HEALTH AND SEXUAL RIGHTS

HIGHLIGHTS FROM THE 7TH

BC GAY MEN'S HEALTH SUMMIT

HELD IN VANCOUVER, BC, ON NOVEMBER 3 & 4, 2011

"EQUITY OF SEXUAL EXPRESSION WILL BE ACHIEVED, NOT FROM AN ENFORCED RIGHT, BUT WHEN IT IS PERCEIVED AS THE RIGHT THING TO DO"

—Terry Trussler, Community Based Research Centre

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The 7th BC Gay Men's Health Summit was held November 3 & 4, 2011. These highlights summarize theme presentations by Terry Trussler, Ilan Meyer, Barry Adam, Rocky James, Cindy Patton and Olivier Ferlatte.

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SUMMIT gay men's health

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CREDITS

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GAY HEALTH AND ~~SEXUAL~~ HUMAN RIGHTS

TERRY TRUSSLER, COMMUNITY-BASED RESEARCH CENTRE

The theme of this Summit is 'Gay Health and Sexual Rights.' In Canada, we have a paradox. We have protections under the Charter of Rights and Freedoms, but in most of our streets and communities we lack genuine freedom of sexual expression without the potential for violence. We still endure denial, abuse and neglect even with legal protections. Many of us still have to contend with bullying in everyday environments like schools and workplaces.

For most of us, freedom of sexual expression is ghettoized in islands of acceptance. While it is true gay men have come far in recent years, we are chilled by the rash of suicides among gay youth in schools and universities. What do these suicides have to tell us about the real state of gay men's health?

We have to see ourselves in comparison with other societies and countries to recognize our relative circumstance – how far we've actually come. Vice squads and mass arrests have long gone here, but Iran still has Morality Police. Yet, even with state oppression, millions and millions around the world are exercising sexual rights in ways no one would-have dreamed in the 1950s. We are part of that.

This year's Summit will continue to provoke our thinking about the multi-faceted and complex nature of gay men's health. As in previous years, intersectionality will challenge the categorical thinking that has pervaded the field. For instance, intersectionality has helped us note how the widespread use of the label MSM (men who have sex with men) in public health, negates the agency of gay men as a social group. We are not just a problematized sexual behaviour. Our growing understanding of how health determinants affect us suggests there is much more than sexual risk behind gay men's massive inequities in the HIV epidemic.

We have to agree with critics of the gay health project that the cure for such inequities lies beyond the scope of health action by itself. We have to change society, not gay men, to improve gay health. To see this we need to move upstream from health problems like HIV, bullying, and suicide, or even remedial health services. When we see how much gay health is determined by gender order, the need for social change to bring gay health into being will become all the more apparent. We need to work on social justice to achieve health ends, and this year's theme will provide a lens to help us see how to achieve that.

THE HEALTH CONSEQUENCES OF ANTIGAY PREJUDICE:

COMPARING MEN EXPOSED TO VERBAL AND PHYSICAL VIOLENCE (BULLYING) VS. THOSE UNEXPOSED.

	BULLIED	NOT BULLIED
Suicidality	64%	34%
Depression	41%	21%
Excess Substances	35%	22%

MINORITY STRESS AND THE HEALTH OF SEXUAL MINORITIES

ILAN MEYER, THE WILLIAMS INSTITUTE, UCLA SCHOOL OF LAW

"What do you think your life would be like without homophobia, racism and sexism?"

The basic premise of minority stress is that prejudice, stigma, and discrimination directed toward members of disadvantaged groups—like sexual minorities—causes adverse health outcomes including mental disorders.

Everybody has stress, but, to what extent do some groups of people experience more than others? In epidemiological terms, stress is socially distributed and socially determined. People don't stress randomly, it comes from circumstance, and some people experience more than others because of their social situation. There is overwhelming evidence, for example, that because of discrimination, LGB populations are at excess risk for mental disorders like anxiety, depression and substance abuse.

Minority stress occurs in two main ways. Structural stressors in the environment emerge from laws and regulations. Marriage equality, for instance, is really about equalizing human rights and eliminating structural discrimination. Marriage laws that treat gay relationships differently than heterosexual relationships are a stigma that has been entrenched in the social structures of most countries.

