognitive appraisal of imbalance between perceived demand and perceived capability. It is perceived as imbalance that leads to a subjective (emotional) experience of stress and changes in the physiological state, and these experiences and changes, in turn, lead to psychological and physiological coping responses. Effective coping responses will reduce or eliminate stress. If coping is ineffective, however, then stress may persist or even increase (Sherry 2005). David Mechanic adds motivation and problems-solving skills are parts of coping ability as it interplays between the various coping abilities and elements of the social structure that determines the outcome (Germain, 1981).

Pandya (2011) study found that 60% of the subjects reported feelings of shame, self-hatred and guilt after being sexually abused. Those who were not

sexually abused (28%) reported feelings of shame and guilt after their first sexual contact. Approximately 75% of those who identified as koti reported confusion with their homosexuality (sexual identity) and their effeminate behaviour. Thus, the childhood experiences may also contribute to the development of a sense of shame which reinforces internalization of homophobia and has a serious impact upon their ability to establish positive self-esteem. Further the study also found that some of them engaged in substance abuse such as alcohol use, tobacco, and 20% showed use of drugs, or other self-destructive behaviours such as cutting veins (20%) and other attempts at suicide (35%), 65% of respondents/participants abandoned their studies and career goals, membership of support groups (80%), secrecy of one's orientation (75%) and attempting to change their sexual orientation (10%). The study finds that only 10% of MSM have disclosed their sexual orientation. Some of the subjects of the study (40%) tried to hide their feminine characteristics as they were often abused with such derogatory terms as "Baylo" (coward), "homo" etc. Some of the subjects group (10%) coped with the stresses associated with labeling by others by accepting it as a challenge for the development of their own identity. Therefore, Internalization of homophobia often results in self-hatred and feeling of worthlessness and being abnormal, non-disclosure of sexual orientation and acceptance of normative heterosexist ideology or networking with other homosexual men.

II.2.5 Reviews related to available services of MSM

National AIDS Control Programme (NACP) is steadily halting the HIV epidemic in India over the period of 2007-2012. The main services of MSM are

preventive interventions which include condom distribution, HIV education, voluntary HIV counseling and testing, and the treatment of sexually transmitted infections (STIs). NACP III, Targeted Intervention has targeted to high risk groups (HRGs) such as IDU, MSM and female Sex Worker (FSW). NACP III Targeted Intervention (TI) for HRGs offer a package of services vary for each major HRG but broadly follows the components of Outreach and communication where NGOs supported outreach and behaviour change communication, interpersonal behaviour change communication. Services provided by NACP III under TI are promotion of condoms, linkages to STI services and health services with a strong referral and follow-up system, promotions and distribution of free condoms and other commodities (lubricants for MSM, needles/ syringe for IDUs) , provision of basic and health services (including abscess management and oral substitution therapy for IDUs and also oral and STI services for MSM/TGs), linkage to other health services (for TB) and voluntary counseling and testing centre (VCTC), provision of safe spaces (drop-in-centre or DICs). They also extended services to creating an enabling environment such as advocacy with key stakeholders/power structures, crisis management systems and legal/rights education, capacity building of FSW, MSM and IDU groups to assume ownership of the programme. Mann et al. (2005) described that the silence and secrecy associated with institutional stigma and discrimination may provide ideal conditions for escalation of AIDS epidemic. NACO (2005) revealed that the fact that HIV was first identified among female sex workers in Chennai and later spread to the general population that fuel still popular presumption that the HIV epidemic in India is “predominantly heterosexual”.

Further it is also expressed that nevertheless, institutional silence may be evidenced in MSM being largely overlooked in HIV prevention and treatment in India. Chakrpani et al. (2002) revealed that lack of epidemiological data appears to be emblematic of inadequate national HIV prevention and care programs for MSM in India and it may be a manifestation of structural factors, including institutional stigma and discrimination.

From the above discussion, it can be concluded that despite of changed in social, political and economic, MSM people remain vulnerable due to social ostracisms such as stigma, discrimination, prejudice, homophobia, etc. The consequence of such situation is creating personality problems such as judgment, stability, reliability and general and social and vocational capabilities. Such conditions affect their psychological well-being. Some of them are coming out and mingling with other but society does not accept their sexual identity. The situation can lead them in engaging with risk behaviour and consequence of it leads to suffer from HIV/AIDS, STD, and STI, mental and psychological problems.

Many studies related to MSM were conducted in Western countries due to acceptance of homosexuality in compared to developing countries. Most of their studies focused on forms of sexuality and its relation to HIV/AIDS. Unfortunately, there were no studies found on psycho-social aspects of MSM. In the above context of review of literature, in Northeast India especially in Manipur, there is no study done for psycho-social problems of MSM but restricted only on HIV/AIDS and STD. Further, as our review of literature has not revealed the existence of services in practical for MSM in India, in this situation in Manipur, the health care providers

rarely touches upon the needs of MSM in providing the services. Thus, the study needs to examine the gaps between MSM and support system that include family, society and policies and programmes for the welfare of MSM in the study area. The study also needs to explore the issues or factors that are associated with psychosocial well-being of MSM under the study area.

The next chapter will discuss the methodology in related to rationale of the study, aim of the study, specific objectives, research design, operational definition, types of data required, source of data, technique and tools of data collection, area of study, process of data collection, sampling and analysis of data.

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