



2008 MSM Pre-Conference
Friday, August, 1, 2008

TRANSCRIPT

Question & Answer Session Craig McClure & David Wilson

- Q: My name is Gabriel and I am from Mexico. So I know your presentation is about the north... How is the situation in North America—the States, Canada and Europe... I really understand the issue, but sexual tourism goes from those countries to Asian countries. When you don't speak English fine and you want to have sex with black or white people, it's not a negotiation. It's about having sex or not. So, I know it's a south issue, but how is the situation in the north, in the developed countries?
- David: I think that's an excellent point. I completely agree that we need to understand the links between the north and south. My suggestion would be that we have understood those links very well from a northern framework and many of our program in the north do focus on men who travel and have either have sex with men or have sex with women. I don't think we've looked at it adequately from the perspective of the south. I think we have to understand the linkages from the perspective of the south.
- Craig: To add a little bit to what David's saying. I think you bring up a really very interesting point that needs a lot more research. Certainly there has been an impact on HIV incidence and HIV prevalence on men who have sex with men in the global south because of travel of men who have sex with men from the global north. There are certainly dynamics around power and finances and as you alluded to, the language issues around negotiations of sex between men from different countries. I think we need to understand those issues much more than we do now.
- Q: Mike Toole from the Burnett Institute in Melbourne. Thank you for that excellent summary of the situation. My question is about the slide that's still showing with the very dramatic red bar across the "averting HIV infections by working with youth". My concern with that and the recommendation that we not focus on youth, in particular, in terms of men who have sex with men is, as your data show, that many men who have sex with men also have sex with women. They don't identify as gay. They don't belong to any defined community. I wonder if the coverage of programs, prevention programs aimed at men who have sex with men is so low that truly many of the men who are not reached are in that mainstream youth bar. Given (that) we don't have any proven interventions to reach these bisexual men, men who don't identify in any particular gay community, surely integrating the risk of anal sex, unprotected anal sex, if not all youth, at least youth in settings, perhaps urban settings where they are more likely to engage in bisexual behavior. I don't have the answer. But, truly (a) part of the cost of interventions to reduce transmission among men who have sex with men belongs in the mainstream youth intervention, unless you have some other alternative interventions for reaching those men.

David: That's a difficult question, and I think it's one that we also faced in relation to earlier epidemics in heterosexual sex work and injecting drug users. My own view is we do need to focus on young people in concentrated epidemics, but I firmly believe we need to focus on young people at greatest risk of infection, by virtue of being in one of the three vulnerable groups. My fear is that if we permit any focus on youth in the general population, we'll have diluted approaches, which continue to obsess with youth having heterosexual sex with each other. Thailand is a classic example. In spite of their epidemiology, they're much more concerned that young Thais are now having sex with each other, heterosexual sex with each other, than they are about their unchecked epidemics among injecting drug users and men who have sex with men. So my response would be, we need to somehow better understand how we can reach young people who are at risk of HIV through being a member of one of the three vulnerable groups. The data we have for sex work shows we really have to do that fast. In both India and Indonesia, half of all the infections among sex workers appear to occur in the first 6 to 9 months of their becoming sex workers. We don't even have those data for men who have sex with men, but we may well find a preponderance of risk in early inception, as well. I don't think I'm disagreeing with you. I just think it's critically important to ensure that our prevention programs are focused on those at greatest risk, on the vulnerable groups. And on youth who belong to vulnerable groups.

Q: Richard from Brazil and Columbia University in the US. David, thank you for the wonderful presentation. One of the things that made it so insightful was the way in which you broke out the intersecting issues of men who have sex with men, but also sex work, and injecting drug use. I wanted to ask you if you can say something about the extent to which the data on transgender persons may get folded into MSM epidemiological data in ways that might distort our understanding. Particularly in many parts of the world, there are intersections with injecting drug use, with sex work, with receptive anal sex, that may give you different epidemiological results. But, it feels to me anyway, that we're missing that nuance and it also was just in a couple of slides in your presentation, so if you can say something on that.

David: Thank you. Let me say that I completely agree with you. I think it's critical that our surveillance on men who have sex with men be based on a taxonomy that at least looks at male sex workers, transgenders, *hijras*, *warias*, and perhaps at high- and low-risk men who have sex with men, by virtue of number of sexual partners. I agree with you. The data I've seen, (the) best quality data from India and from Indonesia, to me do show that transgenders have a higher HIV prevalence than members of the general population. I think there are both behavioral receptive and psychological vulnerabilities that contribute to that. Thank you for drawing attention to something that I critically agree with.

David: Sorry, could I briefly understand your question. Are you interested in the intersection between male sex workers and men who have sex with men?

Q: Yes

David: To my understanding, we have quite a bit of good behavioral data from both South Asia—Bangladesh, for example—and parts of East Asia. I don't think we've got much good integrated bio-behavioral data yet, with a caveat. India's IBBA, the world's largest ever IBBA among vulnerable groups, over 20,000 participants, and Indonesia's latest IBBS grant has not yet been released. But when I think that becomes publicly available, it will hopefully help us to address that point.

