Understanding stigma at systemic and individual level to overcome barriers to HIV related health seeking behaviour among men who have sex with men in Mumbai

Report
HST-ICRW study: Understanding stigma at systemic and individual level to overcome barriers to HIV related health seeking behaviour among men who have sex with men in Mumbai

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EXECUTIVE SUMMARY

Study titled, ‘Understanding stigma at systemic and individual level to overcome barriers to HIV related health seeking behaviour among men who have sex with men in Mumbai” was conducted by The Humsafar Trust in Mumbai in collaboration with International Council for Women- India. This study was supported by United Nation Development Program. It is part of a larger study to validate the Stigma Model in India in different settings.

This research project has addressed stigma at two levels: Individual and Systemic. At both levels, the demand (MSM) and supply (health care providers) sides, would abet a holistic understanding of the issue. This in turn would help address issues pertaining to access of health services by MSM.

The objectives of the study was to review existing policies and practices within a hospital set-up that address issues around stigma and discrimination; to understand form and nature of internalized stigma as well as perceived barriers related to health seeking within MSM community and to formulate an advocacy process to address barriers related to health seeking behavior through a consultative process.

The study adopted a three-staged technique. In the first stage, surveys were conducted with health care staff in public (n=100) and private settings (n=96), and interviews with head of departments and hospital observation was conducted. In second stage, focus group discussions were conducted with office staff and MSM community members to understand issues of internalized homophobia. Finally, in the third stage a consultation was organized with members of sexual minority community and health care providers.
INTRODUCTION

India has a high number of HIV cases in the world and while the prevalence rates for the overall population show decline or constancy, all across the country, the HIV/AIDS epidemic seems to be concentrated among the high-risk groups in the population – one of which is that of MSM. In striking contrast to the overall adult prevalence rates for the Indian population the MSM community has a 7.3% prevalence rate, with the primary mode of transmission being sexual (NACO, 2010). In addition, MSM experience widespread discrimination in various areas of life; from family, relatives, religious communities, employers, and law enforcement agencies to name a few as a result of their sexuality.

‘Same-sex’ behavior has been stigmatized given the strict value systems that are laid by social, cultural, religious and political influences in India. In more than one way, the presence of this over-arching stigma and discrimination, leads to the internalization of homophobia by the MSM community. The communication between these two levels of stigma: one being self-inflicted in the form of internalized homophobia along with stigma in relation to same-sex behavior at the cultural, societal and systems level has an overall impact on the health-seeking practices of MSM.

Self perception of sexuality is amongst all one of the key factors that is responsible for the ‘label/identity’ one applies to self. ‘Sexuality’ has been defined and perceived in various ways. Kessler (1996) has argued that how sexuality is viewed through an essentialist lens which claims that every individual has something innate which is the core of essence of one’s sexuality and one’s sexual orientation. L. Ramakrishan, (2006) has discussed that making distinction while discussing sexuality is terms of behavior, attraction and identity is important for queer politics and discourses on public health.

One’s comfort-ability with one’s sexuality and self will also determine the mental well being of the person. Living in the hetero-normative world where any form of non-procreative sex is stigmatized; men who have sex with men find themselves in a stigmatized and vulnerable position. The fear of disclosure to family or others is often equated with loss of respect, stigma, discrimination and violence. This often also determines who open and willing one is to take health care services. MSM because of the social and cultural non-acceptance of same-sex behavior and fear of being ridiculed; they often internalize this stigma. The internalized stigma may exhibit itself in form of guilt, depression, lack of confidence and unwillingness to open up about their sexuality. This doesn’t only have influence on their mental health, but internalized stigma combined with perception of health care providers as part of stigmatizing society may also restrict them to take health care services. Stigma in this population is multi-layered; at individual level they may internalize stigma and at structural level they may face enacted or perceive stigma. In particular, HIV infected MSM may face the stigma of "being HIV positive", "being engaged in same-sex behavior", and "fear of disclosure", and this stigma may impact their health seeking behavior.

This research project has addressed stigma at two levels: Individual and Systemic. Working at both, the demand (MSM) and the supply (health care providers) sides, in the same context would abet a holistic understanding of the issue which in turn would result in a comprehensive solution to the problem of access to health services.
Low self esteem, concealment of sexuality from family, stress, anger towards society and being positive lead to internalized homophobia which gets clubbed with social stigma faced at health care setting. This is turn reduces health care access making the positive population more vulnerable to health care problems. This also strengthens negative appreciation of health which gets reflected in lower rates of health access. In the project we tried to address internalized homophobia and social stigma faced to increase greater health care access among MSM.

METHODOLOGY
This research project is an attempt to explore the issues of stigma at individual and systemic faced by men who have sex with men and how it impacts their health seeking behavior. There is very little scientific literature that is available on how MSM understands, define and perceive stigma; and also the knowledge and attitude of health care providers (HCPs) on HIV/AIDS in context to homosexual behavior. Though men who have sex with men has been studied in India as a high risk group for HIV/AIDS prevention; still much need to be explored in terms of their experiences, vulnerabilities, strengths, identities, which have direct impact on their mental health and their health seeking behavior. Most of the studies on similar topics have either have worked with health care providers or with the MSM population exploring their knowledge and concerns. Through this study we tried to bring together both the voices of clients and service-providers and evaluate their responses to address the issue at both individual and systemic level.

This section on methodology will look at techniques and methods used to explore the issue. It will lay out the research objectives; sampling and its characteristics, methods and tools of data collection, location of the study, method of data analysis used, experiences at data collection, and replicability and sustainability of the project.

**Research Objectives**

The objectives of the study are as follow:

- To review existing policies and practices within a hospital set-up that address issues around stigma and discrimination
- To understand form and nature of internalized stigma and perceived barriers related to health seeking within MSM community
- To formulate an advocacy process to address barriers related to health seeking behavior through a consultative process

**Place of Study**

We conducted this study at the Humsafar Trust (www.humsafar.org), a community based organization in suburban Mumbai devoted to male sexual health. The Trust started as a drop-in centre for gay men in 1994, providing safe space for the sexual minorities in Mumbai. Some of the activities of the Trust include advocacy, community work and counseling services, networking, care, support and treatment, training, and capacity building. Currently it has a large community outreach programme providing HIV/AIDS information to MSM and transgender persons, and has a target population of more than 10,000 people. A clinic providing STI testing and care and HIV counseling and testing was started in 1999 and more than 3000 individuals have been tested since then. Outreach services are linked to various public health institutes and provide care to HIV infected MSM and transgender persons. The Trust also collaborates with various national and international organizations for HIV prevention and care activities in MSM and transgender persons. The Trust has a research centre with its own Ethics Committee that reviews all the studies conducted in the centre.

