Review Article

Indian J Med Res 136, October 2012, pp 563-570

Men who have sex with men in India: A diverse population in need of medical attention

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Received October 10, 2011

A significant proportion of men engage in sexual relationships with other men which has direct health implications, but the unique health care needs of these patients are often ignored or overlooked. Moreover, due to a fear of stigmatization by the medical community, one of the more significant health risks for men who have sex with men (MSM) may be that they avoid routine or appropriate health care. Physicians and other providers can help overcome this barrier and improve the health care of MSM by keeping a non-judgmental attitude toward these patients, differentiating sexual behaviour from sexual identity, communicating with gender neutral terms, and maintaining awareness of how their own attitudes affect clinical judgment. The purpose of this article is to help contextualize health issues affecting MSM and provide a framework for physicians and other providers to deliver optimum and appropriate health care for men who have sex with men in India.

Key words HIV-1 - MSM - primary care - sex behaviour - sexually transmitted infections

Introduction

Providing high quality and effective health care to patients requires knowledge about their lives and circumstances. This may require taking into consideration a patient's religious and cultural beliefs, socio-economic status, and behaviours that have direct health implications. Because of stigma and ignorance, the health care issues of men who have sex with men (MSM) have often been overlooked[1,2]. The lack of attention to the health care of this population has had deleterious outcomes for both individuals as well as the general public health[3]. To assist physicians and other providers in delivering appropriate care to this population, this article provides a brief historical and cultural overview of MSM in India, and outlines some of their medical needs that clinicians can help to address, and finally discusses psycho-social issues impacting the health of this population and what health care providers can do to help address these issues in a clinical setting.

Who are men who have sex with men?

It is important to understand and distinguish between the concepts of sexual identity, orientation

and behaviour. One's identity is how one identifies oneself, regardless of orientation or sexual desire and behaviour. Sexual behaviour, as the abbreviation MSM usually addresses, does not correlate entirely with sexual identity and orientation in many cases, but rather focuses on a description of sexual practices. For example, a married, self-identified heterosexual male, may still engage in sexual behaviours with other men. Such a person could be categorized as an MSM, even though he might not view or consider such intimacy to be considered as sex in his cultural milieu, and he might not be willing to be forthcoming about his desire to be with other men. However, the term 'MSM' has evolved in many parts of India to now take on meanings of identity as well[2].

Same sex behaviour and relationships in India tend to be much more fluid and the associated sexual identities do not always fall into distinctive categories (*i.e.* heterosexual, homosexual, or bisexual) as these often do in Western cultures. Sexual roles may vary without regard to one's sexual identity or primary orientation[4]. For some men, terms such as *kothi* (receptive or effeminate male partner), *panthi* (stereotypically penetrative or masculine male partner), "double deckers" (men who engage in both penetrative and receptive anal sex) may be invoked to describe their sexual identity, as opposed to thinking of themselves as "gay" (which may be perceived to be a foreign term)[2,4,5]. However, these identity labels do not always predict specific sexual behaviours as male-to-male sexual practices are often fluid[2,4-6]. Other men who privately self-identify as homosexual or gay (often those more educated), may still be having sex with both men and women because of familial pressures to marry and have children[7-9]. Additionally, some men simply do not consider same sex behaviour (including anal sex) as sex but rather just "*masti*" or play and thus may reject even being categorized as MSM - despite the fact that the term was initially intended to be a non-judgmental description of sexual behaviour and distinct from one's sexual orientation or identity[4,10]. Regardless of how men view and label their actions, MSM who engage in high-risk sexual behaviours put themselves and/or their partners at risk for HIV and other sexually transmitted infections (STIs). They need to be counselled regarding how to engage in sexual behaviours with reduced risk of acquiring or transmitting STIs or HIV to themselves or their sexual partners.

Another group often associated with MSM are *Hijras* or *Alis* who are also referred to as transgenders. They too are considered a sexual minority and have been a part of Indian society at least since the existence of the first Sanskrit texts[11,12]. However, *Hijras* or transgenders are different from MSM. Most *Hijras* are born biologically as males and may or may not have undergone ritual castration. In India, some have also undergone hormonal therapy and a few, surgical interventions for sex change. Additionally, transgenders form a distinct group, separate from MSM, who have a host of needs that are different as it relates both to identity, behaviour, and social factors. Since the focus of this paper is on health care needs of MSM, health issues facing transgenders will not be discussed.

