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Risk practices of HIV in men who have sex with men are gender practices. A training of health professionals in a transcultural perspective.

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Abstract

Relations between men who have sex with men (MSM) are power relations between different masculinities. A qualitative study with health professionals assisting MSM looked into HIV prevention in Spain. Barriers were observed in the HIV test at three levels: institutions, social and individual. Deficiencies appeared in public policies: lack of knowledge about MSM realities; lack of tools to assist diversity by health professionals; stigma and prejudice; difficulties to access health. Migration, poverty and vulnerability influence MSM health and the presence of risk practices. We suggest health professionals training in gender transcultural perspective integrated within educative programs to improve MSM's health.
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1. Introduction

In the last decade the incidence of infection by the human immunodeficiency virus (HIV) in men who have sex with men (MSM) has increased internationally (Likatavicius, 2008; Cañellas, 2000). This increase is also evident in Spain, being this group the most represented one among the new diagnoses and the only one with a rising trend

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(CNE[1], 2011-2012). The control of HIV transmission has been a challenge for the public health from the 80s and this situation requires questioning the factors present in the transmission risk practices in this collective and prevention strategies carried out. Different studies highlight the need to increase prevention of transmission among MSM, apart from identifying young people and migrants as the most vulnerable ones (Fernández-Dávila, 2011; Díaz, 2004). Foreign MSM in Spain are also the most vulnerable, specially those from Sub-Saharan Africa and Latin America (CNE, 2011). Different studies emphasize the need for changes in the lines of research to include these collectives, analyzing the reasons why MSM carry out risk practices of HIV transmission (Fernández-Dávila, 2009), the meanings of these practices (Parsons, 2007; Villaamil, 2008), as well as contextual and cultural aspects that may determine the carrying out of said practices (Berg, 2009; Adam, 2008). Thus, it is essential to analyze the sociocultural structures configuring the construction of identities as aspects that affect the daily decision-making process about carrying out risk practices. There already are available some studies including aspects of this identity construction (Yep, 2002; Carballo-Diéguez, 2009), but the situations of vulnerability some MSM groups find themselves in require a deeper and more specific analysis of these structures.

The model of hegemonic masculinity is a gender practice dynamically and culturally built (Connell, 2005) that legitimizes the patriarchy and world domination (Bourdieu, 2000; Connell, 2012; Butler, 2001). Relations between MSM are relations between several masculinities (Connell, 1992), are power relations that place people in a gender hierarchy where the hegemonic ideal is above, creating relationships of supremacy, subordination, competitiveness and marginalization (Connell, 2005). From this perspective, the question is whether risk practices of HIV transmission in MSM are determined by these power relations. Different works highlight aspects from the hegemonic masculinity model as factors of the execution of risk practices of HIV transmission in MSM. Among these aspects we find certain cultural norms evaluating positively traditional values of the masculinity in the case of black men (Millet, 2012; Fields, 2012); strategies to assert masculinity in Mexico (Kendall, 2007); the role of masculinity as an explanatory factor of the agreements to have sexual intercourse (Wheldon, 2010); social and ideological influences present in masculinity and heterosexism in prevention, as well as sexual and ethnic identity (Harper, 2007); reactions and responses to dominant images of masculinity (Wilson, 2010) and moreover gender ideas involved in the decision-making and how these can determine the ways the positions during anal sex are understood (Johns, 2012).

All these works relate aspects of the hegemonic masculinity model with the execution of high risk practices of HIV transmission in MSM. Therefore, this shows the need to do research focused on understanding specific contexts and power dynamics that appear in the relations of MSM. Thus, new needs are created and it is essential to identify and analyze them to provide health services suitable for current situations. There are works that have researched about these needs and have contributed to the widening of the field of study of MSM's health. After analyzing the sociocultural and economical characteristics, a project for the comprehensive care of MSM has been designed in Latin America and the Caribbean (OPS, 2010). Likewise, other organisms work internationally researching into areas such as legal, human rights and care needs, working globally (Ripley, 2010). Recently the World Health Organization has published a series of recommendations for the prevention and treatment of HIV infections, as well as other sexually transmitted infections among MSM and transgender people, aiming at providing tools to guide the response of health systems to the health needs of this collective (OPS, 2012). This work, that stems from the general principles of respect and protection of human rights, stresses the importance of researching these populations as well as analyzing the intervention being carried out that the moment globally. On the other hand, we have an international study that identified barriers in health care for MSM (Arreola, 2012; Dessai, 2013), directly related with health professionals, which shows some of the reasons why the transmission of the infection keeps increasing.

