



## Gay and HIV- Positive: Barrier to Accessing HIV Treatment

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### ABSTRACT

Since the emergence of HIV/AIDS in the developed world, the disease has been associated with male homosexuality. This review paper aims to provide an insight into the extent of HIV among men who have sex with men (MSM) worldwide, their social status in terms of stigma and discrimination they face in the context of being MSM and HIV – positive, organizations working towards their welfare and gaps in the existing HIV prevention and treatment strategies aimed towards them by reviewing available literature and data sources. Despite a decline in the overall rates of HIV in the general population, HIV among MSM is still rising; its prevalence varies universally. While there has been a rise in the number of HIV diagnoses among MSM over the period of time, the true prevalence of HIV and the proportion undiagnosed is not known.

The under reporting of the actual number of cases may be largely due to the fear of anticipated or experienced stigma associated with being gay and HIV-positive. Although the global conversation focuses on novel approaches to HIV treatment and prevention, these men struggle to obtain the most basic HIV prevention and treatment services. This is primarily because of a lack of recognition concerning issues of social stigma and discrimination and thus a lack of strategies, which could help address the issue effectively. Although numerous community-led programs supported by both large and small donors are making substantial inroads against pervasive stigma and discrimination among these men, it is still a major concern and calls for immediate action by policy makers to address this issue in the existing HIV prevention and treatment strategies for this hidden population.

**Key words:** HIV/AIDS; Men who have sex with men; Gay men; Epidemiology; Stigma; Organizations

### Introduction

In the 1980s, New York City was the first city in the world to experience AIDS and in 2010 about 50% of the new HIV/AIDS cases were identified among men who have sex with men (MSM) [1]. Following the outbreak of the disease in the developed world, AIDS has been associated with male homosexuality; gay plague, gay cancer or Gay Related Immune Deficiency” (GRID) were some of the terms associated with AIDS [2-4]. Since then, the number of MSM living with HIV has been increasing globally and the disease has spread to an epidemic. Out of all new HIV infections reported in the USA in 2010, 80% were identified among men, of which 78% were found among MSM [5]. Not only are the prevalence rates among the general MSM population high, but the disparities among ethnic groups within MSM is also

of concern. Data from CDC National HIV Behavioural Surveillance System, 2008 show that 46% of HIV-infected Hispanic MSM were not even aware of their HIV - positive status as compared to 26% of their white counterparts in the USA [4,6]

Though HIV is on the decline globally, it is still a growing concern among MSM. Its prevalence ranges from 3% in the Middle East to 25% in the Caribbean and it is estimated that the rate of HIV among MSM will continue to rise across high-income countries such as Canada, Australia, Americas and the regions of Western Europe [4,6]. Since 2001, the prevalence of HIV among MSM has been increasing annually by 8% in the USA, placing USA at par with the countries that lack widespread awareness and resources about prevention and treatment of HIV such as Thailand, Malaysia and some African and Caribbean nations

[6]. In Brazil, Canada and Italy, the HIV prevalence rates among MSM vary from 11% to 15%, whereas many western European countries have lower rates of around 6%. This has raised concern among public health experts as it is affecting the young generation of men who have not been through the destructive first wave of AIDS, which occurred during 1980s when there was no treatment or diagnosis available for HIV/AIDS [6].

Researchers have shown concern about different behavioural practices among MSM, including high use of drugs, both snorting and injecting -especially during sex parties, which resulted in an 8% rise in new HIV infections among British male homosexuals between 2011-12 [7]. Similar trends have been reported among French MSM where they accounted for 48% of all new HIV cases in 2008 in France. The incidence rate among French MSM was 1%, 200 times higher than the rate estimated for French heterosexuals [8]. While MSM accounted for 64% of newly diagnosed HIV infections during 2003 in Australia [9], MSM comprised about 40% of the total recently diagnosed HIV infections in New Zealand [10]. The infection has shown a rising trend among MSM living in the Asian continent as well. The newly reported HIV cases among MSM has risen four times between 2002-2007 in Singapore whereas the number has risen more than double in Japan over this period [11,12].

