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## *Introduction*

HIV is one of the defining diseases of the last thirty years and despite billions spent on researching treatment, vaccines, and causes; it continues to impact tens of millions of people worldwide. Sexual transmission remains the key route of infection in the majority of new cases with sex between men in minority ethnic communities one of the highest-identified risks.

Misconceptions of the definitions of men who have sex with men (“MSM”) and Black and Minority Ethnic (“BME”) populations influence the ways in which health promotion agencies—whether private, public, or non-profit—interact with these target populations. This in turn impacts the likelihood of successful public health outcomes, such as reduced HIV incidence rates, improved safe sex behaviours for HIV positive individuals, and robust, accurate education provision.

In this paper we contextualise the need for highly developed health interventions to improve the sexual health of BME MSM, as well as critically discuss the effect that the very designation “BME MSM” has on both sexual health epidemiology and our ability to understand current trends and bring future HIV infections under control.

## *The State of Play*

The data provided by the Health Protection Agency (HPA), the Centers for Disease Control and Prevention (CDC), and other comparable public health bodies are widely accepted and rarely disputed, despite the potential for problems arising from definitional terms. These data however have not been enough to galvanise large-scale, consistent, responsive, and engaging health promotion interventions. The highly visible, comparatively well-funded, and often corporately-sponsored social marketing campaigns targeting a homogenised concept of White MSM in the United Kingdom and the United States are at notable odds with similar work targeting various BME MSM groups, which often maintain a “grassroots” feel to them.

In the UK, the London-based non-profit GMFA operates what they refer to as a “Black gay men’s community group,” which seeks to compensate for the health inequalities specifically relating to these groups within the wider label of BME. Originally “Gay Men Fighting AIDS,” GMFA now works across at-need communities providing sexual health promotion and education. Health promotion agencies are also keen to be representative of the diverse communities that typically make up the population of major metropolitan areas and so media work incorporates models or volunteers who represent a range of ethnicities and backgrounds. This cannot, however, be considered strictly tailoring as it implies that BME MSM have the ability and inclination to identify with strategically-placed messages, and delivered in proxy by their community “representatives” in the same settings in which White MSM groups receive the majority of attention and funding.

The need for culturally and linguistically sensitive approaches to HIV prevention work and education is repeated frequently in public health frameworks. The *Face of Global Sex* survey (Durex 2009) found that adolescent Eastern Europeans (eighty-two percent of the sample) regularly use sexual health check-ups as a preventative measure due significant gaps in sexual knowledge, both related to sexually transmitted infection outcomes and pleasure factors. With the European Union expansion and a burgeoning Eastern European ex-patriot communities in the UK, this survey should be considered of high importance in determining the direction and diversification of future HIV prevention work.

Elford et al. (2001) found that cultural differences amongst MSM cannot be underestimated. This paper describes a highly successful peer education model in the US that reported very poor returns when repeated in the UK. Although urban structure is cited as important, the differences in attitudes and sexuality-grounded roles amongst MSM even between two westernised nations must also be considered as a crucial aspect of intervention planning. Akin et al. (2008) found that the sexual behaviour of Latino/Hispanic MSM in Florida was conducive to high rates of HIV transmission including psychological distress, recreational drug use, and issues around cultural and political integration. Although these factors are by no means exclusive to Latino/Hispanic MSM, or the behaviourally bisexual population, the disproportionately high HIV incidence amongst African American MSM, another minority population grouping, is not positively attributed to sexual behaviour (Malebranche 2003), thereby counteracting the popular belief that a health promotion intervention can target BME MSM as a singular group.

