Original Article

Community-based HIV prevention interventions that combat anti-gay stigma for men who have sex with men and for transgender women

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Abstract Men who have sex with men (MSM) have been disproportionately affected by HIV since the onset of the epidemic. Public health discourse about prevention has traditionally focused on individual risk behavior and less on the socio-structural factors that place MSM at increased risk of infection. Anti-gay bias and stigma are key structural drivers of HIV and must therefore be treated as a public health threat. Community-based prevention intervention programs that affirm the healthy formation of gay and transgender identities are strongly needed. Gay affirming school-based interventions and resiliency-focused social marketing campaigns have shown positive impact on health outcomes and should be implemented on a broader scale to challenge anti-gay stigma.
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Introduction

Since the onset of the HIV epidemic in the United States, gay and bisexual men, and other men who have sex with men (MSM), have experienced disproportionate rates of HIV infection. In 2010, the US Centers for Disease Control and Prevention (CDC) reported that MSM are at least 44 times more likely to contract HIV than heterosexual men.[1] In 2009, MSM comprised 64 per cent of all new HIV infections, and were the only

risk category of people in whom new infections were rising.[2] MSM only make up 2 per cent of the US adult population.[3] For MSM of color, the statistics are even more troubling: 42 per cent of new HIV diagnoses among MSM in the United States occur among Black MSM – even though Black MSM represent only about 0.25 per cent of the adult population.[1]

With infection rates on the rise despite the fact that most gay men practice safer sex[4] and are twice as likely as heterosexuals to report practicing safer sex,[5,6] structural drivers of HIV infection must be addressed. A key structural driver is anti-gay stigma. Rejection and social isolation from family and community experienced by MSM contribute to a host of negative health outcomes, including substance use and unprotected anal sex, both of which increase vulnerability to HIV infection.[7] Furthermore, violence driven by anti-gay bias creates hostile and unsafe environments and directly correlates with risky sexual behavior among young MSM.[8] The association of experiencing homophobia within the past year, and unprotected anal sex, has also been documented among Black MSM, indicating that 'homophobia may promote acquisition and transmission of HIV among Black MSM'.[9] Experiencing homophobia or racism within the past year has also been shown to correlate with unprotected receptive anal intercourse with a casual sex partner and binge drinking among Latino MSM.[10] Thus, anti-gay stigma must be treated as a public health threat.

To counter its pervasive and detrimental effects, community-based prevention interventions that reduce homophobia and affirm the healthy formation of gay and transgender identities are urgently needed. This article examines what has worked in community-level interventions (CLIs) and structural-level interventions (SLIs) targeting MSM. It examines school-based interventions to reduce anti-gay discrimination, harassment, and social isolation; community-based social marketing campaigns that promote family acceptance and affirming images of Black and Latino gay men, and the need for an evidence-based intervention to promote family acceptance; interventions to promote community connectedness and social support among older gay men; and interventions to reduce structural drivers of vulnerability and prevent HIV among transgender women.

What Works in CLIs to Prevent HIV Infection

Historically, HIV prevention has focused primarily on individual risk behavior and less on the multi-faceted structural issues that enable the

spread of the virus among gay men.[11] The CDC describes CLIs as interventions 'intended to reduce the HIV risk of an entire community'. A CLI 'directly or indirectly influences the knowledge, attitudes, social norms, or behaviors of individuals in the targeted community … provides the intervention where individuals of the targeted community are likely to be; and … delivers the intervention broadly'.[12] SLIs 'address barriers beyond the individual, such as not having access to condoms. Structural-level interventions are particularly attractive in HIV prevention efforts because they are designed to address external factors that impact personal risk for HIV'.[13]

It is important to look at what has worked in CLIs and SLIs to prevent HIV infection. A meta-analysis of US and international condom distribution interventions based on 21 studies published from 1988 through 2007 found that interventions increasing the availability of or accessibility to condoms, and those that combined individual-level interventions, group-level interventions, or CLIs along with SLIs, were efficacious in increasing condom use.[14] However, none of the 21 studies reviewed targeted MSM.

A 2005 meta-analysis of randomized control trials (RCT) of CLIs aimed at preventing sexually transmitted infections (STIs) and HIV (with results published through 2003) found that only four CLIs that had been tested through RCTs proved effective.[15] One study involving improved syndromic treatment of STIs in Mwanza, Tanzania demonstrated a 38 per cent reduction in HIV incidence, and reductions in the incidence of some other STIs, but not in others.[16] Two CLIs not based on RCT also showed efficacy. A study with Thai military conscripts showed that a Thai government mandated 100 per cent-condom program for brothel-based commercial sex work correlated with a tenfold decrease in STIs and a fivefold decrease in HIV incidence after 2 years.[17] None of the CLIs reviewed in this meta-analysis focused on MSM.