With this, it could be said that an integrated approach to care and health care for MSM presents new challenges for health professionals both at epistemological and educational levels (Gastaldo, 2009). Furthermore, the case of MSM and the most vulnerable MSM collectives, such as migrants, show the first lines of a new paradigm of care

[1] CNE: Centro Nacional de Epidemiología. Instituto de Salud Carlos III. Ministerio de Economía y Competitividad. Gobierno de España.

and health care, since including the vulnerability concept shows new needs and new ways of understanding health (Couto, 2010). The increase of new cases, when from health sciences there has been a great deal of work in prevention campaigns and education and care programs, and the appearance of these new demands related to health, both show us the need to change and look in other directions to improve care from the knowledge of the realities of those people being assisted. Training in gender perspective and from a transcultural point of view in health professionals (Fernández, 2006) will be needed to incorporate these realities and obtain the necessary tools to face these new challenges. This study hereby presented is part of a research where high risk practices of HIV transmission in MSM were analyzed from the perspective of the study of masculinities using the gender approach (Connell, 2012; Sabo, 2000).

2. Method and Aim

The aim of this study was to identify the shortage of preventive messages and the barriers in detecting the infection according to the perception of health professionals assisting MSM and experts in this area in a Spanish context. With this work we intend to give some ideas, from a transcultural point of view, to improve the response in the comprehensive care of the health of men who have sex with men. A qualitative study using the key informant technique was performed. Participants were selected according to their status as specialists and their role in the community, since they could offer privileged information according to the needs of the study, to be considered key informants (Burgess, 1983). Selection criteria include the knowledge and experience in HIV prevention in MSM at care level (public and private programs) and at theoretical political level, working in research and/or activists in lesbian, gay, bisexual, transsexual, transgender and queer groups. Eleven key informants from different Spanish cities were selected to be included in this study. We contacted individually with all the informants through the telephone, email or in person. Participants were informed about the research process, the anonymity of their answers and the aims of the study. Data collection was made through a self-administered questionnaire. Questions included in the questionnaire related to HIV prevention programs were: Who are the messages directed to? Who are included and excluded from these messages? What deficiencies do you identify in these messages? What do you consider the prevention campaigns need to be more effective? Regarding the HIV test, what barriers do you consider exist? How should the context of the test completion be in order to make it easier? For the data analysis the method used was the discourse analysis generated by the informants (Djik, 2005).

3. Results

3.1. HIV Prevention Campaigns in MSM. Messages and Deficiencies

Firstly, we need to emphasize that, except in particular situations, the informants resort to analyzing the general campaigns developed in the last years, showing the lack of specific campaigns addressed to MSM. This is the first result that stands out since when the informants were asked specifically about campaigns addressed to MSM, they mentioned general campaigns developed by institutions as a first reference. Here we find the first deficiency identified by the informants, heterocentrality and lack of specificity of prevention campaigns addressed to men who have sex with men. In this regard, it is observed the homogenizing tendency that the gender structure in our societies imposes not only individually but also institutionally and socially (Connell, 2012). These results agree with the idea that the gender model in our societies is determined by centrality in masculinity (Bourdieu, 2000) and heterosexuality (Butler, 2001). Masculinity may be understood as “the position in gender relationships, practices by which men and women commit to that gender position and the effect those practices have on body experience, personality and culture” (Connell, 2005:71). If we follow this idea, it can be observed that these positions go beyond individual and/or interpersonal practices, thus structuring positions at institutional and political levels and surely with consequences for health (Connell, 2012). Therefore, we can say that institutional decisions regarding HIV prevention in MSM are filtered by gender structure and, definitely resulting in the hegemonic masculinity model. The preventive messages from the campaigns speak to a general society, allegedly heterosexual, and in some cases, where non-heterosexual desire orientations are identified, these are understood homogeneously.

"I have always seen (campaign messages) informative regarding pointing out the virtues of the condom and unfortunately centered in heterosexuality" (Informant 4). "Institutional campaigns are addressed to "everyone" so nobody identifies with it. Then, one always thinks it is addressed to "the others", not oneself. Lately, there have been some addressed to the gay community" (Informant 2).