A 2010 systematic literature review (Deblonde et al.) serves to further complicate the direction for diverse and highly population-specific health intervention work by citing the self-identified barriers to HIV testing in MSM and immigrant minority ethnic groups in various countries. The different behavioural attitudes and risk awareness highlighted across studies such as the Akin (2008) Latino/Hispanic and Malebranche (2003) African American papers are not reflected in the HIV testing literature review. Virtually all groups analysed consistently report a lack of knowledge around testing procedures, fear of an HIV positive test result and a misperception of personal risk as the key barriers to HIV testing. This aspect of public health forms a vital and central part of HIV work regardless of ethnicity, sexuality, or socioeconomic group and so the identified intra-group needs should be harnessed to redouble efforts on encouraging testing and the take-up of support services.

The US has made some steps towards addressing the HIV testing barriers that are replicated across communities. In the CDC's annual *Take the Test* mass media campaigns (2008), several variations of the HIV testing theme have been adapted for access by specific communities. In addition to imagery and text showcasing young White men, adaptations were produced and strategically placed for African-American men and women, Latino/Hispanic men and women and Native American

mothers. Although simplistic when compared to the complex needs highlighted through epidemiological surveillance data, these public health efforts mark an important departure from the othering that is often demonstrated by some grassroots organisations resulting from excessive focus on a particular community's stereotypical behaviour.

Cole (1993) highlights the important counterproductive effects of using nomenclature such as "BME." He suggests that ethnicity be used only as self-definition and that labelling ethnic minority groups with a singular prevailing descriptor such as "Black" detracts from the others intended to be encapsulated in the term. In the UK, the term "Black African" is specific and excludes those of Caribbean descent or those identifying as Black but not necessarily as African (Agyemang et al. 2005). His alternative suggestion that "Asian" be added to "BME," whilst including an additional population group, does little to address the lack of recognition of other ethnicities such as people of Irish, Polish or Mexican origins.

### *BME and MSM*

An important factor in the effectiveness of health promotion initiatives is how BME MSM groups are seen and addressed by health promotion agencies. Principally, the way BME MSM groups are defined by agencies contributes to the poor engagement.

In order to begin to qualify the many ways BME and MSM are used by various organisations, a sample of published reports and articles (n=36) was reviewed using a discursive analytic approach. The reports and articles analysed for the purpose of this are British-based articles that focus on "BME" and/or "MSM" issues related to health and/or community that were published by government, academic, and third sector institutions. The analyses below examines the way "BME" and "MSM" are used within these publications and the meanings of the terminology in specific contexts. Specifically, the ways in which BME and MSM are defined and operationalised by different health agencies, academics, and governmental bodies begins to show how varied these terms are in practice. By analysing these two terms in this way, the difficulties of variation in "BME" definitions can be contrasted to the less varied utilisation of the term "MSM."

#### **Defining "BME"**

The term "BME" is not one that has been standardised across sectors, and therein, the meaning of it differs from organisation to organisation. In practical terms, there is no consensus of who is or is not included in this designation. Beginning with what BME stands for, there is variety on how different organisations label BME communities. A majority of organisations that use BME terminology describe BME as standing for "Black and Minority Ethnic" (or, in two cases, "Black and Ethnic Minority"). Of the organisations surveyed, there were two that expressed BME as being "Black Minority Ethnic" or "Black/Minority Ethnic" (Tower Hamlets Primary Care Trust 2007; DrugScope 2006). In the case of Tower Hamlets Primary Care

Trust, however, the terminology was not consistent, as elsewhere in the publication BME was written out to include “and” between “Black” and “Minority.” Within this publication, both forms may indicate a similar understanding of BME, though there is no explanation given as for why the different wordings are used.

Although a small word, “and” is potentially important for understanding to which groups BME is referring. “Black and Minority Ethnic” potentially includes those from “Black” groups and those from “Minority Ethnic” groups, however those terms are defined within the specified context. However, without “and,” “Black Minority Ethnic” can both be understood to be either inclusive of the same groups, or only referring specifically to “minority ethnics” from contextually understood “Black” groups. In the cases of “non-Black” minority ethnic groups, how the term is written and meant is crucial to knowing whether or not they are included in the BME designation. This is particularly true in the UK, where “Black” historically has been viewed as a political term that may include people of both African and South Asian ethnicities. Depending on one’s assumption of the meaning of “Black” in a given context, this terminology can cause even greater confusion in its inconsistencies.