**Sampling**
Survey with HCPs: A list of all the doctors, nurses, ward-boys and lab-technicians from the five departments (Dermatology, Medicine, PSM, Psychiatry and Surgery) from both hospitals – Private and Public Hospital was be made. Randomized numbers were generated to select proportionate participants from both the hospitals. A total of 100 participants were selected from each hospital with proportionate representation from doctors, nurses, lab-technicians and ward-boys. Even after repetitive replacement and follow-ups only 95 HCPs could be surveyed at Private Hospital, but at Public Hospital a total of 100 HCPs were surveyed.

FGDs with staff and community: Purposive sampling was used to identify seven members from HST-staff based on their involvement and role in HST and experience of working with community. While through referrals and out-reach work another six MSM were identified who were above 18 years of age, and have had sexual behavior with another man, and were willing to participate in the study. Any participant who identified self as ‘hijra’ or ‘transgender’ was not included in the focus group discussion.

Methods of Data collection

Objective 1: To review existing policies and practices within a hospital set-up that address issues around stigma and discrimination

Activity 1.1: Reviewing of existing policies on issues of stigma and discrimination (policy review and interviews with hospital administrators)

Knowledge of available policies, in the health care settings, to guard minorities towards any kind of stigma and discrimination is pivotal in the process of reducing the gap between service providers and service seekers. This would abet our understanding of the gaps and loopholes in the existing policies which would help us come up with recommendations to make these more specific to the given population. We conducted interviews with Head of Departments of the Dermatology, Medicine, PSM, Psychiatry and Surgery in one private and one public hospital. The tools which were used for this activity, ‘Hospital Observation and Document Checklist’ have already been used for the Horizon Study (2005). The study was conducted in multiple countries and in seven hospitals in India itself and the tool has been validated. Output: Documentation of gaps and opportunities between policies and practices within health care system

Activity 1.2: Conducting surveys with health care providers to understand their practices and behavior with MSM and HIV positive persons

We conducted survey with health care staff members (N=200) of the hospital (100 at public and 100 at private hospital). This was to comprehend the gaps between policies and behavior. We wanted to understand the behavior of the hospital staff towards MSM since behavior and attitude of the health care providers has a direct relationship with uptake of health care services by the community members. The survey tools which were used for this activity have already been used for the Horizon Study (2005). The study was conducted in multiple countries and in seven hospitals in India itself and the tool has been validated. Output: 200 surveys with health care providers
Objective 2: To understand form and nature of internalized stigma and perceived barriers related to health seeking within MSM community

Activity 2.1: Conducting FGDs with staff (like counselors, coordinators) and community members
Focus Group Discussions were conducted with community members and staff (including counselors, coordinators and TI in-charge) to understand their view on possible factors that could be leading to low health care access among MSM. Also, the issue of internalized stigma was addressed in the interviews with the Key People of the community and its impact on health care access. The community members provided us with inputs that could help us understand and question the policies from a better position. Output: 2 FGDs with staff and community members.

Activity 2.2: Reviewing existing modules on Internalized stigma and formulating comprehensive counseling module
Output: Guidelines for developing counseling module for working with MSM population with a specific focus on internalized stigma

Objective 3: To formulate an advocacy process to address barriers related to health seeking behavior through a consultative process

Activity 3.1: Dissemination and joint review of the findings to discuss recommendation
Once the existing policies have been reviewed, behavior of health care providers is examined and assessed, issue of homophobia and its role in health care access is understood and addressed; the health care providers and community members are got together to discuss the findings on each side. Based on this joint review, we hope to come up with a suitable advocacy process or recommendations to address perceived and experienced stigma. Output: Advocacy process to work with health care providers and community members to address perceived and experienced stigma

Experiences at data collection
Data collection at the health care setting was a difficult process. A lot of time was lost in getting all the formal documents and permissions at place. Though we have a long working relation with the Public Hospital, but conducting this study was no easy task. Our letter of permission from the Dean was forwarded to the PSM department which forwarded it MDACS office (Mumbai District AIDS control Society). At MDACS we were asked to seek ethics approval from Public Hospital and MDACS as that is the site of the study. We already had already sought ethics clearance from HST-IRB, and re-submission of the proposal to Public Hospital-IRB would have delayed the project. The project was to be completed within a strict nine-month deadline. Similarly the permission from Private hospital was difficult to get, as the project didn’t have a principal investigator from the hospital which we were told was a pre-requisite for approval. It was already six months to the start of the project, when we finally sought all permissions from both the hospital and started the surveys.
The process of data collection also took much longer to finish than we expected. Interviewing health care staff in hospital setting was a difficult task as we had to interview them during their working hours. Getting appointments from the doctors was not easy, more than that finding the nurses and ward-boys as
very difficult as they had different shifts (day–night) and also were continuously replaced to different departments. In the starting we planned to have two field officers for conducting the surveys, but looking at the delay in timeline we did the surveys with a total of seven field officers, out of which three field officers were provided to us by the ICRW team.

**Informed consent**

The informed consent forms were prepared and written consent was taken before conducting the FGDs and survey interviews. All the participants were informed and explained about the nature and importance of the study and also the nature of their participation. Each interview was begun with the interviewer reading out the consent form to the participant, explaining the process and taking questions (if any). They were also informed about the kind of questions they will be asked. They were told about the risks involved and the benefits of the study to the community. The participation in the study was subject to the written consent provided by the participants. There were also informed about the clauses of confidentiality and data safety and how their identity shall me put anonymous in the report.

**Data analysis**

The analysis of the FGD data was done manually by using thematic analysis. Coding and categorizing was used to analyze the data. “The main activities are to search for relevant parts of the data and by naming and classifying them. Through this process, a structure is developed as a step towards a comprehensive understanding of the issue, the field, and last but not the least the data themselves.” (Flick, 2007) The common themes thus obtained from ‘coding and categorizing’ the case studies were compared against each other. The comparative study of these codes gave an account of how similar or different the experiences of participants have been; which helped to get the emerging themes from the data. These themes were clubbed to get the higher level concepts that have been discussed later in the report. The analysis of the survey data was done using SPSS software.