Another type of stress is enacted interpersonally in one-on-one and group situations. Interpersonal stress becomes enacted with major life events, like being fired from a job or not being able to visit your partner in the hospital. But minor events like small but daily reminders of your stigmatized social status can be very impactful, especially if they affect the core of your being like your sexual identity.

Something as trivial as seeing marital status on a form can remind you of years of rejection and discrimination, symbolically represented by a check box. If you write in "domestic partner" you may have to provide an explanation and "come out".

Nonevents can be stressful too: things that don't happen that you anticipate might happen. A lost opportunity in which you didn't get to do what you would have: a career choice, or skipping family functions to mitigate awkwardness. Safety as you walk down the street holding hands with your same sex partner. Nothing has to happen to trigger a stress response beyond heightened vigilance. People in a minority position feel pressure to self-monitor their performance, to make sure they're being appropriate. This is what Freud called using the 'third eye'. Seemingly nothing is going on, but you feel you have to be vigilant.

Sometimes people may not disclose their sexual orientation because the social environment is not welcoming. They could be fired, for example. Those who internalize this discrimination experience stress. Concealing your sexual orientation is a coping mechanism. It can have damaging effects like anxiety, but it can also protect you from violence.

Intersections with different subgroups need more study. Do "double jeopardy" stressors related to both homophobia and racism, for instance, increase mental disorders? Surprisingly, LGB African Americans have fewer mental disorders than Caucasians, and Latinos have about the same as Caucasians. Although this is inconsistent with minority stress hypotheses, it is similar to the general American population. African Americans have more discrimination because of racism, but they actually have fewer disorders than Caucasians. And yet, African Americans and Latinos have more suicide attempts.

How do we think about minority stress theory in a world where, in fact, there has been evolutionary change? Some people argue that we are in a "postgay" world where "you're just like everybody else". On the contrary, minority stress research suggests that "coming out" is still a crucial period. Gay youth are coming out at earlier ages. On one hand it's wonderful, but on the other, it can be dangerous because they are subject to more harassment, violence and rejection from their families. Younger cohorts of LGB populations currently have fewer suicide attempts than older cohorts, but LGB youth still have much higher suicide rates than straight youth.

Certainly, there are areas within minority stress theory that need more investigation. For instance, how does our understanding of the causal mechanisms underlying minority stress inform prevention and intervention? We still need both upstream and downstream interventions to address minority stress. While we can be optimistic about societal changes that have happened, and we are on the path to bigger and better things, we can't close shop now. We must remain vigilant.

For more information: Meyer, I. (2003) Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. Psychological Bulletin, 129:5 674-697.

THE BIOMEDICAL AND THE SOCIAL IN HIV PREVENTION

BARRY ADAM, UNIVERSITY OF WINDSOR ONTARIO HIV TREATMENT NETWORK

There are a lot of actors, organizations and dollars in the field of HIV around the world. By examining the field's social organization we can see how its order affects both its knowledge production and the outcomes of its efforts.

In the Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, the people most impacted by HIV receive the smallest amount of funding. MSM, for example, receive only 2.1% of the total budget of over $900 million.

Here in Canada, only 9.7% of the Canadian Institutes of Health Research (CIHR) grants for HIV prevention research have concerned MSM. This in a country where 51% of the epidemic is concentrated among gay and bisexual men.

At the last 5 international AIDS conferences, 13 of 21 speakers treated prevention primarily or exclusively as a biomedical technology. Only 1 of the 21 speakers mentioned MSM.

These findings trace how research funds are being allocated and thus how knowledge development is being prioritized. Not surprisingly, biomedical conceptions of HIV seem to always lead to biomedical solutions.

When findings from science are translated into everyday practice, however, they become troublesome because real people don't fit well into categories. For instance, based on epidemiological studies, the average gay man should select only partners who are young, white, HIV negative, exclusive tops. Is this "knowledge" helpful or does it advocate ageism, racism and serosorting?

"Treatment as prevention" was the predominant theme at recent world AIDS and CAHR conferences, but it receives very little of this sort of critical attention. On the face of it, treatment has a lot to offer prevention. In a world where a lot of people with HIV/AIDS are not getting adequate care, it's an argument to get them on treatment. And if getting more people on treatment does lower the viral load of the whole population that is also a positive step.

