Stigma and health care among the Men with the experience Sex with men in Dhaka city

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Abstract

Health care is one of the basic needs of the human being. Right to health care is recognized globally by the declaration of various international agreements .The right to health is the economic, social and cultural right to a universal minimum standard of health to which all individuals are entitled. The concept of a right to health has been enumerated in international agreements which include the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities.

An alternative way to conceptualize one facet of the right to health is a "human right to health care." So Men having sex with men (MSM) also deserve the right to health. But stigma plays a significant role as barrier of getting health care services. Bangladesh is a religiously rigid country, so MSM behavior in this country is publicly prohibited religiously, socially and culturally. That's why health care services are a crucial issue for the Men having sex with men (MSM). Here health care for the MSM is related to stigma.

There are so many studies or research work internationally and nationally on HIV/AIDS related health care services and MSM. But stigma related health care service is ignored in these studies. The researcher could not found any study on this topic, that's why the researcher intended to make Stigma and Health care of the Men having sex with men (MSM) as the pivotal area for research.

Therefore, the overall aim of this thesis was to explore the lived experiences of MSM with health care, in particular the intersection of health care related stigma with social, behavioral, and health outcomes in Dhaka city. For this thesis, data were collected via

semi structured, face-to-face interviews with 73 MSM and case study on 8 MSM living in Dhaka city. Using a descriptive narrative approach, the researcher sought to address the influence of health care related stigma in the lives of these men.

Results indicated that MSM participating in this study accessed health services through various agencies. MSM also experienced stigma in multiple and overlapping ways; MSM described stigmatizing experiences stemming from religious sources, communities, family and friends, and from the medical establishment. Moreover, it was revealed that homophobia and HIV-related stigma were related; participants did not differentiate between the two. Homophobia and HIV related stigma were specifically contextualized in relation to urbanity and religiosity.

The results within this dissertation are intended to inform health professionals in the planning and implementation of interventions and treatments for this hidden population in Dhaka city. This exploratory thesis provides insight and contextual information for a highly stigmatized population. Lastly, this project provided urban MSM with a voice.

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List of Figures

Table of Contents

Page no.

Chapter three: Theoretical perspective of the study

Chapter Four: Methodology

Chapter Five: Results

Acronyms and Abbreviations

MSM	Men with the experience sex with men
MSW	Male Sex Worker
HIV	Human Immune Virus
AIDS	Acquired Immune Deficiency Syndrome
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
Kothi	Passive role player in male to male sex
Panthi	Active role player in male to male sex
Doparatha	Both Active and passive role player in male to male sex
Parik	Fixed sexual partner
RMG	Ready Made Garments
DIC	Drop-In-Center
BSWS	Bandhu Social Welfare Society
VCT	Voluntary Counseling and Testing
LGBT	Lesbian, Gay, Bisexual and Transgender
NGO	Non-Governmental Organization

Chapter one: Introduction

Introduction:

> "Stigma represents a kind of death – a social death. Non-stigmatized people, through avoidance and social rejection, often treat stigmatized people as if they were invisible, nonexistent, or dead (Coleman, 1997: 226)."

Homosexual behaviors are illegal and heavily stigmatized in many countries including Bangladesh. This has resulted in MSM experiencing discrimination as well as verbal and physical abuse, imprisonment, and homicide. In the context of health care specially HIV and AIDS, MSM become stigmatized due to assumptions in society that they are core transmitters of HIV infection. Several studies have documented the HIV–related stigma, discrimination, and abuse experienced by MSM in many regions of the world (UNAIDS 2000; Feng et al. 2010; Senior 2010; Global Forum on MSM and HIV 2011). But studies on health care related stigma are not visible in the context of developing countries like Bangladesh.

Due to both high HIV and AIDS prevalence and through association with the disease, MSM have frequently been the target of stigma from health care workers (Lane et al. 2008; Araujo et al. 2009; Chandra & Madison 2009; Fay et al. 2011; Rispel et al. 2011). Several stigma and discrimination (S&D) domains have been identified in health care settings: fear of casual transmission and refusal of contact with people living with HIV (PLHIV); values: shame, blame, and judgment; enacted S&D; and disclosure (Nyblade & MacQuarrie 2006).

Stigma related to MSM has also been documented in many studies conducted in Africa particularly in Jamaica. Findings from a study conducted in 2003 by White and

Carr demonstrated that the connection between HIV stigma and being a homosexual man continued to be a challenge for HIV prevention programs in Jamaica.

This same study documented how HIV–related stigma toward MSM was manifested in Jamaica, including laws; politics (i.e., homosexuality in smear campaigns against opposing political parties); the socio-cultural environment (homophobia supported by religious institutions and popular cultural icons, common street lingo, "don't ask don't tell" policy about disclosing to family and the community); gender (males with HIV assumed to be homosexual); class (poor MSM with HIV who use public services are more visible and stigmatized than wealthy MSM

Statement of the problem:

The health care service is one of the basic rights of the human being. This is one of the human rights too, which has been ensured for the people of the world with no discrimination based on gender, race, ethnicity, nation etc. by the United Nations UN through various conventions and treaties. So, the men with the experience sex with men (MSM) people cannot be denied from the health care service. But in the societies like Bangladesh MSM people are being deprived from the health care facilities. Social stigma is major reason for this deprivation. So the researcher intends to identify the nature of the stigma related to the health care service for the MSM. Discover the typology of the stigma is also the significant issue for the researcher which will indicate the path of the solvation of the problem.

Objective of the study:

Every research has some specific objectives which are the basis of the study, in this study. The researcher has set out some particular objectives. Some of key objective are:

- To explore the stigma among the men with the experience sex with men (MSM).
- To identify the types of stigma those are faced by MSM.
- To explore the health care those are received by the MSM.
- To examine the relationship between stigma and health among the MSM.
- To identify the risky behaviors those are practiced by MSM.
- To discover a way to lessen the stigma related to health care of the MSM.

Research questions:

The researcher has set some question before starting the study.

Some key questions are:

1. Whether the MSM people are stigmatized or not?
2. What is the nature of the stigma?
3. Is there access of the MSM people in mainstream health care service?
4. What types of stigma are related to the health care of the MSM?
5. Is there any discrimination in providing health care to the MSM?
6. Is there any necessity of providing specialized health care to the MSM?

7. What types of specialized health care are receiving by MSM?

Dhaka City: A brief History and demography:

Dhaka formerly spelled as Dacca is the capital city of Bangladesh. It is the principal city of Dhaka Division and Dhaka District. Dhaka is the most populous city in Bangladesh and tenth-largest city in the world, with a metropolitan area of 12 million inhabitants. It is the center of Greater Dhaka conurbation. Standing on the east bank of the Buriganga River Dhaka is the political, economic and cultural heart of Bangladesh. It is one of the major cities of South Asia. Historically known as the City of Mosques, it is also nicknamed as the Rickshaw Capital of the World, with its daily traffic of over 500,000 cycle rickshaws.

The population of Dhaka (areas under the jurisdiction of the Dhaka City Corporation) stands at approximately 7.0 million. The city, in combination with localities forming the wider metropolitan area, is home to over 15 million as of 2013. The population is growing by an estimated 4.2% per year, one of the highest rates amongst Asian cities. The continuing growth reflects ongoing migration from rural areas to the Dhaka urban region, which accounted for 60% of the city's growth in the 1960s and 1970s. More recently, the city's population has also grown with the expansion of city boundaries, a process that added more than a million people to the city in the 1980. According to the Far Eastern Economic Review Far Eastern Economic Review Dhaka will be home to 25 million people by the year 2025.

The literacy rate in Dhaka is also increasing fairly quickly. It was estimated at 62.3% in 2001. The literacy rate had gone up to 72.7% by 2010 which is significantly higher than the national average of 56.5%. The city population is composed of people from virtually every region of Bangladesh. The long-standing inhabitants of the old city are known as *Dhakaia* and have a distinctive dialect and culture. Between 15,000 to 20,000 of the Rohingya, Santal, Khasi, Garo, Chakma and Mandi tribal peoples reside in the city. Dhaka also has a large population of Chinese, Korean, Indian, Pakistani, Nepalese, Burmese and Sri Lankan expatriates working in executive jobs in different industries.

As a cosmopolitan city, Dhaka is the home of various sects of people such as Straight men. Straight Women, Gay, Lesbian, MSM etc. among them MSM are particularly stigmatized for receiving health care services from mainstream service providers. They are seeking health care from specialized service centers. There are some Non-government organizations and government initiatives to provide health care service to them in Dhaka.

Chapter two: Literature review

Stigma:

In the literature review there are some constraints to conduct study on Stigma related to health care of MSM. There are many studies on HIV/AIDS related academic studies and reports of the MSM. But the studies on health care related stigma of the MSM are very few. So the researcher is bound to lessen his literature part of the study.

Men having sex with men (MSM) experience stigma. The word itself literally means "to mark, brand, or tattoo."(Merriman-Webster's Online Dictionary, n.d.). Ancient Greeks invented the word to describe the deliberate marking of slaves, criminals, and traitors to the State with a physical mark (e.g., cuts, burns) to designate them as being "different" and "Other." These marks set them apart from the general public and social mores of the day required these "Others" to be avoided. (Madru, 2003).*

In all of the societies across the world, individuals who are marked were considered discounted, less than human, having deviated from some social norm, or possessing something within themselves that was undesirable and to be feared. Stigma can be defined as "a discrediting social label" (Wright, Naar-King, Lam, Templin, & Frey, 2007) also as behavior characteristics of individuals that run contrary to the norms of social units, that is, they behave in ways that do not support shared beliefs of others (Ahern, Stuber, & Galea, 2006) (cited from Roger L. Blackwell Jr) .

* this part of the writing is heavily drawn from Roger L. Blackwell Jr's 'Health Service Utilization and Stigma among HIVPositive Men-Who-Have-Sex-With Men (MSM) in Rural Appalachia'

Stigma can be negative reactions to socially unacceptable characteristics (Chenard, 2007). Goffman (1963) in his now classic book defined stigma as an undesirable and discrediting attribute that reduced a person from being viewed as a whole person to a tainted or discounted one. According to Foster (2007), stigma may also be considered a social identity within some social category that questions that person's humanity in such a way that they are considered damaged, flawed, or devalued in the eyes of others (Foster, 2007).

Health care related stigma and discrimination has been widely demonstrated across the globe. Goffman (1963) defined stigma as "…a powerful social label, stemming from a discrediting attribute of the individual which radically changes their social identity." He notes discrimination is a way "through which we effectively, if often unthinkingly, reduce […] life chances…" (Cited from Stigma Index Bangladesh)

Stigma and discrimination related to the health care have drawn attention from academic research faculties in recent years. But Bangladesh is lagging behind from this academic discussion about stigma related health care issues of the Men with the experience sex with men. In an academic research Naoko Taira (2007) has stressed on the study of the mental health of the stigmatized people. She insisted on 'enacted' and 'felt' stigma.

Stigma is socially constructed and contingent on relationships and context. It occurs interpersonally, between people through words, gestures, meanings, and feelings and via this subjective process results in such things as labeling, stereotyping, and strong emotional reactions. For example, during an interpersonal exchange those who stigmatize place individuals into distinct categories they then use to base stereotypical belief systems (Foster 2007). In attempting to classify some general characterizations of stigma it is helpful to consider the following terms to help the conceptualization

process: discrimination, labeling, loss of status, discounting, discrediting, stigma on an individual and group basis, institutional, cultural, internalized, and whether the person stigmatized is a primary or secondary target. Parker and Aggleton (2003) citing Foucault's work present the view that the process of stigmatization requires marking of differences between types of people and then placing them into hierarchal systems or structures of power. This structuring promotes the interests and views of the dominant group. Dominant groups legitimize their standing rank wise through hegemonic processes, whereby they "convince" those in the minority to accept their reduced status. Unfortunately, stigmatized individuals or groups often accept this reduced status, which ultimately reinforces their stigmatized condition. On an organizational or institutional level stigma can produce structural discrimination.