However, CLIs have also been shown to be effective in significantly reducing HIV risk behavior among gay and bisexual men and other MSM. In 2008, the Cochrane Review, a systemic review of primary research in health care and health policy, found that community-level HIV interventions with MSM demonstrated great reductions in the number of episodes of or partners for unprotected anal sex, with reductions ranging from 40 per cent to 50 per cent.[18] Reduction in risk behaviors were greater in studies of MSM in which more than 25 per cent were non-gay identifying MSM, indicating that when reached, non-gay

identified MSM may be more responsive than gay-identified MSM to risk reduction efforts. Furthermore, studies with at least 90 per cent white non-Hispanic participants showed greater reductions in risk behavior, underscoring the need for effective interventions for MSM of color. Kelly, Amirkhanian, Seal *et al* further demonstrate the efficacy of community-based interventions, delivered by known or trusted peers, among MSM.[19]

Condom distribution in jails and prisons has been effective in reducing HIV transmission. Providing one condom per week to inmates in the Los Angeles men's County Jail MSM unit prevented one quarter of HIV transmissions.[20] Researchers predicted that allowing inmates more than one condom per week could increase the program's effectiveness.

In summary, CLIs in a variety of national and institutional settings have been shown to be effective in increasing condom use, reducing STI infections, reducing unprotected sex and other sexual risk behavior, and reducing alcohol use. However, these studies overwhelmingly involved heterosexuals, underscoring the need to develop, implement, evaluate, and replicate[21] CLIs that target the specific needs of MSM of all races and age cohorts.

Alleviating anti-gay stigma should not rest solely on the self-efficacy of gay and bisexual men. Though addressing internalized homophobia among MSM is important in validating self-worth and decreasing risky behavior, pervasive structural homophobia, enforced largely by cultural norms, must also be challenged. Members of the broader community must be targeted in order for cultural norms related to sexual orientation and gender identity to evolve.

The balance of this article will outline community-based HIV prevention approaches addressing anti-gay stigma currently being utilized in the field, often with little or no funding.

School-based Interventions

Anti-gay bias and homophobia are rampant in schools across the nation. Recent media attention surrounding a spate of suicides by young gay men in 2010 demonstrates the threat of violence and harassment many lesbian, gay, bisexual, and transgender (LGBT) students experience at school. As a result, many feel unsafe and report higher rates of social isolation, depression, suicidal ideation, and unprotected sex.[22] Lesbian, gay, and bisexual (LGB) youth who experienced three or more incidents of harassment within the preceding year engaged in behaviors that put

their health at risk at a higher rate than their heterosexual peers who were also harassed.[23]

Gay-affirming interventions that combat bias are emerging in public schools across the country. Among these interventions are Gay Straight Alliances (GSAs), non-discrimination policies, anti-bullying curricula, and curricula designed to provide positive and inclusive examples of the contributions that LGBT people have made to US and world culture. Nationally, GSAs are the most widely adopted school-based intervention. Four thousand GSAs are currently registered throughout the United States. GSAs bring together students, faculty, and school staff to end homophobia in their schools.[24] GSAs are typically student-initiated and offer LGBT students, those questioning their identity, and straight allies, counseling and support. They create a 'safe' space where students can gather to discuss issues related to sexuality and gender identity.[25] Through participation in GSA activities, students are able to make friends without hiding their sexual orientation or gender identity, helping them to develop important social skills and self-esteem. Even students who do not actively participate in GSAs benefit from their presence. One study found that in schools with GSAs, 35 per cent of students said gay, lesbian, and bisexual students could safely choose to be open about their sexuality. In schools without GSAs, only 12 per cent said students could safely identify as openly lesbian, gay, or bisexual.[26] A study with Salt Lake City students found that following their involvement in the GSA, they reported an improved sense of physical safety and sense of belonging to the school community. They also reported improved relationships with their families, developing a higher comfort level with their own sexual orientation, learning strategies for dealing with others' presumptions about their sexuality, and feeling better about their ability to contribute to society.[27]

Data from the Massachusetts Youth Risk Behavior Survey show that young gay and bisexual men at schools with GSAs are less likely to have unprotected sex, a key HIV risk factor.[28] Clearly school-based interventions such as GSAs can help young people affirm and cultivate a healthy gay identity, thereby supporting resiliency and reductions in HIV risk behavior.

