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Globalization, Structural Violence, and LGBT Health: A Cross-Cultural Perspective

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1 Introduction

It is a daunting task to provide even a partial analysis of the health of lesbians, gays, bisexuals, and transsexuals (LGBTs) from a global perspective owing to the cross-cultural and regional variation in the social construction and expression of sexuality as well as the still incomplete scholarly literature on the topic. This chapter, however, argues that it is precisely such a global vantage point that is required to apprehend the contemporary context of health and illness among LGBT populations. Although LGBT health is shaped by local cultural meanings and practices, it is also inherently embedded in large-scale processes and the position of local LGBT populations within the global system. In the era of a highly mobile, hybrid, and fundamentally interconnected world in which material and symbolic cultures are linked across vast distances, the meanings of LGBT sexuality and their consequences for health in specific locales cannot be understood if nations are viewed in isolation (Altman, 1989). Indeed, the nature of global interconnectedness requires us to engage LGBT health as a fundamentally transnational phenomenon involving the interplay of meanings, practices, and vulnerabilities that extend beyond the purely local. For example, the acquired immune deficiency syndrome (AIDS) epidemic among gay-identified men in the United States and Europe may be intimately related to the meanings and practices that drive risky practices in Papua New Guinea, Uganda, or Bolivia. Furthermore, the flow of the discourses, meanings, persons, and practices that shape LGBT health are always multidirectional, necessitating a more complicated theoretical approach that truly engages the issue of LGBT health from the global perspective.

This chapter draws on a growing ethnographic and social scientific literature on LGBT persons to analyze LGBT health at both local and global levels. Approaching LGBT health from an anthropologic perspective, we take the position that the meanings and social consequences of socially deviant or nonnormative sexualities are subject to

cross-cultural variations because LGBT persons are always situated within specific cultural systems and are also connected to larger political and economic inequalities that are expressed at a global scale. Thus, although this review is necessarily partial and is constrained by the limits of the literature currently available, particularly the relative paucity of cross-cultural studies of both lesbian and transgender health, the discussion seeks to organize the literature available within a dual conceptual framework that emphasizes two fundamental features of LGBT health: (1) the large-scale structural inequalities at work both locally and globally that influence LGBT health; and (2) the cultural variations in the meaning, expression, and practice of LGBT persons in various contexts. As other chapters in this volume examine the literature on LGBT health in developed settings, we draw primarily on ethnographic evidence in the developing world to illustrate the ways that the social and structural context (including both cultural meanings and political-economic forces) manifests in the health of LGBT persons.

We want to emphasize from the outset that although we use the designation LGBT throughout this text, readers must be mindful that this category, like others we discuss in this chapter, is not unproblematic when viewed cross-culturally. Whereas the notion of an LGBT population seeks, at one level, to emphasize diversity (clearly calling attention to the L, the G, the B, and the T as distinct subsets of this heterogeneous population), when applied cross-culturally it can itself become an ethnocentric imposition. Some activists in non-Western and developing societies have adopted it, whereas others have questioned its application. Even some who have adopted it have wished to further diversify it: In many parts of Latin America, for example, reference is made to the LGBTT population, with the second T having been added to distinguish between *transgender* and *transvestite* subgroups. In short, from a cross-cultural perspective, whenever LGBT is used in this analysis, we ask that readers remember that this is a somewhat problematic construct that must be subjected to constant critique to avoid imposing a category that fails to have a fully agreed upon (or universally shared) meaning across social and cultural boundaries.

2 Structural Violence and LGBT Health

The concept of *structural violence* provides an important point of departure for discussions of LGBT health in cross-cultural settings. Structural violence refers to the ways by which social inequalities and political-economic systems place particular persons or groups in situations of extreme vulnerability, and this vulnerability is expressed in patterns of morbidity and mortality (Farmer et al., 1996). Precisely because social inequalities such as class, race, and ethnicity intersect with sexual inequalities, the shape of LGBT health in any social or cultural setting is inextricably linked to the relations that exist between these various forms of social inequality. This highlights the importance of placing any discussion of LGBT health in a broader historical and political-

economic framework to understand the range of social forces that affect the health of LGBT communities and populations around the world in an era of intense globalization.

