

The Role of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ)-focused Psychosocial Approaches as Part of Human Immunodeficiency Virus (HIV) Prevention Efforts in Singapore

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Introduction

Earlier this year, the American Psychological Association passed a resolution endorsing its support for a combination approach towards human immunodeficiency virus (HIV) prevention, one that effectively employs both biomedical and psychosocial methods.¹ Despite the recent success of preventive medical treatments such as the Pre-exposure Prophylaxis Initiative (iPrEx) in which HIV-negative men who were given Truvada showed a 44% decrease in infection rates,² and in the CAPRISA04 trials where women who received Tenofovir gel reported a 39% in contraction rates,³ psychosocial approaches are still needed to optimise the overall success of any prevention effort. Furthermore, despite the existence of successful behavioural methods, there are still individuals who continue to engage in unsafe sexual practices. Resultantly, the behavioural aspects of prevention (and their success), as represented by these biomedical methods necessarily depend on psychosocial forces.⁴

HIV Prevention For the Men Who Have Sex with Men (MSM) Population

The Joint United Nations Programme on HIV/AIDS (UNAIDS) identifies the MSM population as one of the key high-risk groups for HIV.⁵ Indeed, epidemiologic studies from around the world have consistently identified the MSM group as the major contributor of HIV infections.^{6,7} This trend very recently surfaced in Singapore as well, with data from the Ministry of Health revealing that the majority of new HIV infections in the past year was the result of homosexual and bisexual sexual activities, surpassing that of the heterosexuals' for the first time.⁸ MSM were also identified by as more than 44 times as likely to be diagnosed with HIV compared to other men.⁹ Resultantly, a closer look at effective prevention strategies for this population is warranted.

In a review of criteria for best practices in HIV prevention programmes, the conveying of population-specific

information was identified as a key component.¹⁰ Indeed the needs for the MSM population are specific and unique, given the socio-cultural environment they operate in. MSM are an especially vulnerable population, with research showing that there are a substantial number of psychosocial factors interacting with HIV risk factors to produce an even elevated tendency for HIV risk behaviour.¹¹ MSM particularly face, in what America's Centers for Disease Control and Prevention (CDC) term as a "syndemic". A syndemic is defined as "two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population".¹¹ In the literature, psychosocial issues such as drug use, complex familial dynamics, lack of social support, homophobia, the pressure of masculine socialisation in the hetero-normative socio-cultural environment, current life stressors and sexual identity issues were identified as especially affecting MSM and contributing to this HIV "syndemic".¹¹ Indeed much research from throughout the years has supported the link between psychosocial distress and risky sexual behaviour. Substance abuse, loneliness, low emotional control, poor coping skills, low acceptance of gay sexual orientation, social conflict, a sense of invincibility and unrealistic optimism over the efficacy of anti-retroviral therapy were some of the psychosocial contributors to unsafe sexual practices.¹²⁻¹⁴

These factors are found to promote HIV risk behaviours, increased HIV infections and to also interfere with the efficacy of traditional HIV prevention methods in high-risk individuals.^{11,15,16} Furthermore, there is a need to further understand the reasons behind men who continue to practice unsafe sex, despite available information about the risks of doing so.¹² Understandably then, motivations behind unsafe sexual practices need to be looked at, over and above the promotion of safe sexual acts. As such, psychosocial interventions that address the context in which HIV risk behaviours occur in MSM are hence necessary to fully tackle the issue of HIV prevention and to optimise the likelihood of individuals engaging in protective behaviours. An improvement in overall psychosocial functioning in

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MSM then, can possibly effect a change in their sexual behaviours for the better.¹²

Psychosocial approaches to prevention in the MSM community have generally focused on both community-level and individual-level interventions, as there is a necessity to consider individual level processes (self-esteem, self-efficacy, affect regulation), interpersonal processes (social support, intimate relationships, conflict management) and societal level processes (discrimination, prejudice) to fully account for the multiple influences of high-risk sexual behaviour that occur in MSM.¹⁷

The efficacy of these interventions is broadly the result of an additional 3 criterion: the building of cognitive, affective and behavioural self-management skills, the addressing of environmental barriers (in implementing the behaviour change) and the provision of tools to develop ongoing social and community support.¹⁰ As such, many programmes target, at the individual level, psychological variables such as self-efficacy in the use of condoms, and addressing attitudes, beliefs, motivations and perceived social norms about HIV protective and risky behaviours.¹⁰ Additionally, knowledge about protective behaviours and skills to successfully carry them out are also incorporated in these programmes to facilitate actual behaviour change in MSM.^{10,18}

Individual programmes also target at MSM of various profiles. It must be noted that the act of sex is more than just a mechanical act, and is often couched in the dynamics of sexual identity and sexuality. Heterosexually identified MSM and bisexually identified MSM present varying sexual and behavioural patterns from gay MSM.¹⁹ As such, HIV prevention programmes need to be able to cater to specific needs of these subgroups of individuals so as to render any prevention efforts useful and successful.

