Anthropological Assessment for Culturally Appropriate Interventions Targeting Men Who Have Sex With Men

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Although social and cultural factors play a fundamental role in the health of sexual minority populations and the development of culturally appropriate interventions, public health activities and research have sometimes lacked appropriate sophistication or attention to issues of cultural competency.

In areas such as HIV prevention for men who have sex with men (MSM), biomedical interpretations of same-sex phenomena should be applied with caution. Communities and societies may broadly understand same-sex desire, attraction, behavior, and identity through age-structured/initiatory, gender-defined, profession/social role–defined, or egalitarian/gay frameworks.

When more detailed, locally specific information is required, such as for youth, ethnic minorities, or urban versus rural populations, the approach to rapid anthropological assessment presented can provide nuanced insights for effective health programs targeting MSM. (*Am J Public Health.* 2003;93:867-871)

ETHNOGRAPHIC APPROACHES can inform the design of evidence-based, culturally appropriate public health programming essential for successful HIV prevention.[1] Anthropological assessments can also aid in understanding the basic ecology of health and disease in any population.[2] For men who have sex with men (MSM) and other sexual minority groups, the issues include (1) identifying the causes and important factors that explain the variations in frequencies of a particular illness or pathology, (2) identifying variations in prevention or treatment forms with relation to particular illnesses or pathologies, (3) identifying and explaining the variations in individuals' choices of forms of treatment, and (4) finding ways in which the organization of prevention and treatment forms can be made more effective for a specific population.[3] A fifth role for anthropology in public health would be to foster a sensitivity to and critical self-reflection upon the field's underlying biomedical beliefs, taxonomies, institutions, and modes of providing care.[4]

Discussions of human sexuality raise a daunting linguistic challenge. Despite the need for clear and accurate nosological systems to describe human sexual expression, the dynamic and multifaceted character of human sexuality refuses to fit neatly into any taxonomy. Terms such as "heterosexuality" and "homosexuality," although they may appear helpful on the surface, rarely live up to their promise as secure categories, nor can such static descriptions of sexuality capture the dynamic nature of sexual expression over time or provide insights into the culture-bound limits of these terms. Although such "fuzzily bound categories" may suffice for common usage, they are hardly the grist for a formalized analytical mill.[5]

Modern terminology and biomedical models of homosexuality were developed in the 19th century, and became the object of study for pioneers such as Hirschfeld[6] and Westermarck.[7] The pervasive assumption that these "scientific" concepts of sexuality apply universally is not only incorrect, it also impedes appreciation of the relative differences within and between cultures with respect to same-sex behavioral phenomena. As Carrier writes, "Additional anthropological research on human sexual behavior is urgently needed in different culture areas of the world . . . to counteract the myopia of many who continue to view it only through the screen of Western behavior, beliefs, and social and clinical labels."[8(pxi)]

Public health science relies upon what Good calls "biomedical hermeneutics" as the interpretive means by which signs and symptoms map onto their biological and physiological referents.[9] Individuals and groups have their own analogous mappings, which mediate the recognition and communication of symptoms, behaviors related to illness, and beliefs about health, illness, appropriate treatments, etc. In the case of public health, a privileged place is held for professional over lay beliefs, assigning the label of "knowledge" to the former and "beliefs" to the latter.

Translating sexuality concepts presents difficulties not only between cultures, but also within the same culture over time.[10–12] Folk understandings, norms, and experiences of sexuality can be fluid. The culture of Chauncey's "gay New York" circa 1900,[12] for example, is neither the same pattern found in other American cities at that time, nor the same as that of New York in 1969, or in 2003.

Despite the limitations of existing terminology and static formulations, there are useful theoretical and social organizational frameworks of same-sex sexuality. One such framework[4,5,13] consists of age-structured/initiatory, gender-defined, profession/social role–defined, and egalitarian/gay models. The definitions of these categories and representative historical and cross-cultural examples are summarized in Table 1.