**Innovation**

Given the complex nature of the socio-cultural realities the participant is placed in, it is very important not only to work with individual but also with all the factors and stakeholders that influence his decision making process. Unless we make a more conducive environment, better policies, safe spaces, and support systems, issue of internalized homophobia and HIV related stigma cannot be addressed. By addressing the issue at multiple levels, we are trying to look at the issue from a more holistic and comprehensive approach which in turn will help individual cope with perceived and enacted stigma. We believe one’s experiences neither lie in isolation nor in abstraction, therefore we also need to look at the phenomenon at both, individual and systemic levels.

**Replicability and Sustainability**
The project aimed at bringing about changes in perception and creating awareness which are sustainable processes. Even the redesigning of organizational policies, awareness messages, and the combined consultation will have a strong and long lasting impact. The project though focuses on MSM population; it can be implemented with any high risk groups facing multiple levels of stigma. The project has used the method of joint review by bringing both the sides together. This approach can be replicated in most of the settings and marginalized groups.
FINDINGS

1.1 Findings from the surveys:

A survey questionnaire was administered to a sample of 195 (n=100) health care providers across two hospitals; one private and one public health care facility. To capture the whole range of attitudes, behaviours and practices in a hospital setting, sampling was done across cadres. The sampling frame included doctors, nurses, house-keeping staff and lab staff. Probability sampling method was employed and to ensure representativeness, method of PPES was used. Lists of all employed staff from five departments (medicine, surgery, dermatology, psychiatry and community medicine) were obtained. Proportionate sample from each cadre was then drawn out through random sampling.

Of the total sample size of 100 we conducted surveys with 95 Health Care providers, at the private hospital. Out of the 95, around 30% were doctors including associate professors, and resident doctors. Apart from doctors, nurses (10.5%), lab staff (7.4%) and house-keeping staff (47.4%) were interviewed. At the public hospital, 100 surveys were conducted with HCP, with 39% sample size being doctors, 19% nurses, 5% lab staff and 28% house-keeping.

<table>
<thead>
<tr>
<th></th>
<th>Private Hospital</th>
<th>Public Hospital</th>
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</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td></td>
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<tr>
<td>Mean Age</td>
<td>33</td>
<td>39</td>
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<tr>
<td>Below 30</td>
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<td>35</td>
</tr>
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<td>31-50</td>
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<td>Above 50</td>
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<td>18</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>45</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>55</td>
</tr>
<tr>
<td>Designation (in %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>30</td>
<td>39</td>
</tr>
<tr>
<td>Nurses</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>House Keeping</td>
<td>47</td>
<td>30</td>
</tr>
<tr>
<td>Average Experience (in years)</td>
<td>3.5 years</td>
<td>14.6 years</td>
</tr>
</tbody>
</table>

Table 1: Demographic data of the sample in private and public health care facility

Knowledge and Awareness:

Private Hospital: Assessing awareness about HIV among HCPs, 87% believed HIV can be transmitted and around 23% believed HIV is curable. Assessment of knowledge about bodily fluids that facilitate
transmission of HIV led to the following results. Semen, blood, vaginal fluid and breast milk were believed to transmit HIV by 71%, 94%, 77% and 54% respondents respectively. Whereas body fluids like saliva, sweat, tears and urine were believed to transmit HIV by 30%, 13%, 13% and 25.5% respondents respectively. Exploring knowledge about factors leading to HIV, needle prick (78%), sex without condom (75%) and direct blood transfusion (78%) were rated as major factors by the respondents. Apart from these, other factors reported to transmit HIV were transmission from mother to baby (56.5%), handling soiled linen and touching skin of an HIV positive patient (11%).

Exploring the knowledge about homosexuality amongst HCP, over 35% reported homosexuality to be unnatural and thought that it can be cured and altered. Over 60% respondents affirmed to the statement ‘homosexual men are at higher risk of HIV’ and 5% thought it is illegal to provide treatment to homosexuals.

**Public Hospital**: Assessing awareness about HIV among HCPs, 91% believed HIV can be transmitted and over 10% it is curable. Assessment of knowledge about bodily fluids that facilitate transmission of HIV led to the following results. Semen, blood, vaginal fluid and breast milk were believed to transmit HIV by 83%, 97%, 79% and 45.5% respectively. Whereas body fluids like saliva, sweat, tears and urine were believed to transmit HIV by 21%, 4%, 5% and 15% respondents respectively. Exploring knowledge about factors leading to HIV, needle prick (82%), sex without condom (86%) and direct blood transfusion (77%) were rated as major factors by the respondents. Apart from these, other factors reported to transmit HIV were transmission from mother to baby (49%), handling soiled linen (3%) and touching skin of an HIV positive patient (4%).

Exploring knowledge about homosexuality amongst HCP, over 40% reported homosexuality to be unnatural and 38% thought that it can be cured and altered. Over 69% respondents affirmed to the statement ‘homosexual men are at higher risk of HIV’ and 7% thought it is illegal to provide treatment to homosexuals.

![Graph 1(a): Percentage of respondents in agreement of transmission through the bodily fluids](image-url)
Fear

Private Hospital: On being asked if they know any HIV patients, 38% HCPs responded in an affirmative. Assessment of fear of HIV on engagement/contact with a HIV + patient, the four procedures during which most fear was experienced were Invasive procedure (71%), removing used needle from syringe after attending to an HIV + Patient (63%), taking blood sample of HIV + patient (60%) and putting IV drip on a person with HIV (56%). Other areas where fear was experienced while coming in contact with an HIV+ person were touching the saliva (46%), touching the sweat (34%), changing bed sheet (21%), changing clothes (22%), checking blood pressure (16%), and serving food (9.5%).

Over one quarter of respondents stated that these fears will have an effect on interaction with HIV positive patients. While over 32% will avoid complete contact and 24% will refrain from touching the HIV+ patient, 54% stated they will wear gloves at all times with HIV+ patients and 24% will wear masks at all times.

Apart from fear of HIV, the respondents were inquired on their fears in coming in contact with a hijra/transgender to which 29% affirmed the fear. Due to this fear, 47% respondents stated avoiding contact, 17% reported refraining from touch and 8% HCPs stated they would refer the patient to another staff.

3% respondents reported knowing a homosexual person and 41% stated they will not be comfortable taking sexual history of a homosexual patient.