A growing cross-cultural literature has emerged that is relevant for our discussion of the social inequalities that shape the environments in which LGBT populations live and the specific expressions of structural violence they face. In the developing world, much of this literature has focused on processes that have been stimulated by the extension of industrialization and capitalist economic restructuring in a wide range of societies—as much in Latin America, Asia, and Africa as in the more extensively researched societies of western Europe or North America (Altman, 1989; Parker, 1999; Drucker, 2000; Appadurai, 2001). These studies have demonstrated that certain expressions of global capitalism have led to the transnational spread of identities, meanings, and terms of Western notions of LGBT identity in a broad range of societies, including, for example, Argentina (Pecheny, 2001; Brown, 2002), Brazil (Parker 1999, 2002), Chile (Frasca, 1997, 2003), China (Wah-shan, 2000), the Dominican Republic (Padilla, 2007, in press), India (Reddy, 2004), Indonesia (Wieringa, 1994, 1995), Mexico (Carrier, 1995, 1999; Carrillo, 1999, 2002), Namibia (Croucher, 2002), Peru (Cáceres, 1996; Cáceres & Rosasco, 1999), Senegal (Teunis, 1998), South Africa (Gevisser & Cameron, 1995; Donham, 1998; Phillips, 2000, 2004), Taiwan (Chao, 2000), or Thailand (Jackson, 1997, 2000; Jackson & Cook, 2000). Despite this diverse literature, relatively less attention has been placed on what has been described as "dependent development and gay identity" (Parker & Caceres, 1999), in which the shape of these appropriated cultural forms and identities is analyzed within local and global systems of power and inequality. Such a framework is essential when considering the influence of structural violence on LGBT health, and it has several consequences for our understanding of the health of LGBT populations in the developing world.

First, in resource-poor areas of the world, the large-scale political-economic environment—and therefore many of the structural vulnerabilities faced by LGBT persons—is quite distinct from the structural circumstances that have been described for LGBT communities in developed, industrialized nations such as the United States (D'Emilio, 1993). For example, integration into the wage economy may have facilitated independence from natal households among some LGBT men and women in the United States, thereby allowing them financial independence from the what D'Emilio (1993) describes as the "imperative to procreate." In contrast, the formal wage economy in the developing world is often highly constrained and precarious, functionally precluding large numbers of LGBT persons from achieving material independence. Murray (1992) has discussed this phenomenon as the "underdevelopment of gay communities," a somewhat problematic term intended to draw attention to the ways LGBT communities in the developing world may be constrained by structural factors characteristic of the larger conditions of underdevelopment, such as economic dependence on family and kin networks, lack of housing, low literacy, low access to education, and high unemployment.

Indeed, a growing ethnographic literature on LGBT populations in a variety of cultural settings has begun to document the specific ways that *nonnormative sexualities*—understood as expressions of sexual identity or practice that deviate from the expectations of particular hegemonic "sexual cultures" (Parker, 1990)—may be particularly vulnerable to the structural and social inequalities routinely experienced by poor populations in many areas of the world (Farmer, 1990, 1992). This literature, although not always informed by applied public health approaches, has nevertheless described some of the ways that the inequalities confronting many poor populations in the developing world are often particularly pronounced among those who are further stigmatized by their nonnormative gender, sexuality, or sexual behavior. We believe that to understand the social epidemiology of LGBT health in the developing world we must also understand the particular structural constraints LGBT persons face, and this requires attention to the linkages between political-economic factors and the disadvantaged position of LGBTs as a marginal and stigmatized group within local systems of gender and sexuality. Furthermore, because much of this structural violence is reinforced by institutionalized and governmental policies that systematically undermine the human rights of LGBT populations, some international agencies have begun to recognize such expressions as violations of sexual rights (Ungar, 2000; Schliefer, 2004).