Age-structured/initiatory patterns refer to interactions that may be construed as sexual between older and younger individ-

TABLE 1—General Social Organizational Frameworks of Same-Sex Phenomena

Organizational Framework	Same-Sex Phenomena
Age-Structured/Initiatory	Regarded as "masculinizing" or necessary to proper maturation and development (Classical Greece, New Guinea, pre–Meiji Restoration Japan, Siwa warriors)
Gender-Defined	Assumption or mixing of gender-defined roles, usually with the retention of at least some aspects, privileges, and prerogatives of masculine gender (Java, Tahiti, Native American *berdache* individuals, *activo/pasivo* distinction in Mediterranean and Latin American cultures)
Profession/Social Role-Defined	Behavior based upon occupational or other social role (shamans of Borneo, Korea, Siberia, Northwest Pacific coast of North America; female impersonators of Korea, Japan, Indonesia)
Egalitarian/Gay	Characterized by (1) group consciousness of distinctiveness, (2) elaboration of a subculture, (3) egalitarian social roles and relations (i.e., not based upon age differences, gender role, etc.), and (4) widespread presence of exclusively same-sex relations (gay communities of North America, Europe, contemporary Japan; areas of cultural diffusion secondary to globalization)

Note. Within each category, additional considerations include variations in sexual identity or self-concept among racial and ethnic minorities and emergent sexual socialization among youth. One or more general patterns can be present in any community, and patterns can evolve over time.
Source. Adapted from Silenzio.[4]

uals, although these relationships may not be considered explicitly sexual within the indigenous culture. They are sometimes referred to as "initiatory" in that they may be considered essential to normal growth and development.[13,14] Age-structured patterns for MSM include some of the best historically documented examples of same-sex sexuality. The prominent role of pederasty in classical Greece[11,15] has served as an important influence on Western culture for centuries.[16] Same-sex experiences in the early Christian period appear to have been less open,[17] but are likely to have continued in Europe through at least the Renaissance.[18] Age-structured organizational patterns existed historically in Japan[19] and Korea,[20] and across Asia and Oceania.[5] As with the Siwa warriors of Libya, where initiation to adult male status related to the symbolic meanings of semen,[14,21] contemporary examples are found in New Guinea and Melanesia.[22] Evans-Pritchard's studies of the Azande describe both an age-structured organizational pattern among males and a gender-defined pattern among females.[23,24]

The concept of the *berdache*, or two-spirit, individuals in Native American cultures[25–30] provides some of the best-documented examples of gender-defined patterns for MSM. These patterns refer to the assumption of some or all of the conventional roles and responsibilities of the opposite gender, or of a combined or distinctive third gender role. Extreme cross-gender behavior has also been described among the *hijra* of India,[31–33] the *bayot* of the Philippines,[34,35] the *mahu* of Polynesia,[36,37] and the *xanith* of Oman.[38–40]

Another well-described gender-defined pattern is the *activo/pasivo* pattern of relationship found widely across the Mediterranean and Latin American culture areas. This pattern is characterized commonly as stigmatizing for the passive partner, although not necessarily for the active partner. The precise definition of "active" and "passive" may be variable and quite fluid. Studies of MSM *activo/pasivo* relationships have been done for in Brazil,[41,42] Mexico,[43] Central America,[34,44] and the Mediterranean basin.

Although there can be significant overlap between gender- and profession/social role–defined patterns—and some writers suggest that the distinction is not always clear[13]—there are many examples of profession-defined patterns among MSM. The essential distinction is that MSM sexual contact is linked to the professional or social role of an individual or group. Examples of this are found among the shamans of the peoples along the entire Pacific Rim arc from North America to Siberia, down into Southeast Asia and Melanesia.[5] Profession-defined patterns, specifically male prostitution, have been part of several cultures of the Near East,[45] as well as many other areas of the world, throughout history.

The egalitarian/gay pattern usually refers to the social expression of MSM and other sexual minorities that have taken shape over the past century. The hallmark of this pattern includes egalitarian social roles that are not necessarily based on entrenched differences in gender, power, or sex roles. The term "gay community" refers to a cultural system of institutions, including social and political organizations, businesses, publications, and community centers, as well as territorially or geographically defined areas such as ghettos, neighborhoods, and other places identified as "gay" or "gay-friendly." To this we can add social networks and groupings, including gay and lesbian families.[46,47] The egalitarian/gay concept has been described as a work in progress, with significant differences in the experiences of successive generations over time.