Culture and sexuality in India

Although in Indian culture, heterosexuality has been openly considered the norm, there is much evidence, both historical as well as recent, showing that men in India have and continue to engage in different types of sexual or other relationships. For example, some men may not even consider anal intercourse sex when done with another man[4]. Ancient Indian scriptures as well as more secular texts provide evidence of same-sex (*i.e.* male-male or female-female) relationships. The Ayurvedic texts, Susruta and Caraka Samhitas, dating from the first century detail taxonomies of gender and sexual variations, including same-sex desire[12]. Scriptures such as the *Puranas* and *Mahabharata* among others also provide references of same-sex relations and behaviour[11,13-15]. The stigma that has become attached to such relationships and behaviours, has been attributed in part to colonial influences[16,17], family and community attitudes towards marriage and having children, and somewhat more recently to Hindu nationalism[18] rather than religious inscriptions itself *per se*[19,20]. One source of this stigma included the addition of section 377 to the Indian penal code by the British in 1860, which still exists in Indian law. Colonial influences imported a much more repressive attitudes towards sexuality than what had perhaps existed in pre-colonial India[16]. This law criminalized same sex behaviour and has been an ongoing source of discrimination and harassment and has also hindered prevention efforts to combat HIV/AIDS[21-23]. Recently, the Delhi High Court has ruled against section 377, which will help HIV prevention efforts, although appeals are ongoing and the Supreme Court is now considering the case.

Data from many different surveys across the country show that same sex activity exists and is prevalent across India in both urban and rural areas. Furthermore, MSM are a part of all socio-economic groups and span

all religious as well as other social groups. One study done in several villages reported that nearly 10 per cent of single men and 3 per cent of married men engaged in same sex behaviour[24]. Another survey showed that 7 per cent of male college students in Chennai had their first sexual experience with another male[25]. A different sexual behaviour survey in Uttar Pradesh reported that approximately 54 per cent of male respondents indicated some type of same sex behaviour during their lifetime[18]. Another study conducted at a drop-in center for MSM in Mumbai showed that nearly 23 per cent of MSM were married and that being married to a woman was actually associated with a much higher risk of being HIV positive (23.8% for married men vs. 9.1% for others)[8]. These surveys, as many sexual behaviour surveys are, can be problematic for several reasons, since these did not use probability-based sampling, the true prevalence of these behaviours in Indian society is unknown. Another potential bias is the probable under-reporting of same sex behaviour due to stigma surrounding such behaviours and relationships. However, the point is that same sex behaviours in India are prevalent and warrant attention from the medical community in delivering appropriate health care.

Need for better attention to health

Historically as well as now, most discourse regarding the health of MSM populations worldwide has centered on HIV and the AIDS epidemic. Although the majority of HIV transmission in India is heterosexual, a disproportionately large amount of transmission occurs among MSM[26]. MSMs in India have a higher prevalence of HIV than the general population (7.3 vs 0.36%, respectively)[26], with estimates varying according to region and subpopulation of MSM. For example, MSM recruited for testing by peer referral in Tamil Nadu had a HIV prevalence of 8 per cent and the married MSM subpopulation in the study had a rate of 14 per cent[27]. In Mumbai, men seeking services at a voluntary counseling and testing center had HIV rates of 12.5 per cent[8], those recruited from two clinics had a rate of 17 per cent[28], and male sex workers had a rate of 33 per cent[29]. Additionally, National AIDS Control Organization's (NACO) BSS and HIV Sentinel Surveillance surveys estimate HIV prevalence to be between 5 to 17 per cent among MSM in over 28 districts and 10 States (Karnataka, Andhra Pradesh, Manipur, Maharashtra, Delhi, Gujarat, Goa, Orissa, Tamil Nadu and West Bengal)[26].

The information available about STIs in Indian MSM is much more limited. A study from Tamil Nadu which used respondent-driven sampling found a herpes simplex virus-2 (HSV-2) and syphilis prevalence of 28 and 8 per cent, respectively[27]. In a study from Mumbai and Hyderabad, 13.6 per cent had gonorrhea and 5.1 per cent had *Chlamydia*[30]. In a clinic based study in Mumbai, 20 per cent of MSMs were diagnosed with a clinical STI[28]. In Delhi, 41 per cent of respondents to a survey study reported having a recent STI[31]. In STI clinics in Pune, 21.5 per cent of MSM had a genital ulcer disease, 5.8 per cent had syphilis, and 4.3 per cent had gonorrhea[32]. In general, the prevalence of STIs among MSM appear to be high.

