

HIV/AIDS discrimination towards men who have sex with men in low- and middle-income developing countries: a qualitative systematic review

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Abstract

Men who have sex with men (MSM) are a high risk group in relation to the virus HIV/AIDS. Stigma and discrimination are barriers faced by MSM limiting the effects of sexual health programmes in low-and middle-income countries. This small-scale review aims to develop understanding of research about MSM's experiences of HIV/AIDS-related stigma and social discrimination and strategies to tackle HIV/AIDS-related stigma and social discrimination. Seven papers were selected for in-depth review from CINALH, MEDLINE and Google Scholar. Thematic analysis was used for data synthesis. Sexuality-related stigma and discrimination were presented in the studies from individual, community, structural and political levels. Amongst other issues the papers described peer and parent attitudes leading to MSM migrating and engaging in sex commercials. Stigma and discrimination were seen in the field of employment, housing, healthcare services and office enforcement. Stigma and discrimination encouraged MSM to conceal their homosexuality and HIV-positive status. Supporting and enabling environments, education and empowerment were recommended to minimize sociological barriers which impede MSM to access sexual health programmes.

Introduction

HIV/AIDS is an important global health issue due to its ability to spread across geographical borders through global travel and population migration in addition to the link with increasing harmful drug use, changing lifestyles and sexual mores (Weinberg, 2005). The impacts of this can be seen both nationally and globally.

Men who have sex with men (MSM) are among an at risk group of HIV/AIDS which include women, youth, intravenous drug users, commercial sex workers, prisoners, and refugees (Global Health Council, 2011). MSM are considered a bridge to HIV infection in the general population (Ainsworth, Beyrer and Soucat, 2003; IRIN, 2011). In low and middle income countries MSM are also a HIV/AIDS high-risk group, with approximately a nineteen times higher risk of infection than in general reproductive adults (AMFAR, 2008). HIV/AIDS prevention strategies such as screening, behavioural change and even policy change have been applied to the MSM community. However, high-risk sexual behaviours amongst this population are increasing (Elford and Hart, 2003). Stigma and social discrimination is one of the main issue that influences HIV/AIDS transmission in MSM population (MSMGF, 2010).

MSM are subjected to both sexuality-related social discrimination and stigma associated with HIV/AIDS. Centres for Disease Control and Prevention, (CDC, 2011) demonstrated that gay and bisexual men and lesbians who experience strong rejection from families have a 3.4 times greater likelihood of having unsafe sex when compared to their peers receiving more family support. In addition, negative attitudes toward homosexuality from society may result in MSM concealing their sexuality, exposing them to a greater risk of mental health and unhealthy behaviour such as smoking and reluctance to access healthcare services. These sociological factors may promote an environment in which MSM are far less visible within their societies. Furthermore, in low and middle-income

countries, some MSM may face HIV/AIDS-related stigma and social discrimination via local punitive laws and norms.

This study has focused on MSM living in low and middle income countries for which there is a lack of evidence such as qualitative systematic reviews regarding the experiences of HIV/AIDS-related stigma and social discrimination. HIV/AIDS is an important health problem involving significant expenditure in limited-resource countries. Therefore, studying experiences of stigma and social discrimination in those countries could be invaluable in dealing with this pandemic.

A systematic review was the main method used to evaluate and to interpret available information (Glasziou, Irwig, bain & Colditz, 2001). Seven studies were included in this review: Andrinopoulos, Figueroa, Kerrigan & Ellen, (2011) in Jamaica; Okal, Luchterss, Geibel, Chersich, Lango,& Temmerman.(2009) in Kenya; Niang, Tapsoba, Weiss, Diagne, Niang, Moreau et al. (2003) in Senegal, Chakrapani, Newman & Shunmugam, (2008); Chakrapani, Newman & Shunmugam, McLuckie & Melwin. (2007) in India; Wilson, Babu, Comfort & Ekstrand (2011) in Nepal; and Wong et al. (2006) in China. Sexuality-related stigma and social discrimination were generally seen in four levels of interaction: individual, community, structural and political, as are presented in Table 1.

The review shows that individually, MSM experienced fear of HIV infection and AIDS in addition to rejection and isolation surrounding their sexuality in these six geographical areas. These fears lead to concealment of their sexuality leading some MSM to avoid HIV testing. According to Andrinopoulos et al. (2011) and Wong, Zhang, Wu, Kong & Ling (2006), socio-economic status has also been associated with HIV/AIDS discrimination with some MSM from higher socio-economic backgrounds in Kenya being less likely to experience incidence of stigma and social discrimination (Okal et al, 2009).

Within families and the wider community, homosexuality-related stigma and discrimination was more prevalent than that of HIV/AIDS and was normally seen particularly in families holding strong traditional or religious beliefs. Such discrimination influenced MSM to migrate to urban areas resorting to becoming commercial sex workers in the face of being unable to secure employment.

