



HIV among men who have sex with men in the Caribbean: reaching the left behind

Willy Dunbar¹, Jean William Pape² and Yves Coppieters¹

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ABSTRACT

Objectives. To present the epidemiology, social and cultural factors driving the HIV epidemic among men who have sex with men (MSM) in the Caribbean region and to highlight the regional and national responses, and what remains to be addressed to close the gaps in order to ending AIDS by 2030.

Methods. A literature review was performed in the following databases: PubMed and Scopus. Articles published in the past 10 years were selected. The outcomes of interest were sociocultural risk factors, description of regional and national efforts and potential challenges and barriers to effective control of the epidemic among MSM. This report concentrates exclusively on publications related to MSM living in the Caribbean countries.

Results. 11 peer-reviewed studies, 9 grey literature reports and programme frameworks were thematically analysed. The prevalence of HIV among MSM is high and the rates also do vary among Caribbean countries. Several factors influence the epidemic among MSM in the Caribbean but stigma and discrimination underlie the social vulnerability and play a central role in driving the HIV epidemic.

Conclusions. To end the AIDS epidemic by 2030, MSM can no longer be kept unchecked in the era of the Sustainable Development Goals with the motto 'Leave no one behind'.

Keywords

HIV; sexually transmitted diseases; equity; Caribbean Region.

The HIV epidemic hit the Caribbean in the late '70s, and currently this subregion of the Americas presents the highest HIV seroprevalence rate (1.2%) after sub-Saharan Africa (1). Approximately 340 000 persons are living with HIV/AIDS in the Caribbean. This number includes, in 2018, 16 000 persons who became newly infected. 72.0 % of people living with HIV (PLWHIV) in the Caribbean were aware of their HIV status. Of those who were aware, 77.0 % were accessing antiretroviral treatment (ART). Of those on treatment, 74.0 % were virally suppressed. Nearly 90.0 % of new infections in the Caribbean in 2017 occurred in Cuba, Dominican Republic, Haiti and Jamaica while 87.0 % of deaths from AIDS-related illness occurred in the Dominican Republic, Haiti and Jamaica (1).

Even though the Caribbean countries consider health as a fundamental human right and entitlement, the healthcare

systems are meaningfully differentiated from one country to another in terms of healthcare delivery, health policies, financing and governance (2). In term of meeting expectations regarding the HIV epidemic, progress has been made to ensure adherence to care and prevention through awareness, education and pre-exposure prophylaxis (PrEP) (3, 4).

A focus on men who have sex with men (MSM) in the Caribbean showed that they accounted for nearly a quarter of new infections in 2017. Thus, MSM are the group most affected by HIV in the Caribbean (5), and several factors are behind this high burden. Although sex between men is rather frequent in the region, male homosexual behaviour does not usually imply homosexual or bisexual self-identities (6, 7). Homosexuality is still a source of stigma, discrimination and human rights violations in many islands (8). Many MSM fear public exposure,

¹ Université libre de Bruxelles, Brussels, Belgium. ✉ Willy Dunbar, wduanbar@ulb.ac.be

² Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO), Port-au-Prince, Haiti

social rejection and are likely to access healthcare or social services late in their disease course if at all (9, 10).

Despite the clear need for targeted and adapted interventions, HIV services for MSM remain severely under-resourced, leading to poor program coverage in many Caribbean countries. This paper aims to present: 1) the HIV infection among MSM in terms of epidemiology, social and cultural factors driving the epidemic, and regional and national responses, and 2) what remains to be addressed to close the gaps in order to identify areas for further research and programme development towards ending AIDS by 2030.