Family Acceptance of Gay and Bisexual Identities

The greater the extent to which one experiences family rejection because of one's sexuality during adolescence, the poorer the health outcomes for

LGB young adults.[7] In addition to experiencing higher rates of substance use, depression, and attempted suicide, LGB youth rejected by their families were 3.4 times more likely to report having engaged in unprotected sexual intercourse, compared with peers who reported little to no experiences of family rejection.[7] For this reason, parental acceptance of gay and bisexual sons is central to preventing HIV.

An intervention to promote family acceptance of LGBT youth at a community level is needed to have population-level impact. The US National Institute of Mental Health (NIMH) recently solicited research on 'interventions to decrease homophobia … in families, communities, and medical settings'.[29] However, none of the six studies funded addresses family acceptance. NIMH or the US National Institute of Child Health and Human Development should issue a request for proposals for the development of a family acceptance intervention to reduce family rejection of LGBT youth.

One community-level approach to promoting family acceptance is social marketing. Gay Men's Health Crisis (GMHC), a New York City-based HIV/AIDS service provider, has implemented a series of social marketing campaigns that draw on a strength-based intervention model to combat anti-gay bias. Strength-based, or resiliency-based, campaigns show great efficacy in changing an individual's behavior.[30] Behavior modification can be catalyzed by strength-based messaging that emphasizes not what is wrong, but what is helpful and achievable by an individual. Messages emphasizing what could be gained from preventive efforts, such as using sunscreen (in a 1999 American Cancer Society study), showed greater impact in both the awareness of health benefits and the actions taken to increase them.[31] Similarly, another study showed that the likelihood of taking preventive measures, as opposed to simply detective measures for breast cancer, significantly increased with positive messaging.[32]

In 2008 GMHC implemented a campaign titled 'My Son is My Life', modeling behavior in which a Black father supports his gay son. Informational palm cards and ads in print media and on bus shelters highlighted reactions parents can have upon learning their son is gay, and illustrated steps parents can take to provide support and love. The image on the palm card read 'I know he is gay, and I don't always understand, but that doesn't change my love for him'.

Another campaign that ran in 1000 subway trains and 150 subway stations in New York City in 2010 promoted positive, strength-based

images of Black and Latino gay men. The campaign, titled 'I Love My Boo', depicted young Black and Latino men in loving, affectionate embraces in public settings – a portrayal of gay men of color rarely seen in mainstream media – and encouraged gay men to aspire to committed, long-term relationships, and to counter anti-gay stigma. The images featured the taglines 'We're about trust, respect and commitment', and 'We're PROUD of who we are and how we LOVE'.

Strength-based messaging is an intentional decision to move away from fear-based messaging, which several studies confirm is less effective in altering behavior. In fact, studies observing participants' response to fear messaging showed higher levels of anger, sadness,[33] depressed mood, deflection of anxiety onto other groups, and less ability to practice safe behaviors.[34] Thus, best practice in shaping public health campaigns should be to avoid fear-based tactics, and use strength-based methods that affirm self-agency of the targeted group.

Resiliency in Community Connectedness – Including for Middle Age and Older Gay Men

Connectedness to LGBT communities is an important coping resource for LGBT people that provides non-stigmatizing environments and affirms positive self-appraisals.[35] Community connectedness – including supportive social relationships – has also proven protective against HIV infection.[36] Greater community involvement counters the negative effects of anti-gay bias on sex practices among gay men by providing social support, enhancing feelings of self-efficacy and positive self-identity, and reinforcing peer norms supporting safer sex practices.[37]

As the HIV-positive population in the United States ages, greater emphasis on HIV prevention among middle age and older adults is necessary. Data from the CDC show that most new infections among white gay and bisexual men occur among those aged 30–49.[38] Eleven per cent of new HIV infections in the United States from 2006 to 2009 occurred among people 50 and older.[2] Older gay men often experience declining self-esteem as they age. Some experience 'accelerated aging', the phenomenon of feeling older at an earlier age than one's chronological age.[39] This aging experience may present issues of social isolation for gay men over 40 who are single and equate physical attractiveness with youth. These men may put themselves at risk for HIV by meeting

anonymous partners on the Internet and coupling these experiences with alcohol and substance use.