The high rates of HIV and STIs in Indian MSM may be due to several reasons, including lack of education, lack of access to basic health care, marginalization, social stigma, and the psychological consequences of such which may in turn, lead to increased risk-taking behaviours, commercial sex work, increased exposure to sexual violence, and substance use[33-38]. However, appropriate interventions among this group, including health care access, counselling, and STI treatment are proven ways to decrease the transmission in this population and in controlling rates of HIV incidence in the whole population.

Aside from issues related to HIV and STIs, however, there is likely little attention to the health care needs of MSM throughout medical education leading to a lacuna in knowledgeable care for this population[3]. This lack of knowledge is of concern for general practitioners and others practicing primary care including quacks and non-licensed practitioners, as they form a primary entry point to the health care system and are in a position to help patients achieve the best health possible and lead fulfilling lives. This would include, but not be limited, to behavioural counselling and education on HIV prevention or infecting others, screening for and addressing mental health issues, as well as providing appropriate medical care as needed. As such the information on MSM in India is relatively limited, as there has historically been a lack of research in this population. However, this is changing and by extrapolating from what we know from more recent studies in India and studies in other countries, it is possible to provide a framework for delivering optimal health care to MSM in India.

HIV and STI prevention among MSM

Although significant health care issues for MSM are similar to the routine health recommendations for all men, independent of sexual behaviour and

orientation, there are unique issues that need to be considered and addressed to optimize HIV and STI prevention. Aside from periodic STI/HIV screening, which all non-monogamous sexually active Indian men should undergo at least annually, other medical conditions may be more common in MSM and deserve additional clinical scrutiny. Medical providers should screen MSM for hepatitis B virus and immunize susceptible patients, given the propensity for sexual transmission of this infection among MSM[27,28,39,40]. MSM, especially HIV infected MSM may also need to be routinely screened for anal human papillomavirus (HPV) related neoplasia, as rates of anal cancer are significantly elevated[41,42].

The World Health Organization (WHO) provides guidelines for prevention and treatment of STIs including symptomatic management[43]. The Centers for Disease Control and Prevention (CDC), USA provides updated and basic guidelines for health promotion and prevention of STIs among MSM[44]. The NACO, New Delhi also provides STI treatment guidelines including syndromic management for the general population and presumptive treatment for high risk groups[45]. Some MSM are at increased risk for HIV infection and other viral and bacterial STIs. Studies show that some MSM in India may have multiple sexual partners and frequently do not use protection (*i.e.* condoms)[8,38,46-48]. Another study, which reported nearly 10 per cent same-sex behaviour among men in rural India, indicated that all anal intercourse between men was unprotected[24]. These studies underscore the need for a much more vigilant and aggressive prevention and education campaigns targeted towards MSM. Previously receiving little attention, MSM are now increasingly being recognized in India as a group that is at increased risk for HIV and other STIs[2,26,38,49,50]. It is imperative that clinicians ask all patients in an open and non-judgmental fashion about their sexual behaviour and provide routine HIV testing and STI screening and treatment. Clinicians should be comfortable to routinely ask about sexual practices, focusing on what the patient does, rather than how the patients identify themselves.

Since STIs can often be asymptomatic, MSM should be considered for routine screening of STIs, even in the absence of any physical complaints or symptoms. In the United States, the Centers for Disease Control recommends that the following studies be performed at least annually for sexually active MSM: *(i)* HIV serology - if HIV negative or not previously tested; *(ii)* Syphilis serology; *(iii)* Urethral culture or urine nucleic acid amplification test for gonorrhoea; *(iv)* Urethral or urine test (nucleic acid amplification) for *Chlamydia*; *(v)* Pharyngeal specimen collection to test for gonorrhea in men with oral-genital exposure; and *(vi)* Rectal gonorrhoea and *Chlamydia* screening in men having receptive anal intercourse[51].