Public Hospital: On being asked if they know any HIV patients, 34% HCPs responded in an affirmative. Assessment of fear of HIV on engagement/contact with a HIV + patient, the four procedures during which most fear was experienced were Invasive procedure (74%), removing used needle from syringe after attending to an HIV + Patient (64%), taking blood sample of HIV + patient (62%) and putting IV drip on a person with HIV (54%). Other areas where fear was experienced while coming in contact with an HIV+ person were touching the saliva (43%), touching skin (38%), touching the sweat (23%), sharing utensils (20%), changing bed sheet (8%), changing clothes (9%), checking blood pressure (3%), and serving food (2%).

Graph 1(b): Percentage of respondents in agreement to the given factors of transmission
Over one quarter of respondents stated that these fears will have an effect on interaction with HIV positive patients. While over 20% will avoid complete contact and 18% will refrain from touching the HIV+ patient, 85% stated they will wear gloves at all times and 41% will wear masks at all times with HIV+ patients.

Apart from fear of HIV, the respondents were inquired on their fears in coming in contact with a hijra/transgender to which 17% affirmed the fear. Due to this fear, 52% respondents stated avoiding contact, around 10% reported refraining from touch and 29% HCPs stated they would refer the patient to another staff.

9% respondents reported knowing a homosexual person and 43% stated they will not be comfortable taking sexual history of a homosexual patient.

![Fear of getting infected by HIV (In percentage)](chart.png)

**Graph 2:** Percentage of respondents in agreement to the given statements

<table>
<thead>
<tr>
<th></th>
<th>Private</th>
<th></th>
<th>Public</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical</td>
<td>Para-medical</td>
<td>Medical</td>
<td>Para-medical</td>
</tr>
<tr>
<td>Fear touching sweat</td>
<td>6</td>
<td>25</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Fear sharing utensils</td>
<td>8</td>
<td>23</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Fear taking blood pressure</td>
<td>2</td>
<td>13</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Fear changing bed pans</td>
<td>2</td>
<td>16</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Fear changing clothes</td>
<td>2</td>
<td>17</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Fear serving food</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

*Table 2: Of the given percentage, frequency of respondents in agreement to the statements
  Medical: Doctors & Nurses
  Para-medical: House-keeping & Lab staff*

**Attitude towards PLHIV and homosexuality**

Attitudes often times are the drivers of behaviour. Hence, attitudes were assessed to comprehend behaviour of HCP towards PLHIV and MM.
Private Hospital: Statements assessing attitudes towards PLHIV led to the following results. Over 70% respondents believed ‘HIV is punishment for bad behaviour’. Close to half the respondents stated ‘PLHIV should be ashamed of themselves’, ‘it is someone’s fate to get HIV’ and ‘children living with HIV should not be allowed to study with other children’.

In terms of homosexuality, over 50% respondents believed ‘homosexuals should be counselled to change their behaviour’ and ‘it is homosexual men that spread HIV’. Close to 40% also said that ‘homosexuality is abnormal’. Close to 20% respondents affirmed to the statement ‘homosexuals do not deserve to receive treatment’.

Public Hospital: On inquiry, a little over a quarter of respondents stated ‘HIV is punishment for bad behaviour’. And close to 25% respondents stated ‘PLHIV should be ashamed of themselves’, ‘it is someone’s fate to get HIV’ and ‘children living with HIV should not be allowed to study with other children’.

In regards to homosexuality, around 50% respondents stated ‘HIV is god’s way of punishing homosexuality’ and ‘it is homosexual men that spread HIV’. One quarter of respondents believed ‘homosexuals deserve to get HIV’.

![Graph 3(a): Percentage of respondents in agreement of the given statements](image-url)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Private Medical</th>
<th>Private Paramedical</th>
<th>Public Medical</th>
<th>Public Paramedical</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV is a punishment for bad behaviour</td>
<td>18</td>
<td>45</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>PLHIV should be ashamed of themselves</td>
<td>2</td>
<td>36</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>It is someone’s fate to get HIV</td>
<td>10</td>
<td>33</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Children with HIV should not be allowed to study</td>
<td>11</td>
<td>28</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>
HST-ICRW study: Understanding stigma at systemic and individual level to overcome barriers to HIV related health seeking behaviour among men who have sex with men in Mumbai

<table>
<thead>
<tr>
<th>with non-infected children</th>
<th></th>
</tr>
</thead>
</table>

**Table 2:** Of the given percentage, frequency of respondents in agreement to the statements

*Medical: Doctors & Nurses*

*Para-medical: House-keeping & Lab staff*

![Graph 3(b): Percentage of respondents in agreement of the given statements](chart)

### Attitude towards homosexuals (In percentage)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Private</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>HS men are promiscuous</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>Homosexuality is abnormal</td>
<td>Par-medical</td>
<td></td>
</tr>
<tr>
<td>HSs do not deserve to receive treatment</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>HSs should be counselled to change behaviour</td>
<td>Par-medical</td>
<td></td>
</tr>
<tr>
<td>HSs getting HIV is God's way of punishing them</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>HSs should marry a female</td>
<td>Par-medical</td>
<td></td>
</tr>
<tr>
<td>HSs should get HIV</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>HSs should be treated in a separate ward</td>
<td>Par-medical</td>
<td></td>
</tr>
<tr>
<td>HSs do not deserve to marry a female</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>HSs should be counselled to change behaviour</td>
<td>Par-medical</td>
<td></td>
</tr>
<tr>
<td>HSs getting HIV is God's way of punishing them</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>It is homosexual men that spread HIV</td>
<td>Par-medical</td>
<td></td>
</tr>
</tbody>
</table>

*God's way of punishing HSs do not deserve to marry a female HSs getting HIV*
Table 3: Of the given percentage, frequency of respondents in agreement to the statements

**Medical**: Doctors & Nurses
**Para-medical**: House-keeping & Lab staff

Enacted Stigma (Number of respondents consider it reasonable behaviour)

Society reacts and behaves in various ways towards people with/ suspected to have HIV or AIDS. Also, people react differently to individuals engaging in same-sex behaviour. The survey assessed how reasonable or unreasonable different behaviours can be in relation to HIV and homosexuality. 12 statements were asked in relation to assessing attitudes towards HIV and 6 in relation to homosexuality.