Relationship of stigma with Spirituality and Religiosity:

Homosexuals have always had a problematic relationship with traditional religious faiths and their corresponding social institutions. The Westernized religious institutions have not only been unsupportive of same sex coupling, their codified beliefs label homophile orientation and activities as sinful and outside the faith's accepted code of behavior. All over the world religious prescriptives endorse and support a solely heterosexist worldview (Barret & Barzan, 1996; Fulton, Gorusch, & Maynard, 1999; Greene, 2009; Lynch, 1996; Mark, 2008; Rodriguez & Ouelllete, 2000; Schuck & Liddle, 2001; Yarhouse & Burkett, 2002; Yarhouse & Tan, 2005). Study demonstrates that MSM growing up in the church hear messages that constantly reinforce this negative view. They are subjected to messages such as gays go to hell, will burn in hell for being gay, that they are bringing this country down, and that they might even have a demon inside of

them. Kubicek (2009) notes that, The more they hear these homophobic messages the more likely MSM will "start believing that it's true."(Kubicek et al., 2009, p.612). Same sex relationships violate this socially constructed boundary and therefore threaten the stability of the system (Greene, 2009). Traditional value orientations may contribute to negative views on homosexuality and HIV/STI. Socially disadvantaged MSM populations tend to have a more conservative mindset, and be more supportive of conservative values and less tolerant of diversity in populations. Religious belief-ideology has a more prominent role in shaping the social norms of rural communities. Cultural and social oppression influence many MSM to hide their sexual orientation and may contribute to nondisclosure of health concerns related to sexuality with health providers. Health resources available to MSM may be limited or nonexistent.

The religious mindset of the traditional societies like Bangladesh has a ugly look towards the MSM practices. In Bangladesh the Muslims are major in populations, so the MSM people are more undermined in this country. The traditional norms and values does not allow the homosexuality. But a portion of the total population is practicing homosexuality in Bangladesh, which is quite strange matter.

Most of the MSM people grow up in the context of a culture that has extremely harsh views towards homosexuals and same sex behaviors for example Bangladeshi MSM people. One thing to remember is that unlike other members of marginalized groups (e.g., CHT ethnic minorities) MSM as children do not grow up with parents who share this stigmatized identity. As this is very embarrassing for the family in the community life. It is seen that, the majority of MSM grow up in heterosexually

oriented households. Consequently, there is no parental buffering from a dominant heterosexist orientation, nor do they have visible and appropriate role models.

It happens that, even before they themselves are aware of their same sex orientation or attractions, these children have already begun to learn and internalize all the popular myths and stereotypes that society promulgates about homosexuality which is a matter of wonder. In a study about religious mindset, Fulton et al. (1999) were to set out to explore the relationship among religious orientation, homophobic sentiment, and fundamentalism among Christians. They hypothesized that negative attitudes towards homosexuals was a function of fundamentalist beliefs, low intrinsic and high extrinsic social motivation, and a lack of open-mindedness in the search for truth. Those who scored higher on the fundamentalist scale were more rejecting of homosexuals than those who scored lower on fundamentalism. Some of this antipathy is understood to correspond to fundamentalist ideology (i.e., literal interpretation of biblical passages concerning same sex behaviors). However, researchers concluded that much of the anti-homosexual sentiments espoused by fundamentalists were in excess of what was *required* by their religious ideology.

Many MSM have religious conflicts with their sexual identity and orientation (Bartoli & Gillem, 2008; Borgman, 2009; Foster, Arnold, Rebchook, & Kegeles, 2011; Garcia, Gray-Stanley, & Ramirez-Valles, 2008; Harris, Cook, & Kashubeck-West, 2008; Kubicek et al., 2009; Lynch,1996; Rosik, Griffith, & Cruz, 2007; Schuck & Liddle, 2001; Wagner, Sarafini, Rabkin, Remien, & Williams,1994;Yarhouse & Tan, 2005). Yarhouse and Tan (2005) addressed conflicts that adolescents were experiencing in their emerging sexual and religious identities.

.Some non-Judeo-Christian-Islamic faiths are also more affirming of sexual minorities than their Westernized counterparts (Blando, 2009; Smith & Horne, 2007).

Stigma and Access to Medical Care and Health Services:

Wilkerson (1994) takes on issues related to gay related stigma and the ways in which medical science expresses, perpetuates, and legitimizes homophobic values. The author presents several aspects that illustrate the moral authority of medicine that can serve to oppress MSM and those living with HIV/AIDS. For example, health care providers (e.g., doctors) have been reluctant or have even refused to treat MSM and those living with HIV/AIDS for either fear of infection or because they believed MSM patients did not deserve to access their services. Also, she documents the struggles that nontraditional families have had in the area of visitation rights and decision-making powers in regards to health care. (Cited from Roger L. Blackwell Jr)

She posits that moralistic assumptions are often presented as medical fact. The use of language to convey moralistic and fear-based pronouncements further polarize both clients and communities as this can lead to placing "sin, shame, and blame" on MSM. This conceptualization can then carry over into media representation and medical theory and conceptualization of MSM and HIV/AIDS. As an example, she reminds us that in the early years of the AIDS epidemic risk and transmission were discussed in terms of specific risk groups or identities instead of behavioral practices. This set up an Us (i.e., not at risk) versus Them (i.e., Others at risk) mentality that is still prevalent today.

She concludes that in order to overcome medical homophobia, the mistreatment of MSM people by health care personnel must be exposed, the use of medical language to vilify same sex practices must be opposed, and medical institutions should be held to principles of social justice.

Researchers suggested that through enacting universal precautions measures should reduce stigma. They also recommended that agencies strengthen training programs by including stigma-reduction modules as part of overall programming for health care professionals. Sayles, Ryan, Silver, Sarkisin, and Cunningham (2007) explored the impact of stigma in healthcare related settings from the perspective of MSM and HIV positive participants in the Los Angeles, CA area. Their qualitative designed study used focus groups to generate ideas and real life examples related to HIV stigma and how this might influence the health and the health care services used by these participants. Their data analysis revealed four key domains of HIV stigma from their sample: blame and stereotypes of HIV, fears of being contaminated, negotiating disclosure of their HIV status, and renegotiation of social contracts.

Chapter three: Theoretical perspective of the study

Erving Goffman's Theory on Stigma:

Society teaches its members to categorize persons by common defining attributes and characteristics (Goffman, 1963). Stigma: Notes on the Management of Spoiled Identity is a book written by Erving Goffman in 1963 about the idea of stigma and what it is like to be a stigmatized person. It is a look into the world of persons who society does not consider "normal." Stigmatized people are those that do not have full social acceptance and are constantly striving to adjust their social identities: physically deformed people, mental patients, drug addicts, prostitutes, etc. Goffman relies extensively on autobiographies and case studies to analyze stigmatized persons' feelings about themselves and their relationships to "normal" people. He looks at the variety of strategies that stigmatized individuals use to deal with the rejection of others and the complex images of themselves that they project to others.

Three Types of Stigma:

In the first chapter of the book, Goffman identifies three types of stigma: stigma of character traits, physical stigma, and stigma of group identity. Stigma of character traits are "blemishes of individual character perceived as weak will, domineering, or unnatural passions, treacherous and rigid beliefs, and dishonesty, these being inferred from a known record of, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior." Physical stigma refers to physical deformities of the body. Finally, stigma of group identity is a stigma that comes from

being of a particular race, nation, religion, etc. These stigmas are transmitted though lineages and contaminate all members of a family.

What all of these types of stigma have in common is that they each have the same sociological features: “an individual who might have been received easily in normal social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us.” When Goffman refers to “us,” he is referring to the non-stigmatized, which he calls the “normals.”

According to Goffman there are three forms of social stigma:

1. Overt or external deformations, such as scars, physical manifestations of anorexia nervosa, leprosy (leprosy stigma), or of a physical disability or social disability, such as obesity.
2. Deviations in personal traits, including mental illness, drug addiction, alcoholism, and criminal background are stigmatized in this way.
3. "Tribal stigmas" are traits, imagined or real, of ethnic group, nationality, or of religion that is deemed to be a deviation from the prevailing normative ethnicity, nationality or religion.

Stigma Responses:

Goffman discusses a number of responses that stigmatized people can take. For example, they could undergo plastic surgery; however they still risk being exposed as someone who was formerly stigmatized. They can also make special efforts to compensate for their stigma, such as drawing attention to another area of the body or a disabled person learning to swim really well. They can also use their stigma as an excuse for their lack of success, they can see it as a learning experience, or they can use it to criticize "normals." Hiding, however, can lead to further isolation, depression, and anxiety and when they do go out in public, they can in turn feel more self-conscious and afraid to display anger or other negative emotions.

Stigmatized individuals can also turn to other stigmatized people or sympathetic others for support and coping. They can form or join self-help groups, clubs, national associations, or other groups to feel a sense of belonging. They might also produce their own conferences or magazines to raise their morale.

Stigma Symbols:

In chapter two of *Stigma: Notes on the Management of Spoiled Identity,* Goffman discusses the role of "stigma symbols." Symbols are a part of information control – they are used to understand others. For example, a wedding ring is a symbol that shows others that someone is married. Stigma symbols are similar. Skin color is a stigma symbol, as is a hearing aid, cane, shaved head, or wheelchair. Stigmatized people often use symbols as "disidentifiers" in order to try to pass as a "normal." For instance, if an illiterate person is wearing 'intellectual' glasses, they might be trying to pass as a literate person. Or a homosexual person who tells 'queer jokes' might be trying to pass as a heterosexual person. These covering attempts,

however, can also be problematic. If a stigmatized person tries to cover their stigma or pass as a "normal," they have to avoid close relationships, and passing can often lead to self-contempt. They also need to constantly be alert and always checking their houses or bodies for signs of stigmatization.

Rules for Handling Normals:

In chapter three of this book, Goffman discusses the rules that stigmatized people follow when handling "normals."

1. One must assume that "normals" are ignorant rather than malicious.

2. No response is needed to snubs or insults, and the stigmatized should either ignore or patiently refute the offence and views behind it.

3. The stigmatized should try to help reduce the tension by breaking the ice and using humor or even self-mockery.
4. The stigmatized should treat "normals" as if they are honorary wise.
5. The stigmatized should follow disclosure etiquette by using disability as a topic for serious conversation, for example.
6. The stigmatized should use tactful pauses during conversations to allow recovery from shock over something that was said.
7. The stigmatized should allow intrusive questions and agree to be helped.
8. The stigmatized should see oneself as "normal" in order to put "normals" at easy.

Deviance:

In the final two chapters of the book, Goffman discusses the underlying social functions of stigmatization (such as social control) as well as the implications that stigma has for theories of deviance. For instance, stigma and deviance can be functional and acceptable in society if it is within limits and boundaries.

Social stigma:

Social stigma is the extreme disapproval of (or discontent with) a person or group on socially characteristic grounds that are perceived, and serve to distinguish them, from other members of a society. Stigma may then be affixed to such a person, by the greater society, who differs from their cultural norms. Social stigma can result from the perception of mental illness, physical disabilities, diseases such as leprosy, illegitimacy, mental illness, sexual orientation, gender identity, skin tone, education, nationality, ethnicity, ideology, religion (or lack of religion or criminality. Attributes associated with social stigma often vary depending on the geopolitical and corresponding sociopolitical contexts employed by society, in different parts of the world.

Stigma: A social, cultural, and moral process:

The concept of stigma has undergone important shifts in definition and characterization since its initial articulation by Erving Goffman in the 1960s. Here, we contend that the study of stigma has focused too heavily on psychological approaches and has neglected to sufficiently incorporate understandings of stigma and stigmatized individuals as embedded in local moral contexts. What exactly is encompassed by the conceptual

umbrella of stigma is far more than a compelling theoretical question, since definitions of stigma directly inform efforts to empirically research and combat stigma.

The modern idea of stigma owes a great deal to Goffman, who viewed stigma as a process based on the social construction of identity. Persons who become associated with a stigmatized condition thus pass from a "normal" to a "discredited" or "discreditable" social status. In his original discussion of stigma, Goffman included both psychological and social elements, but his ideas have primarily been used in the analysis of psychological impact of stigma on individuals. This has created an understanding of the psychology of the stigmatized, focusing on the processes by which stigma is internalized and shapes individual behavior. Yet, this has been to the exclusion of considerations of how social life and relationships are changed by stigma. Recently, the field of sociology has contributed to this discussion by creating a broader understanding of stigma that identifies social processes that occur within the sociocultural environment whose effects can be observed within the individual. Specifically, the model of stigma proposed by Link and Phelan3 includes a component of structural discrimination, or the institutionalized disadvantages placed on stigmatized groups. This opens the door for us to begin to elucidate the ways that power – social, economic, and political – shapes the distribution of stigma within a social milieu.

More recently, anthropological contributions to the study of stigma have focused on stigma as embedded in moral experience and on the stigmatized as a person with a moral status. The moral standing of an individual or group is determined by their local social world, and maintaining moral status is dependent on meeting social obligations and norms. Individuals with (or associated with) stigmatized conditions

are *de facto* unable to meet these requirements. Thus, stigma decays the ability to hold on to what matters most to ordinary people in a local world, such as wealth, relationships, and life chances. Yet, we must remember that the stigmatized and those who stigmatize are interconnected through local social networks. Although stigma may share features across contexts, it uniquely affects lives in local contexts. Understanding the unique social and cultural processes that create stigma in the lived worlds of the stigmatized should be the first focus of our efforts to combat stigma. Measuring what matters most is facilitated by ethnographic methods, through which the local value systems can be explored in far greater depth than what is possible through standard survey instruments.