But is "treatment as prevention" justified as being the primary way of doing HIV prevention? And how does it translate into everyday life?

Even considering Canada's universal access to treatment, including clinics dedicated to HIV treatment, there are important caveats to consider:

- about 1/3 of HIV positive people don't know they have an infection;
- some people who are diagnosed HIV positive are not in care;
- others are in care, but not on antiretroviral medications;
- others are in care, on medications, but have detectable viral loads.

Only about 1/3 of positive people in treatment then, have an undetectable viral load. And U.S. research has shown it may be more like 19%.

These scenarios suppose favourable conditions. However, when "treatment as prevention" becomes ordinary life, its presence may be processed in unexpected ways. Some men may feel that an undetectable viral load is rationale for not having to practice safer sex. But their self-perception may not always correlate with their true viral load. While the goal of treatment as prevention is to reach "undetectable" virus, blips can occur activated by other chronic conditions or STI like herpes, syphilis and gonorrhea.

Treatment as prevention represents our modernist faith in biomedical and technological solutions. But actually, our hoped for and expensive technofixes have not been as effective as the condom. The degree of investment in biomedical solutions has been huge. But the results have been mixed. After 25 years of vaccine research much work remains to be done. Both PEP and PrEP trials have had mixed results, and may risk creating drug resistance.

The most effective HIV prevention strategy to date has been the community mobilization of LGBT communities in the 1980s & 90s to adopt condom use. These interventions are languishing now by the push for biomedical fixes.

The effectiveness and acceptability of interventions change over time, so what worked previously may not work now because sexual cultures are evolving. We have not fully learned from how gay men communicate with each other on the Internet, for example. There are limits to treatment as an effective intervention for HIV prevention. Is it really the basket we want to put all of our eggs into?

For more information: Adam, B.D. (2011). Epistemic fault lines in biomedical and social approaches to HIV prevention. Journal of the International AIDS Society, 14 (Suppl. 2): S2.

WILL SEXUAL RIGHTS DETERMINE GAY MEN'S HEALTH?: INSTITUTIONAL IMPACTS ON INDIGENOUS MEN'S HEALTH

ROCKY JAMES, INDIGENOUS GLBT CONSULTANCY OF BC

Indian residential schools have left a legacy of abuse and fear on Indigenous men's health. The first Indian residential school opened in the 1870s and the last closed in 1996: more than a hundred years of colonial oppression. There were 130 Indian Residential Schools in Canada. More than 150,000 Aboriginal children attended.

About 80,000 survivors are alive today.

Fear-based learning was the norm in the residential schools. First Nations people learned, through sexual, physical, and mental abuse, to hate themselves and to desire to be something other than they were.

Repeated abusive and traumatic experiences occurred between school personnel— priests, nuns, support staff—and aboriginal children. Then fear based learning spread from the residential school to the family home, to the community, and into the First Nations psyche.

The impact of residential schools is not part of a far off history. People are still dealing with the impacts of institutionalization today. There are 1000s of survivors struggling to cope with self-hatred, substance abuse and chronic health conditions.

Oppression occurred by targeting the sexuality of children who lacked the intellectual and emotional capacity to understand what was happening to them, their brothers and sisters, and their identity as Indigenous people.

There is a conspicuous absence of material in academic databases on the topic of Indigenous GLBT human rights in Canada, which indicates that GLBT Indigenous people have not held enough leadership roles.

In searching mainstream media like newspapers, you see the occasional piece depicting Indigenous people in a Pride event. But try to find a single piece of work written by an Indigenous GLBT leader that critiques social customs, organizational behaviour, and public policy from an Indigenous perspective.

Fear-based learning of the residential school system inhibited leadership and other opportunities for Indigenous GLBT people in Canada. To counter colonial oppression, we need knowledge produced by Indigenous GLBT people. Indigenous GBT men need to reconcile coming out with two different communities, both tribal and GLBT communities. Giving two-spirited men time to reconcile their truth with the GLBT community provides healing desperately needed by such men, and creates opportunities to reestablish a connection with both cultures.

If Indigenous people are not contributing as leaders and writers, then Indigenous people are being "written about", an action in danger of being synonymous with colonialism and anthropology that excludes the interpretation of the people being studied. More two-spirited men need to be invited into academia and activism.