Various studies from Latin America of transgendered persons, for example, demonstrate that same-sex attraction or cross-gender behavior during childhood or adolescence can produce vehement retribution or violence from family and community members. In her study of effeminate *jotas*, or young men displaying cross-gender behavior in a poor section of Mexico City, Prieur's research showed that many of these persons were forced out of school—and often out of their homes—because of their effeminacy, leaving them, according to Prieur, "largely excluded from the educational system and from ordinary working life" (Prieur, 1998, p. 67). Structurally excluded from numerous domains of productive life and subject to various forms of systematic abuse, Prieur concludes that commercial sex work may actually be (somewhat paradoxically) an *upwardly mobile choice* for these adolescents, or at least one that does not contribute further to their marginal social status: "For the young jotas who have left school and not had the opportunity to enter the labor market, starting to sell sexual services does not represent further exclusion, does not mean that the distance from *straight* society increases" (Prieur, 1998, p. 72). Kulick's (1997, 1998) work on transgendered Brazilian prostitutes, or *travestís*, similarly demonstrates that once detached from extended kin networks, and after being violently expelled from home, many *travestís* were left largely without support structures when they became homeless, hungry, ill, or reached the final stages of human immunodeficiency virus (HIV) infection. He further demonstrates the ways that international sex work networks facilitate the *travestís'* trips to European cities, where many of them are made further vulnerable by restrictive policies, antiimmigrant laws, abusive authorities, drugs, and violence. Thus, although it is inappropriate to think of Mexican *jotas* or

Brazilian *travestís* as in some way bereft of autonomy or agency—because both of these ethnographic studies also demonstrate the elaborate and poignant ways that transgendered sex workers use their expert knowledge of gender and sexuality to survive—the studies exemplify the persistent and extreme structural violence that confronts transgendered persons in Latin America, shaping their vulnerability to physical and psycho-emotional risks.

The stigma and discrimination experienced by transgendered persons demonstrates, on one hand, the extreme consequences of non-normative gender and sexuality in many cultural contexts and, on the other hand, the logic behind the desire—even perhaps the *necessity*—to pass as normal for those LGBTs who are able to do so. "Passing" is a phenomenon often associated with the sociologist Erving Goffman's (1963) classic analysis of stigma management; it refers to an individual's ability to convince others, through the use of a variety of strategies and techniques, that she/he does not belong to a stigmatized social category. For instance, Carrillo described a case from his ethnographic research in Mexico involving two lesbian women who over an extended period of time "had engaged in elaborate schemes and arrangements to be able to live as a lesbian couple while also pretending that they were divorced women supporting each other as close friends" (Carrillo, 2002, p. 145). Such patterns are consistent with observations about lesbian invisibility throughout Latin America, where remaining silent about one's sexuality is a functional response to the fear of losing the privileged social status conferred by heterosexuality; it is a rational coping mechanism in the context of very real threats to lesbian women's well-being (Eiven, 2003). Indeed, an International Gay and Lesbian Human Rights Commission (IGLHRC) report on Spain suggests that owing to tradition and economic crisis most unmarried women are forced to live with their parents until their early thirties, and lesbians who reveal their sexual orientation to their family face nearly insurmountable rejection and condemnation (Hernandez, 2003).

Although the health implications of passing—often overlapping with what Carrillo refers to as *sexual silence*—is only beginning to be documented, the HIV/AIDS epidemic has spurred a number of authors to draw connections between cultural silence about homoeroticism and the spread of HIV. In an important piece on the epidemic among Latin American and Latino populations, for example, Alonso and Koreck (1993) argued that the continued transmission of the HIV virus was closely related to the deeply ingrained cultural silence about sex and sexuality, particularly same-sex behavior, despite the commonality of clandestine same-sex encounters in Latin American societies. In the case of sex between men, they argued that Latino silence was a fundamental barrier to effective prevention of HIV, an argument that has been put forward in various versions by other researchers as well (Parker, 1992, 1996, 1999, 2000; Cáceres, 1996; Díaz, 1997, 1998; Carrillo, 2002; Arend, 2003; Padilla, 2007, in press).

One of the least studied aspects of sexual silence is the way it influences LGBT health in the context of their familial and household relationships. For example, some cross-cultural literature on gender and