By combining observation with in-depth interviews, we can see the difference between individual's stated moral ideals and their actions. This knowledge in turn facilitates understanding what stigma does to people and how it can be addressed.

The present focus on legislation to prevent formal, institutionalized consequences of stigma is admirable, but it does not create large social change. Anthropology can contribute to this discussion by examining the altering of moral worlds that lead to large cultural changes. We only have to look to the examples of depression and smoking in the U.S. context to see that the relative stigma of specific conditions and actions can and does change across time. For example, there is a significant trend toward destigmatization of depression that indicates a major cultural shift. Conversely, smoking has become increasingly stigmatized, and smoking rates in the U.S. have substantially dropped. Despite much scholastic attention and public education efforts to achieve these trends, we do not really understand the processes by

which these shifts in norms and moral experience have occurred. We currently know surprisingly little about the moral processes that undergird stigma.

Until we admit this, we will limit our ability to understand and create effective strategies for overcoming stigma. Most stigma research has failed to address this central issue. In addition to the psychological and macrosocial components of stigma, we must understand how the moral standing of individuals and groups in local context affects the transmission and outcome of stigma. By focusing on how local values enacted in people's lives affect stigma, we will be able to create more effective and measureable anti-stigma interventions.

Chapter Four: Methodology

Types of study:

This study has been conducted to explore the nature of health care services received by the Men having sex with men (MSM). How many MSM people are getting health care facilities and who are the health care service providers are important points of the study. It was also conducted to identify the inequalities in health care services between mainstream people and MSM. The researcher did set hypothesis prior to conduct the research also. In this context both quantitative and qualitative i.e. mixed research method was more appropriate for discovering the main phenomena. This study is a mixed method study where cluster sampling survey and case study method has been applied.

Universe and study unit:

The registered beneficiaries of the Bandhu Social Welfare Society (BSWS) in Dhaka city are the universe of the study. The study unit of this research is 73 MSM people for survey and 8 MSM people for case studies who are randomly selected from Darussalam area Jatrabari area of the Dhaka city.

Area of the study:

The study has been conducted in the Dhaka city, the capital of Bangladesh. In Dhaka city, there are four DICs of Bandhu Social Welfare Society (BSWS) which are located at Uttara, Darussalam, Lalabag and Jatrabari. So the researcher has selected two DICs; Darussalam and Jaterabari as the area of study. Researcher is acquainted with the behavior, culture, norms and values of the MSM. A few language of MSM community is well known to the researcher, this introductory knowledge about MSM have helped the researcher to conduct survey and case studies

with the MSM people. Nevertheless this area is easy to communicate for the researcher.

Sampling procedure:

In the study, researcher considered cluster sampling method for selecting sample. The cluster sampling is the appropriate sampling method for conducting research on such kind of hidden population like MSM. The time limitation, manpower, accessories and budget were also responsible to conduct the study on the basis of cluster sampling. The researcher selects cases with specific purposes in mind.

Sample size:

73 MSM people for quantitative survey and 8 MSM people for case study have been taken as respondents for the present research

Socio-demographic characteristics of the sample:

A total number of 81 MSM people were approached to participate in the survey and case study process. Almost every participant agreed to participate. Respondents' ages ranged from 18 to 35 years old. All of the respondents are living in Jatrabari and Darusslam area. All respondents of the research are the beneficiaries of the specialized health care service.

Data Collection Technique:

The research has been conducted on the basis of primary data. Primary data has been collected with the semi-structured interview schedule on the basis of a questionnaire (both open and close ended) to collect necessary information in the light of research objectives. Observation technique also followed during interview for developing the case report. After taking informed consent, the data were collected by an interviewer. The interviews were semi-structured and held in each participant's known language (Bangla/local standard language). Participants were interviewed alone in order to ensure privacy and to prevent that partners would influence each other and give them the opportunity to speak frankly. The respondents were somehow known to the researcher. By applying some techniques, information has been collected as the respondents were reluctant to provide some information regarding the identical issues. An informal relationship was developed with the respondents during the period of taking interviews. This helped in collecting information being eased. Cases have been taken from two different places.

Data analysis:

Analysis and interpretation of data is the pre-condition of the research. All the written and recorded materials were transcribed and translated into English. The data analysis started simultaneously with the data collection and was an iterative and continuous process. The analysis was done through MS excel and manually as it is both quantitative and qualitative research method. The analysis followed the analytic hierarchy, from data management to descriptive and explanatory account.

Finally, links between stigma, health care facilities, and behavior of the medical professionals, perspectives and characteristics of the participants were identified.

Ethical Consideration and Ethical issues of the study:

Ethical issues related to social research are very important and have been much discussed; it is a study of triangulation method. All qualitative researchers should give serious thought to these particularly as the nature; qualitative research adds its own complications. In this research the researcher has dealt with some ethical issues pertaining to qualitative case study research; include confidentiality, informed consent, emotional safety and reciprocity.

i. Confidentiality: This target population is the hidden population on identical issues. Very few people would willingly express their private details, opinion and emotions in public documents knowing that their names would be published. Thus, confidentiality is a vital requirement for credible research. In this cases the researcher pay as much as attention as possible to maintaining the confidentiality of the individual respondents (participants), changing the facts where necessary as long as these changes (name of the respondents, address) do not distort the essential element .

ii. Informed consent: Gaining informed consent is essential for all sorts of research and the flexible nature of the qualitative research design causes particular problems. Because of such an emergent design the researcher has emphasized the importance of repeatedly confirming informed consent, as the participants did not have full knowledge on the health care facilities especially medical technological facilities. Informed consent has then reflected awareness that such events could not entirely be

predicted. As a result, a revised view of informed consent was seemed warranted; I which consent was negotiated at different points in the research cycle.

iii. Emotional safety: Qualitative interview research gives inquiries many opportunities to involve the participants emotionally about sensitive topics. In this research, ethics were dictated interviewed elicit intense discussion of painful life events of the respondents; the researcher did not introduce topics gratuitously. The topics were either be volunteered by the respondents or inquired about when they were the focus of the study.

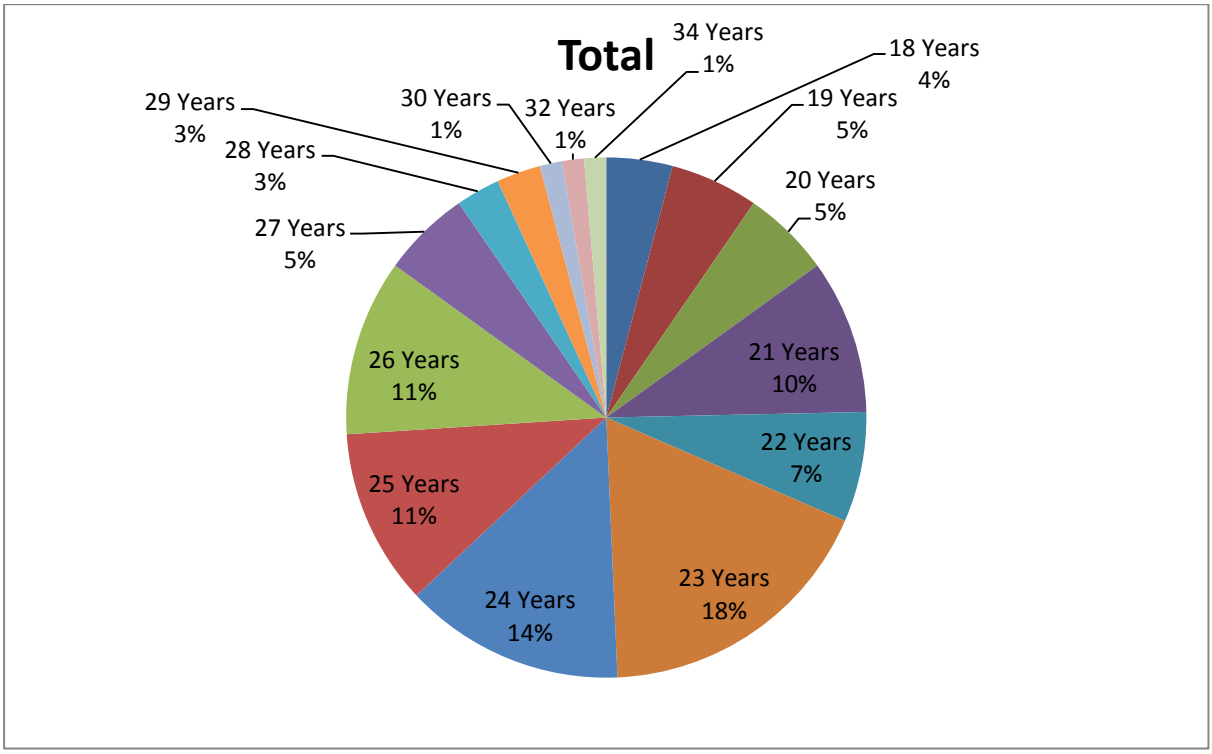
iv. Reciprocity: The question of reciprocity is important to note. The reciprocity of research was more keenly noticed among the researcher and the participants.

Limitations of the study:

- The prime limitation of this study is unavailable literatures related to this topic
- The time limit was not enough to do the thesis in ideal way.
- The budget problem was faced by the researcher as it was limited.
- It was very difficult for the researcher to manage the participants. As they are hidden people in identity issues.
- Participants were not flexible sharing their personal experience.
- Respondents used so many special words/languages which was very much problematic for the researcher to translate into bangla and English.

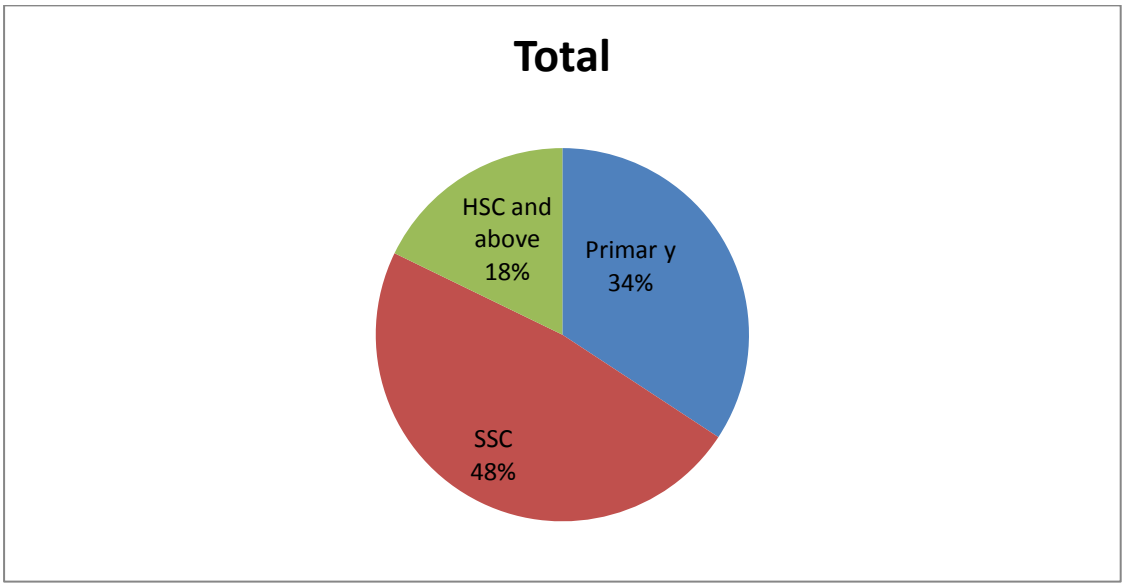
Chapter Five: Results

Figure 5.1 Age structure of the respondents:



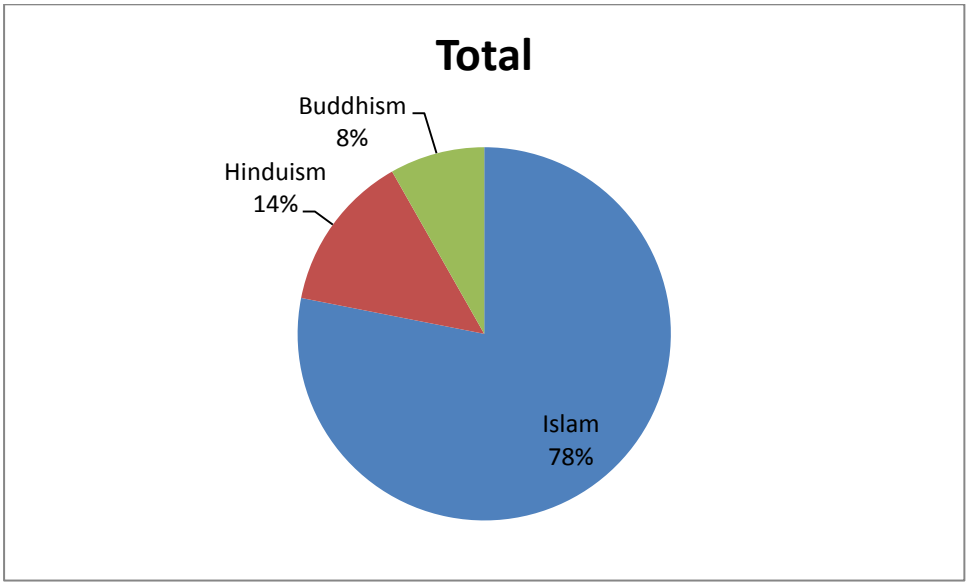
There were a total number 73 MSM people who are respondents of this study. By analyzing the age structure of the respondents, it is found that, 4% respondents are at the age of 18, 5% are at the age of 19, 5% are at the age of 20, 10% are at the age of 21, 7% are at the age of 22, 18% are at the age of 23, 14% are at the age of 24, 11% are at the age of 25, 11% are at the age of26,5% are at the age of 27, 3% are at the age of 28, 3% are at the age of 29, 1% are at the age of 30, 1% are at the age of 32 and rest 1% are at the age of 34.