Unfortunately, many of these recommendations are not possible for most patients in India as costs are prohibitive. As per WHO and NACO guidelines, syndromic management of genitourinary symptoms coupled with routine screening for high risk patients who can afford the screening may be the most feasible option[43,45]. This approach represents a challenge since routine screening based on a risk assessment is more ideal than syndromic management alone in order to decrease the STI/HIV burden in India, which is recognized by NACO. Presumptive treatment of STIs for high risk MSM may be one option though, especially since asymptomatic STIs are highly prevalent in this population[30]. Since HIV and STI transmissions do not occur in a vacuum, patients should be encouraged to have partners (both male and female partners, including wives) tested and screened for HIV and STIs. This may be challenging, especially for MSM who are also married, since this is likely to upset marital dynamics; but it is important that physicians encourage patients to have their partners tested if the chain of transmission is to be stopped.

The Centers for Disease Control guidelines also recommend immunization of sexually active MSM for hepatitis A and B virus. Although hepatitis B vaccination is now a part of India's Universal Immunization Programme, the target group is currently children. Therefore, by default, adults are excluded and so MSM should be considered for these immunizations, since both of these hepatic viruses are readily sexually transmitted.

Regardless of a patient's stated history of consistently using condoms for anal intercourse, screening is necessary because some STIs, such as syphilis and gonorrhoea, may be transmitted via oral sex and condom protection is not 100 per cent effective. Additionally, physicians should be knowledgeable about common presentations of symptomatic STIs in MSM (*i.e.*, genitourinary and anorectal abnormalities). Both genital and anorectal examinations should be included as part of the routine clinical exam, since patients may not be forthcoming in discussing sexual behaviours such as receptive anal intercourse. If symptoms are present, syndromic management and/

or other specific diagnostic tests should be conducted. It is also important that health care providers educate MSM that STIs including HIV can be asymptomatic and may spread to partners without the presence of any abnormalities[1].

The importance of prevention counselling cannot be overstated. Currently there are only a few HIV prevention and education programmes aimed at MSM in India. Through the National AIDS Control Programme (NACP)-III, NACO does have specific strategic initiatives for MSM and will be a priority population in NACP-IV[49,52]. At this time, existing interventions may only be reaching a fraction of the MSM population, particularly given that this group is "hidden" and most do not belong to any type of support network or social groups that can be readily accessed[36,38,53]. Counselling MSM on avoiding or reducing STI risk may require careful and nuanced discussions[54]. Clinicians can play an important role in motivating patients to reduce risky behaviours by discussing the high rates of STIs and HIV in MSM in India, by explaining the transmission synergy between HIV and STIs, and by helping them understand how STIs are contracted. Effectively providing such counselling will require physicians and other providers to understand the patients' attitude regarding sexual behaviours. It is important to understand if a patient engages in "*masti*" or sex with other men, since many men view *masti* as non-sex and even potentially a safe alternative to having relationships with women and may thus deny having sex with other men.

Human papillomaviruses (HPV) are also sexually transmitted and common in MSM[55]. HPV is most commonly associated with the development of anal and genital warts. The same strains of HPV that are associated with cervical cancer (usually types 16 and 18) can also develop into anal carcinoma[55]. Anal carcinoma is increasingly common among men infected with HIV and other MSM who engage in receptive anal intercourse, so it is important to consider screening on a regular basis[42,55]. Anal Papanicolaou smears are recommended yearly for men who are infected with HIV due to growing evidence that HIV infected individuals are at increased risk for HPV-related neoplasms. Screening of HIV-uninfected MSM should likely occur at least every 2 to 3 years, since they are more likely to progress to anal cancers than HIV-uninfected men[56]. HPV vaccination for MSM is also now recommended, although cost and access for the vaccine is currently challenging.

Other health issues of concern for MSM

Mental health issues are another clinical area that deserves special attention for the care of MSM. Secondary to social rejection and stigmatization, clinical depression may be more common in MSM than other men. Behavioural studies of mental health and depression among MSM in India are extremely sparse, however, a couple of studies that do exist show high rates of depression, anxiety, suicidality, and other psychosocial issues[36,57,58]. Clinicians should screen them for psychological and mental health disorders, and should help patients cope with the stigma associated with being a sexual minority[57,59]. More research is required though to help to better guide mental health interventions for MSM in India.