household health suggests that in many cultural contexts relationships with family and other household members may be crucial determinants of numerous health outcomes, and relationships with adult women may be particularly important in this regard (Browner, 1989; Browner & Leslie, 1996; Clark, 1993). However, for LGBTs who may not feel capable of discussing or acknowledging their sexuality with their immediate household and family, adequate support for LGBT-related health concerns is unlikely to be forthcoming. Furthermore, even if household members become aware of one's sexuality, the rejection, reprimand, or even physical abuse that can result may further place LGBT persons in more precarious health situations or contribute to negative health outcomes. For example, Díaz's (1998) work among Latino gay men in the United States suggests that when the familial support for one's gay identity was not forthcoming many men in his study were in danger of losing access to crucial social networks they needed for survival. Díaz sees these contacts as essential for assisting individuals in an already marginalized ethnic group to cope with the structural conditions they face in the larger society. Furthermore, Carrillo argued, Díaz "has gone so far as to suggest that sexual silence creates a psychological split between sex and affection that among homosexual men results in a search for anonymous sex, loneliness, longing for a romantic relationship, problems practicing safer sex, and a deep-seated absence of affective intimacy in the context of sex" (Carrillo, 2002, p. 149). In addition to maintaining sexual silence, family members may also directly influence or manipulate sexual behaviors and practices, as dramatically illustrated by Bolt-Gonzales's (1996) analysis of lesbians in Nicaragua, which demonstrates that lesbians' relatives and significant others may play an important role in imposing reproductive decisions and forcing maternity.

Ironically, even as LGBT activism and movement politics in certain countries have led to the possibility of LGBT persons adopting children or raising their own biologic children, LGBT families continue to face social and legal restrictions that reinforce sexual marginalization. The Human Rights Watch (2004a) reported the case of a Chilean lesbian mother who was deprived custody of her children by the High Court because she refused to hide her lesbian relationship from her children. Similarly, in the relatively progressive political environment of Spain, where lesbians are legally permitted to adopt a child, a report by the International Gay and Lesbian Human Rights Commission reported in 2003 that women were not allowed to adopt as a couple, and a lesbian mother who is open about her sexuality may face serious social consequences (Hernandez, 2003). Although Spain has recently resolved legislative ambiguities that allowed continuing discrimination in marriage and adoption (McLean, 2005), these examples demonstrate the broad impact of institutionalized discrimination on the private lives and sexual rights of LGBT persons, even in presumably progressive social and political contexts.

The fact that sexual silence may be related to certain health risks may lead one to assume that open self-identification as gay or lesbian may mitigate such risks for LGBT persons. However, there is no reason to

believe that this is necessarily so based on the highly limited evidence presently available. The literature on the relation between self-identification as gay and HIV risk behavior among minority men in the United States, for example, has provided ambiguous results. Whereas some scholars argue that gay identification can lead to positive health behaviors among men who have sex with men because of positive gay community norms that reinforce safer sex practices (Seibt et al., 1993; Turner et al., 1993; Kelly et al., 2002; Chng et al., 2003), other studies suggest that gay identification among Latino men may actually *increase* high-risk behavior (Marks et al., 1998). From a global perspective, part of the ambiguity involves the fact that the very notion of sexual disclosure assumes there is a fundamental LGBT essence that is either hidden or truthfully exposed, and this is not a universal understanding of sexuality or sexual identity across cultures and societies. A significant proportion of the same-sex behavior in many cultural settings may not be definitive of a homosexual identity in any way analogous to gay identity in places such as the United States or western Europe. Therefore, any attempt to understand the relation between sexual identification and health risks in the developing world, by necessity, must consider the local meanings of same-sex practices in specific cultural settings in addition to the nature of social inequalities and structural violence.

In sum, the existing cross-cultural literature on LGBT persons demonstrates that the combination of social marginality and large-scale structural inequality often leads to particularly acute manifestations of structural violence among marginalized genders and sexualities in the developing world, and this disadvantaged position of LGBTs is a crucial factor—perhaps *the* most crucial factor—in shaping LGBT health outcomes. At the same time, the ways that structural violence unfolds and its linkages to local cultural meanings and definitions of sexuality are variable and depend on the local cultural context. Understanding both of these processes is essential for conceptualizing LGBT health. Moreover, we argue, it demands greater emphasis on ethnographic and qualitative approaches to LGBT health in the developing world to better understand the local meanings of sexuality in specific cultural contexts and their connections to the structural violence faced by LGBT persons.