**Private Hospital**: Over 40% respondents believed it is reasonable behaviour ‘to refuse to share a toilet with a PLHIV’, ‘to refuse to rent a room to PLHIV’ and ‘not allowing a child to play with another child with HIV’. Also, over 30% believed it is reasonable ‘assign separate utensils to PLHIV’, ‘to limit participation of PLHIV in community events and no longer inviting them to social events’, and ‘to inquire about how a person got infected’. Over a quarter of respondents believed it reasonable ‘to avoid using something touched by PLHIV’ and ‘to divorce a husband/ wife if either is infected with HIV’.

While exploring if ‘a HIV patient’s status should be disclosed to hospital staff’, 52% affirmed to this statement but the numbers dropped to 35% if the patient was assumed to be a family member.

**Public Hospital**: Statements like ‘refusal to rent a room to PLHIV’, ‘not allowing a child to play with another child with HIV’, ‘assign separate utensils to PLHIV’, ‘to limit participation of PLHIV in community events and no longer inviting them to social events’, ‘to inquire about how a person got infected’, ‘to avoid using something touched by PLHIV’ and ‘to divorce a husband/ wife if either is infected with HIV’ received a response of close to 10% as being reasonable.

While exploring if a patient’s HIV status should be disclosed to hospital staff, 58% affirmed to this statement but the numbers dropped to 23% if the patient was assumed to be a family member.
HST-ICRW study: Understanding stigma at systemic and individual level to overcome barriers to HIV related health seeking behaviour among men who have sex with men in Mumbai

<table>
<thead>
<tr>
<th>Not inviting PLHIV to social events</th>
<th>medical</th>
<th>medical</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Limiting participation in community activities</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Not allowing a child to HIV to play with another child</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Assigning specific utensils to PLHIV</td>
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<td>27</td>
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<tr>
<td>Avoiding using something touched by PLHIV</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Divorce a partner because of HIV</td>
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<td>17</td>
</tr>
<tr>
<td>Refusing to rent a room to PLHIV</td>
<td>17</td>
<td>21</td>
</tr>
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</table>

Table 4: Of the given percentage, frequency of respondents in agreement to the statements

Medical: Doctors & Nurses
Para-medical: House-keeping & Lab staff

General Practices at the Hospital:
On inquiry, 63% in private and 46% in public health facility believed it is necessary for all patients to get tested for HIV. Of the 63% in private hospital, 21 respondents were doctors and nurses and 35 were para-medical staff (house-keeping and lab technicians). At the public facility, of the 46%, 21 respondents were the medical staff and 20 were para-medical staff.

Diagram 1: Percentage of respondents who believe all patients should be tested for HIV

Private Hospital: Inquiry about general practices at the hospital like HIV testing, care of PLHIV and ways of disclosure of a patient’s HIV status yielded following results. Close to half the respondents stated that a PLHIVs status gets disclosed through gossiping within staff and around 25% of respondents stated that a PLHIV patients status is declared to other patients.

Public Hospital: Over 40% respondents stated that a HIV patients bed pans and bed sheets are not changed as frequently due to their HIV status. Close to 30% stated that a HIV patients status if disclosed
to family members without their consent and 7% stated that patients are tested for HIV without their consent.

Graph 5: Percentage of respondents in agreement of the given statements

<table>
<thead>
<tr>
<th></th>
<th>Private Medical</th>
<th>Private Paramedical</th>
<th>Public Medical</th>
<th>Public Paramedical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing a patient for HIV without consent</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Senior health provider passing the patient to junior health provider due if PLHIV</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Disclosing HIV status to patients' family without consent</td>
<td>18</td>
<td>9</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>Health providers gossiping about a patients HIV status</td>
<td>16</td>
<td>9</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>A provider not having bed pans/ clothes changed as frequently due to HIV status</td>
<td>27</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Health worker informs other patients about patients HIV status</td>
<td>7</td>
<td>5</td>
<td>5</td>
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</tbody>
</table>
Table 5: Of the given percentage, frequency of respondents in agreement to the statements

<table>
<thead>
<tr>
<th>Medical: Doctors &amp; Nurses</th>
<th>Para-medical: House-keeping &amp; Lab staff</th>
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1.2 Policy Review and Hospital Observations

To meet the Object 1, policy review and observation was conducted at both the hospitals – Public and Private. Interviews were conducted with head of departments and senior doctors/ faculty to inquire about awareness and availability of written policies of HIV and related issue. Similarly, hospital observation (particularly in wards) was conducted to examine the practices of the staff in connection to patients known to be HIV positive.

Private Hospital

Written Policies

During the interviews it was told that most of the departments under study (except Community Medicine) are unaware of any written policies or protocols at the Hospital. Department of Community Medicine mentioned about written policies being present but they were unavailable for review/ seen by the research team. The staff was aware of policies and protocols on universal precaution, admission of PLHA, confidentiality regarding HIV status and disclosure of HIV status. The staff was not aware of any policy on recruitment policy for HIV positive staff, testing of staff or recording of HIV status. It was informed that their knowledge about these polices and protocol has been gained through their classroom teaching or experience at job.

Observations

General observation of hospital practices:

It was observed that there were separate disposal bags for organic and inorganic wastes. Waste management system seemed to be highly effective. Also, there were posters in all wards displaying proper waste management techniques. Needles and other disposable medical equipment were disinfected using Hypochlorite solution and then broken and thrown away in containers meant for syringes and other medical instruments. In addition, thermometers and other equipments are put in a disinfectant solution before being used on another patient. Those cans were emptied on a regular basis and hence were not seen to be overflowing. Doctors visit the ward once in the morning, and then based on requirement; while nurses are at the wards at all times. The wards are cleaned thrice a day, and linen was washed and changed every day; and in case of blood spills, lines are disinfected and reused. Similarly, management and handling of bodily fluids, e.g. vomit, blood, etc. is done using disinfectant.

Observation of hospital practices in regard to patients known to be HIV positive:
It was told by the hospital ward staff that Universal Precautions are taken for all patients. Files of HIV-positive and HBsAg-positive patients are marked UP (Universal Precaution). It was informed that patients known to be HIV positive are isolated and kept in a separate room. Although, same equipments are used for PLHA operation, but are then disinfected before re-use. At the surgery ward, it was told all medical procedures to be done with HIV-positive patients including surgery happen at the end of the day after all other HIV-negative patients since the room and tools need to be disinfected after operating on a HIV-positive patient. Separate AIDS kits are used in the Operation Theatre for PLHA. While treating a patient known to be HIV positive, the ward staff and nurses use double/triple gloving and extra masks, goggles and aprons. (Only surgery ward mentioned not using extra masks but agreed using double gloves). Also, fumigation of rooms used by PLHA is conducted. One of the nurses, while being interviewed for practices in ward, pointed out to a positive patient disclosing his status.