HIV among MSM has seen a considerable growth in the developing nations as well. HIV among Chinese MSM has risen from 1.4% in 2001 to 5.3% in 2009 whereas HIV prevalence among MSM in India was estimated at 7.3% in 2010, more than twenty times the general population rate [13,14]. MSM constituted 41% of all reported HIV cases in 2007 in Hong Kong, more than any other group at risk in the country [15]. Cross-sectional studies from Southeast Asia have shown an HIV prevalence ranging from 8.7% in Cambodia to 7.8% in Vietnam and 30.8% in Thailand among MSM [16-20]. Compared to the national adult HIV prevalence of 15.2%, a cross sectional survey conducted in Sub-Saharan Africa among MSM found a 33% self-reported rate of HIV infection in Zambia [21]. While the reported HIV prevalence among MSM was 43% in Kenya, 22% of MSM surveyed were found HIV-positive vis- a- vis the national HIV prevalence of 2% in Senegal [22-25]. The data clearly demonstrates an increasing global trend of HIV epidemic among MSM. While there has been a

rise in the number of HIV diagnoses among MSM over the period of time, the actual prevalence of HIV and the proportion undiagnosed is not known. The under reporting of the actual number of cases may be largely due to the fear of anticipated or experienced stigma associated with being gay and HIV- positive [26]. However, research in developing countries is more limited since the concept of homosexuality is far less socially acceptable in the developing nations hence more research is needed on these populations—not only for prevalence rates but also for their socio-cultural acceptability [27].

### ***HIV in MSM and Co-Morbidities***

MSM with HIV are also at greater risk for contracting other chronic diseases including anal cancer, which has significantly doubled in the last decade among this population [28]. Rates of anal carcinoma in MSM are as high as 35 per 100, 000, with a majority of carcinomas found among those with a positive HIV status [29,30]. A recent study conducted by the University of Amsterdam explored relation between increasing rates of anal cancer and receptive anal intercourse among MSM with HIV. The study found that the Dutch population had a higher annual increase of anal cancer rates than their Western counterparts. An annual increase of 2.2% in anal cancer rates has been identified among MSM in other Western countries whereas the same risk has increased by 51.7% from 2007 - 2011 in the Dutch population alone [28]. Apart from the risk of contracting anal cancer, MSM have increased vulnerability to sexually transmitted infections (STIs) such as chlamydia, gonorrhea and syphilis as well [31]. Studies have identified that sores or lesions caused due to STIs pave the way for HIV transmission among MSM through the anal route [31]. Data collected from STI clinics from January 2008 to March 2010 in New York found that rectal STIs significantly increased the risk of HIV infection among MSM. Specifically, 1 in 15 MSM who began the study as HIV negative and had a rectal STI, were detected & confirmed HIV - positive within a year of the STI diagnosis [31]. Similar trends were observed in a study conducted on 831 MSM attending voluntary counselling and testing (VCT) services at the Humsafar Trust from January 2003 through December 2004 in Mumbai, India. An HIV prevalence rate of 12.5% was found among these MSM. These results show that MSM with an STI or found to have reactive venereal

disease research laboratory test during their VCT visit had more chance of having HIV infection [32] than those without having an STI. In many cases MSM account for the majority of primary and secondary syphilis infections as well. A greater than 4-fold increase in the number of syphilis cases was observed between 1998 -2005, with >90% of cases occurring among MSM attending STD clinics in Atlanta, San Francisco, and Los Angeles [30].

### Materials & Methods

This paper reviewed literature from online journals, academic and organizational papers. Different online databases and search engines were employed to access the relevant data, using keywords and their combinations to maximize support and gain evidence for the study. To balance specificity and sensitivity of the search terms and fields, iterative refinements were carried out. The initial strategy included the terms AIDS or HIV and homosexuality which generated a range of articles too wide to go further with. Filters were applied for males and years of publication which narrowed down the search. Relevant articles were sought by using the term epidemiology, HIV/AIDS, men who have sex with men (MSM), gay men, stigma and organizations. Lastly, articles matching the study objectives, published in English language periodicals up to February 2014, were included in the review paper.