Interestingly, there were ten organisations that did not use the BME abbreviation in their reports or articles, including all five analysed from the Office of National Statistics (ONS—UK census organisation). This is particularly important because some organisations cite the BME designation as coming from ONS categorisation (i.e., POST 2007:1), when in fact the ONS does not use that terminology to describe populations.

When organisations did not use “BME,” forms of “minority ethnic” and “ethnic minority,” were found to be used to qualify groups on the basis of ethnicity and minority statuses. The word order may at times provide some connotative distinctions; however for the purposes of this analysis, they are being treated for all intents and purposes as synonymous. In these cases, the “Black” qualifier—which has been criticised by some as excluding “Black” groups from (other) ethnic minority groups (Cole 1993)—has been omitted.

There was variety across the surveyed organisations with regard to which ethnic groups were included in the BME designation. There were two general groups of dichotomy that emerged during the analyses: White/BME, and White British/BME. There is variation amongst the organisations as to whether all “White” groups (however defined) or only White British groups are contrasted with BME. A further issue is the question of whether White minority ethnic groups are to be included in the BME classification. Unique to the contexts of the UK, this is of particular importance when considering Irish groups, as Northern Ireland is geopolitically part of the UK but is not part of Great Britain. Practically, at present, this leaves great room for inconsistency in how BME groups are articulated and operationalised by UK organisations.

Most organisations (approximately four-fifths) in this study either explicitly or implicitly contrasted White/BME or White British/BME, with about half using one or the other dichotomies consistently within their publications. Explicit dichotomies are those where the text specifically references a population group type in contrast to BME (i.e., Coleman and Testa 2008; ONS 2005; Raleigh et al. 2010), whereas implicit dichotomies (Afiya Trust 2010; Atewologun and Singh 2010) are those where the descriptions of BME and non-BME imply such a dichotomy.

The remaining organisations featured seemed contradictions in their operationalising of BME. In the case of the ONS and in a study on breast cancer, reports at times contrast BME with “White British” and at other times contrasts BME with “White,” which potentially includes non-British White groups (ONS 2003; Renshaw et al. 2010). In speaking about her research project on BME groups, Bakare criticises the terminology “BME” as not being appropriate for “non-White groups,” but then goes on to mention new ethnic communities in Britain, which in fact do include ethnic minorities commonly classified as White groups (most notably, Eastern European populations in the UK) (Bakare 2007). In the example of a report specifically on ethnic minority men who have sex with men, the ethnic minority men are contrasted to a White British group, which acts as a functional control group in this study (Elford et al. 2010). Speaking specifically about the groups analysed, the report states that in addition to non-White census categories, migrants from Central and South America and Eastern and Central Europe were also included in the study. There is currently no census category quantifying groups from Central and South America as a specific ethnic grouping; however Europeans from the Eastern and Central regions are currently included (by common understanding) in the White Other category. As this distinction was made, it is unclear whether other “White Other” groups were considered in this study. One final example; in the study by Long et al., when discussing the ethnic diversity of the UK, they include the Irish population when discussing non-White groups:

There is enormous variation in ethnic make-up across different parts of the UK: Scotland, Wales and particularly Northern Ireland are much ‘whiter’ than any English region. In terms of the non-British population other non-white groups are significant (including the Irish they amount to a further 4.4% of the population in England in 2005, for example), though given scant regard in the research literature.  
Long et al. 2009: 4, emphasis added

This example leads well into the final and related issue surrounding the lack of standardisation for BME, which is exactly which groups are considered to be BME. As the term is often used without much explanation as to its contextual meaning—let alone what it stands for in each instances of a given usage—there are clearly assumptions being made by organisations that their particular understanding of the term is the same as others’ understanding of the term. This may be acceptable if that were indeed the case. But when analysing the text of reports and articles, it becomes evident that there are actually many understandings and

operationalisations of BME in current use, rendering assumptive understandings essentially futile.