"Whenever there have been specific campaigns for fags, they have used strange references such as judge Grande Marlaska, so I doubt they are effective and I reiterate my astonishment to how the most vulgar media power relations prevail over the slightest common sense" (Informant 4).

Preventive campaigns addressed to MSM population have had an homogenizing line about ways to have sexual intercourse between men, allowing to make them visible as long as this refers to a hegemonic-normative gay identity (Guasch, 2006). Institutions have tried to have control over bodies and sexualities (Foucault, 2005) justifying themselves on naturalist assumptions and letting aside the social essence of sexuality (Butler, 2001; Foucault, 2005; Haraway, 1995). Thus, the positions regarding gender and masculinity certain men build and that are not normative, have been excluded, thereby losing possibilities to identify and connect with migrant men, men belonging to different cultures, men who do not identify themselves with this normative gay identity or non-homosexual men who have sex with other men.

"It is clear (...) that the main deficiency of these campaigns is reaching, if not most of the population at least a significant part which, beyond social conventions, can find themselves in this type of practice and will not have the preventive tools necessary if they did not identify themselves with the campaigns in the first place" (Informant 10).

So according to our informants, we can say that messages and information that preventive campaigns have been giving in the last year have been hardly specific. This fact has been identified by our informants as a deficiency to work on in order to improve and make campaigns more effective.

"Ministry campaigns try to include everyone but that is why the message is diluted and it reaches nobody. Nobody identifies themselves with it. The campaign 'Bears, protected species' worked better because it was addressed to a specific subculture with its own language, images, in their bars, webs, etc. People identified themselves with it and they became interested. The same could be done with immigrants, prostitutes, trans, leather, sauna flings,..." (Informant 2).

Informants report that specific campaigns have better results than general ones. If thanks to the advance, models related to transmission prevention have included new perspectives insisting more on risk behaviors than on risk groups, from what has been called anthropologic-cultural approach (Estrada, 2004), informants emphasize the idea that specific practices are not being considered and that the use of the condom as the only universal measure is being stressed without taking into account the specific characteristics of the different populations along with their language, expectations and motivations. Apart from heterocentrality and very little specificity, informants have provided specific deficiencies they have identified in preventive messages. One of the deficiencies they spotted was the lack of knowledge about the specific practices of MSM and the diversity of practices and of men. One of the messages the informants have reported is the universal use of condoms. They have also reported the tiredness and the lack of other preventive measures more in line with the meanings of sexual practices and the reasons why these are carried out. The analysis of the meanings of sexual practices among MSM in social interaction contexts sheds some light on the motivations and explanations of the protagonists about daily decisions regarding prevention (Villaamil, 2008).

"The risk of passive anal sex is not clearly explained, there are no explicit or specific references to anal sex" (Informant 2). "They don't talk clearly about practices which entail risk of HIV infection, they talk generally and don't cater for particularities" (Informant 5).

Recent studies about HIV transmission in MSM talk about how important it is to identify new sexual practices that involve some risk of transmission (Díaz, 2012; Parsons & Bimbi, 2007), some of them even include identity components, such as bareback (Berg, 2009), that are done intentionally. Regarding this lack of knowledge, the concealment of the realities of people who live with HIV has been highlighted in the informants' contributions. There is an evident smokescreen created in relation to the real problems seropositive people have; the consequences in their lives or their needs are not evident either, a fact that also allows some laxity regarding prevention strategies used by MSM (Fernández-Dávila, 2007). Some studies have emphasized that improving

treatments make easier the increase in risk practices (Marks, 1999). The distance with the reality of seropositive people seems to favor the increase of new diagnoses.

"Prevention campaigns have been very weak, with a superficial view, they should show problems seropositive people face, not only medical, but psychological or social too" (Informant 9). The concealment or shortage regarding the different realities of MSM appeared as well in relation with the ideas the informants gave about those being excluded from the preventive messages. "(Messages from preventive campaigns exclude) men who have not a clear homosexual identity but who have sex with other men; transsexual men; men who work as prostitutes having risk practices with other men, without identifying themselves as homosexuals"; "poor people, immigrants, women, gays in the closet and from isolated places or villages" (Informant 5 and Informant 2).