Public Hospital

Written Policies

During the interviews conducted with head of departments and other senior faculty it was realized that the senior staff is aware about existence of Hospital policies on Universal Precaution, Confidentiality regarding HIV status, Disclosure of HIV status and Policy on surgery. But in terms of written policies in regard to HIV testing and related issues it was told that there are no written policies in place. Similarly it was reported that they are not aware of or have any knowledge of any policy (written or otherwise) on admission and care of PLHA, HIV testing of patients, recording of HIV status, counseling protocol/guidelines, recruitment policy of HIV positive staff or testing of staff for HIV. The mode of awareness on policies and protocols as informed by the staff was gained during college and then on the job. There are policies around discrimination, care of PLHA; and there is a HIV core committee which looks into these issues and acts as a redressal cell. It looks at functional difficulties and implementation of written policies given by NACO. The core committee members are from Dept. of Microbiology, PSM, Surgery, and Medicine. It was suggested by the hospital staff that NACO, Government and MDACS should collaborate to come up with written guidelines/policies and disseminate to class III and class IV employees; and written policies should be drafted.

Observations

General observation of hospital practices:

Similar to the practices at the Private hospital, at the Public hospital also there are separate disposal bags for organic and inorganic wastes. Needles and other disposable medical equipment are disinfected using Hypochlorite solution and then broken and thrown away in containers meant for syringes and other medical instruments. These cans are emptied on a regular basis and hence were not seen to be overflowing. Beds were in a good condition, and they were clean and showed no signs of unhygienic practices. Doctors visit the ward once in the morning, and then based on requirement, while nurses are at the wards at all times. Linens are washed and changed every day and in case of blood stains, linens are disinfected and reused. Gloves are disposed after use; and equipments are disinfected before re-use. Thermometers are put in warm water (if Dettol is not available) before using on another patient. It was
told that double gloves and other Universal precautions are taken while doing any invasive procedure like drawing blood etc. These too become difficult sometimes due to lack of supplies being a public/municipal facility.

**Observation of hospital practices in regard to patients known to be HIV positive:**
Files of the patients known to be HIV positive are marked UP (Universal Precaution), positive or sero-positive. Either HIV positive patients are kept in separate rooms or their beds are put in the centre vertically to demarcate them from other HIV negative patients. All medical procedures to be done with HIV positive patients including surgery happen at the end of the day after all other HIV negative patients since the room and tools need to be disinfected after operating on a HIV positive patient. At the surgery department it was informed that, it is not allowed to do HIV testing without consent. And they do it only if symptomatic signs are seen or on medical suspicion. If the patient refuses to give consent in these cases, they are still operated on and not forced to take the test. Universal precautions are anyway taken for all patients. Confidentiality is maintained. The operating doctor will only inform his subordinate staff and the staff that come in contact with the patient for safety reasons. Double gloves and other universal precautions are taken, as reported by Surgery staff. With patients with known status, the staff uses double gloves, masks and goggles for extra precaution. Also the rooms used by PLHA are fumigated.

### 1.3 Findings from Focus Group Discussion with community

The following findings are based on the two FGD conducted with Humsafar staff and community members to explore and understand internalized homophobia.

**A. Factors influencing Internalised Stigma**
Sex, although being an individual expression of desire, is ranked by the society in its level of appropriateness. As evidenced by numerous studies, non-hetero-normative or homo-social behavior does not have complete acceptance in the socio-cultural context. A person with same sex desires comes from a society which is widely hetero-normative and has grown up to such models of sexual expression as being ‘normal/ideal’. Considering it is not just an individual’s journey of self-discovery but has a two way impact, individual on society and society on individual, sexual identity formation of a person cannot be looked at in isolation to the societal purview. Sexual expression and synthesis of sexual identity into the overall concept of self is a result of intrapersonal, interpersonal and collective beliefs of society at large. Failure to integrate sexual behavior in one’s self-concept might result in internalization of societal ideas around non-hetero-normative expression of desire resulting in self-stigmatization and negative effect.

**A.1 Self-Acceptance:**
Self-acceptance is defined as moving from identification of incongruence within an individual to eventual integration of assumed sexuality as part of self. The incongruence may persist due to a
mismatch between their characteristics, their perception of those characteristics and the society’s perception of those characteristics.

In the current study, a pattern was observed across individuals in terms of self-acceptance. This could be evidential that sexual identity formation is a developmental process putting each individual at a different stage of ‘coming to terms’ with ones sexuality. It finds its beginning in the feeling of ambiguity due to lack of vocabulary to define these states of desires. Going from a strong belief of being part of the majority to gradual realization of being otherwise can lead to a lot of self-questioning. This stressful mental state can lead to confusion resulting in personal alienation which is marked by the key statement “I am the only one like this”. A need to understand self and the alternating mental states may lead an individual to sources of information and socialization with people similar in their experiences. This self-exploration may help an individual make sense of and develop a vocabulary required for identification of these feelings. Giving a name to an abstract feeling may help alleviate the ambiguity bringing an increased sense of clarity. Self-identification may eventually lead to self-acceptance in terms of comfort with one’s sexuality and ‘not being part of the majority’.

“Initially when I started off, I knew that I had to keep it a secret. I didn’t really understand why or I didn’t feel guilty about it but I knew that people shouldn’t know because something could happen if people knew about it, but later on when you get older like 13 14 puberty and everything then you start feeling guilty because you realize there are these norms and these things that are allowed and not allowed and then you start feeling guilty about who you are and everything so that went on for some time till eventually I accepted myself, but initially, initially it was good but you had to keep it a secret one should know and then after that there was a lot of guilt associated with it and then it became alright.”

Each stage of identity formation is marked by a key statement, assessment and comprehension of which allows for movement between stages. Discussions with the participants brought to focus that acceptance of sexuality is not an absolute concept but lies on a continuum, the journey to which is not always one way but is marked by a lot of back and forth between stages.