Bisexually identified MSMs often have varying motivations for engaging in HIV risk behaviours. Few contexts have been identified in the literature in which these risky behaviours occur amongst bisexuals. These contexts include male sex work, exploration of sexual identity and drug use. Within these contexts, risky sexual behaviours are carried out for the purposes of economic gains, done secretly or as an act of sexual experimentation.²⁰ These motivations make for HIV prevention interventions especially challenging to reach out to these groups of individuals. It also shows that interventions that are targeted solely at gay-identified MSM may not be effective in reaching out to non-gay identified MSM. Bisexual men, as compared to gay men were also less likely to perceive safer sexual behaviours as the norm amongst peers.²¹ Those with female partners were also found to engage in higher unprotected sex with them than those who did not have.²⁰ Generally, bisexually identified MSMs presented

the highest sexual risk.²²

Research has shown that specific programmes tailored to behaviourally bisexual men are needed due to the unique status that these men hold in the wider population of MSM. Bisexual men were found to be less likely to commit to face-to-face interventions due to their concerns with not receiving help pertaining to the specific challenges they face. Similarly, with the heterosexually identified MSM, prevention interventions such as outreach programmes need to be contextualised enough to specifically meet the needs of this group. A programme run in the United States, “Wake Me Up Brother”, outreach was done by heterosexually-identified MSM in areas where non-gay identified MSM congregated.²⁰

Amongst those who are coming out and exploring their sexuality, the demographic tends to be much younger—in their adolescence and young adulthood.²⁰ Sexual activity in these youths is employed as a means of exploring sexual orientation and also as a way of forming identity.²³ This group of individuals often have sexual contact with both sexes, and the chances of them seeking anonymous sex and sex in return for economic or survival gains are considerably high.²⁰ This, coupled with a lack of role models and perceivable support, can disproportionately place them at an elevated risk for HIV.²² Prevention efforts with this group of individuals hence have to focus on issues pertaining to healthy sexual identity exploration and involve the building up of effective skills to negotiate safer sex with others.

Overview of Results of Psychosocial Prevention Work Overseas and Some Notable Interventions

Meta-analyses of psychosocial interventions conducted in America and Europe show several common aspects. Firstly, an education component is included, in which information about sexual health and HIV risk reduction is provided. Secondly, there are skills based training such as sexual assertion training, modelling and rehearsal of safer sex negotiation skills, and modules which focus on building better relationship skills and social support. Apart from these behavioural components, psychological components such as confidence building were also targeted.¹⁸ Counselling in areas of sexual risk behaviours and culturally-specific counselling focusing on development of identity were also conducted.^{18,24} In terms of the effectiveness of these programmes, a 22% net reduction in unprotected sex was reported in the intervention studies conducted in the US, with a smaller and non-significant reduction reported in the studies done elsewhere.²⁴ The Healthy Relationships Intervention was a notable HIV prevention intervention which incorporated behavioural and psychosocial elements such as motivation enhancement, coping skills, risk

reduction behavioural skills training and health education, and focused on the building of healthy relationships amongst MSM in the context of the HIV epidemic.²⁵ Results showed that there was an overall reduction in intercourse with non-concordant partners. Another psychosocial prevention project of note is ‘The Explore Study’ which consisted of 10 individual counselling sessions that extensively covered individual risk factors from the impact of drug abuse to the interactions between personal, social and environmental factors that can potentially result in unsafe sex practices.²⁶

HIV Prevention Programmes in Singapore by Oogachaga

In 2007, the Ministry of Health led a visit to the AIDS Council of New South Wales (ACON) in Sydney Australia along with representatives from Oogachaga, Action for AIDS and Fridae.com, to understand its MSM HIV prevention programme and its success in keeping HIV infection among MSM in check.²⁷ Under what was later described as the “Sydney Model”, the MOH worked very closely with MSM friendly and related community non-governmental organisations such as Action for AIDS and Oogachaga in developing specific prevention programmes for the MSM community in Singapore.

Since its inception in 1999, Oogachaga has incorporated education on HIV and sexually transmitted infections (STI) into its flagship MSM programme—the Oogachaga Men Support Group.²⁸ This component has been an important part in the programme in the past 13 years. By 2007, under the concept of the “Sydney Model”, Oogachaga integrated HIV education systematically into its other programmes for the gay, bisexual and MSM population.

These supportive programmes are conducted at both the individual-level and community-level. The most direct individual or small group approaches include the hotline, email counselling, face to face counselling services and support groups. These work well with MSM who are not open about their sexuality or facing specific life issues that need to be addressed in privacy. Sessions with these clients are often intensive, as they focus on the alleviation of stress related to sexual orientation and gender identity. These issues are known to be critical in contributing to the syndemic of HIV risk. In 2011 alone, close to 1100 MSM used Oogachaga supportive services.