To discover grey literature (documents published by organizations, rather than academic journal articles or books), Google Scholar was used to sought organizational websites related to HIV and MSM. Citation searches and author searches were carried out on a few included articles as a final check against missing key reports. At the end, all full text articles were read, each article was analysed critically and those considered to have met the proposed criteria were included in this review.

### The status of HIV - positive MSM in communities – Stigma and its consequences

There is a concern of a strong negative stigma towards HIV - positive MSM globally. The social status of MSM with HIV in any country is extremely appalling. Populations at risk for HIV/AIDS infection experience stigma, which is especially true for MSM, who are often blamed for the epidemic because of traditional attitudes towards homosexuality, promiscuity, moral

degeneracy, and being “diseased” [33,34]. MSM may experience double discrimination: discrimination on the basis of sexual orientation and discrimination on grounds of actual or perceived HIV status [2]. In such an environment, many MSM are not open about their sexual preference and despite prevention efforts and formulating treatment programs to control the epidemic, HIV infection rates remain high [35]. Studies have shown that fear of stigma and discrimination has contributed to negative self-images and low self-esteem, significantly higher rates of depression and suicide, chronic stress and mental health problems, increased sexual risk behaviour and decreased testing and uptake of HIV treatment and prevention services among these men [35-37]. Many of them live their life under considerable stress and face the disapproval of religious instituted societal norms and the weight of implicit and explicit homonegativity [34].

A study conducted in Mumbai, India identified HIV prevalence of 12.5% among MSM in the region with 14% of them reporting STD symptoms. However, only 68% of them collected the reports of their laboratory test. It was identified that fear of social stigma and discrimination associated with HIV - positive status and homosexuality was associated with such behavior [32]. Even though homosexual behavior itself has never been illegal in countries like Vietnam, male to- male sex is still not socially acceptable, and MSM face high levels of stigma and discrimination [35]. A majority of these men keep their sexual identities and behaviors secret and may remain undiagnosed. It is argued that when these untreated men engage in sexual activities with their uninfected male partners, they may initiate unsafe sex and thus they may unknowingly spread the infection [35].

The silence and secrecy associated with institutional stigma and discrimination may provide ideal conditions for escalation of the AIDS epidemic [35]. This includes multiple and overlapping stigma from health providers, employers, other service providers, family members and friends. This subjective process results in labelling, stereotyping, and strong emotional reactions among HIV - positive MSM, not only in the community but within their households as well. Often it takes the form of verbal assault, “Bible bash”, sayings related to going to hell, abhorring their sexual behaviors and all such standard labelling and oratory [34]. This

often results in elaborate concealment and lifestyle adjustments in order to keep their status and medications under wraps. Such attitudes reinforce negative attitudes about being gay and HIV – positive, serve as consternation to those living with HIV and pose a barrier to medical compliance as well [38].

Reportedly, health care providers often hold attitudes of 'blame and shame' towards gay men living with HIV, files are marked 'UP' (Universal Precaution), 'positive' or 'sero-positive' and the beds of such patients are kept in separate locations [38]. For example, staff had used double gloves, masks and goggles for extra precaution while handling such patients, exacerbating the stigmatized situation [38]. Consequently, these men often hide or deny their sexual identity while seeking medical care leading to remarkable negative consequences. HIV/AIDS and homophobic stigma may influence how or even when MSM seek health care services [2,34]. These men experience greater social discrimination at their work place. They may be fired from jobs and experience difficulties in finding a place where they can work comfortably without being discriminated due to their HIV - positive and homosexual status [34]. For example, after learning that a gay cinema projectionist was arrested for gross indecency in a public toilet, he was fired by his employer. His work colleagues were hesitant to work with him since he was mistakenly assumed as HIV- positive. Knowing that a gay man is HIV-positive or that his partner is HIV-positive can lead to discrimination as well. In one such instance, following disclosure of HIV-positive status by a gay man to his employer, he was refused to continue his job following his return to work after his sick leave ended, although the employer and fellow colleagues seemed very supportive initially. In this light, an understanding of issues around stigma and discrimination would help MSM cross barriers associated with stigma with respect to sexual risk, disclosure issues, access to health care, employment and other facilities [2,37].