3 Violence, Human Rights, and LGBT Health

The literature on violence against LGBT persons, although far from comprehensive, demonstrates that the structural violence faced by LGBT persons is not limited to the impersonal domain of social, political, and economic inequalities. Indeed, such violence frequently manifests in very real expressions of physical and sexual abuse against this population. Although relatively little is known about exposure to violence and abuse from within LGBT communities (as in the case of domestic violence by sexual partners) or from individuals or groups outside these communities who perpetrate physical violence against LGBT persons, a growing international human rights literature attests

to systematic and institutionalized abuses and social cleansing practices perpetrated by governments or their functionaries (police, military, paramilitary forces, death squads) against LGBT persons in many parts of the world. Furthermore, the existing literature on domestic violence in LGBT communities demonstrates the close connections between the larger social inequalities and silences faced by LGBT persons and the risk of domestic violence in LGBT communities. Here we summarize this emerging literature, drawing on the few descriptive or ethnographic studies available as well as the documentation of such human rights abuses now available through international organizations such as Amnesty International.

Whereas the practice of domestic violence among same-sex partners has been well documented in the United States (Merrill & Wolfe, 2000; Relf, 2001a,b), there is still a lack of literature about battered LGBT persons in many parts of the world. In the United States, lesbians report pushing or being pushed more frequently than gay men, a pattern that is reflected in a suggestive study from Brazil, which demonstrated that 20% of the calls to a telephone hotline involved women who were assaulted by their female partners (Eiven, 2003). Nevertheless, this may be a reflection of the underreporting of battering among men, an artifact of the fact that the authorities tend to underestimate partner abuse among gay men, or a consequence of the reduced believability of battered men in comparison to (heterosexual or lesbian) women (Poorman et al., 2003). However, because of the paucity of literature on LGBT domestic abuse in developing settings, it is unclear to what degree the patterns observed in the United States are generalizable cross-culturally. Some ethnographic studies suggest that in developing settings underreporting may be similarly pronounced because prior experiences of persecution or abuse by authorities toward sexual minorities is likely to result in the fear that admission to same-sex behaviors will result in further police abuse (Kulick, 1998; Prieur, 1998; Padilla, 2007, in press). In addition, the generalized shame and stigma surrounding nonnormative sexual behaviors and identities is likely to contribute to underreporting.

An important study of abuse in LGBT relationships in Australia, which reported that domestic violence is the third most severe health problem facing gay men today after AIDS and substance abuse, demonstrates the intimate connections between societal homophobia and the risk of domestic violence (Vickers, 1996). Describing LGBT domestic violence as "the second closet," the author argues that LGBT persons who abuse their partners often use homophobia and heterosexism as a weapon of control over the partner in a variety of ways, such as threatening to reveal the partner's sexuality to friends, family, employers, or the wider community; convincing their partner that violence is an expression of gay life; or arguing that nobody is going to help or believe the story of violence due to homophobia (Vickers, 1996). Because of the discretion about the relationship that both partners are supposed to protect, domestic violence therefore functions as a second closet for many LGBTs who do not reveal their situation owing to the institutionalized homophobia and heterosexism present in the criminal

justice system, support services, and the larger society (Vickers, 1996). The lack of ability in many cases to discuss such relationships with family and other social peers creates further barriers to reporting the abuse and to seeking any support systems or programs that may be available.

The situation of domestic violence is further exacerbated by the patterns of hate crimes, abuse, and persecution of LGBT persons by those outside the community. In the 2001 global report on torture and hate crimes against LGBT person by Amnesty International, provocatively titled "Crimes of Hate, Conspiracy of Silence," LGBT populations are said to be systematically denied human rights and full citizenship throughout the world. Importantly, the report argues that this denial is often rooted in a conspiracy of silence between the state, other institutions, and society, and that such silence functions to maintain and reinforce human rights violations against LGBT persons, such as discrimination in employment, access to military or state professions, and access to social and medical services (Amnesty International, 1997). Systematic abuse and discrimination based on sexual identity are often legitimized by law, policy, and practice in many countries, and torture may even be legitimized when employed against LGBT persons. A parallel indictment of international human rights abuses published by the International Gay and Lesbian Human Rights Commission (2003) argues that torture is a widespread means for regulating sexuality and enforcing norms of gender and sexuality, and that the effects of *sodomy laws* in many parts of the world justifies detention of people based on their sexual orientation, denial of public services, and the abuse of LGBT persons by police, doctors, and health practitioners. Recently, additional human rights organizations, such as the Human Rights Watch, have released statements denouncing the systematic torture, persecution, assassination, and hate crimes against the LGBT population the world over. Their report highlights numerous tragic cases of systematic abuse, such as one recent atrocity in Sierra Leone in which a lesbian activist—the victim of constant harassment and violence from neighbors and the compliance of local police and the government—was found murdered after being repeatedly raped and stabbed (Human Rights Watch, 2004c). The graphic nature of the abuses detailed in this report emphasizes that such violence is rarely based on simple political differences that can be addressed through traditional mechanisms of legal or policy reform; rather, it is generated by deep hatred and moral outrage that is systemic and pervasive, requiring broad social and cultural transformation.

