

## A Study on Mental Health Status of MSM (Men Having Sex with Men)



### Social Science

**KEYWORDS :** Mental Health, MSM, HIV/AIDS, High Risk Behaviour

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### ABSTRACT

*MSM account for 1.5% of new HIV infections in India as estimated from persons testing positive for HIV at the Integrated Counselling and Testing Centres across the country during 2009-2010. In 2006, it was estimated that there were 3,50, 000 high risk MSM in India. Men may have sex with men for a variety of reasons including; attraction to other men, for pleasure or experimentation, societal or cultural norms, because of their environment (i.e. prisoners) or for financial reasons. The results of the study show that moderate level of mental health was found among the respondents. The demographic variables namely marital status and income influence the level of mental health.*

### Introduction

In Indian society, sex is a taboo and only associated with reproduction. Premarital sex is not culturally accepted by Indian society and sexual preferences have no role. Indian men enjoy much more liberties than women. Women usually have their sexual debut after they marry, have monogamous relationships and are often dominated by their husbands. Strict societal norms only recognize heterosexual activity: homosexual activity was illegal in India until 2009<sup>1</sup>.

The term "Men who have Sex with Men (MSM)" was coined in 1990 by epidemiologists for seeking better terminologies related to behaviour rather than to sexual identity. MSM account for 1.5% of new HIV infections in India as estimated from persons testing positive for HIV at the Integrated Counselling and Testing Centres across the country during 2009-2010. In 2006, it was estimated that there were 3,50, 000 high risk MSM in India. MSM are currently the only group in India among whom the HIV seropositivity is increasing and MSM married to women are considered to be the main source of transmission of HIV to usually monogamous married Indian women<sup>1</sup>. 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)<sup>2</sup>.

Men may have sex with men for a variety of reasons including; attraction to other men, for pleasure or experimentation, societal or cultural norms, because of their environment (i.e. prisoners) or for financial reasons<sup>3</sup>.

MSM are often forced to sell sex for their economic livelihood. They often run from their families in order to avoid physical abuse, emotional stress and conflicts with traditional family values. Health care providers discriminate them, refuse to provide services and often breach confidentiality. Stigmatization and discrimination are worse for HIV-positive MSM. Therefore, MSM suffering from any clinical symptoms are reluctant to visit any health care facility. Thus this study was undertaken to know the health status of the MSM i.e., mental health, psychological distress and well-being in particular.

### Review of Literature

To compare three groups of men who have sex with men (MSM)—men who had attended a sex party in the past year (45.2%); men who had been to a sex party more than a year ago (23.3%); and men who had never been to one (31.5%)—on socio-

demographic and behavioural characteristics. The result of the study shows a significantly higher proportion of past year attendees were HIV-positive (28.1%), single (31.7%), demonstrated sexual compulsivity symptomology (39.2%), recently used drugs (67.8%), averaged the greatest number of recent male partners (Mdn=15, <90 days), and had greater instances of recent unprotected anal intercourse (UAI) with male partners (median=3, <90 days). Adjusting for covariates, those having been to a sex party in the last year were significantly more likely than others to report UAI. Free lubricant (93.4%) and condoms (81.0%) were the most desirable services/products men wanted at sex parties<sup>4</sup>.

The HIV/AIDS epidemic was first recognized among men who have sex with men (MSM). Male-to-male sex remains the predominant reported mode of exposure in Massachusetts, with the proportion of HIV diagnoses attributed to male-to-male sex increasing over time. Among males diagnosed with HIV infection during adolescence and young adulthood (13–24 years) within the three-year period 2008 to 2010, male-to-male sex was the most frequently reported mode of exposure at 75% (N=123). MSM/IDU accounted for an additional 4% (N=7) of exposures in this age group<sup>5</sup>.

WHO Thirty years after the initial description of the human immunodeficiency virus (HIV) in North American men who have sex with men (MSM), the global community faces re-emerging and newly documented HIV epidemics in MSM worldwide, including in regions with generalized epidemics. There is a clear need to scale up and improve (and, in some cases, to start) sustained, comprehensive and effective HIV prevention efforts targeting MSM in low, middle, and high income countries alike<sup>6</sup>.

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. Clinicians should screen them for psychological and mental health disorders, and should help patients cope with the stigma associated with being a sexual minority Sivasubramanian M, Mimiaga (2011). More research is required though to help to better guide mental health interventions for MSM in India<sup>7</sup>.

The present study was to find out the extent of high-risk behavior and prevalence of self-reported sexually transmitted diseases

among self-identified men who have sex with men, registered with selected non- governmental organizations in Delhi. Majority (80%) were anal-receptive, received money for sex (61%) and were involved in all types of sexual intercourse with men (oral-86%, manual-97%, and anal-94%). Consistent condom use with male partner was low (46%), most common reason (52%) for not using condom was, that either the condoms were not available or the partner objected. Self-reported sexually transmitted infection(s) was 41% in the past 12 months<sup>8</sup>.

**Objective of the Study**

1. To study the socio-demographic profile of the respondents.
2. To assess the level of mental health of respondents.
3. To study the demographic variables influencing the level of mental health of the respondents.

**Methodology**

Descriptive design was adopted for the present study. The MSM group under the Suraksha Project of Rajiv Youth Foundation at Palakkad District comprises the universe of the study. Convenient sampling was used to select the samples for the study. The size of the sample was 47. Interview schedule was used to collect the data from the respondents. It consists of 38 questions and two sections namely demographic profile and mental health status scale. Data was analyzed using statistical tools namely t-test and F-test.