Table 1. Stigma and social discrimination at different levels

	Andrinopoulos, et al., 2011	Wilson et al., 2011	Chakrapani et al., 2007	Okal et al., 2009	Chakrapani et al., 2008	Wong et al., 2006	Niang et al., 2003
Individual level							
Psychological experiences	X	X	X	X	X	X	X
Socio-economic status	X	X		X	X	X	X
Community level							
Family e.g. belief and traditions		X	X	X			
Peer/partner			X	X		X	
MSM community			X				
Power relationships	X		X				X
Structural level							
Workplace/Employment		X		X			
Healthcare providers			X	X	X	X	X
Housing				X			
Law enforcement		X	X				
Political level							
Law			X	X			

Sexuality related discrimination was seen in four social areas: employment, rental housing, health care and law enforcement. Discrimination in healthcare services was evident in three forms: lack of confidentiality and privacy, prejudice and rejection. There was a failure to consider MSM's needs and/or denial of equal access to some healthcare when compared to other populations. Some MSM in China, India and Kenya concealed their homosexuality and homosexual activities when accessing healthcare services (Wong et al., 2006; Chakrapani et al., 2007; Okal et al., 2009). In India, stigma and discrimination associated with condom use was also reported not only against MSM but also against outreach workers supplying condoms (Chakrapani et al., 2008). MSM may also be at risk of violence from law enforcement officers. Being of feminine appearance also provoked law enforcement officers toward using violence (Chakrapani et al., 2008).

Stigma and discrimination surrounding condom use have also been employed as weapons in an attempt to control MSM. A study conducted in India mentioned law and policies relevant to such discrimination. According to Chakrapani et al. (2008), the government neglected to provide resources and services for MSM with fear of false arrest due to carrying condoms and victimisation through violence by law enforcement officers common. Moreover, MSM expressed apprehension when carrying condoms due to their use as evidence of engagement in public sex and/or prostitution (Chakrapani et al., 2007; Chakrapani et al., 2008; Wilson et al., 2011). Abused official power in addition to blackmail and extortion was also discussed by participants in India. (Chakrapani et al., 2007).

Conclusion

HIV/AIDS-related stigma and social discrimination within the countries included in this study commonly originate from three groups: sexual orientation, HIV-positive status and socioeconomic status. This may be due to having a less diverse multicultural profile as compared to developed countries such as the UK. Generally people who live with HIV/AIDS in these developed nations experience HIV/AIDS-related discrimination through sexuality, gender, race/ethnicity and social class (Parker and Aggleton, 2002). In the UK and USA MSM tend to encounter stigma and social discrimination as a result of their ethnicity and migrant status (Nemoto Operario, Soma, Bao, Vajrabukka & Crisostomo, 2003; Wilson & Yoshikawa, 2004).

The stigma and social discrimination described in this review are generally far more likely to be related to homosexuality than having an HIV-positive status. Although there are different countries included in this review (India, Nepal, Jamaica, Senegal, Kenya and China), the reasons for stigma and discrimination are similar. Compared to more affluent countries such as the UK, Parker & Aggleton (2002) state that MSM still feared stigma associated with disclosing their sexuality and health status; even though UK law protects the rights of those who live with HIV/AIDS. Furthermore Parker & Aggleton (2002) make the assertion that, social class is associated with HIV/AIDS-stigma and discrimination with a study in Kenya agreeing that having a higher socioeconomic status could avoid homosexuality related stigma and social discrimination (Okal et al., 2009).

MSM are known to experience HIV/AIDS-related stigma and social discrimination from most areas of society. Busza (1999) demonstrated similar findings involving HIV/AIDS related stigma and social discrimination among families, communities, workplaces, healthcare services and religions in Southeast Asia. Furthermore, Walker (2007) described that family members, partners of people with HIV, carers, health and social care professionals and even AIDS activists may have had experiences of social discrimination. Furthermore, disclosure of positive HIV/AIDS status within the MSM community could elicit discrimination from their own peers. In low and middle income countries such as China, Feng, Wu & Detels (2010) presented similar findings of discrimination within the MSM community, leading in a failure to participate in HIV testing services and HIV/AIDS treatment.

Recommendation

HIV/AIDS-related stigma and social discrimination can affect MSM's health. There are numerous factors which influence the spread of HIV infection including cultural beliefs, family socio-economic status, employment, housing, healthcare services, and social networks. Therefore, dealing with HIV/AIDS in an MSM population is not only concerned with managing the immunodeficiency virus but also the associated socio-economic and environmental issues. Cedac (2010) proposed the three E's model to tackle HIV/AIDS-related stigma and discrimination: environment, education and empowerment. Due to both individual and collectively differing needs according to each given setting, studying of MSM's needs based on geographical areas could help policy makers, health professionals, health practitioners and social workers understand and respond to their requirements appropriately. Moreover, subgroups of MSM such as transgender, bisexual men, and commercial/casual sex workers could bring about differing results with these subgroups of MSM likely to have different risk determinants of HIV infections according to their sexual and sociological roles.

Understanding of MSM's experiences of HIV/AIDS-related stigma and social discrimination is vital for health practitioners, social workers and policy makers in providing appropriate HIV/AIDS prevention and sexual health promotion programmes.

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