Substance abuse, including alcohol may also be another area that is of high importance. Although there is little research on this topic in relation to MSM in India[35], trends seen in MSM elsewhere may hold true for India as well. In other countries, MSM tend to smoke cigarettes more than the general population, making risk assessment and counselling in this area important[60]. The prevalence of alcohol and drug abuse problems in this population also exceeds rates found in the general population in other countries[61]. Directly discussing the short and long-term effects of drugs, including tobacco and alcohol, and providing prevention options including harm reduction programmes, and triage to appropriate counselling are vital in helping patients circumvent serious complications from substance abuse.

Challenges

The general stigma in Indian society surrounding the discussion of sex and behaviour is a major barrier to not only HIV/STI prevention and education, but also other health issues. Further, the added stigmatization of same sex behaviour in India further hinders HIV prevention efforts and overall health care delivery. Reducing stigma across the country will take time, however, there is much a physician can do during a clinical session to help patients be more comfortable and open to discussing their sexual behaviour[33,62-64].

Patients' sexual history should be elicited, and, for some, so should their sexual desires[1]. Answers to questions regarding sexual behaviour, such as "Do you have sex with men, women, or both?" have clear implications for medical care. Additionally, questions need to be explicit and specific as some MSM may deny having sex with other men as they view it simply as "*masti*". Questions about sexual desire can also

be particularly important for men not comfortable discussing issues related to their sexual identities. Physicians may encounter patients who may initially appear uncomfortable but express relief when given an opportunity to talk about their desires and possible conflicts regarding wanting to be with another man or about wanting to "come out" and live openly as a homosexual[1]. It is difficult to prescribe exactly how to begin such a discussion, and questioning patients along these lines can be challenging to fit into a routine clinic visit. Listening to the patient by asking open-ended, nonjudgmental questions is a good way to start. For example, asking, "Do you ever have any attraction to other men?" can be a helpful way to begin this conversation. Many men who identify themselves as being gay or attracted to other men or who are struggling to do so express having lingering internal conflicts regarding their family and friends, which keep them from being completely comfortable with themselves and their evolving sexuality[1]. Showing empathy and making referrals for counselling can help those experiencing conflicting feelings. Having a list of mental health professionals in the area who are comfortable in accepting patients in need of this type of counselling would be useful.

Men who are not gay-identified or do not consider themselves as a MSM may take longer, if ever, to share sexual behaviour information with their provider. They may also believe that STI/HIV prevention is not relevant to them. This highlights the importance of physicians in creating an open and non-judgmental environment and being proactive in soliciting information about sexual behaviour to help protect the patient as well as their partners. Although it may be challenging to elicit such information from married Indian men, the importance is underscored by a recent study showing that MSM married to women have a substantially higher risk of being HIV-infected than unmarried MSM[8]. Although these challenges may appear difficult to surpass, it is possible to provide effective counselling when patients feel comfortable[54].

Clinicians should keep in mind that different patients may come to terms with their sexual identity at different ages, including those who are middle-aged or older and/or are married to women. Coming to terms with one's identity at any age can be complex, and little is known about sexual identity formation and development in India. Among all adolescents, including those who identify as gay or bisexual, identity formation is an important developmental task that is not one-dimensional, but rather encompasses a mosaic of multiple identities within various realms of life (*e.g.* occupation, gender, sexuality, religion)[65]. Just as with adult MSM, a knowledgeable and caring physician can be an important resource in helping gay youth overcome the challenges associated with a sexual minority identity and to lead healthy and productive lives.

Conclusions

The purpose of this article was to contextualize the health care needs of MSM and provide a framework to help physicians and other health care providers begin a conversation with their patients to provide optimal health care. As shown by several studies and even documentation from historic sources, men in India, as in other societies, engage in sexual relationships with other men. But the stigma that is associated with same-sex behaviours, with reasons being rooted in historical and cultural reasons, is a significant barrier in delivering appropriate care. It is possible that not all clinicians will be able to provide non-judgmental care for MSM or other sexual minorities; in such cases, it is vital that providers refer the patients to others who can deliver such care.

Much more work is needed to determine how to best help MSM minimize sexual risk, address mental health concerns, and engage in healthy lives. More research is needed in all areas concerning MSM as well as other sexual minorities in India since relatively little is known about this population. Despite these lacunae, physicians and other health care providers can make a significant difference in helping their patients access and receive optimum health care and lead more healthy lives.

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