METHODS

To identify peer-reviewed articles, abstracts and reports of HIV studies conducted among MSM in the Caribbean we performed a search of PubMed and Scopus on June 2019 using Medical Subject Headings (MeSH) terms or other associated terms for HIV cross referenced with “stigma”, “discrimination reduction”, “social stigma”, or “homophobia”, as well as “men who have sex with men”, “gay men”, “gay man”, “bisexual men”, “bisexual man”, “homosexual men”, “homosexual man”, or “homosexuality, male”, “high-risk groups”, “prevalence”, “Caribbean”, and individual country names. We considered original research articles, reviews and reports published in English, French and Spanish over the period of January 2009 through May 2019. The 2009-2019 period was selected since an emergence of international interest in the role of MSM in HIV epidemics globally has become more apparent and major innovations took place in HIV testing, prevention, treatment, retention strategies, monitoring and evaluation tools and elimination initiatives.

The initial screening search was based on the titles and abstracts of the articles. Following the search, we reviewed bibliographies of major articles for further references not indexed in the search engine. We also reviewed relevant documents from international organizations such as UNAIDS, Pan Caribbean Partnership against HIV/AIDS (PANCAP) and AIDS case reporting to the Pan American Health Organization (PAHO)/WHO, studies and reports on the social and cultural aspects of Caribbean homosexuality.

For peer-reviewed articles, inclusion criteria were determined a priori: studies including HIV prevalence data, sociocultural risk factors driving the epidemic among MSM; description of regional and national efforts and potential challenges and barriers to effective control of the epidemic among MSM; country report or an abstract at a conference with peer-reviewed blinded abstract selection process; studies from Caribbean region. This report concentrates exclusively on publications related to MSM living in the Caribbean countries.

Each article reviewed was analysed with a standardised tool seeking to identify data on the HIV epidemic among MSM, social and cultural factors, the regional and national responses, the challenges and barriers that remain in the Caribbean. Data were extracted using forms detailing study location, study objectives; thematic areas mentioned above; data collection; methodology (design, setting, population, MSM sample size); results and outcomes; and specific sexual and HIV stigma-related issues. After data extraction for each paper, the studies were grouped and combined with other relevant documents

mentioned above according to the objectives of this review. Narrative summaries are presented below.

RESULTS

The initial search generated 1 644 published articles on HIV in MSM globally. Of that total, 11 peer-reviewed studies, 9 grey literature reports and programme frameworks that specifically referenced HIV in MSM population in the Caribbean and other literatures reporting on homosexuality in the Caribbean were analysed in depth.

The epidemiology of HIV among MSM in the Caribbean

The Caribbean has a global HIV prevalence at 1.2%. Although the HIV transmission is mainly heterosexual it has a concentrated epidemic among key populations such as MSM and sex workers, and MSM accounted for nearly a quarter of new infections in 2017 (5).

High-quality data on HIV prevalence among MSM in the Caribbean is highly limited. Many studies used convenience sampling with very small samples and most provided limited information about the methodologies employed or samples included. Nevertheless, these studies represent an important step forward in countries that obviously had no previous data about HIV prevalence among MSM (11). Although reliability and significant variations in new infections among the countries in the Caribbean region represent a major concern, the prevalence of HIV among MSM is high and the rates also do vary among Caribbean countries. The prevalence is particularly high in Trinidad and Tobago (32.0 %), Bahamas (25.0 %) and Haiti (13.0 %). The lowest prevalence percentages are still high at 5.0 % in Guyana and around 6.0 % in Suriname and Cuba (12).

In 2014, only 51.0 % of MSM were reported to have access to HIV services, a level that has remained unchanged for several years (13). Moreover, access to HIV testing in MSM varies enormously from country to country, ranging from 5.0 % to 70.0 %, and 64.0 % of MSM in Jamaica reported having sexual relationship with women, which also contributed to the spread of HIV in the general population (14, 15).

In recent reports, estimation of the population size of MSM by country, the prevention programmes and antiretroviral treatment coverage among them represented a major challenge (16). Knowledge of HIV status varies between 23.7% in Grenada to 97.5% in Suriname (5), and regular condom use between 42.0 % in the Dominican Republic to 82.0 % in Saint Kitts and Nevis.