### **Organizations working for the welfare of HIV - positive MSM**

Various bodies with the global solidarity are working for decelerating the stigma and discrimination towards MSM living with HIV/AIDS, in terms of physical, social, and psychological challenges. Receiving adequate social support, whether it is informational or in terms of a strong

social network, creates a vital and influential impact on the psychological well-being of these men, as HIV- positive MSM generally experience more discrimination than their non-MSM counterparts [39]. Those living with HIV/AIDS need effective, customary and reliable health care and counselling services. Many government organizations and departments, private and civil society organizations working on central and state levels have come forth to assist in developing policies and programs to advance equity amongst PLHIV particularly MSM for the diminution of stigma and discrimination, hence, constructing a congenial environment for their livelihood.

One NGO, the Liga Colombiana de Lucha Contra el SIDA, in Bogota, Colombia, has been working for the past three decades with terminally ill AIDS patient primarily gay men. The unique feature of this multidimensional HIV prevention program for MSM includes regular mapping of the sites frequently visited by MSM through observational techniques and informal discussions with the target groups and carrying out anonymous surveys with these men. The data collected is then used for developing prevention brochures/flyers/videos, organizing prevention workshops and for designing outreach programs aimed for the welfare of HIV - positive gay men [40]. Similarly, Family Health International is supporting various MSM programs in countries like Bangladesh, Nepal and Indonesia. The program activities include outreach and peer education, establishment of drop-in centers or safe places where MSM can socialize. It also provides them the educational and health services, organize community mobilization events, provide referral services to STI treatment, counselling and testing, care and support specially sensitized and tailored for the welfare of MSM through local and national-level advocacy [41]. Kazakh NGO Alliance is also working towards increasing awareness on the modes of HIV transmission among Kazakh MSM community. Being a conservative society, it is very difficult for the community to accept the phenomenon of male homosexuality in Kazakhstan. Consequently, the NGO faced numerous difficulties and also faced cash crunch in operating this set up. Despite these challenges, the organization has received positive feedback from the community [42].

To address the issue of risky sexual behavior and sharply rising rates of HIV amongst Chinese MSM, the Ministry of Health, China

declared the launch of an extensive program in 2008. The campaign was aimed towards 700,000 PLHIV in China out of whom 11.1% were MSM. Besides providing improved access to treatment and access to voluntary HIV counselling and testing services, the campaign has focused on the coverage of HIV prevention activities, running hot-lines, internet chat rooms and websites for the target population [43]. To deal with the plight of HIV - positive MSM in India, certain core components and combination HIV interventions were framed in June 2001 with an effort to establish targeted intervention programs through community based organizations. The current prevention interventions for MSM in India involve mainly single dimension modalities including condom distribution, HIV education, voluntary HIV counselling and testing, and the treatment of STIs [37].

While the global conversation focuses on novel approaches to HIV treatment and prevention, GMT (Gay men, other MSM and Transgender individuals) struggle to obtain the most basic HIV prevention and treatment services. This is primarily because of a lack of recognition concerning issues of social stigma and discrimination and thus a lack of strategies, which could help address the issue effectively. Until stigma and discrimination are not minimized, uptake of HIV prevention and treatment services will remain low. Although numerous community-led programs supported by both large and small donors are making substantial inroads against pervasive stigma and discrimination among HIV - positive MSM, it is still a major concern and calls for immediate action by policy makers [44,45]. Supportive interventions that include capacity building, community mobilization, stigma reduction programs, income-generating activities, and advocacy for legal/policy reform and human rights protections are central to addressing the issue besides focusing on the prevention and treatment strategies.

## Discussion and Conclusions

In almost all regions of the world, MSM had significantly higher rates of HIV infection [6]. MSM with HIV were also found to be at greater risk for contracting other chronic diseases including anal cancer, which has significantly doubled in the last decade among this population [28]. Apart from the risk of contracting anal cancer, MSM had increased vulnerability to STIs such as chlamydia, gonorrhoea and syphilis as well [31]. Since the emergence of