Figure 5.2 Highest Educational Qualification of the respondents:



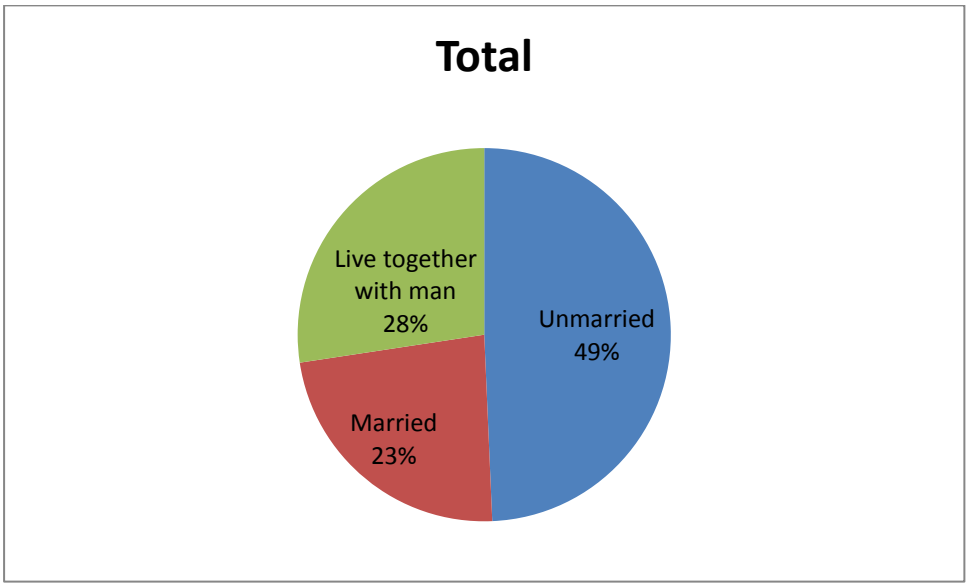
Among the 73 respondents 34% are in primary level, 48% are in secondary school certificate (SSC) level and rest 18% are in HSC and above level.

Figure 5.3 Religious Belief of the respondents:



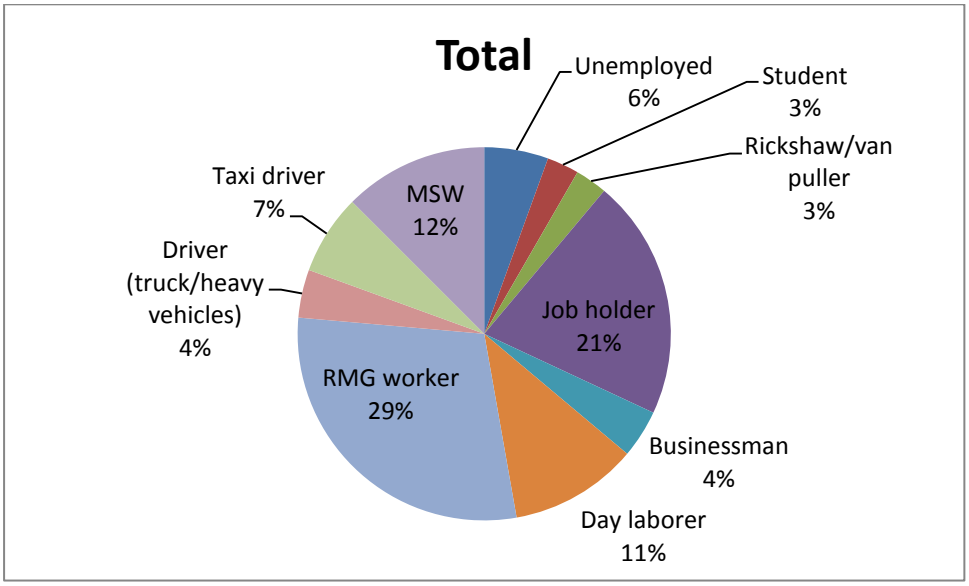
Among the 73 respondents 78% are muslim, 14% are Hindu and rest 8% are Buddhist.

Figure 5.4 Marital status of the respondents:



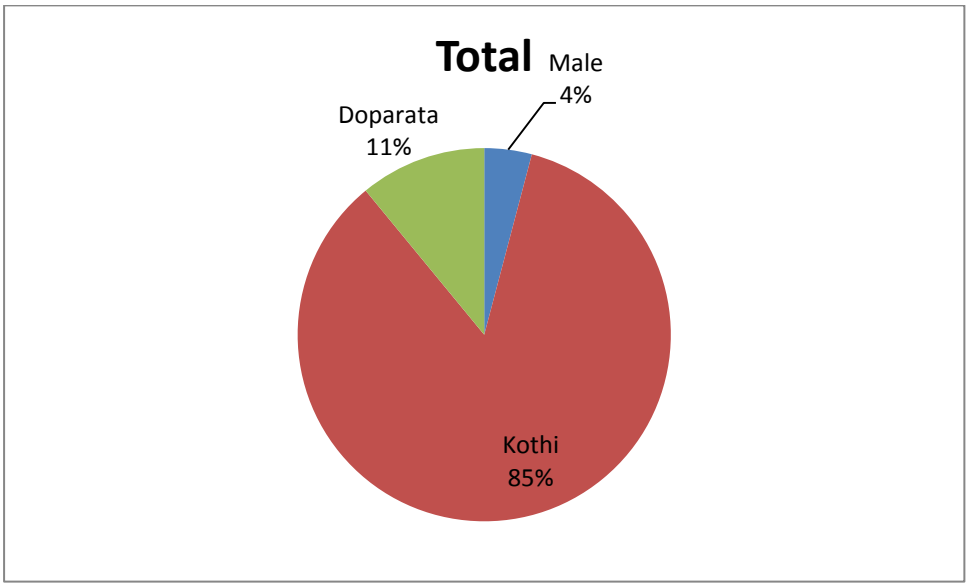
Among the 73 respondents, 49% are Unmarried, 23% are married, and rest 28% are living together.

Figure 5.5 Profession of the respondents:



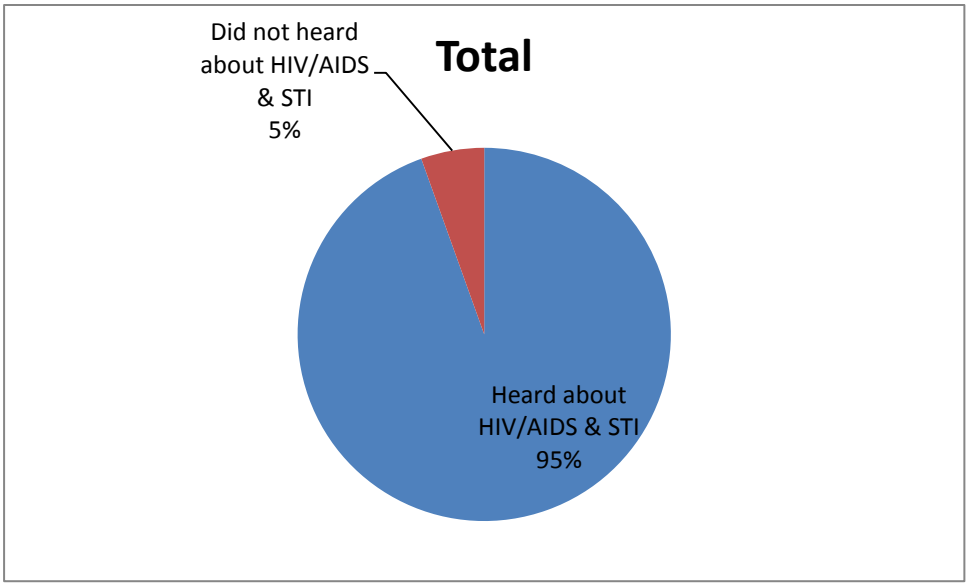
Among the 73 respondents 3% are student, 3% are rickshaw puller, 4% are businessman, 11% are day laborer, 29% RMG workers, 4% truck, heavy vehicles driver, 7% taxi driver, and rest 6% are unemployed.

Figure 5.6 Particular MSM identity of the respondents:



Among the 73 respondents 85% are kothi, 11% are doparata and rest 4% are male.

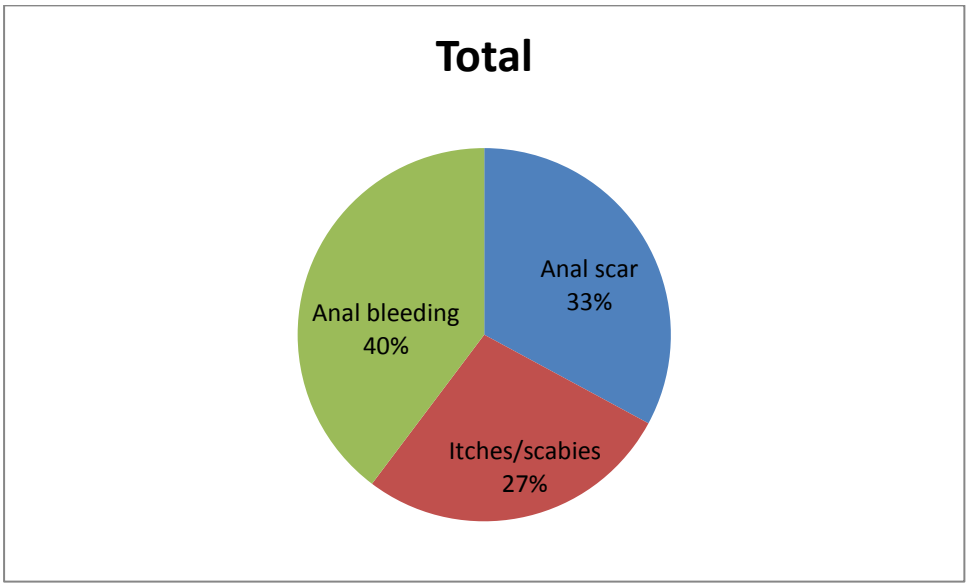
Figure 5.7 HIV/AIDS and STI knowledge:



Among the 73 respondents 95% of the respondents heard about HIV/AIDS and STI.

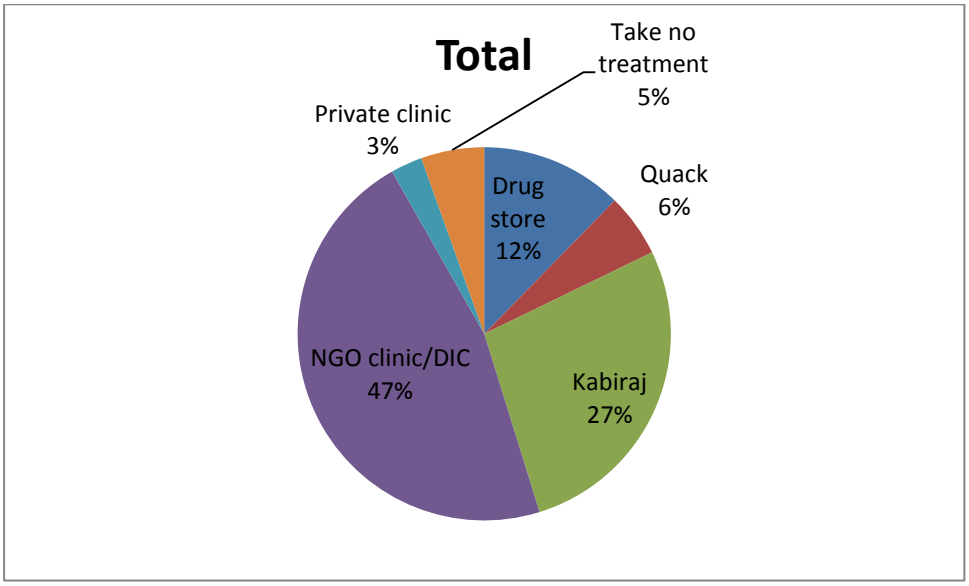
Rest 5% did not heard about HIV/AIDS and STI.