Using the ONS census categorisations to describe the ethnic populations in the UK, generally speaking, a large majority of the organisations agree that the term BME includes the aggregated Black, Mixed, Asian, Chinese, and Other ethnic groups (e.g., Dougan et al. 2005; Hickson et al. 2004; POST 2007; Raleigh et al. 2010). It is also generally accepted that the “White British” category (comprising of English, Welsh, and Scottish) describes the ethnic majority and therefore is not included in the BME designation in each case reviewed. However, as seen in the analysis above regarding to what BME is contrasted, in some instances there is scope for inconsistency as to who is included in either group.

The source of most of the inconsistency is whether non-British White groups are treated as part of the ethnic majority groups (i.e., simply “White”) or whether they are classified as being part of the ethnic minority groups (i.e., differentiated from the White ethnic majority groups). Both cases have been seen in these analyses, as illustrated by the dichotomies discussed above. However, in addition to those, there is yet more inconsistency when considering White Irish groups specifically. There is no standardisation as to whether “White Irish” includes those from Northern Ireland, or if it is restricted to individuals from the Republic of Ireland. Even though geopolitically Northern Ireland is not a part of Great Britain, one report aggregates “White Irish” (whether or not it comprises of Northern Ireland ethnicities in addition to Republic of Ireland ethnicities) as being part of the White British ethnic majority group (Raleigh et al. 2007). Perhaps less controversially, most other reports aggregate White Irish groups into the “White Other” group, and therefore is treated as other White non-British groups are in ethnicity analyses. From this point, some organisations aggregate the combined “White Other” groups into a general “White” classification to contrast with BME (e.g., Hickson et al 2004), or will aggregate the combined “White Other” groups into the BME groups, for comparison with White British groups (e.g., Joule and Levenson 2008).

As the numerous examples show, there are currently multiple definitions and uses of BME in use across many organisations in the UK. Practically, this has serious ramifications for understanding and conceptualising ethnic groups and likely has a direct negative impact on engaging effectively in terms of health promotion and behavioural interventions with groups labelled as BME groups.

### **Defining “MSM”**

The variability of terminology among organisations with an interest in MSM is substantially less than that for BME. However, that being stated, there is also not a standard definition for the term MSM, which also can create inconsistencies in research, analyses, and ultimately programmes. Inconsistencies in the manner the category “MSM” is operationalised is problematic in terms of effective end-solutions and high quality public health work.

The general consensus among the major sexual health reports and articles is that MSM stands for “Men who have Sex with Men” (e.g., Dougan 2005; Elford 2010; Hickson 2004; Prost et al. 2008). However in terms of operationalisation, there are three variables we have identified that are not accounted for in this classification, and also are not often addressed in reports and articles about MSM: type of sex, gender, and habitualness.

In “MSM,” the type of sex for consideration is not standard across reports and often is not specified when the terminology is used in text. For example, it is not clear or uniform whether sex is specific to penetrative sex (i.e., anal sex) or whether it can include oral sex or other sexual activities. This is an important consideration when examining risk factors for HIV transmission, as some sexual activities are less likely to provide a chance for exposure than others. When collating data by organisations who have classified men into MSM categories, the type of sex that the men have had/are having may not be adequately taken into account when analysing risk behaviours and transmission rates by ethnicity.