Q: Hello, my name is Hector Carrillo from Mexico, originally, but also from San Francisco State University. I'm responsible for the pink and yellow report that's circulating here, which is based on an ethnographic study of Mexican, gay and bisexual, immigrant men who moved to California. I'm very glad that we're touching on this issue of the global south versus the global north, and I have a quick comment and a question. The comment is that I think part of what happens here is that in epidemiological and social behavioral studies, it's very hard to capture the kind of nuance about sexual cultures and sexual subjectivities, and the sort of way in which homosexuality becomes integrated into different cultural settings, particularly in the global south. I'd like to hear more about your thoughts on the complementarity between epidemiological and survey behavioral research methods and more sort of on the ground connected to activism, but also connected to just population types of qualitative ethnographic type studies. If you see this report that's circulating, you will see that there are very different interpretations among Mexican men about their connections with family, about their connections with society at large, about the kinds...what it means to them to enter different sexual contexts in the U.S., etc...I would be curious to just sort of hear you talk a little bit about how that kind of research can be integrated into our epidemiological understanding of the situation. Thanks.

David: That's an excellent point, and it's a core challenge. If we just step back and if we look at how we have done with epidemiological bio-behavioral surveillance in the general population in Africa, we see the scale in the challenges. The DHSs—the national population-based surveys, and the DHS pluses, have been invaluable and they are very high quality, but they still lead to systematic under-reporting of sexual partners. We recently tried to model Southern Africa's epidemic using DHS plus data, and you cannot construct the epidemic based on the behavioral reports and the DHSs. We have to turn to alternative ways of asking about numbers of partners, and alternative studies show far greater rate of partner change. Summarily, in India, we found that general population behavioral surveys cannot allow you to create an epidemic in India's proportions. Indian's have had to create alternative, creative methods—polling booths, etc..., to begin to get valid behavioral data. And I cited the difficulties about getting disclosure from men who have sex with men in Vietnam, so clearly, we need better overall bio-behavioral surveillance, but we also need better ways of eliciting information about sexual behavior in large-scale surveys and we need targeted socio-behavioral studies, including ethnographic studies. What we now try to do is promote bio-behavioral and ethnographic studies by including a careful ethnographic component in each of our bio-behavioral surveys. In addition to those, we will need to invest in good socio-behavioral research. The challenge, as I have said earlier, I think, is to draw upon the immense wealth and experience skill in the north, but develop behavioral approaches that do justice to the size of epidemics and size of challenges in the south.

Q: My name is Michel de Groulard, and I am from the UNAIDS regional office for the Caribbean. Thank you David for this excellent presentation. I cannot agree more with what you have presented. I would like to look at what this means for the wider epidemic. I think we discussed that with you recently. In the Caribbean, the prevalence among men who have sex with men is 20 times higher than with the general population, which means that most of the men, we don't know exactly the figures, but the vast majority are infected by other men. And unfortunately, the reality that we have to live with in the Caribbean, at least, and in other parts of the world, is that this is the main driver of the

epidemic, because these men who are infected by other men, because of the high level of stigma and discrimination in the region, they are the ones infecting the women.

David: Two very brief points. Daniel Halperin and colleagues have a paper coming out in the *New England Journal of Medicine*, quite a careful paper, suggesting that in fact the majority of infections in many Latin American contexts, including the DR (Dominican Republic) and Brazil may now be among men who have sex with men. (This is) a very careful study. And as you know, one of the conclusions of our emerging Caribbean epidemics, for which UNAIDS and the World Bank are collaborating on is the fact that men who have sex with men are likely to be a key driver. My perception is that has not been said at a senior policy level often enough. I think we need to get better evidence that has to be taken up by agencies such the World Bank—they have the capacity to talk to Ministries of Finance, and more widely, governments—but I do think that better data, better analysis, better use of the existing data is critical. And I think that the Caribbean's an enormous challenge, because having worked extensively in Africa, and only recently in the Caribbean, I think the comparably greater homophobia we face in the Caribbean is striking, and we really do need to overcome it. Thank you.

Q: Carlos Caceres from Cayetano Heredia University in Lima...thanks for this chance. Just wanted to thank you for the excellent presentation, but also to point out that it's crucial to consider issues regarding legal frameworks around sexual diversity and human...states of human rights. Recently (unclear 7:26) took some work with UNAIDS trying to look at these aspects in lower- and middle-income countries, and clearly, there are many countries where homosexuality is still illegal, and they're highly repressive. Some are less repressive, but still it's illegal. Some others have a neutral stand where actually human rights, the enactment of protection measures, is still very weak. We can't assume that the government and societies are just willing to consider any group for prevention. In many cases, we still have to consider issues around human rights and we have to push to create a climate where actual public health work is possible. Thanks.