A.2 Definition of Gender roles

The strict gender roles assigned to each sex along with the extreme patriarchal structure of our society, gives very little freedom for self-expression and exploration. Perception of gender roles to be on the extremes (either completely male or completely female) defines constructs like sex and gender to be absolute, rejecting a possibility of movement or swing between the two extreme points. Exploring the definition of gender on personality and behavior, the study observed the community members to confirm to the societies beliefs around gender and gender roles. Confirming to such gender beliefs and failure to comply can have implications on coming to terms with ones sexuality. While individual’s belief around gender and gender roles lead to a feeling of guilt and self-blame, cultural definition of these constructs obstruct adequate self-expression. Self-expression is an important aspect of integration of ones sexuality into the overall identity. The cultural relevance to gender roles being internalized resulting in inadequate self-expression can be seen in Married MSM in the form of them leading a dual life (one conforming to and the other non-confirming to social views).
“Man should behave manly. He should be strong and have impressive looks. According to society's foundation, a man should be strong with a good personality.” While other participant went on to state, “A female is shy but a man is open in his behavior”.

“One thing comes to a MSMSs mind that if I cannot produce a kid means something is missing in me, and this is because I do all these things outside and I am MSM”.

“There is a big difference that happens after marriage. Like gay men have different dressing style, hair style, style of living and talking etc. After marriage everything has to change totally”.

A.3 Social Factors
Numerous social factors influence the process of internalization of stigma. Interplay between the psychological and social factors can either facilitate or impede movement to the next stage. The interaction effect between these two factors could explain the variations in behavior within the MSM community and time spent by each individual in a particular stage.

The factors can be as varied as rejection by family, concern about family’s reputation and safety, level of faced and observed stigma and discrimination, along with experience of being exploited to lack of social support and access to organizations/sources of information. It was seen that although there was self-acceptance, rejection and fear of bringing shame to the family induced negative affect about self, making them question their behavior. Another point of concern was their family’s reputation in a society abiding by the heterosexual culture as normative. Perceived non-acceptance by family and guilt of non-disclosure was also seen to be responsible for associating shame with ones sexuality and sexual behavior. Married MSM had an additional fear, for the safety of their wives and were surrounded by a constant fear of indirect disclosure. This was observed to lead to decreased social involvement which could translate into decreased avenues of social support.

Access to organizations that work with sexual minorities had an effect on their acceptance of self since they serve as a ‘safe space’ and was looked at by the community as support systems. The rallies, marches and other advocacy events organized by CBOs also help an individual socialize and come in contact with people with alternate sexualities. This could help reduce the feelings of alienation escalating the process of self-acceptance. While there is a fear of disclosure, socialization within community acts to strengthen support systems since not much support is received from society at large.

“In my sister’s office, they came to know I am gay, and asked my sister about it. So she said I don’t know any such person but they still teased her so much that she came home and cried. I felt really guilty and thought what I am doing is wrong.” “My father is putting so much of faith in me and what is this that I am doing, means having sex with guys and all. They trust me so much and I am breaking their trust”.

“It’s scary to go to weddings, and to relatives, that someone should not identify me as gay. It is scary to go out with her (wife), because there is a constant fear of identity disclosure”.

“It happens like this that if my sister’s husband is trying to cruise on me then it is scary as we think whether we should do it or not? If we do then if some problem happens, what about our sister and if we don’t, he might torture her in different reasons”.
“After marriage they (MSM) have to live a dual life. Because of this they are under a lot of pressure and are always disturbed”.

“I am an employee in a media company. 80% people know I am gay, I wear anything of my choice. Now no one dares to tease me as ‘gud’ or ‘mamu’. Even if they do, it doesn’t affect me, it’s nothing like getting scared. It’s all on us and how we carry ourselves off”.

“In a rally we realize that how many people are there in the community, means how much do they support and what amount of public comes. I didn’t used to go because of the media, if someone sees then mother will ask questions. But we realize how many people come and support.”

While social acceptance and approval was observed to be vital in strengthening self-confidence and healthy integration of self, negative interaction between environment and individual was seen to develop self-doubt and self-stigmatization. While there is no denying the lack of tolerance in society towards same sex sexuality, self-acceptance was seen to have a connection with resilience to societal stigma.

B. Impact of Internalized stigma
All the input from society leading to placement of self on the scale of self-acceptance, results in a proportionate output in the form of behavior. Understanding the dynamics of an individual in relation to his environment can help develop a profile of the individual in terms of present stage of acceptance and probable behavior manifestations. This can be backed by the current findings which brought forth emerging patterns of behavior influenced by current standing of an individual along with the study of mediating social factors.

The direct impact of IS was seen to affect disclosure which in turn could feed into various behavior patterns. The current study identified disclosure to be of four kinds, based on the concept of private v/s public identity borrowed by Cass. Depending on whether the acceptance is at the private level or transcended to be at a public level, disclosure can be either complete, partial, avoidant or non-disclosure.

Each form of disclosure was seen to manifest itself in certain forms of behavior. Complete disclosure was seen to be associated with formation of meaningful and secure relationships as well as resilience to stigma and discrimination; whereas the other forms of disclosure, depending on the environmental factors, led to self-destructive or confirming behavior stemming from concealment of sexuality.

“Think about a straight couple walking on the road, the feeling that they have in their heart, I also have the same feeling.”

“Many people think that if wife conceives then we will not have to do anything with her for nine months. She will get busy with the wife and I can do whatever I want with my life.”

“Once I was able to accept myself, I came out to my friends. They kept asking me questions as to how it happens and what is it etc. They wanted to understand. So I did not face any issues”.

Avoiding disclosure by engaging in confirming behavior (e.g. Marriage) was likely to lead to self-destructive practices like alcoholism, depression multiple partners, less meaningful and secure relationships, feelings of dissonance due to bifurcated sexuality; private and public etc. Non-disclosure
was also seen to be associated with increased stigma, violence and exploitation illustrating a three way relationship between Self-acceptance, disclosure and Internalized stigma.

1.4 Discussion points from- Consultation to address HIV related stigma faced by men who have sex with men at Health Care settings

The aim of the Consultation was to bring together the MSM community and health care staff to disseminate and jointly review the findings from Objective 1 and 2. Based on this joint review, it was intended to come up with a suitable advocacy process or recommendations to address perceived and experienced stigma.