**Analysis and Interpretation**

**Table 1: Demographic Profile of the Respondents**

Variables	Particulars	No. of respondents	Percentage
Age	21 to 25 Years	12	25.5
	26 to 30 Years	22	46.8
	31 Years & Above	13	27.7
Religion	Hindu	22	46.8
	Christian	13	27.7
	Muslim	12	25.5
Educational qualification	8 <sup>th</sup> to 10 <sup>th</sup> Std	13	27.7
	Pre-degree	24	51.0
	Degree	10	21.3
Occupation	Employed / Business	32	68.0
	Others	15	32.0
Monthly income	Below Rs.5000	17	36.2
	Above Rs. 5000	30	63.8
Type of family	Nuclear	11	23.4
	Joint	36	76.6
Marital status	Single	34	72.3
	Married	13	27.7

From the table 1, the demographic profile of the respondents shows that less than half (46.8%) of the respondents are between the age group of 26-30 years, less than half (46.8%) of the respondents belongs to Hindu religion, more than half (51%) of the respondents had completed their pre degree, more than two-third of the respondents (68.0) were employed or doing business, less than two-third (63.8%) of the respondents were earning an income above Rs.5000/-, majority of the respondents (76.6%) belong to joint family and majority of the respondents (72.3%) were unmarried.

**Table 2: Level of Mental Health of the Respondents**

Variables	Particulars	No. of respondents	Percentage
Mental health	Low	15	32.0
	Moderate	20	42.6
	High	12	25.4
	Total	47	100.0

The table 2 depicts the level of mental health of the respondents. It shows that more than two-fifth (42.6%) of the respondents had moderate level of mental health, 32 percent had low level of mental health and 25.4 percent had high level of mental health.

**Table 3: Significance Test for Mental Health Score based on Demographic Variables**

Variables	Test	Value	Result
Age and mental health	ANOVA	0.38	Insignificant
Education and mental health	ANOVA	0.665	Insignificant
Occupation and mental health	t-test	0.032	Insignificant
Income and mental health	t-test	2.932	Significant
Family type and mental health	t-test	0.588	Insignificant
Marital status and mental health	t-test	3.021	Significant

From the table 3, the ANOVA result shows that the calculated F-ratio value is 0.38 which is less than the table value 3.209. Since the calculated value is less than the table value it is inferred that the satisfaction scores do not vary significantly the age groups. The ANOVA result shows that the calculated F-ratio value is .665 which is less than the table value 3.209. Since the calculated value is less than the table value it is inferred that the satisfaction scores do not vary significantly in the age groups. The calculated t-test value is .032 which is less than the table value of 2.014. Since the calculated value is less than the table value it is inferred that the mean mental health scores do not differ significantly between the occupational groups. The calculated t-test value is 2.932 which is greater than the table value of 2.690 at 1% level of significance. Since the calculated value is greater than the table value it is inferred that the mean mental health scores differ significantly among the monthly income. The mean value shows that respondents who were earning an income below Rs.5000/- (mean = 71.18) had better mental health compared to married. The calculated t-test value is .588 which is less than the table value of 2.014. Since the calculated value is less than the table value it is inferred that the mean mental health scores do not differ significantly between the nuclear and joint family groups. The calculated t-test value is 3.021 which is less than the table value of 2.014 at 5% level of significance. Since the calculated value is less than the table value it is inferred that the mean mental health scores differ significantly among the marital status in the mental health score. The mean value shows that respondents who were single (mean = 57.85) had better mental health compared to married. The finding is supported by the findings of Khumalo I. P. et.al. (2012) their study found that marital status explains different amounts of variance in mental health<sup>9</sup>.

**Summary of the findings**

- Less than half (46.8%) of the respondents are between the age group of 26-30 years
- Less than half (46.8%) of the respondents belongs to Hindu religion.
- More than half (51%) of the respondents had completed their pre degree.
- More than two-third of the respondents (68.0) were employed or doing business.
- Less than two-third (63.8%) of the respondents were earning an income above Rs.5000/- Majority of the respondents (76.6%) belong to joint family and majority of the respondents (72.3%) were unmarried.
- Moderate level of mental health was found among the respondents.
- There is a significant difference in the level of mental health

score among the different income groups of the respondents.

- There is a significant difference in the level of mental health score among the single and married respondents.
- There is no significant difference in the mental health score based on other demographic variables.

#### Suggestion

Scientific and medical understanding is that sexual orientation is not a choice, but rather a complex interplay of biological and environmental factors. While some religious organizations hold the view that homosexual activity is unnatural or dysfunctional, research shows that homosexuality is an example of normal variation in human sexuality and not a source of negative psychological effects. Prejudice and discrimination against homosexual and bisexual people, however, have been shown to cause psychological harm.

- Hence, this study suggests the Government to provide appropriate health care support for the MSM which will improve their physical and mental health status.
- Sex education should begin at school level to increase the knowledge about sex and its related problems.
- Awareness on sexually transmitted diseases can be organized frequently for the MSM which will protect them from HIV/AIDS.
- Media can also play a vital role in giving proper understanding about sexually transmitted infection and prevention of spreading.
- Proper guidance and counseling should be given to MSM on their health status and its consequences.

#### Conclusion

As in other countries, men in India engage in sexual relationships with other men, which is evident from the literatures and research studies. But the stigma that is associated with same-sex behaviours was found to be a significant barrier in delivering appropriate care. Mental health is an important aspect which is yet to be focussed, as MSM are more vulnerable to it. Much more work is needed to determine how to best help MSM minimize sexual risk, address mental health concerns, and engage in healthy lives.

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