Reports and articles around MSM rarely consider gender and how it can vary within the MSM categorisation. There is uncertainty about who is considered a man for the purposes of this classification, which particularly comes to light when considering transgendered individuals. As “MSM” is not a classification that individuals choose to identify into, the role of the researcher in contrast to the researched becomes especially significant. It is unclear whether transgendered males (female to male) would be considered as MSM, or even transgendered females (male to female) as the former identifies as male whereas the latter was born a biological male though later identifies as female. As with types of sex, this designation and the inclusion or exclusion of transgendered individuals potentially affects the type of sex individuals may have, as well as the risks of transmission during those types of sex. The CDC acknowledges that transgendered individuals have an elevated risk of HIV infection (CDC 2007) but does not clearly state its categorical views on the classification of transgendered people into their MSM surveillance. The HPA’s latest report, *HIV in the United Kingdom* (2009) refers only to sexual behaviour and not gender identity in its data analysis.

Habitualness is also not often accounted for when designating individuals as MSM. MSM, in cases, could refer to men who regularly have sex with men (whether exclusively or in addition to women) or could also include men who have had sex with men in the past, but not presently. Presumably, these two groups of men would have different needs in regard to HIV health promotion, however they can become obscured when either put together into one group, or when the MSM designation is not specific as to which group it is referring. Crucially, the broad spectrum of men included with “MSM” in health promotion targeting is likely to miss the men who have experimented sexually with another man, become unknowingly infected with HIV, and decides that his sexual desires are predominantly heterosexual. In this case, they may have no reason to think that they have been at risk of HIV and will not engage with health promotion campaigns



that use the social identification, “gay,” and simultaneously be missed in the clinical “MSM.”

### **BME MSM**

Considering both BME designations and MSM designations, these inconsistencies and ambiguities subsequently limit the amount of meaningful comparability and sharing amongst organisations working with different groups. In terms of statistics and trends, research often cannot clearly be interpreted and applied to useful broader contexts due to the inconsistency of the BME designation within research. One result of this is that the few organisations that are able to engage with specific BME MSM groups are not able to extrapolate their methods for the use in other BME (MSM) groups, and larger less-specialised agencies are not able to successfully employ methods and research across the diversity made invisible by the overarching term “BME.”

Britain has a rich mix of cultures and communities. Some of these reflect long-standing history and heritage, while others reflect more recent and ongoing social changes and new ways of life. Ethnicity is, therefore, far from a static concept. It is a rich balance of ancestry, religion, culture, nationality, language, region[,] etc. [...] Understanding people’s ethnicity and *their sense* of national identity *is key to understanding many current social and economic trends.*

ONS 2003: 4, emphases added

BME groups cannot be homogenised in their operationalisation in the same way that “non-BME” (or “White” or “majority”) often are; and where those interventions remain relatively successful despite the homogenisation of these majority ethnic groups, BME interventions ultimately fail. Similarly, MSM designations need to be clarified and perhaps more inclusive in order to capture better the diversity that is found within those groups. The result will be more specific and meaningful research that will lead to improved engagement and programmes to improve the sexual health of BME MSM groups.

### *Specialised HIV Health Promotion*

The focus on the HIV health promotion issues facing one population group, however ill-defined, can be both justified and contextualised historically and epidemiologically.

In 2010, HIV forms just part of a layered approach to sexual health; the main focus of which depends on locality, funding and in geographic areas with established and robust public health models in place, actual need. Although a frequent topic of discussion in public health circles, popular literature, and the media, the focus on HIV has shifted somewhat from the frenetic and urgent need for research in the early days of the epidemic (Klotz 1998; Odets 1995; Rofes 1998) to a consistently

problematic drain on quality of life and public health costs without notable exemption in any country with the capability of gathering surveillance data.

This change in attitude and approach, notably in the developed world, belies the progress made by pharmaceutical companies in producing highly effective drugs to curtail the progress of HIV in infected individuals and the notable lack of impact that health promotion work has had on curbing new infections. A consistent factor throughout our limited historical HIV prevention framework is the sustained and ongoing disproportionately high rates of HIV prevalence and incidence amongst MSM, BME of any reported sexual identity, and BME MSM as it is has been defined by public health bodies.