Factors underlying the Caribbean HIV epidemic among MSM

Several factors influence the epidemic among MSM in the Caribbean but stigma and discrimination underlie the social vulnerability in driving the HIV epidemic and play a central role. Thus, it is mandatory to catch the social construction of heteronormativity in the region that is also central to the problem because any other form of sexual orientation outside the norm is seen as a deviant act. Therefore, this situation reinforces rejection, ostracism and discrimination.

Homophobia and stigma toward MSM are among the key factors that may be understood in the context of what is socially acceptable to be a man in the Caribbean region. The “heteropatriarchy concept” defines the existing social and political organization in different Caribbean countries, shaped by a history of slavery, colonialism, and a post emancipation nationalism. Heteronormativity can be defined as the institutions, structures, practices, identities, and understanding that legitimize and hierarchize heterosexuality as the normal, natural, and only socially and morally accepted form of sexuality. Thus, an heteronormative and hegemonic model of masculinity is essential to the socialization process and the cultural identity of many Caribbean countries (17).

Caribbean cultural constructions of masculinity impose obligations and restrictions leading to risky sexual practices besides the practice of sex between men remains a criminal offence in most Caribbean countries (18). Highly stigmatized by both religious and social norms, homosexual practices are driven underground. Some men are involved with both male and female sexual partners, and sometimes they appear to adopt a socially acceptable heterosexual lifestyle. Marrying women and fathering children are, for some, a strategy to avoid negative consequences of public disclosure of homosexuality and can be used to help dispel doubts about masculinity. By having female sexual partners, MSM fulfil the traditional gender roles and respect the heteronormative and hegemonic model of masculinity (18). In this way, structural factors are interconnected and converge to increased individual risk practices, thus increasing both social and other individual drivers of HIV vulnerability.

Another factor is violence towards MSM which is not only perpetuated at a community level but also overlooked by police forces. The lack of legal protections contributes to insecurity, including poverty and homelessness for those who are rejected, which elevates HIV vulnerability and decreases access to sexual and HIV information, testing, prevention and care (19).

Moreover, access to prevention, counselling and testing, care and treatment remain difficult in most Caribbean societies (20). Fear of non-voluntary disclosure, confidentiality and a lack of privacy aggravate lack of access (21). Health care providers are perceived as judgmental and unable to respect confidentiality (22). In a study conducted in Jamaica, participants revealed social-ecological barriers to HIV testing. Barriers included healthcare provider mistreatment, confidentiality breaches, and HIV-related stigma. Healthcare provider discrimination and judgment in HIV testing provision presented barriers to accessing HIV services, and resulted in participants hiding their sexual orientation and/or gender identity (23).

Confidentiality concerns included clinical settings that segregated HIV services from other health services, fear that healthcare providers would publicly disclose their status, and concerns at LGBT-friendly clinics that peers would discover they intention to get tested or their HIV status (21). HIV-related stigma contributed to fear of testing HIV-positive; this intersected with the stigma of HIV as a “gay” disease (24). Reports about the difficulties of starting HIV prevention program among MSM in some countries, in correlation with a strong sexual discrimination, lead to legal invisibility of MSM serologic status.

Moreover, studies describe stigmatizing attitudes by university students and health/social service providers towards PLWHIV and LGBT persons in many Caribbean countries, with

the highest levels of stigma directed towards MSM living with HIV (24). In another study comparing attitudes of the populations towards MSM in Trinidad and Tobago, Grenada, Guyana, Belize, St. Lucia, Suriname and St Vincent, the attitudes revealed strong homophobic feelings, stigma and discrimination. This also negatively affects the involvement of MSM in successful national HIV responses (25).