The geography of gay-identified communities is complex. There are differences between prevalence estimates in the 12 largest American cities (16.7% who report same-gender attraction, desire, or appeal, and 9.2% who identify as homo- or bisexual) as compared with national averages (7.7% and 2.8%, respectively) and with rates in rural areas (7.5% and 1.3%, respectively).[48] This finding is consistent with claims that the gay and lesbian subcultures are primarily urban phenomena, with urban–rural social differences mirroring those in the general culture. However, data from the 2000 US Census complicate this issue. Data are available only for cohabitating same-sex couples, of which there were 594 391 reported in the United States.[49,50] Despite the significant underreporting that is likely to have occurred, these same-sex couples are found in all but 2 of the more than 14 000 US communities of 5000 or more people. There are important geographic differences in

egalitarian/gay patterns within and between societies in the developed and developing world, such as for New York,[12,51,52] San Francisco,[53,54] Los Angeles,[55] Chicago,[56] and locations outside the United States such as Rio de Janeiro,[41] Israel,[57] and many others. These locally elaborated subcultures are certainly not monolithic. Within the United States, for instance, there are also very important differences between the "mainstream" gay subcultures and the experiences of minority and "nonghetto" MSM.[58–62]

RAPID ETHNOGRAPHIC ASSESSMENT OF MSM

Anthropological assessment can assist public health workers in responding to this dizzying cultural diversity. Although the broad categories suggested in Table 1 are useful stepping-stones to understanding cultural differences in same-sex attraction, desire, identity, and behavior among MSM, they provide little specific detail to help in the design or evaluation of culturally sensitive interventions. To explore the pragmatic application of these ideas and move beyond the general 4-point framework presented in Table 1, public health researchers and practitioners may use rapid ethnographic approaches for sexual minority populations in the developed and developing world. Rapid and focused ethnographic approaches are intended to address specific concerns and provide detailed analysis and information in a brief period of time. Similar approaches have been used by the author to study questions ranging from the organization of HIV/AIDS primary care in the early years of the epidemic[63] to planning for culturally sensitive college health services for gay and lesbian students.[64]

Ethnographic research approaches are useful tools for qualitative and combined quantitative–qualitative research; nonetheless, the application of these approaches in public health research and program assessment has been relatively infrequent. This often has been due to the perceived need for extensive amounts of time or intensive immersion in fieldwork, although rapid ethnographic approaches have been repeatedly used successfully.[65–67]

Ethnographic accounts attempt, so far as is possible, to represent the world from the perspective of another individual or group under study in order to communicate that perspective to others. Ethnography is best thought of as a research approach, often relying upon an ad hoc combination of methods rather than upon a single specific method. Although participant observation is the method most often associated with ethnographic research, other methods of data collection and analysis may also be employed as part of a particular ethnography, including quantitative methods.[68] Ethnographic accounts draw upon a diversity of available methods as appropriate in order to analyze or interpret the phenomenon in question, and to provide detailed and useful types of information not easily obtained through other approaches.[69]

Formative research is a form of rapid ethnography adapted in part from anthropological approaches to the study of AIDS and HIV prevention.[70] It is well suited to address the methodological complexities of research with sexual minorities and has been used successfully to study MSM who do not necessarily identify themselves as gay.[71] The process of formative research allows formal and informal groups, such as health departments, public health researchers, community-based organizations, and grassroots community groups, to develop culturally appropriate interventions and to refine these interventions through ongoing collaboration. Higgins et al.[72] have identified 11 steps in formative research that are summarized in Table 2.

The major steps of the formative research process begin with the project team carefully identifying the population of interest. They develop a preliminary taxonomy and subsequently test and refine these initial definitions. Once the taxonomy is defined, the team conducts a thorough search of the existing scholarly and lay literature and other documentation about the target population. They collect data from staff who are internal and external to the project team and who have knowledge about the target population, as well as from other individuals who interact with the population of interest. The results of these steps are organized and analyzed to help further refine the taxonomy and define the major sectors and other subgroupings of the target population. This permits the project team to prioritize segments of the target population to study, or to identify those segments of particular interest.