Indirect individual approaches are often more challenging to implement. Oogachaga’s initial attempts in 2007 to conduct HIV and STI specific workshops with blatant safer sex messages proved to be ineffective as participation rates progressively became low. While these programmes fulfilled the objectives of educating the participants on HIV and STIs, there was an overall lack of appeal of the programme to the targeted MSM community, due to the

fact that concerns on HIV and STIs did not rank high with them. Since then, Oogachaga has redesigned its approach by conducting programmes which address interpersonal processes that are beneficial in increasing safer sex practices. These interpersonal variables include social support, intimate relationships and conflict management. Oogachaga has since delivered needs-specific interpersonal skills programmes to 3 groups of MSM: young MSM aged 18 to 25, mature MSM aged 40 and above and the general MSM group aged 18 and above.²⁸ Programmes for young MSMs focus on the understanding of one’s sexuality and impart coping skills to deal with the stress of coming out. General MSM programmes include interpersonal skills building such as self esteem and same sex relationship skills. Lastly, mature MSM programmes include education on ageing successfully. Despite the needs-specific content of these programmes, they all aim to provide a non sexual environment to MSMs to better understand sexuality and build healthier social networks. MSMs further learn to cope with stressors, increase their assertiveness and self efficacy in safer sex negotiation. These reduce the occurrences of maladaptive coping behaviours such as risky sexual practices and substance abuse. The programmes have also raised an awareness of MSM friendly resources and imparted information on HIV testing to the participants.

Oogachaga also actively promotes general mental health well-being in the lesbian, gay, bisexual, transgender and questioning (LGBTQ) community, acknowledging that psychosocial health can contribute to better HIV-preventive behaviours. Consistent with research from other countries, a May 2012 report on homophobia and transphobia survey by Oogachaga saw more than 70% of the LGBTQ respondents report higher incidences of eating disorder, excessive use of Internet or excessive sexual activity.²⁹ Furthermore, 63% of gay and bisexual male respondents and 80% of transgender female respondents who have experienced sexual orientation and gender identity (SOGI) based discrimination self reported suicide thoughts or attempts.²⁹ Oogachaga hence provides psychosocial education to promote better community health, especially to those who have faced SOGI based discrimination, which in itself is a potential contributor to maladaptive behaviours. The past few years have also seen Oogachaga collaborating with other social service and mental healthcare institutions in delivering topical workshops on addictions, mental wellness and MSM-specific psychological issues.

Coupling these community-based psychosocial education approaches with individual-level interpersonal skills programmes, Oogachaga has managed to integrate the practical and psychosocial needs of MSMs with education on HIV/STIs and delivered them in a contextualised manner to more than 700 MSMs in 2010 and 2011.

Peer-led prevention approaches for the LGBTQ community have also begun to take root in Singapore. Oogachaga in 2011, began a community empowerment programme, “Take Action” which invited individuals to propose and implement ideas that fostered community cohesion, raised HIV/STIs, sexual health and mental health awareness in the LGBTQ community. More than 30 active LGBTQ community groups also exist in Singapore.²⁸ The presence of these groups demonstrates the level of interest in contributing to the well-being of the community, including a better overall understanding of HIV/STIs. Despite the informal status of these groups, they are critical to HIV-prevention efforts amongst MSM, as they represent an extensive network within the MSM population which might be hard to reach through traditional media or even social media platforms managed by larger non-governmental organisations, including Oogachaga and Action for AIDS. Oogachaga’s “Take Action” programme provides the leaders of these informal groups with the skills to actively impart positive sexual health behaviours within their own networks.

Since 2007, Oogachaga MSM HIV prevention work has gained much momentum and recognition in the community. Through its various programmes, publications and its websites Oogachaga.com and Congregaytion.sg, Oogachaga has reached more than 14,000 MSM in 2010 and 27,000 MSM in 2011

Conclusion

HIV prevention approaches around the world, including Singapore have seen an increasing utility in incorporating psychosocial approaches in HIV prevention work, over and above biomedical ones. Psychosocial interventions are especially critical in dealing with the risky sexual practices worryingly present in the MSM population, from which the majority of current and new HIV infections stem from. The ‘syndemic’ that contributes to and amplifies HIV risk behaviours in MSM necessitates the implementation of psychosocial approaches in this group, which aim to improve psychosocial health in tandem with reducing risky sexual practices.

In Singapore, the work of Oogachaga in the past few years and the recent increase in peer-led community approaches to holistically improve the psychosocial and sexual well-being of LGBTQs are promising. These programmes assist in the provision of necessary information related to sexual health, and provide the necessary skills and motivational tools to implement safer sex practices in the lives of MSM. The contextualised approach in which these programmes are delivered further facilitate the identification of specific problems local MSM face and an understanding of the ways these act as barriers to successful HIV prevention efforts. These can potentially act as catalysts for an even more

extensively developed prevention programme in Singapore. Furthermore, these psychosocial approaches assist in the elucidation of the specific psycho-behavioural strategies that can potentially be effective for biomedical prevention techniques to be successful. Above all, these psychosocial approaches promote a self and community ownership in tackling the HIV issue in Singapore’s LGBTQ community, which inarguably perhaps is the most critical factor in the engagement of positive sexual health behaviours.

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