The extent of the human rights violations against LGBT persons underlines the need to consider these phenomena as an additional expression of structural violence that is expressed in the very physical risks to life and limb that are confronted by LGBT in many settings as a consequence of institutionalized discrimination. Policies and programs aimed at improving LGBT health, in addition to providing health services and programs specifically designed for LGBT persons, must therefore also address themselves to abusive policies of states or international organizations, and seek to apply political pressure

through existing human rights bodies that are increasingly documenting such human rights violations among sexual minorities.

4 HIV/AIDS and LGBT Health in Cross-Cultural Perspective

Within the broader context of structural violence and the global and local structural constraints LGBT persons face, we turn to the phenomenon that has become emblematic of the intersection between sexuality and health in the contemporary world: the HIV/AIDS pandemic. As Cáceres (2005) argues in a review of LGBT health issues focusing primarily on Latin America, discussions of LGBT health urgently need to move "beyond AIDS," a sentiment with which we wholeheartedly agree. Nevertheless, in many ways HIV/AIDS provides an essential context for our discussion of LGBT health in the developing world, as so much of the social, economic, and political context of LGBT health has been irrevocably shaped by this single health problem. In this section, we argue that the impact of HIV/AIDS on LGBT health in the developing world cannot be adequately understood without considering at least three factors: (1) the complex ways the development of the local HIV epidemic intersects with existing patterns of stigmatization and discrimination toward LGBT persons; (2) the general lack of emphasis placed on designing appropriate programs to meet the sexual health needs of a *diversity* of LGBT groups and identities in specific sociocultural contexts; and (3) the relations among LGBT populations, community-based organizations, and patterns of state funding and support for LGBT communities and programs. We believe it is essential that this discussion be viewed within a self-consciously global context because the discourses surrounding HIV, as much as the virus itself, are highly mobile, such that scientific or popular understandings of the epidemic in Washington may have intimate connections to beliefs, practices, or policies in Bombay, Durbin, or Buenos Aires. Thus, consideration of the responses to AIDS among LGBTs in the developing world can never be understood as entirely independent of the influence of models and interpretations in the high-income countries from which much of the AIDS-related research, funding, media, and scholarly literature has emanated since the beginning of the epidemic.

For a number of reasons related to global patterns in the epidemiology of HIV/AIDS, as well as the historical timing of recognizable gay and lesbian communities in the urban industrialized West, the HIV epidemic in the United States and Western Europe became associated early in the epidemic with gay-identified men (Epstein, 1996). As argued in several critical analyses of popular interpretations of AIDS early in the epidemic (Treichler, 1988; Watney, 1988; Patton, 1990), the somewhat arbitrary historical impact of HIV infection on gay men in the urban West has led to an incautious yet persistent association between HIV and gay *identity* that tends to reinforce existing social stigma toward LGBT persons and to confirm the popular perception of their inherent perversion and pathology. This tautologic association—

what might be termed the *homosexualization of AIDS*—became a highly influential conceptual model that was rapidly globalized during the first decade of the pandemic and has continued to inform both popular and scientific interpretations of emerging epidemics in various parts of the world (Bolton, 1992a,b; Hoffman & Bolton, 1996; Treichler, 1999).

In the most general terms, there have been at least two consequences for the developing world of this particular restigmatization of LGBT persons vis-à-vis their conceptual association with HIV/AIDS. First, as HIV becomes more prevalent in a given region, LGBT persons—particularly gay-identified men or their analogous identities in a given cultural system—may be presumed to be the primary vectors of HIV infection, often regardless of the actual behavioral epidemiology of HIV transmission, and may also be blamed for the negative consequences of HIV on the wider community. That is, the tautologic association between gay identity and HIV has functioned to reinforce convenient stereotypes that exist in many societies (Human Rights Watch, 2004b), notwithstanding their inevitable cross-cultural variations in expression and intensity, while also offering a convenient explanation for the apparent cause of the epidemic. Not only has this compounded the historical discrimination and scapegoating experienced by LGBT persons in numerous locales, it has created many challenges for HIV prevention campaigns as the epidemic has evolved, as individuals who do not identify themselves with any nonnormative sexual identity or behavior may not consider themselves at risk for HIV infection and may therefore forego appropriate behavioral or preventative measures.