Figure 5.8 Types of diseases affected by MSM:



Among the 73 respondents, 33% affected by Anal scar, 27% by itches/scabies, and rest 40% by anal bleeding.

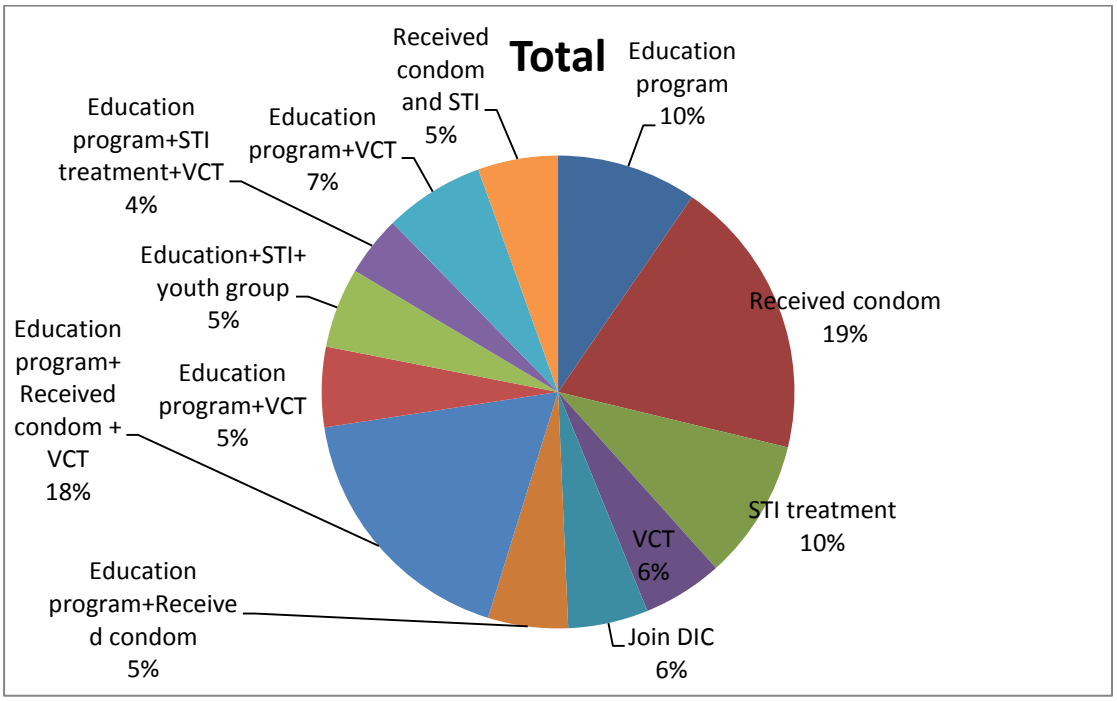
Figure 5.9 Health care providers where MSM used to go:



Among the number of 73 MSM people as respondents, 5% respondents used to take home treatment. 6% respondents used to go to the quack, 27% respondents used to go

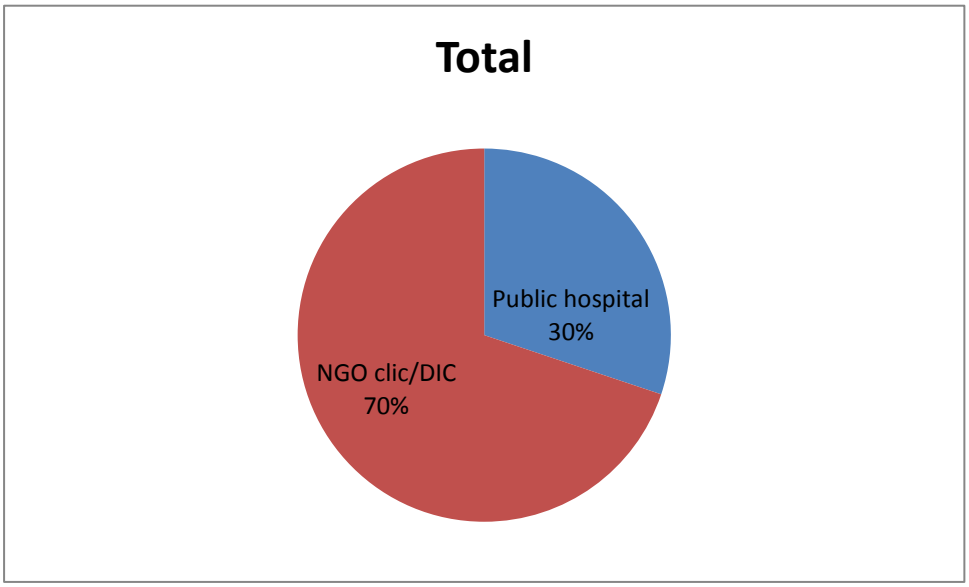
to the Kabiraj, 47% respondents used to go to the NGO clinic/DICs and rest 3% respondents used to go to the private clinic.

Figure 5.10 Participation of MSM in sexual health rights programs:



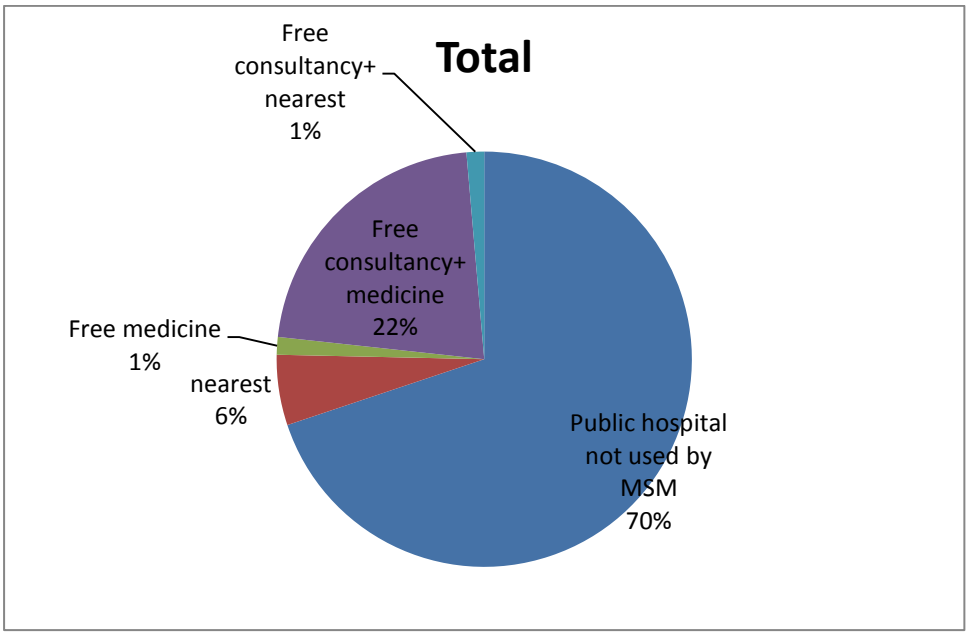
Among the 73 MSM people as respondents 10% respondents take part in education program, 19% respondents take part in receiving condoms, 10% respondents take part in receiving STI treatment, 6% respondents take part in VCT program, 5% respondents take part in education program and receive condom, 5% respondents take part in education and VCT program, 5% respondents take part in education, STI and Youth group program, 4% respondents take part in education, STI and VCT program, 7% respondents take part in education and VCT program and rest 5% respondents take part in condom and STI program. In this chart, it can be noticed that most of the respondents take part in education program, receive condom and STI treatment.

Figure 5.11 Nature of Health care centers used by MSM:



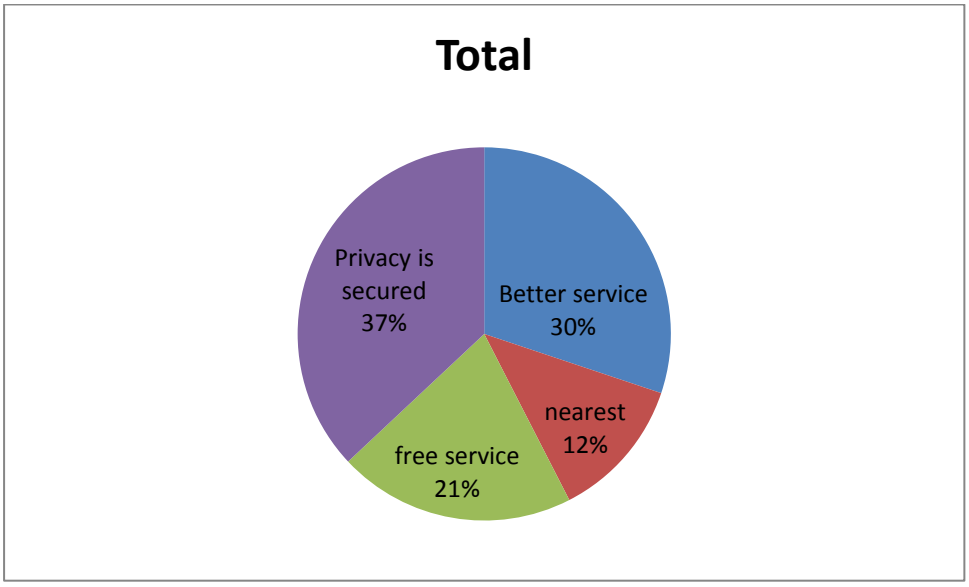
There are two types of health care centers which are used by the respondents. Among the 73 MSM people as respondents 30% are used to go to the public hospital and most of the respondents, approximately 70% are used to go to the NGO clinic or DICs.

Figure 5.12 Reasons to go to the public hospitals:



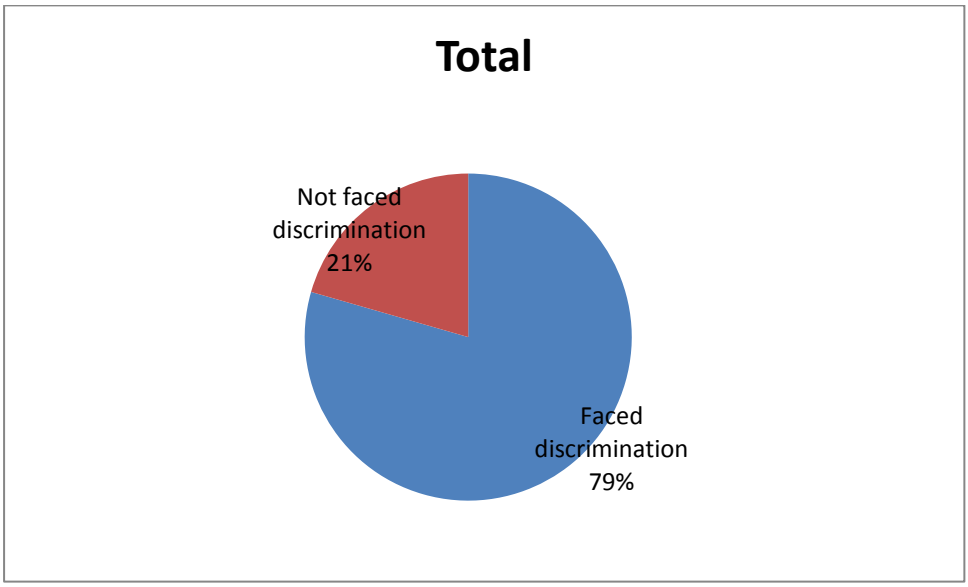
In this section respondents were asked that why are they go to the public hospitals. 6% respondents replied that they go for reason of nearest in distance, 1% respondents replied that they go because of free medicine, 22% respondents replied that they go for free consultancy and medicine, 1% respondents replied that they go for free consultancy and nearest to them in distance.