The latest available surveillance data from the Health Protection Agency shows that of all new UK HIV diagnoses in 2009, thirty-eight percent occurred during sex between men (HPA 2009). Fifteen percent of new diagnoses occurred heterosexually with sixty-eight percent amongst the “Black African” ethnic population. The terminology, definitions, and compartmentalisation used in these data results in a less than ideal structure in which to accurately assess, at least statistically, the specific needs of BME MSM. The knowledge that separately, BME and MSM are at the greatest risk in terms of HIV infection is evidence enough to justify accelerated or prioritised work with these groups. Despite the identified need for work in this area, viewing “BME” and “MSM” as mutually exclusive is problematic due to the myriad of ways in which both individuals can identify themselves and the way in which public health bodies can label them. “MSM” is a clinical term used in professional circles and is unlikely to be understood by laypersons. “Gay” is a social identifier which is not specific enough to assist in public health surveillance but its frequent use by laypersons to describe any man who has sex with another man can make any data that rely on self-identification difficult to deconstruct into useful information.

The HPA uses the cultural or sexualised term “gay,” in its statistical narrative relating to this data which potentially limits our ability to understand when we know that certain BME groups may be more unlikely to identify as “gay” (Njaka 2010); rather it has been found that a significant number may identify as heterosexual but maintain covert sexual relations with other men (Martínez-Donate et al. 2009). As a singular example of this, Martínez-Donate et al. (2009) found in a study of over one thousand Latino/Hispanic men in the US, the majority self-identified as heterosexual but many maintained sexual relationships with other men.

Comparable surveillance techniques in the US, presented by the CDC, report a very similar epidemiological structure to that of the UK. Latest available data from this country reports that fifty-three percent of new HIV diagnoses are generated by sex between men. The differing behavioural titles given to this, in the CDC’s case “Gay, Bisexual, and MSM” could account for the slightly higher reported figure than that of

the UK's more restrictive definition. The CDC also reports disproportionately high incidence in Black MSM and Latinos/Hispanics (2010).

With the UK reporting approximately 33,000 undiagnosed infections (HPA 2009) and the US reporting almost 250,000 (CDC 2010) in the same category, the need for greater understanding and effective preventative work with BME, MSM and the groups combined is clearly indicated.

### *Key Recommendations*

The multi-faceted nature of HIV healthcare needs amongst BME MSM makes selecting some recommendations over and above others problematic unless desired public health outcomes can be clearly prioritised to target geographically-based communities. This would be most useful where data on issues such as undiagnosed infection or hepatitis co-morbidity is known and comes from robust data sources.

The University of Illinois at Chicago's Project WISH clinic is a prominent example of community-based, peer-led interventions that can deliver high-quality outcomes that cannot be similarly achieved in medically-based politicised settings such as the UK's National Health Service. In using peer educators to engage with Chicago's highest risk communities, including Latinos/Hispanics and African Americans, a service can be provided by members of an individual's own community group thus neutralising any language or access barriers that can be associated with larger-scale projects.

Community engagement can be harnessed to direct prevention efforts in many directions, from increasing HIV testing to encouraging condom use or preventing new transmissions by enhancing behavioural work with HIV positive individuals. This technique can also be used to address the repeatedly cited HIV testing barriers of fear of a positive test result or misperception of risk. Peer work can provide individuals with education and incentives to maintain good sexual health. It can also begin to address the barriers to HIV prevention that are caused by problems around ethnic identity and cultural aspects of sexual health.

However effective community work may be at a localised level, it is unlikely to result to wide-scale international changes in attitudes towards HIV or indeed those groups, such as BME MSM, at most risk. For this to occur the many fragmented and disparate international agencies working within different public health hierarchies and towards different HIV-related outcomes, must critically and urgently assess their understanding, use, and application of "BME," "MSM," and the two groups combined. Overarching goals such as HIV vaccines and consistent condom use can be applied to multiple diverse groups of people but emphasis on the methods of delivery and culturally-appropriate interaction should be prioritised to ensure that no one ethnic group is missed simply because of a linguistic misunderstanding.

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