The findings from the Objective 1 and 2 were presented at the consultation which brought about discussion among various Head of Departments (HODs) from hospitals and other participants. Few HODs even expressed their surprise towards the findings. One of the HOD present at the consultation mentioned, “Firstly, we have not reached what we thought we did. Secondly, the attitude towards the children with HIV should not be allowed to study with non-infected students was really a shock.” Another HOD added, “Feeling of a failure when the results were discussed and all were shocked after the horrible situation even after 20 years of work.” It was also pointed that a person who is working in the wards, and is spending more time with the patient might have a very different and enriching experience to know, instead of the OPD staff which sees them for couple of hours. One of the participants also stated that, ward boy stigmatization is much more vulnerable feeling for the patient as compared to the doctors stigmatizing the patient. But because of the size of the sample taken, the results with so much of pin-pointing truths, it becomes really challenging and difficult to accept and then look for the change.

It was also discussed that there may be a difference in the treatment of patients in public and private hospitals; public sector doesn’t have the choice, unlike private sector. But the reality is that most of the time, these private flexible settings also have stigmatization at different levels in the process. One of the participant on the issue of sharing of HIV status of patient to hospital staff or marking the patient’s file, he stated, “But isn’t the privacy of the status at risk of being revealed by the staff who is going through the reports? A non-verbal stigmatizations and ignorance are good factors which are making even the hospital setting unsafe in terms of a person’s self-image and mental health.”

There was also a discussion around the compulsory HIV testing for any form of surgery. It was stated that there is no ‘opt-out’ for HIV testing. It was told that in case of surgery they don’t ask for consent at all for HIV testing. One of the public hospitals was taken as an example, where when HIV/AIDS testing is not prescribed the doctor sends them to the lab outside for testing and in private clinics there is no pre-test, post-test counselling for the clients before and after testing.

One of the participants mentioned about the HIV core committee in one of the public hospitals. It was told that there are several policies which have been circulated among all the professionals, but even then
people are not aware of what are the recent updates. Few doctors present at the consultation negated the finding that no written policies are present at the hospital in place. But they accepted that the hospital staff might not be aware of the written policies being there at the hospital. Few doctors also mentioned that in the public hospital, according to the university rules, as well as the MDACS the training programs are provided to all the schools like class 3 and class 4, yet if people don’t turn up that has to be dealt with. It was added, that the fact that even after the training, the attitudes have not changed among the staff people. It means it is a failure, whether they come-forth or not. It is just like a paper documentation thing; attitude change is a very gradual process. One of the participants shared a case from hospital, “A dead body of a person with HIV/AIDS was wrapped in 4 layers of plastic and kept away from rest of the dead bodies, where no one was ready to touch it. Although there has been a change, even then it has to be addressed especially by the senior faculty, to help the juniors model the same behaviour.”

On the practice of hospital staff wearing 2-3 gloves while treating HIV patient, it was told that, it is because the gloves used at the hospital are recycled, so they have to wear the gloves. One of the participant shared, “In Mizoram, she found out that a pregnant lady who was being treated for HIV and was being surgically treated for child birth, the nurses shouted about wearing the triple gloves. The girl asked whether it is the same for other patient as well, and she was told ‘no’, it was only for HIV patients”.

Few senior doctors felt a bit offended by knowing the fact that professionals are unaware of policies and protocols. And they invited the research team to present the findings with the hospital staff and also in the HIV core committee.

The discussion was followed by group exercises. All the participants were divided in two groups. The first group was asked to work towards the question of policies, if they are needed, and what all they must include to address HIV based stigma. The second group, worked on strategies to address HIV based stigma in health care setting and also how to make efforts sustainable.

Group 1:  What is a policy? – It gets generated (in layman terms) it’s an institutional, government, or organizational plan, to bring a change. If we identify something, it gets stigmatized. The presenter explained it through the normal probability curve, how sexual orientation is different. The presenter stated, the moment we are hiding our identity it means that it is a feeling that segregates us, and will bring stigma to us. When people start accepting their orientation and saying it bluntly then stigmatization would degrade automatically. We need to accept the variations and move on.

Why policy is required? – To bring uniformity in the variations. It is on the paper, and is considered by the public law. But what if it’s just on the paper and not implemented? The presenter added, policies have a flaw in implementation that they are stretched overly long by the public sector.

Corruption as a major drawback in the implementation, and public should be aware of its rights so that if the public sector isn’t implementing it, so they can demand it themselves. Agent policy should be there for the result. Policy should not be very rigid, and not open for changes. There are several policies which
lack the guidelines well. Policy should be framed keeping in mind institutional demands. It should be different on the basis of different diseases and abnormality. Because every problem has it’s on risk. Attitudinal change and behavioural shift – social skills training, or other trainings, no lecture method is beneficial. The internalization in the patient is dependent on the patient itself. Policies must be directive in nature and should go to the grassroots level as well.

Group 2: The presenter discussed that there should be groups in the hospital for addressing the stigmatized situations. Grievances committee can also include one community member to address these issues separately. It was stated that there should be different employment opportunities for HIV positive persons and NGOs paying on behalf of the patient for the treatments. There is also a need to address issues of funding and sensitization is required. Sensitization of the higher authorities is required a lot, in order to help others accept it better. Apart from the private and public settings, other settings should also be identified in terms of stigma types. It was also discussed how to involve private sector into all these activities. And it was stated that it should be a lawful act; and strategies should include advocacy and sensitization. Executive committees can be the best part to look up to the strategic sensitization. It was discussed that there are various committees and groups of specialist doctors and departments and they should be used as spaces to target private practitioners. CBOs and NGOs may not be able to address issues with these committees but they can provide concrete evidences through research findings.

**Conclusion:**

The study poses certain limitation as findings can’t be generalized, as only one public and one private hospital were included. At the same time the findings from the study do indicate the need to work at an institutional level to create an equitable environment. Although training and working with hospitals show knowledge on HIV and universal precaution, many findings have shown higher agreement on social exclusion of HIV positive patients and value judgments against high risk population (including MSM). There is a gap between knowledge and attitude, hence addressing values and judgments on morality, gender, and sexuality should be an integral part of HIV training. Policy review and hospital observation have corroborated the findings from survey. There is a need to draft policies on hospital practices and HIV based discrimination. These policies should be displayed in the hospital, and the information about these policies must be given to all the staff at the hospitals. Unless there is an equitable and safe environment at the hospital setting, it will act as a barrier towards HIV related health seeking behavior among men who have sex with men.