Figure 5.13 Reasons to go to the NGO clinic/DIC:



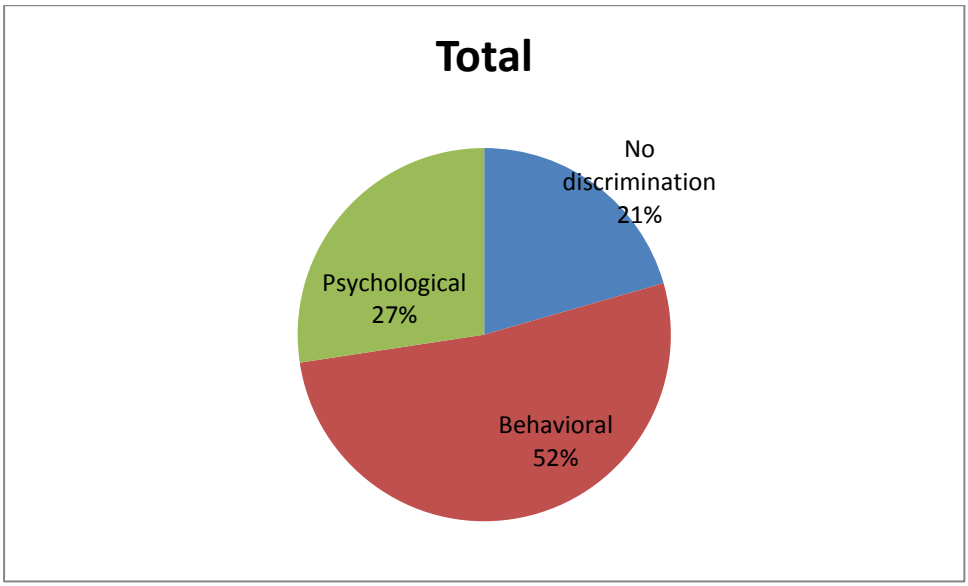
In this section respondents were asked that why are they go to the NGO clinic/DIC 12% replied that they go for the reason of nearest in distance, 21% respondents replied that they go because of free service, 37% respondents replied that they go to the NGO clinic/DIC as this is a place where their privacy is secured. 30% respondents replied that they go for better service.

Figure 5.14 Discrimination faced by MSM:



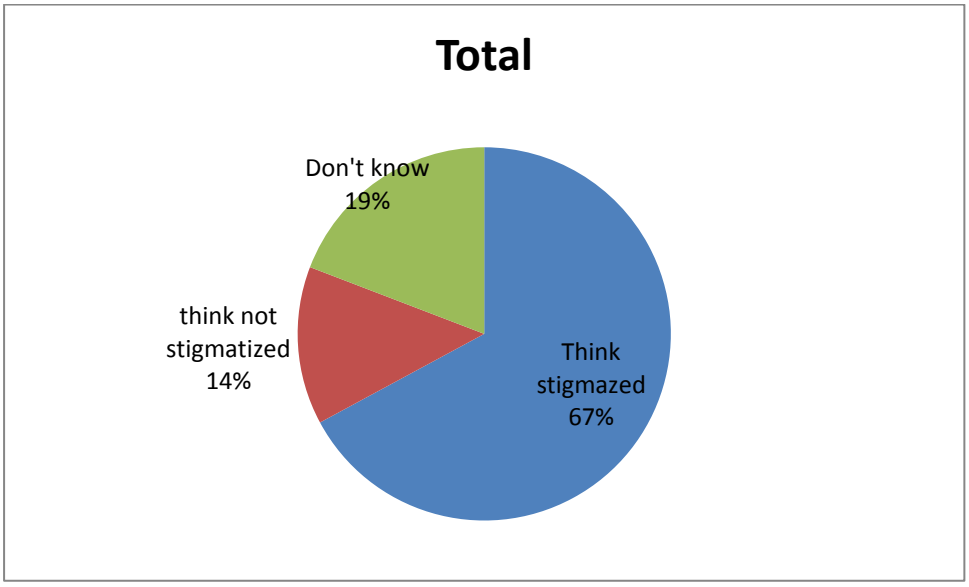
In replying the question of whether they face discrimination or not in receiving health care, 79% replied that they faced discrimination. Rest 21% of the respondents replied that they do not face discrimination in receiving healthcare.

Figure 5.15 Types of discrimination:



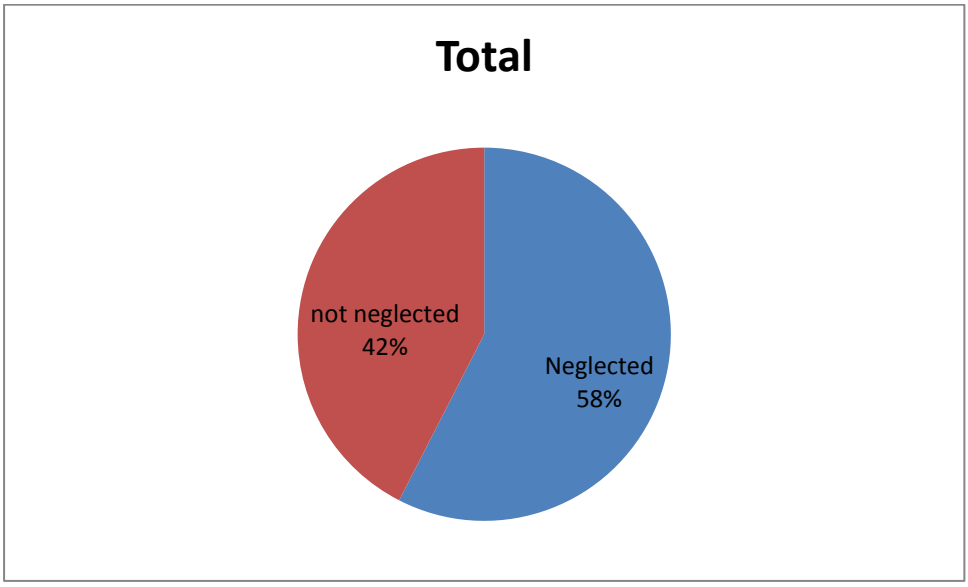
In answering about the types of discrimination which they faced, 52% replied that they faced behavioral discrimination and rest 27% replied that they faced psychological discrimination while receiving health care.

Figure 5.16 Perception of MSM whether they think themselves as stigmatized or Not:



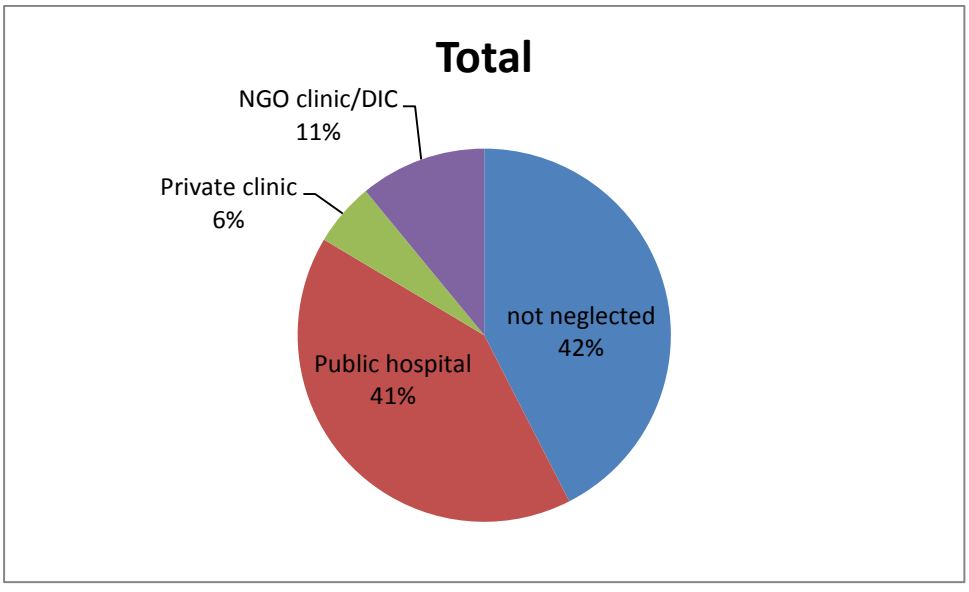
An important question was about their perception to be stigmatized or not. 67% respondents said, they think that they are stigmatized, 14% are not stigmatized. And rest 19% do not know whether they are stigmatized or not.

Figure 5.17 MSM people have has been Neglected or not to receive health Care:



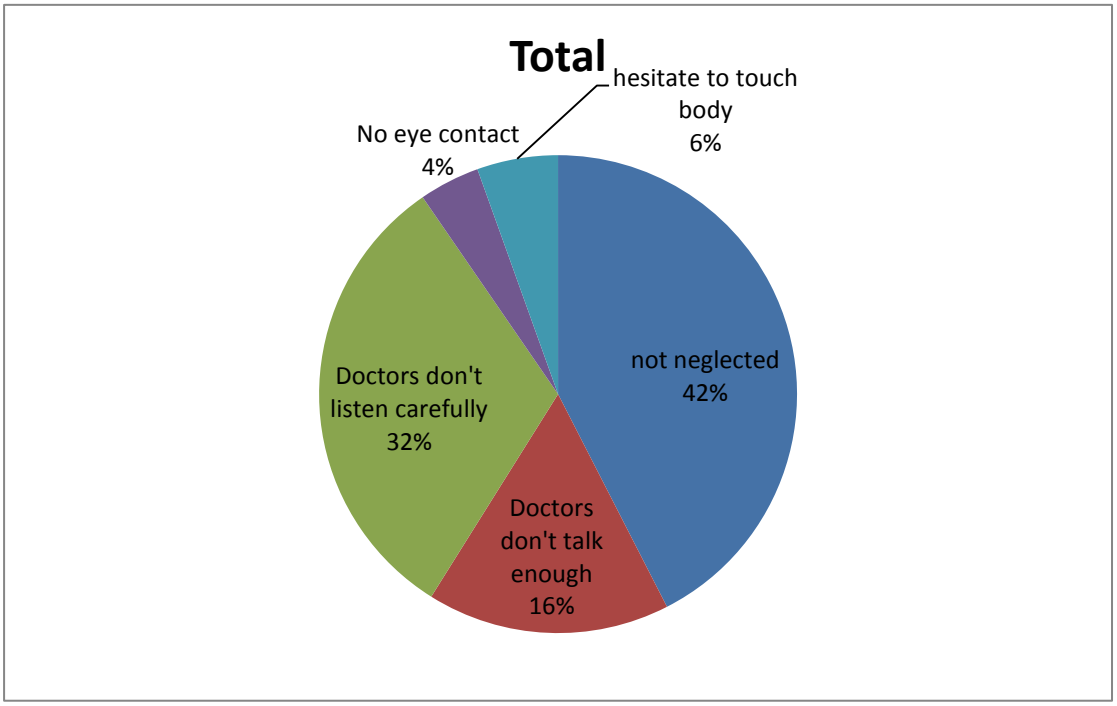
This show that 58% respondents have been neglected to receive health care and 42% respondent have not been neglected.

Figure 5.18 Institutions that neglected MSM to provide health care:



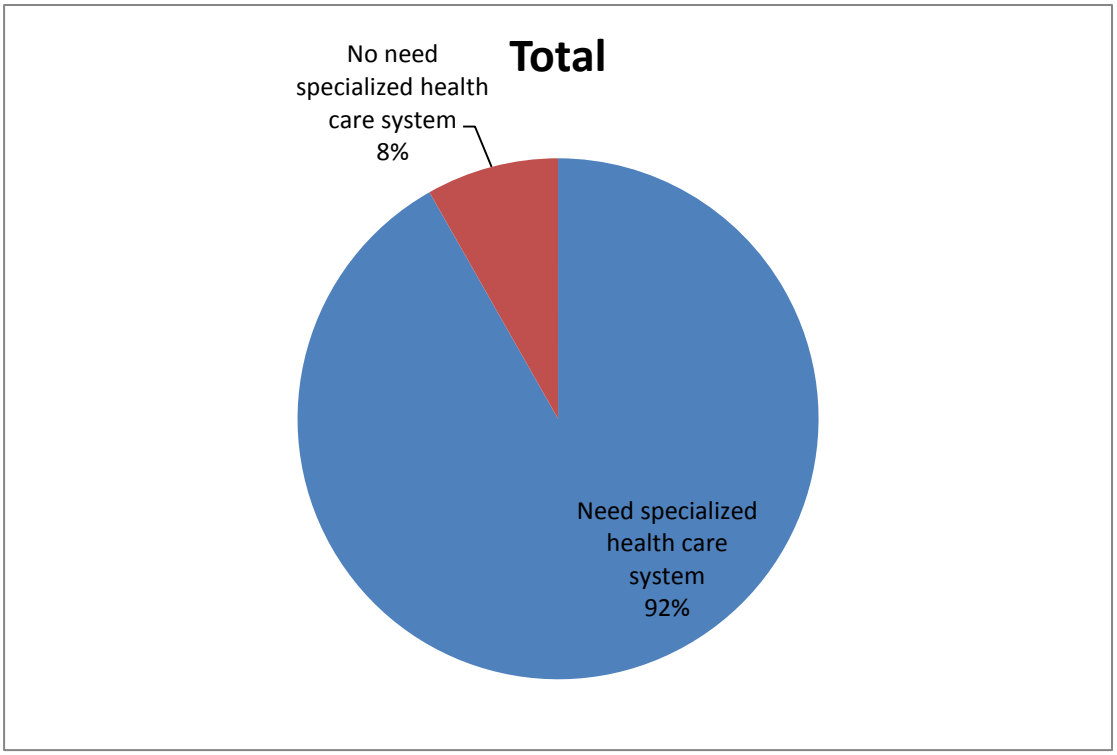
Among the 73 number respondents, 41% have been neglected in public hospitals, 6% have been neglected in private clinic and rest 11% respondents have been neglected in NGO clinic/DICs

Figure 5.19 Types of negligence:



In types of negligence, 16% respondents replied that doctors do not talk enough with them, 32% respondents replied that doctors so not listen them carefully, 4% replied that they have no eye contact with health care providers. Rest 6% respondents replied that the doctors hesitate to touch their body or infected organs in fear of infections.