WHERE ARE THE GAY MEN?

From Barry Adam's presentation:
The Biomedical and the Social in HIV Prevention

9.7% of the Canadian Institutes of Health Research budget for HIV prevention proposals mention MSM in the proposal.

2.6% of conference abstracts at the 2010 International AIDS Conference in Vienna were about MSM.

Allocations of the Global Fund to Fight AIDS, Tuberculosis and Malaria ($903 million)
3.5% IDU: ($31 million)
3.2% Sex Workers: ($29 million)
2.1% MSM ($19 million)

From Len Tooley's presentation:
Where are the Gay Men? Representation of MSM at Canadian Association of HIV Research Conferences 2007-2011.

7% of abstracts addressed MSM exclusively.

In a review of 1,605 abstracts, 87% made no reference to MSM.

Of 119 exclusively MSM abstracts, 40% were in the Social Science track, and 51% were in the Public Health Sciences track.

RIGHTS LANGUAGE AND HIV TREATMENT

CINDY PATTON, SIMON FRASER UNIVERSITY

Since the beginning of the epidemic, HIV/AIDS and human rights have been inextricably linked. Given that HIV affects some of the most marginalized of the world's citizens, human rights have been a common and urgent ethos. As recently as 2010, the theme of the International AIDS Conference in Vienna was "Rights Here, Right Now." Today, however, we are witnessing a shift in AIDS policy, a shift that elevates the role of medication in the global epidemic. The newly minted rubric is "treatment as prevention".

While the underlying concept is by no means new, the implementation of treatment as prevention has been widely promoted as a new paradigm, especially here in British Columbia. Our homegrown "STOP HIV" program, for example, forcefully asserts itself as superior to locally existing rights-conscious, risk-based approaches to prevention and care – the approach that's been the global standard for more than a decade.

Until now, the consensus route forward has been "universal access to care" not mandatory treatment and strong support for "community self-determination" not the blanket use of drugs for prevention. But now the rights-based consensus is being challenged.

Instead of rights, the language of treatment as prevention uses epidemiological concepts. The "at-risk" group reemerges to displace notions of "minority citizenship". To advocate for the cost-effectiveness of expanding HAART, persons living with HIV/AIDS are constructed as potential transmission points associated with cost units.

This dehumanizing language is compounded with a limited view of rights as merely "informed consent" and "voluntary participation". The human rights approach to homophobia, colonialism and drug policy – widely explored in social science research since the 1980s – is being replaced by a prevention strategy that paints the dispossessed as irrational.

Yet, many scientists are skeptical of the "treatment as prevention" approach: its models do not accurately reflect actual behaviour—the ability to maintain drug regimens, for example. Others question the feasibility of mass voluntary testing programs. Yet others argue the model may be projecting anywhere from between 5 to 50 years into the future.

"NOW THE RIGHTS-BASED CONSENSUS IS BEING CHALLENGED."

— Cindy Patton, Simon Fraser University, Rights Language and HIV Treatment

In the United States, the Testing and Linkage to Care program—the same thing as "seek-and-treat"—was implemented as a research study, and not as a policy-by-fiat. Therefore, the US program received ethical review, and the protocols are publicly available to scrutiny.

In the 3 by 5 Initiative of the WHO program for low and middle income countries, there were parallel paths of treatment and prevention because there was a concern that, as people began ramping up treatment programs, they would stop doing prevention work.

Questions remain as to what this "new" treatment as prevention paradigm will mean for WHO's efforts to combat HIV. We are now witnessing a troubling shift in what has been the consensus all along about how to do HIV prevention and care, crafted by many countries and many NGOs: work that lowered the cost of drugs with the pharmaceutical companies through international trade agreements.

As in the past, we must re-ground our ethics in the realization that the supposed right to be free from HIV/AIDS at the population level does not scale down equally to all members of society. We should never allow costing arguments to cloak themselves in a language of compassion. We should never allow wrongs to appear right in financial terms. Justice is justice regardless of the price.

Read the full article: Cindy Patton (2011): Rights Language and HIV Treatment: Universal Care or Population Control?, Rhetoric Society Quarterly, 41:3, 250-266. Link to this article: http://dx.doi.org/10.1080/02773945.2011.57532

ARE THERE ARE ENOUGH GAY DOLLARS FOR HIV PREVENTION?