Filling a gap for much needed HIV prevention services for middle age and older gay men, the Fenway Institute piloted a group intervention in 2008 to reduce HIV sexual risk, depression-related social withdrawal, and anxiety-related social avoidance in gay and bisexual men aged 40 years and older. The intervention brought together racially diverse groups of gay men, ranging from 49 to 71 years of age to socialize and discuss topics like safer sex. Men who participated in the intervention reported a significant decrease in depressive symptoms as well as a significant increase in condom use self-efficacy.[40] Importantly, the intervention also helped socially isolated older gay men develop social support networks, a critical resiliency factor against HIV.

Transgender Women and HIV

Transgender women are a historically underserved and economically marginalized population that demonstrates high vulnerability to HIV infection owing to a host of socio-economic factors. Transgender is an umbrella term used to describe individuals whose gender identity and expression do not conform to societal norms and expectations traditionally attributed to the gender assigned at birth.[41] Transgender women are people who express their gender as female though biologically born male. Currently, there are no national data on transgender women and HIV. Until 2011, CDC recorded HIV incidence and prevalence among transgender women within the MSM risk category. Thus, the full extent of the HIV epidemic among this population is unknown. However, independent studies report transgender women are among the most vulnerable to HIV infection; the CDC began to revise its data collection system in 2011 to start tracking new HIV infections among transgender people.[42]

Like gay men, transgender women experience pervasive stigma and discrimination that increases their risk for HIV infection. Addressing HIV among transgender women requires culturally competent and effective HIV prevention campaigns. A 2008 GMHC campaign in New York City, titled 'I know my rights … Do you?', focused on expanding transgender women's access to public accommodations by explaining a local nondiscrimination ordinance (2002) covering gender identity. Palm cards featuring young, transgender women of color as models with text based on interviews and focus groups, addressed access to health care,

homeless shelters, and employment, as well as how to effectively self-advocate in the event of discrimination.

Creation of behavioral interventions developed with and by transgender women is also necessary. Children's Hospital in Chicago and the Fenway Institute in Boston are currently funded by the National Institutes of Mental Health to test the efficacy of a behavioral intervention developed by and for young transgender women ages 16–29. Nearly 400 young transgender women are being recruited in Boston and Chicago for the project.[43] In addition, the Center of Excellence for Transgender Health at the University of California at San Francisco has adapted the CDC's SISTA intervention (Sisters Informing Sisters on Topics about AIDS) for transgender women.[44]

Conclusion

The disproportionate burden of HIV among gay and bisexual men, as well as transgender women, makes it vital for US health departments and other social institutions to combat anti-gay bias as a public health threat, and to develop interventions that reduce experiences of homophobia. These include: school-based initiatives that affirm LGBT youth; social marketing campaigns and other interventions that promote family acceptance and reduce social isolation of LGBT youth; interventions that promote community connectedness and social support, especially for older gay men; and interventions that reduce transgender women's vulnerability to HIV. Effective LGBT-affirming CLIs should be developed, implemented, evaluated, and replicated on a broad scale to challenge anti-gay stigma and social isolation, and promote the health and well-being of gay and bisexual men and transgender women.

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Editorial Note

Programs in the US and those abroad that seek funds from the US Centers for Disease Control an Prevention (CDC) and the primary source of US foreign aid for HIV/AIDS (Pepfar) face problems when they try to help protect men who have sex with men and transgendered women from discrimination – discrimination that increases vulnerability to HIV infection. One set is addressed in this paper, and another in the 33.4.[1]

Cahill *et al* in this issue describe the need to *design* more community level interventions to protect men who have sex with men and transgendered women from discrimination that puts them at higher risk for HIV infection – especially those among racial or ethnic minorities.

Sergut Wolde-Johannes reports that even community level interventions already designed and implemented must meet the US agency standard of being 'evidenced based' – incorporating only protocols and strategies that have been rigorously empirically studied and found effective – if they are to be eligible for funding from the main sources.

Readers of Cahill *et al* – will appreciate Wolde-Yohannes for her nuanced picture of the dilemma, how to get beyond the lack of programs for populations at particularly high risk in the United States, Africa, and elsewhere(where US funding is important) – to effective programs that are implemented at the scale needed to turn the tide of HIV infections.

Phyllis Freeman, Co-Editor

[1]Wolde-Yohannes, S. (2012) Persisting failure to protect populations at risk from HIV transmission: African American women in the United States (US) *Journal of Public Health Policy* 33(3): 325-336.