Figure 5.20 Whether MSM people think of the need of specialized health care system for them or not:



In the answer of the question about the necessity of specialized health care for them, 92% respondents demanded specialized health care for them. Other 8% of the respondents did not see any necessity of the specialized health care for them. They think, normal health care service can meet their necessities.

Chapter Six: Discussion

Health care is the crucial issue all over the world. Especially in developing countries health care is out of reach for the minority groups. Even in developed countries, there is a lack of health care for the low income population. Unless health insurance is not ensured, there are no health care facilities. So health care is very important issue for analyzing the lives of people across the world.

Where there are constraints of health care service for the mainstream people, the health care for the men with experience sex with men (MSM) is out of question. In developed world, there are some LGBT rights programs, whose duty is the assure the rights of the LGBT people by arranging awareness programs, campaigns etc. but I developing countries like Bangladesh, there were constrains of arranging such kind of programs. As a result the issue of the health care service for MSM is under darkness. Bangladesh is a religiously rigid country, where Islam is the most practiced religion in this country. Islam has crucially banned the homosexual behaviors. So in Bangladesh the MSM people cannot upright their heads demanding their rights.

Culture is another factor which is the key role player in any sects of the society. Bangladesh has the traditional culture for thousand years which does not allow the homosexual behaviors. So, men with the experience sex with men (MSM) are the vulnerable group religiously and culturally in Bangladesh.

Stigma plays a vital role in hiding a very sensitive sexually minor group who are threat for the society. Threat is being used in the sense that, they are used to practice very risky behavior i.e. homosexuality. So, if they are not under observation, they can increase the health risk for the society of Bangladesh which is very alarming for the future generation. In this research, the researcher intended to identify the nature of

stigma which is preventing the MSM people from health care service, the types of stigma which are faced by MSM. Discrimination is another factor which also prevents the MSM people from the health care service. So stigma and discrimination are much related in this study. Nevertheless, the national health care policy towards the MSM is a significant element to find out the stigma and discrimination against men with the experience sex with men (MSM) in health care service.

In the light of collected data, the researcher is in a position of suggesting that the men with the experience sex with men (MSM) are vulnerable to in receiving health care system. As they are hidden population, they cannot express their MSM identity publicly, so they are not able to receive health care from public health care centers. 9f they express their MSM identity to the health care providers, they face misbehavior from them. So in fear of misbehavior, they do not uncover their MSM identity. As a result, they go to out of the mainstream health care service.

The most shocking matter is that the MSM people live with the 'normal' people. They have psychological, social, and sexual contact with the mainstream people. In this context, the normal as well as mainstream people are in the most risky conditions. Mainstream people or normal people can be affected by those MSM people who are affected by the sexually transmitted diseases (STI) or HIV/AIDS and other diseases.

An important issue of the health care related stigma is the religious norms and values in Bangladesh. As Bangladesh is a country of religious rigidity, there is a tendency of banning the homosexual people from the society. Sometimes MSM people are confined to four walls or neglected from the societal interactions.

On the other hand, other religions like Buddhism and Hinduism have banned the MSM people from the societal activities. So, MSM people are stigmatized religiously

from taking part in societal participations or interactions. This particular religious factor is responsible for stigmatizing the MSM people in health care service. So, the researcher intends to conclude the discussion by saying that

'we stigmatize the MSM people means we stigmatize ourselves'.

Chapter Seven: Conclusion and Recommendation:

Conclusion:

The purpose of this study was to reveal the stigma and their types which are dominantly related to the health care service among the men with the experience sex with men. Particularly, the researcher was interested to examine the existence of stigma and their depth. In Bangladesh, the men with the experience sex with men (MSM) are vulnerable to health risks. As they are stigmatized socially, culturally and religiously, they are going to the underground. If, mainstream people fail to trace them. They will lose the path of human development. Because, they are the part of human society. So to develop human index, MSM people have to count in making development policy. To concludes the study the researcher is very much optimistic about the process of lessening the stigma related to the health care service

Recommendation:

The research intends to recommend that, the study towards stigma related to the health care among the men with the experience sex with men (MSM) is very insufficient. The mainstream academic researchers should extend their field of study towards this type of study which will be helpful to the academic prosperity in this special kind of research field.

References

Allen, D.J., & Oleson, T. (1999). Shame and internalized homophobia in gay men, *Journal of Homosexuality, 37*(3), 33-43

Amadio, D.M.,& Chung, Y.B. (2004). Internalized homophobia and substance use Among lesbian, gay and bisexual persons, *Journal of Gay & Lesbian Social Services, 17*(1), 83-100

A Review of Human Development Consequences. UNDP Regional Centre in Colombo , p3.

Barret, R., & Barzan, R. (1996). Spiritual experiences of gay men and lesbians, *Counseling and Values, 41*(1), 4-15

Brown, L., Macintrye, K., & Trujillo. (2003). Interventions to reduce HIV/AIDS Stigma: What have we learned?, *AIDS Education and Prevention, 15*(1), 49 69

Brown, D., BeLue, R., & Airhihenbuwa, C. (2010). HIV and AIDS-related stigma in The 197 context of family support and race in South Africa, *Ethnicity & Health, 15*(5), 441-458.

Corrigan, P., & Matthews, A. (2003). Stigma and disclosure: Implications for coming Out of the closet, *Journal of Mental Health, 12*(3), 235-248.

Coyne, C., Demian, C., Randolph, M., & Friend, D. (2006). Social and cultural Factors in southern West Virginia: A qualitative study, *Preventing Chronic Disease, 3*(4), A124.

Davies, M. (2004). Correlates of negative attitudes toward gay men: Sexism, male Role norms, and male sexuality, *The Journal of Sex Research, 41*(3), 259-266.

DeJong, G.F., & Ford, T.R., (1965). Religious fundamentalism and denominational Preference in the southern Appalachian region, *Journal for the Scientific Study of Religion, 5*(1), 24-33.

Diaz, R.M., Ayala, G., Bein, E., Henne, J., & Marin, B.V. (2001). The impact of Homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 US cities, *American Journal of Public Health, 91*(6), 927-932.

Dooley, J. (2009). Negotiating stigma; lessons from the life stories of gay men, *Journal of Gay & Lesbian Social Services, 21*, 13-29.

Dorgan, H. (2006). Cultural traditions: Religion. In R. Abramson and J. Haskell (Eds.) *Encyclopedia of Appalachia*. Knoxville, TN: University of Tennessee Press

Duffy, L. (2004). Suffering, shame, and silence: The stigma of HIV/AIDS, *Journal of the Association of Nurses in AIDS Care, 16*(1), 13-20

Fortenberry, J.D., McFarlane, M., Bleakley, A., Bull, S., Fishbein, M., Grimley, D.M., Malotte, et al., (2002). Relationships of stigma and shame to gonorrhea and HIV screening, *American Journal of Public Health, 92*(3), 378-381.

Garcia, D.I., Gray-Stanley, J., & Ramirez-Valles, J. (2008). "The priest obviously doesn't know that I'm gay": The religious and spiritual journeys of Latino gay men, *Journal of Homosexuality, 55*(3), 411-436

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Harmondsworth: Penguin.

Greene, B. (2009). The use and abuse of religious beliefs in dividing and conquering between socially marginalized groups: The same-sex marriage debate, *American Psychologist, November, 64*(8), 698-709.

Ickovics, J., White, K., Stasko, E., Ghose, T. (2007). HIV Related Stigma and Discrimination in Asia.

Islam, M.T. et al. (2002). Knowledge on, and Attitude Toward, HIV/AIDS among

Staff of an International Organization in Bangladesh. ICDDR,B: Centre for Health and Population Research. *Journal of Health, Population, & Nutrition* , 20(3):271-2.

Morrison, K. (2006). "Breaking the Cycle: Stigma, Discrimination, Inter nal Stigma and HIV". Geneva:UNAIDS

UNAIDS(2007). Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes. A resource for national stakeholders in the HIV response. . http://data.unaids.org/pub/Report/2008/jc1420_stigma_discr_en.pdf

Appendix

Case studies:

Case study 1

Name: Rakib Uddin

Age: 27

Profession: Job holder

Educational qualification: HSC

Mr Rakib lives in a mess with friends for 2 years. He had migrated from village to Dhaka city with his family in 1996. He has 3 brothers and 2 sisters. He was used to live with family in Dhaka but he has started to live in a mess with friends for two years. Because of his MSM feelings he took this decision. At the age of 12 he was abused sexually by one of his relatives in their house. From that time he was used to have sexual relationship with that relative. He said that

"When my uncle pushed me I was aroused a special kind of feelings, from that time I was used to have anal sexual relationship with my uncle. He taught me how to have a sexual relationship"

Before two years ago his parents wanted him to get married. But he has no feelings towards female. He just wants to have sex with male. In this circumstance he left the house and started to live with friends in mess where he has a fixed male sexual partner that is called *Parik* in Khoti community. As he has only a fixed sexual partner he thinks he is quite safe from STIs and HIV/AIDS. Whenever he feels sick he goes to the hospital for general treatment. But while it is illness about sexual kind or disease

in sexual organs i.e. anal problem he goes to the DIC of BSWS. Because, once he went to the public hospital some years ago with anal problem, the doctor did not paid attention on him. The doctor was not sincere about the treatment as he is a MSM. He felt shame of doctor's behavior and stopped to go to the public hospital with sexual problems. As his anal problem is frequent he was eagerly waiting for a safe health care center. One day a friend of him suggested for going to the BSWS DIC for the treatment. And he found the place very sensitive about their treatment and privacy. He thinks that he is stigmatized of receiving health care in public hospitals. And Specialized health care service like DICs are very helpful for getting the health care for them.

Case study 2

Name: Al Amin

Age: 24

Profession: day laborer

Educational qualification: primary

Mr Amin is a day laborer in profession. He is a married person. He lives in near gabtoli with wife. The couple has no children. He got married one year ago with a girl chosen by his family. As he is a khoti in MSM community, he does not feel any attraction towards women mentally and sexually. But he had to get married with women as his family wishes that. As he stated

"I have no attraction to girls from my adolescence period. Since then I used to avoid girls. But now I am living with my wife."

As he is a MSM person, he has some exceptional disease that do not exists in other men, Such as bleeding and scar in anal. He went to a public hospital at the first time when he got affected with this type of disease. The doctor did not concentrate on his treatment as it was anal problem. So, he felt insult, from then he did not went to the public hospital for the treatment of this anal disease. He is now receiving treatment from Bandhu Social Welfare Society (BSWS) DIC as it is quite friendly to him.

Case study 3

Name: khairul Alam

Age: 19

Profession: RMG worker

Educational qualification: SSC

Mr khairul alam is a MSM who claim himself as a khoti in behavior. He lives with his family in Savar. He has a fixed partner which is called parik in MSM community. He used to have sex regularly with his parik. So he does not tensed about HIV/AIDS and other STIs. He believes his sexual partner (parik) so he does not care about using condom during sexual intercourse with his parik. He argued

"I have a parik who is all in my life; I love him like a girl does a boy. He is also cares on me. So I do not use condom during our sexual intercourse. I believe that, he does not go to any other women or khoti. So I am not feared about HIV/AIDS or STIs."

He often goes to the government hospital for receiving treatment. As he goes to the government hospital for general treatment, he does not face any kind of special discrimination of being MSM people. He receives lubricant and condom from NGO clinic when he needs of them.