As we can see, migrants and their social and sexual realities are excluded from preventive messages. Migrant MSM and other collectives considered a minority, ultimately excluded, are not taken into account in the design of those campaigns. Economical and social inequalities of the migrants cause difficulties and deficiencies in their access to health and in the mobilization of resources, both personal and community, to improve their health. "Migration is a vulnerability factor since in relocating people can have risk behaviors, that is, sexual intercourse without protection, sometimes aggressive and forced, sometimes free and pleasant" (Núñez, 2011). Thus different scenarios are built and they make this sexual risk behavior easier. The political-economical model of HIV care in MSM developed at the end of the 90s (Estrada, 2004) considered the change "from individual risk to concepts such as social and individual vulnerability and social exclusion" (Estrada, 2004:116). The masculinities of migrant MSM can be understood as marginalized masculinities (Connell, 2005). Within the gender hierarchy that sets the relationships between masculinities, those of migrant MSM are on an inferior scale given their distance from the hegemonic masculinity model, making easier the risk practice of HIV transmission and exemplifying power and inequality relationships.

3.2. Barriers to HIV Detection in Men Who Have Sex With Men

Results related to the opinion of the key informants about these aspects were organized in three levels: institutional, individual and social. At institutional level, the lack of knowledge by the health systems about the social reality of MSM and the lack of tools to cater to affective-sexual diversity, were the main factors. All the informants agreed on pointing out the existence of these barriers. At individual level, appeared in general the specific ignorance of the infection, transmission, prevention and risk reduction strategies by the users. At this same level, the fear to the result of the test appeared significantly as a barrier that made difficult having the test. Specific individual situations found in the migration processes were also decisive in doing the HIV test. At social level, the stigma and prejudice of the possibility of seropositivity as a decisive barrier making difficult having the tests were also highlighted. At this level, the difficulties to access the health systems and places or sites where it is possible to do the test were also stressed.

4. Conclusions and Contributions

This paper has identified different deficiencies in the preventive messages of HIV prevention campaigns around us: heterocentrality and little specificity, ignorance about the specific practices of MSM and concealing the realities of those living with HIV. On the other hand, we have highlighted barriers to HIV detection in MSM individually, socially and institutionally. As it has been stated, the gender structure has a heterocentric and homogenizing base, therefore, campaigns, according to informants, have hardly been specific and have not worked correctly. Moreover, this lack of specificity has left aside vulnerable collectives such as migrant people. Institutional, social and individual barriers refer to the ignorance of MSM realities at the same levels. According to the gender approach (Connell, 2012), there are power relations in the relationships between men. These relationships are found in migration contexts since in many occasions there is no horizontality to negotiate preventive measures, appearing vulnerability situations. Furthermore, actions from institutions are "gender facts that produce effects on health transnationally although their mechanisms can be indirect" (Connell, 2012; 1681). Gender structure and its impositions reach the institutions which exercise power, showing a hierarchy where the

hegemonic masculinity model (Connell, 2005) is the pivoting axis where the health care, public campaigns and policies are structured over and that legitimizes the exclusion of minorities. For this reason, we consider it is essential to provide care and prevention tools based on health education from a gender perspective and originating from specific situations given in migration contexts. Therefore, it seems necessary to break the institutional barriers detected in this study and in others (OPS, 2010) and to take into account the importance of community involvement in the design of HIV prevention campaigns in MSM. The community focus allows to know the real needs of MSM, the existing resources and the best optimization for their use, the meanings given to practices considered risk practices and demands from sectors, not only normative, but also paying attention to a diversity of situations and contexts such as migratory movements. With this study we suggest adding different skills to the training of health professionals that can provide them with the necessary competences to ensure a comprehensive attention to MSM, carrying out and designing prevention and health education actions from a gender perspective and with a transcultural approach. The conception of sexuality in transnational perspective (Kaplan & Grewal, 2001), identifying and analyzing sociocultural implications about health locally and globally, must be added to the educative discourse for health professionals. Hereby we propose a new line of research where studies providing tools to add these competences to degree and continuous training syllabuses of health agents are developed. According to the results of this study, some working areas to develop these competences could be: knowledge and respect for the affective-sexual diversity; knowledge about the stigma and its relationship with care and health care from an anthropological, sociocultural approach; learning about the analysis of experiences and subjectivities as aspects shaping health and risk practices, as well as decision-taking regarding health; acquiring skills of care personalization, such as offering alternatives, strategies for risk reduction, specific prevention according to the context of each user and lastly learning how to identify the population with a specific vulnerability, such as migrants. We are aware of the need for further research in this line, as well as the creation of teaching guides specifying the inclusion of these skills in their syllabuses, from a gender perspective and with a transcultural approach.

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