Once the priorities for further study or intervention have been established, the team targets "gatekeepers," individuals who can control or provide access to the population of interest. Members of the target community or other key participants can be contacted through these gatekeepers, at least initially, for interviews or other data collection. After analyzing and interpreting these findings, the team conducts focus group interviews with members of the target community. These focus groups not only provide the opportunity to critique the data generated by individual interviews, but also allow for member checking, triangulation, and other activities designed to help increase the trustworthiness of the rapid ethnographic assessment.[73–76]

CONCLUSIONS

Public health education, research, and interventions focused on MSM in the United States and abroad may often fail to sufficiently take sociocultural factors into account. In the case of HIV/AIDS and sexually transmitted infections, trying to understand these epidemics merely through the history of disease vectors and their interplay with individual human hosts, without detailed consideration of social-level factors, would be wholly inadequate. Such an approach leads to an overemphasis upon secondary and tertiary approaches at the expense of primary prevention and other measures. Initial successes at relieving rates of HIV transmission among segments of the MSM population point to the potential of such measures, yet the partial reversals of some of these successes and the limited successes among MSM in minority communities suggest that remaining sensitive and responsive to the range of social and cultural concerns is of paramount importance.

While the general framework of same-sex cultural frameworks summarized in Table 1 offers the opportunity to at least par-

TABLE 2—Rapid Ethnographic Assessment for Men Who Have Sex With Men and Other Sexual Minorities

Action Step	Objective
Define the target or at-risk populations	Develop preliminary working definitions of the population(s) of interest
Search for information and gaps in knowledge about the target population	Conduct a thorough search of the literature and other documentary evidence to identify gaps in knowledge about the target population
Survey internal staff members who have knowledge of the target population	Identify internal staff members and others with knowledge of the target population and collect data through semistructured interviews or surveys
Survey external systems staff and volunteers at other agencies with knowledge of the target population	Move beyond immediate staff and contacts to gather additional information from other formal agencies or professionals familiar with the target population
Survey "interactors"	Indentify individuals who have informal contact with and knowledge of the target population, but who are not themselves part of the target population
Reduce and integrate the information from the internal and external interviews	Closely examine and integrate the data generated, providing the foundation for subsequent steps
Define and prioritize sectors and subgroupings of the target population	Revise initial taxonomies in light of data that have emerged; prioritize sectors and subgroupings for study based upon issues such as accessibility, levels of risk, and relative size of the population
Obtain access through "gatekeepers" and other means to conduct observations	Identify individuals who can control or promote access to the target population for participant or nonparticipant observation
Interview key participants or members of the target population	In-depth semistructured or structured interviews to gather "insider" views of the sectors and subgroupings of interest
Interpret data from all the previous steps	Formally reduce, analyze, and interpret data
Conduct focus groups with members of the target population	Formally use focus groups to provide critiques of individual interview data and to conduct "member checking" of findings, interpretations, and conclusions

Source. Adapted from Higgins et al.[72]

tially escape the prison of Euclidian biomedical taxonomies, rapid ethnographic assessment techniques such as formative research offer public health practitioners and researchers the opportunity to move beyond this simple approximation of sexual diversity. Indigenous forms of same-sex interactions and attraction are demarcated by and interpreted within any given society or group in specifically localized frames of reference.

Although the process of cultural globalization has included the diffusion of the egalitarian/gay framework around the globe, we must also recognize that the egalitarian/gay model may also be exogenous to the experiences of many within the United States.

Human sexuality cannot be definitively fixed or located in a static taxonomy, and ongoing cultural change must also be accounted for. Failure to appreciate this level of historical complexity undermines not only the cultural competencies of public health personnel, but also the effectiveness of public health education, research, and service. Anthropological approaches offer the potential to address this complexity to learn from our own as well as other cultures. Same-sex desire, attraction, sexual behavior, and identity are dynamic historical processes profoundly influenced by culture. Public health practitioners, advocates, and others need to be sensitive and open to how target populations of MSM frame these issues and experience these phenomena. Culturally sensitive and appropriate interventions for MSM should ideally be based in ethnographic data specific to the population of interest in order to be effective. Using the comparative lenses of anthropology and cultural studies, we may begin to appreciate the needs of MSM and other sexual minority populations in fundamentally different ways. ■

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