Case study 4

Name: Mohi Uddin

Age: 25

Profession: Van driver

Educational qualification: can sign only

Mr Uddin lives in Mirpur with friend in a mess. He lives in a room of the mess with a friend who is his sexual partner. He used to have sexual intercourse with that partner. Though they are sexual partner but they are used to pay their own living cost individually. They are used to use condom during sexual intercourse in most of the time. Because Mr Uddin is aware about HIV/AIDS which he has learned from the education and awareness program. He goes to the BSWS DIC regularly to take part in education and recreational programs. He receives condom and lubricant to use. He does not go to the government hospital, because once upon a time he went to the government hospital with scar in anal, the doctor gave him just medicine for some days, after completing the provided medicine he went to the hospital again because of not curing the anal scar. The same doctor insulted him by hearing his sexual behavior. He said

"You people are the devils of world. You all will be cursed and will go to hell for your behavior. Do not come to me for this treatment again. Go to hell!."

The doctor was lost his temper, from that day Mr Uddin did not go to the government hospital with this anal problem. He found the Bandhu Social Welfare Society (BSWS) DIC later and used to receive the treatment regularly.

Case study 5

Name: Kamal Uddin

Age: 21

Profession: restaurant worker

Educational qualification: Primary

Mr kamal is the 2nd child of four children of his parents. He lives with his family near swamibag in old Dhaka. He is used to have sexual relationship with his friends. Though he lives with his family, he is used to pass night with his friends in the restaurant sometimes. But he claims that, he often have sexual intercourse with the restaurant owner. In exchange he gets extra benefit from his job giver. As a MSM, he is affected by STI, for example: he has scar in the anal. So he is used to go to the government hospital for the treatment. But the scar did not cured, so he went to the hospital several times, in this circumstances the doctor was bother on him. So he stopped of going to the hospital. At this stage the scar was spread over his body. So, he went to a private chamber of a doctor, where he had to paid a handsome amount of money to the doctor. But hearing his disease history, the doctor suggested him to abandon the MSM behavior. He did not take it positively. He argued that he is not able to give up the MSM practice.

Case study 6

Name: Sohrab Mia

Age: 29

Profession: MSW

Educational qualification: Primary

"When I was at the age 15, I had abandoned my family. Because, I know my family never ever will be able to recognize my sexual identity. So I did not want to embrace my family in front of society."

Mr Sohrab described himself by telling the above statement. In the adolescence period, when he was growing older he felt that he is not like other boys surrounding him. So, left his family with a hidden sadness in mind. Now he is Male sex worker, who is used to sell sex in the parks and hotels. As a male sex worker he is a most vulnerable MSM people. So he needs to go to the health care center for the VCT programs regularly. As a MSW he is known face among the people of his area, so he does not go to the nearest hospital, rather he goes to the DIC which is run Bandhu Social Welfare Society (BSWS). He does not feel any fear of his identity as it is a specialized health care center dedicated to the male with the experience sex with men (MSM).

Case study 7

Name: Mohammad Rokan

Age: 22

Profession: Student

Educational qualification: Alim equivalent to HSC

Mr Rokon is a student who is studying in the honors level in a Madrasha. He stays in the residential hostel of the madrasha. As he studies in a religious institution, he cannot go to the hospitals with his health problems which are related to the MSM behavior. So he is a vulnerable to the health problems especially sexual health. When he goes to the hospital he cannot consult with the doctor about his sexual health problems. Because he wears a religious dress which represents religious values, so feared of insult he cannot express his sexual identity. So he is used to go to the NGO clinic/ DIC for the treatment.

Case study 8

Name: Mahabub Hossen

Age: 25

Profession: job holder

Educational qualification: HSC

Mr Mahabub is a Job holder who is working in a company in Dhaka. He has wife and two children in the village. Due to the financial constraints he cannot go to village regularly rather he goes to the village once in a month. So he feels alone in Dhaka. As a human being, he is fond of having sexual affairs with women. But, as he cannot go to his wife regularly, he meets his sexual needs with male. Because he thinks, female sex workers are bearers of HIV/AIDS, so he do not go to the female sex worker. Rather he used to have sexual intercourse with male. As a result, he is habituated of having MSM behaviors. So these risky behaviors have led him to the STI patient. Of being a job holder, or of shame, he cannot go to the doctor for the treatment of STIs. So he thinks is stigmatized of receiving health care service from mainstream health care centers.

Questionnaire

Stigma and health care among the Men with the experience Sex with men in Dhaka city

Questionnaire for quantitative data collection through interview

This questionnaire is formulated only for the purpose of academic research. The provided information will be used only for academic purpose and confidentiality will be maintained. No name or Identity of the respondent will be disclosed.

1. Personal information			
Question no.	*Answer Options*	*Code*	*Skip*
Name			
1.1 Age			
1.2 Have you ever been to school?	Yes No	1 2 →	 1.4
1.3 What is your highest educational qualification?	Primary SSC HSC and above	1 2 3	
1.4 What is your religion?	Islam Hinduism Buddhism Christianity Others (specify)……	1 2 3 4 98	
1.5 Marital status	Unmarried Married Live together with man Live together with woman Divorced Widowed	1 2 3 4 5 6	

1.6 Do you have children?	Number of children		
1.7 With whom are you living now?	Parents Guardian (relatives) Guardian (non-relatives) Single With friends With wife With sexual partner With siblings	1 2 3 4 5 6 7 8	
1.8 How many members in your household?	Number		
1.9 How many years do you living in this area/city?	Exact year		
1.10 What is your profession?	Unemployed Student Rickshaw/van puller Law enforcing agency Job holder Businessman Day labourer RMG worker Driver (truck/heavy vehicles) Taxi driver Male Sex worker Others (specify)……	1 2 3 4 5 6 7 8 9 10 11 98	
2. Sexual behaviour and life styles related			
2.1 How you intend to identify yourself?	Male Khoti Panthi Parik Doparata Others(specify)……	1 2 3 4 5 98	

2.2 Have you ever have sex?	Yes No	1 2 →	 3.1
2.3 In which age you had sex?	Age		
2.4 Which gender was your first sexual partner?	Male Female	1 2	
2.5 How many *Male* sexual partners you had in last 12 months?	Numbers		
2.6 What is the average sex rate with your *male* sexual partner in a week?	Rate		
2.7 How many *female* sexual partners you had in last 12 months?	Numbers		
2.8 What is the average sex rate with your *female* sexual partner in a week?	Rate		
3. STI/HIV/AIDS knowledge and practice related			
3.1 Have you ever heard about STI/HIV/AIDS?	Yes No Don't know	1 2 → 99 →	 4.1 4.1
3.2 From where you have heard ?	Friends Family members Health worker/center Sexual partner NGO health center/DIC Peer educator Others (specify)……	1 2 3 4 5 6 98	
3.3 Do you think MSM practice is risky for HIV/AIDS	Yes No Don't know	1 2 99	
3.4 How much possibility of	Very high	1	

affecting by HIV/AIDS of yourself?	High A little No possibility Others(specify)……	2 3 4 98	
4. Health problems/diseases faced by MSMs and treatment related			
4.1 Do you face any special kind of desease as MSM practitioner?	Yes No Don't know	1 2 99	
4.2 What kind of desease you faced?	Urinal pain Emiting liquid from sex organ (not semen) Scar in the pennis Scar in the anal Swelling the groin Itches/ scabies Pimple/pustule Wart Bleeding from anal during sex others(specify)……	1 2 3 4 5 6 7 8 9 10 98	
4.3 What you have done while you faced above one of these diseases?	Took home treatment Went to the pharmacy Went to the quack Went to the kabiraj Went to the govt. hospital Went to the NGO clinic Went to the peer educator Went to the private clinic Took no treatment others(specify)……	1 2 3 4 5 6 7 8 9 98	
4.4 When did you go to the Doctors after facing problem?	Less than one week More than one week but less than one one month More than one month Others(specify)……	1 2 3 98	

4.5 How much money did you spend for the treatment?	Money in amount		
4.6 How much time did the doctor allocated forr your treatment?	Time in minutes		
4.7 Have you ever tested HIV/AIDS?	Yes No	1 2 →	 4.11
4.8 Did you get the result?	Yes No	1 2 →	 4.10
4.9 Did you share your result with anyone?	Yes No	1 2	
4.10 Do you think HIV test can be done with secrecy? (other than associated persons with test)	Yes No	1 2	
4.11 What measures do you take for avoiding STIs?	Do nothing Wash pennis with dettol Use condom always Use condom sometimes Take medicine Mouth sucking Thigh sex others(specify)……	1 2 3 4 5 6 7 98	
4.12 Have you ever participated in sexual and reproductive health rights program?	Yes No	1 2 →	 5.1
4.13 What kind of programs ?	Education program Received condom Received STI treatment Went to youth center Went to youth group program VCT program Went to DIC Others(specify)……	1 2 3 4 5 6 7 98	
5. Stigma and discrimination related			

5.1 Do you have medical access?	Yes No	1 2	
5.2 Have you ever gone to the government hospital to receive treatment?	Yes No	1 2	
5.3 Have you gone to the any hospital/clinic in last 12 months to receive treatment?	Yes No	1 2	
5.4 What types of hospital it is?	Government Private NGO clinic/DIC Others (specify)……	1 → 2 3 → 98	5.5 5.6
5.5 Why you have gone to government hospital? (*If 5.5 is applicable then go to 5.8)*	Free of consultancy cost Free medicine facilities Near to my residence Better service Privacy is secured Friendly behavior of doctors Others (specify)……	1 2 3 4 5 6 98	
5.6 Why you don't go to the public hospita?	Far away from my residence Poor service Doctors are not friendly Doctors inult me others(specify)……	1 2 3 4 98	
5.7 Why you have gone to NGO clinic/DIC?	Free of consultancy cost Free medicine facilities Near to my residence Better service Privacy is secured Friendly behavior of doctors Others(specify)……	1 2 3 4 5 6 98	
5.8 What types of	General treatment	1	

treatment/consultancy do you receive?	Family planning STI VCT HIV/AIDS Condom/lubricant Counselling others(specify)……	2 3 4 5 6 7 98	
5.9 Who provides you health care?	Doctor Nurse Clinic offiials Counsellor Peer educators Others (specify)……	1 2 3 4 5 98	
5.10 Have you ever faced discrimination due to MSM identity in receiving health care?	Yes No	1 2 →	 5.14
5.11 From where you have been discriminated?	Public hospital NGO clinic/DIC Private clinic Others (specify)……	1 2 3 98	
5.12 Who have discriminated you?	Doctor Nurse Clinic offiials Counsellor Peer educators Others (specify)……	1 2 3 4 5 98	
5.13 What types of discrimination it is?	Behavioral Physical Psychological Identical Others (specify)……	1 2 3 4 98	

5.14 Have you ever been tortured physically?	Yes No No answer	1 2 999	 → 5.16 → 5.16
5.15 Who have tortured you physically?	Family member/relatives (male) Family member/relatives (female) Boyfriend/girlfriend Male friend/familiar person Female friend/ familiar person Male teacher Female teacher Male health worker Female health worker Unknown male Unknown female Others (specify)…… No answer	1 2 3 4 5 6 7 8 9 10 11 98 999	
5.16 Have you ever been tortured sexually?	Yes No No answer	1 2 999	 → 5.18
5.17 Who have tortured you sexually?	Family member/relatives (male) Family member/relatives (female) Boyfriend/girlfriend Male friend/familiar person Female friend/ familiar person Male teacher Female teacher Male health worker Female health worker Unknown male Unknown female Others (specify)…… No answer	1 2 3 4 5 6 7 8 9 10 11 98 999	
5.18 Do you think that you are stigmatized in receiving health	Yes No	1 2	

care for being MSM?	Don't know	99	
5.19 have you ever been neglected to receive health care for being MSM?	Yes No No answer	1 2 → 5.23 999	
5.20 By whom you have been neglected to receive health care?	Doctor Nurse Clinic offiials Counsellor Peer educators Others (specify)……	1 2 3 4 5 98	
5.21 By which institution you have been neglected to receive health care?	Government hospital Private clinic NGO clinic/DIC Others (specify)……	1 2 3 98	
5.22 What type(s) of neglency was/were that/these?	Doctors don't talk enough Doctors don't listen carefully Have no eye contact Hesitate to touch my body/organs Underestimate me Discourage the MSM behavior Don't diagnose the disease, just give medicine Prohibit to come for consultancy Others (specify(……..	1 2 3 4 5 6 7 8 98	
5.23 Do you think MSM people need specialized health care system?	Yes No	1 2	
5.24 Why? (Explain the reasons)			