OLIVIER FERLATTE, COMMUNITY-BASED RESEARCH CENTRE & SFU

HIV prevalence is estimated to be 0.09% in Vancouver's general population or 1 in 1,000. Among gay men it is 18.1% or 1 in 5.

BC's gay population has accounted for at least 40% of all new HIV cases every year for the last decade. Yet, in 2001, an environmental scan of community HIV prevention activities found that only 1.4% of HIV prevention funding went towards gay men's prevention—$104,000 of $7.5 million.

After years of such disparities, $1.2 million was injected into gay men's HIV prevention in 2011: a 12-fold increase over 2001. But over half of the dollars were allocated for short-term initiatives and much of the apparent gains were for medical interventions that supersede other health initiatives addressing the social, emotional and sexual vulnerabilities of differently positioned gay men.

Intersectionality-based policy analysis (IBPA) applied to documents and statements of key informant personnel shows how multiple forms of power have affected HIV prevention funding for BC's gay men. IBPA systematically applies intersectionality principles and concepts to the reading of documents and transcripts to expose how social power affects the formulation and implementation of policy.

For example, while funding since 2011 seems to represent a very significant increase in HIV prevention resources aimed toward gay men, the actual investment remains noticeably inadequate considering the relative size and scope of the gay epidemic. Most of the money was allocated for short-term initiatives. The lack of more commensurate and long-term investment in gay men can be readily explained by the near invisibility of "gay" in the texts of most related health policy documents and professional discourse on the HIV epidemic. The fact is: there has never been an explicit strategy for gay men's HIV prevention in British Columbia. Nor at the federal level.

The same kind of absence and neglect were apparent when the provincial "STOP HIV/AIDS" strategy was implemented. Seek and Treat for Optimal Prevention of HIV/AIDS (STOP) was touted as a radical new four-year HIV prevention pilot project, financed with $48 million. Yet, despite its ambitious goals to resolve the epidemic, early strategy documents appear not to have even considered gay men. It was only when gay advocates pointed to the outlandish omission of men who have sex with men (MSM) in STOP strategy documents that gay men's prevention became part of the policy and funds specific to gay communities were allocated.

Even so, despite having included gay men and MSM in some components of its policy, STOP HIV/AIDS continues to promote social marketing campaigns that exclude and deny the place of gay men in the epidemic. For example, a widely disseminated STOP marketing campaign stated: "Forget what you've heard about high-risk groups. HIV does not discriminate." This message discounts real social and health disparities underlying HIV in gay men in BC while propagating a common myth. HIV in fact does discriminate against gay men and MSM due to complex, interacting biological and social factors that increase gay men's probabilities of becoming infected.

The current public health discourse permits and sustains this kind of social blindness to gay men's marginalization within the HIV field. Gay men are typically described among its professionals as "privileged" due to a baseless social construction that paints gay communities as a homogenous group of well-off Caucasian men. Such constructions surreptitiously deny the oppression of gay men while incidentally rejecting homophobia and heterosexism as the true drivers of the epidemic.

Public health rhetoric fails to acknowledge the excess vulnerabilities of multiple and intersecting identities that gay men may hold such as their ethnicity, aboriginal status, social class or age. Its assumption of privilege and rejection of the real oppression that gay men actually experience are convenient devices to deny adequate resources— gays are not seen as "victims" of HIV.

IBPA analysis showed that much of the recent gains in funding have been for "medicalized" interventions—increased testing and access to treatment—at the expense of community-led initiatives that promote healthy sexuality. This is quite problematic as community efforts of the past have generally been much more successful at reducing HIV transmission than public health initiatives.

Medicalized interventions can only hope to offer partial gains given the already high uptake of testing and treatment among gay men. Their impact has probably peaked. Therefore, other strategies will have to be promoted in order to reduce social inequities faced by gay men, particularly strategies that address gay men's sexuality more directly. However, such policies appear to be either non-existent or difficult to fund due to the continuing discomfort that our governments and public health institutions seem to have with being perceived to be supporting sexualities they see as perverted.

The complete analysis is published in An Intersectionality-Based Policy Analysis Framework (2012) edited by Olena Hankivsky. It can be downloaded at: http://www.sfu.ca/iirp/ibpa.html