Regional and national responses

Even in this non-favourable environment, several international funding programmes such as The President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to fight AIDS and the USAID have economically supported the Caribbean countries and have also launched specific initiatives, in partnership with national institutions, to expand MSM’s access to and retention in HIV services. In efforts to reach the ambitious 95-95-95 goals of the Joint United Nations Program on HIV/AIDS (UNAIDS) by 2030, MSM are a high priority (26). A strong presence of civil society organisations and community-led networks is also noticed in the Caribbean, with civil society instrumental in both the region’s HIV response and human rights activism.

To control the HIV epidemic in the Caribbean MSM patients and those at risk need to flow efficiently, consistently, and sustainably through the entire HIV continuum of prevention, care, and treatment services (27). This seamless integration of interventions requires strong linkages among program components so that HIV transmission is reduced and people diagnosed with HIV obtain early access to antiretroviral treatment and other social supports (27). The Pan American Health Organization (PAHO) has also advocated for combination prevention programs as rights-, evidence-, and community-based programs that promote a combination of biomedical, behavioural, and structural interventions designed to meet the HIV prevention needs of specific people and communities (28).

In terms of HIV testing and prevention, different strategies to testing are being considered and experienced in the region to increase the number of MSM who are aware of their HIV status, but efforts are constrained by health system and policies insufficiently tailored to their needs, health providers layered stigma and limited community-based services (29). HIV self-tests are available in some countries like the Bahamas and Trinidad and Tobago. However, as of 2017, most governments were yet to document their use. This method intends to expand testing to people from key populations like MSM, whose need is significantly greater due to the concentrated nature of the epidemic (28). The regional median for condom use among MSM in their most recent sexual encounter is 63%. All countries provide free condoms to MSM but levels are often inadequate and stigma impedes the distribution flow. Only one third procure condoms using domestic resources. It is essential to increase the availability, access, affordability and use of condoms and also compatible lubricants through targeted distribution schemes (28).

One major recommendation by the World Health Organization (WHO), prior to the start of the International AIDS conference in Melbourne since 2014 was the use of pre-exposure prophylaxis (PrEP) for all MSM as an additional HIV prevention method (30). In 2018, only the Bahamas and Barbados were providing PrEP through the public health system. Although PrEP is available through private providers in the

Dominican Republic, Jamaica and Suriname it is not fully distributed. Efforts are also noted in Cuba, Dominica and Haiti so it can be fully implemented (31).

Persistent challenges

The conservative nature of Caribbean societies makes it difficult to identify, define and reach MSM groups. This is compounded by the limited availability of disaggregated data, particularly in smaller countries where health information and monitoring systems are not well developed or controlled rigorously. Many countries report data on MSM, and despite high rates of population mobility in the region, there is very little data on HIV prevalence among migrant and mobile populations. Further, the vast majority of countries do not collect or report data for subgroups of stigmatised and isolated populations who often face multiple and overlapping vulnerabilities and risks. These include non-identifying MSM and MSM sex workers who do and do not identify as homosexual (32).

Barriers to testing for MSM are still numerous. For example, in the majority of the countries, testing centres are concentrated in large cities or in localities where confidentiality seems to be an issue. Besides, almost all the countries provide sensitivity training for health workers involved in HIV screening and care for MSM, but civil society organisations that participated in national consultations on HIV prevention reported a lack of sensitivity among these professionals besides the absence of LGBT issues in medical curriculum (28).

PANCAP has led and coordinated advocacy efforts to accelerate the human rights agenda and to eliminate stigma and discrimination. Although all Caribbean states have integrated some elements of human rights in their national response to HIV, in many instances new policies are not being fully implemented. In spite of these efforts, stigma and discrimination persist. Recent surveys of health facilities on three islands have found stigma and discriminatory practices present across all levels of staff (33).

Although progresses have been reported, the Anglophone Caribbean has maintained some of the most regressive anti-homosexual laws in the world. Same-gender intimacy, regardless of consent or physical location, was criminalised in 11 Caribbean Community (CARICOM) states. Sentences ranged from life imprisonment in Barbados and Guyana to 10 years in Belize, Dominica, Grenada, St. Kitts and Nevis, and St Vincent and the Grenadines. There were also laws against cross-dressing and constitutional bans on legal recognition of same-sex relationships. Trinidad and Tobago prohibited entry for homosexuals (34).