HIV infection among gay men, HIV/AIDS had been linked to male homosexuality, which is further stigmatized to the extent that PLHIV were judged by their homosexual behaviour and perceived lack of responsibility [46]. Consequently, the HIV/AIDS epidemic had reinforced negative attitudes towards homosexuality [47,48]. The discomfort and distress that resulted from the anticipated consequences of disclosure such as rejection by family, eviction from home, social isolation, maltreatment within the healthcare system etc. underlie the compelling motivation to keep the disease status a secret and had presented powerful disincentives to accessing HIV prevention services. This had often resulted in delaying the treatment initiation and even postponement of learning HIV -positive status for as long as possible until they became symptomatic. Consequently, the disease followed a chronic, untreated course and many HIV -positive MSM denied their sexual orientation, continued to engage in risky sexual behaviors and avoided utilizing HIV prevention services [49]. While there had been a rise in the number of HIV diagnoses among MSM over the period of time, the actual prevalence of HIV and the proportion undiagnosed was not known. The under reporting of the actual number of cases might be largely due to the fear of anticipated or experienced stigma associated with being gay and HIV- positive [21,22]. Thus, stigma and discrimination were central to multi-level barriers to the uptake of HIV prevention and treatment services.

The literature reveals the widely recognized urgency of scaling up HIV programs to reach MSM since current prevention and treatment strategies are insufficient for this wave of HIV spread [50]. These men suffer from stigma and discrimination, yet are often absent from the design of programs and HIV prevention campaigns [50]. Because the HIV/AIDS epidemic and the cultural, political, and economic forces that shape it are community and culture specific, no two national responses can be exactly the same. Therefore, to respond to the multi levels of HIV risk among MSM, combination HIV prevention interventions are being used to maximize effectiveness. Research and experience point to a series of recommendations that are broadly applicable to HIV/AIDS funders and policy makers [44]. Funders and program implementers should be flexible when carrying out HIV interventions specific to local social contexts as it may be very difficult to attempt to reduce negative

attitudes towards PLHIV without addressing homosexual stigma. In this light, numerous community-led programs supported by both large and small donors have been making substantial inroads against pervasive stigma and discrimination among HIV-positive MSM [44].

Given stigma and discrimination as one of the most potent barriers to the utilization of HIV prevention and treatment services, interventions should involve multiple stakeholders - the general public, healthcare providers and the HIV affected MSM communities themselves. It has been observed that the existing dominant HIV prevention strategy of personal responsibility (e.g., use a condom, get tested) has unintentionally fostered negative outlook towards PLHIV. This calls for a need to address homosexual stigma in the general population with joint accountability and responsiveness and designing the interventions to maintain a focus towards homosexuality and homosexual stigma, which might help avoiding internalizing the negative consequences that follow addressing their overall health as well [52,53]. In addition to the campaigns which promote acceptance in the general public and combat discrimination against these men, targeted interventions are needed for healthcare providers as well [14]. Global institutions such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) recommend that certain core components should be included in a comprehensive package of services for MSM [54]. Health providers and staff should be trained and educated on the specific knowledge, attitudes, and skills necessary for working with MSM. Additionally, MSM-friendly clinics should be set up; the staff should be trained for confidential record-keeping, providing non-judgmental, non-discriminatory treatment services and counselling on disclosure of HIV status and sexuality to family and peers. MSM peer outreach and engagement in HIV care and treatment services would also fill an important gap. This could be achieved by addressing HIV-related stigma and discrimination in these communities through targeted interventions aimed at creating supportive peer norms together with the help of community leaders [14]. Healthcare system guidelines should be developed in consultation with these communities to address discrimination based on sexual orientation and gender identity. The perspectives of providers underscore the need to

consider the social and contextual factors of a community when designing and implementing HIV prevention strategies for these men that may help shape future HIV prevention efforts [49]. These efforts might seem theoretical and unrealistic but if worked on in a comprehensive, rigorous and planned manner, success could be achieved.

The findings of the review paper are widely dispersed, providing an opportunity for a literature to emerge demonstrating the relationship between social stigma and lower uptake of HIV prevention and treatment services among HIV- positive MSM. In addition to the themes extracted from this literature review, it will be useful to 1) investigate stigma's parameters among HIV- positive MSM through rigorous scientific enquiry and the ways to address the issue effectively and 2) create an evidence base that investigates causality between social stigma and lower uptake of HIV prevention and treatment services among HIV- positive MSM.

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