Weaknesses in health systems continue to present barriers to access and sustainability of services, particularly where parallel service delivery systems for HIV have been established. Vertical systems are inefficient, costly and perpetuate stigma and discrimination, resulting in low rates of entry and retention in treatment. Of major concern is the loss of patients at various stages along the HIV treatment continuum, as this reduces the proportion achieving viral suppression (28).

Intra-Caribbean migration, including high levels of transnational mobility and return migration, may increase the vulnerability of certain migrant subpopulations including MSM who face a range of barriers to accessing health services (33).

Many countries continue to face deficiencies in research capacity and in translating findings into actionable recommendations for policy and programme development (35).

Finally, the Caribbean region is characterised by a wide range of economic and human development levels which can have a huge impact on HIV care for the general population, including MSM. While some Caribbean states have developed-country status, at the other end of the spectrum we find some with low-income status. In between these extremes, many countries are all classified as middle-income, in spite of their vastly different economies and high levels of vulnerability to external shocks. Vulnerability resulting from the lack of economic diversity and heavy reliance on international funders and donors for HIV programmes is compounded by limited in-country institutional capacities (32).

DISCUSSION

Although homosexuality is not viewed the same in all the Caribbean countries, it is largely related to a person's beliefs about its origins. According to a study conducted in Barbados, Guyana and Trinidad and Tobago, attitudes towards homosexuality are grounded in strong rooted stereotypes. Therefore, although there is tolerance in certain social classes, MSM are often perceived as sources of both symbolic and realistic threat to society.

This report showed that MSM face a disproportionate share of the HIV epidemic in the Caribbean region relative to the general population. In many countries, the HIV risk to MSM is exacerbated by social, cultural, and political factors. These include cultural biases against MSM; limited access to information and services; low national investments in health; and legal, institutional or social barriers, including negative bias among providers, that make it difficult for MSM to negotiate safe sex or obtain adequate healthcare services. This situation is also compounded by adverse human rights environments that still prevail in many countries in the Caribbean where MSM may fail to seek treatment.

Among MSM, HIV rates are unacceptably high and could provide a reservoir for further and increased HIV spread among Caribbean general population. Nevertheless, these data must be interpreted with caution due to significant under-reporting from many countries as well as a considerable lag in reporting from some countries. Special measures need to be taken by health authorities and regional organisations to build bridges with the MSM community and empower them to promote safe sex and reduce HIV infection rates.

Reducing the high HIV prevalence among MSM in the Caribbean remains one of the most critical challenges in effectively controlling the HIV epidemic. It is unlikely that this will be feasible with current methods of prevention and treatment unless significant progress is made in reducing the strong stigma associated with homosexuality, removing the structural barriers to them accessing social services, addressing their social vulnerability, and empowering them to practice safe sex. A clear response to improve the legal/human rights environment affecting sexual diversity is needed in the Caribbean, not only on grounds of progress of the international agenda on human rights, but also based on a public health and development perspective. Multisectoral efforts should be made to show the social harm of homophobic laws

and practices, and to generate initiatives leading to positive changes (32, 33, 35).

In the Caribbean, renewed commitment to combination prevention and treatment that is tailored to MSM is urgently needed to be fully implemented and closely monitored to accelerate reductions in new HIV infections by strong prevention programmes and increase retention in care for those on antiretroviral treatment.

Another important point is achieving the funding required to end the AIDS epidemic. This will demand renewed international commitment, innovative financing and an intensified strategic focus. Low-income Caribbean countries, especially those with a heavy HIV burden, will need substantial international support to ensure rapid scale-up to end the epidemic.

Conclusions

The prevalence of HIV among MSM is high and the rates also do vary among Caribbean countries. Several factors influence the epidemic among MSM in the Caribbean but stigma and

discrimination underlie the social vulnerability in driving the HIV epidemic and play a central role. To end the AIDS epidemic by 2030, the global community will need to defy expectations in terms of tolerance and solidarity. MSM can no longer be kept unchecked in the era of the Sustainable Development Goals with the motto 'Leave no one behind' while working towards a world free of HIV.

Authors' contributions. WD and YC conceived the original research idea and led the design of the study. All authors developed the protocol. WD and YC conducted the analysis. WD developed the first draft of the article. All authors oversaw the development of the article and contributed to the revisions. All authors reviewed and approved the final draft.

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La infección por el VIH en hombres que tienen relaciones sexuales con hombres en el Caribe: alcanzar a los que quedaron atrás

RESUMEN

Objetivos. Presentar los factores epidemiológicos, sociales y culturales que impulsan la epidemia de la infección por el VIH en los hombres que tienen relaciones sexuales con hombres (HSH) en el Caribe, así como destacar las respuestas a nivel nacional y regional y las brechas que deben cerrarse para poner fin a la epidemia de sida para el 2030.

Métodos. Se realizó una revisión bibliográfica a partir de búsquedas en las siguientes bases de datos: PubMed y Scopus. Se seleccionaron artículos publicados en los últimos diez años que abordan los factores de riesgo socioculturales, la descripción de las iniciativas nacionales y regionales, y los posibles retos y obstáculos al control eficaz de la epidemia en los HSH. Este informe se centra exclusivamente en aquellas publicaciones sobre los HSH en los países del Caribe.

Resultados. Se realizó un análisis temático de 11 estudios arbitrados y 9 artículos y marcos programáticos de la bibliografía gris. La prevalencia de la infección por el VIH en los HSH es alta y las tasas varían entre los países del Caribe. Existen varios factores que influyen en la epidemia de la infección por el VIH en los HSH en el Caribe, pero el estigma y la discriminación están en el centro de la vulnerabilidad social y ayudan a impulsar la epidemia.

Conclusiones. En la era de los Objetivos de Desarrollo Sostenible y su lema de “no dejar a nadie atrás”, no se puede continuar desatendiendo a los HSH si se quiere poner fin a la epidemia de sida para el 2030.

Palabras clave VIH; enfermedades de transmisión sexual; equidad; Región del Caribe.

HIV em homens que fazem sexo com homens no Caribe: alcançando os que ficaram para trás

RESUMO

Objetivos. Descrever o perfil epidemiológico e fatores socioculturais determinantes da epidemia de HIV em homens que fazem sexo com homens (HSH) na região do Caribe e chamar atenção para as respostas nacionais e regionais e o que ainda falta para suprir as falhas e eliminar a aids até 2030.

Métodos. Uma revisão da literatura foi realizada nas bases de dados PubMed e Scopus com a seleção de artigos publicados nos 10 últimos anos. Os desfechos de interesse foram fatores de risco socioculturais, descrição das iniciativas nacionais e regionais e potenciais desafios e obstáculos ao controle efetivo da epidemia de HIV em HSH. O estudo se restringiu exclusivamente a publicações relativas a HSH vivendo nos países do Caribe.

Resultados. Onze estudos avaliados por pares e 9 relatos da literatura cinzenta e enquadramentos de programas foram analisados tematicamente. A prevalência do HIV é alta em HSH vivendo no Caribe e os índices variam entre os países. Diversos fatores influenciam a epidemia em HSH, mas o estigma e a discriminação constituem a base da vulnerabilidade social e têm um papel central na epidemia do HIV no Caribe.

Conclusões. Para eliminar a epidemia de aids até 2030, os HSH não podem mais ficar sem monitoração na era dos Objetivos de Desenvolvimento Sustentável com sua missão de “não deixar ninguém para trás”.

Palavras-chave

HIV; doenças sexualmente transmissíveis; equidade; Região do Caribe.