For example, in Farmer's ethnographic account of the emergence of the HIV/AIDS epidemic in Haiti, the initial victims—who were apparently infected through heterosexual contact—did not believe they could be HIV-infected because of their assumption that only homosexuals get AIDS (Farmer, 1992). Such notions were directly in line with reports emanating from the United States and elsewhere at the time in which gay men were configured as the prototypical (or even exclusive) victims of what was often referred to as a "gay plague." These discourses and stereotypes have emerged in many parts of the world in their various local manifestations, and the erroneous beliefs they generate about who is at risk for HIV (and by extension, who is *not* at risk) have been repeatedly identified as barriers to HIV prevention in countries as wide-ranging as India (Bhattacharya, 2004), South Africa (Toms, 1990; de Gruchy & Germond, 1997), and Mexico (Liguori et al., 1996; Liguori & Lamas, 2003). Thus, a growing amount of social science research in international contexts has now demonstrated that as the AIDS epidemic expands the stigma and fears of contagion that are associated with it—what Jonathan Mann referred to as the "Third Epidemic" in the evolution of AIDS—are often linked to the historical patterns of social inequality and hierarchy in the local setting (Mann, 1987; Parker & Aggleton, 2003). LGBT persons are typically disadvantaged in such hierarchies. This not only makes them vulnerable to further discrimination, which may in turn increase their risk for HIV infection, it also, and ironically, results in greater risk to the so-called

general population, who may see AIDS as a problem exclusive to the Other and thus fail to understand that the boundaries between self and other are rarely as impermeable as social stereotypes would have us believe.

The permeability of the boundaries between LGBT persons and the general population has been a key epistemologic issue in both public health and social scientific research on HIV/AIDS since the beginning of the epidemic. Early in the epidemic, the notion of a *bisexual bridge* between what was often conceived as a relatively self-contained high risk group of homosexually behaving men and the general population was frequently invoked both as an impending threat to the larger society and as a potential epidemiologic explanation for the different male-to-female ratios of HIV infection in various areas of the world (Aggleton, 1996a). In 1987, for example, Padian (1987) pondered the marked difference between the 1:1 male/female ratio of HIV infection in Africa and the 14:1 ratio in the United States; she offered that higher levels of bisexual behavior among men could conceivably account for this contrast (Padian, 1987, pp. 951–954). Such analyses were also centrally concerned with the global transition from what was then termed *Pattern I*—the epidemiologic scenario originally emerging in the United States and western Europe in which gay men, IV-drug users, and recipients of blood products were the primary victims—to *Pattern II*, whose ideal representation is the generalized, predominantly heterosexual epidemic in sub-Saharan Africa (Patton, 1990). Aggleton (1996a) describes the concept of the bisexual bridge as follows:

> [M]ale bisexuals have often been characterized as a "bridging group," enabling HIV to be transmitted from apparently discrete sub-populations of behaviourally homosexual and behaviourally heterosexual individuals. Most usually, it is suggested that bisexual men pose a special threat to their female partners through having had sex with other men, particularly exclusively homosexual men. Such accounts stereotype reality in that they posit the existence of two identifiable and discrete groups of individuals, the "homosexual" and the "heterosexual," that are capable of being "bridged" by a third type.

Early in the epidemic, bisexual behavior and the notion of a bisexual bridge therefore provided a convenient framework for conceptualizing—however crudely—an epidemiologic transition that appeared to be occurring particularly rapidly in some world regions. Yet, as implied by Aggleton's comment, the categorizations used in this framework also tended to impose definitions of sexual identity that may not correspond to social reality in other societies and cultures.

Partly as a response to these epistemologic questions and pushed by social scientific critiques (Parker, 1987, 1990, 1992; Parker & Carballo, 1990; Bolton, 1992a, b), the 1990s brought a growing awareness of the problematic dimensions of epidemiologic language, including its tendency to equate gay identity with an independent risk group or to neglect the various ways that homosexuality is understood in cross-cultural settings. This led to a shift in public health terminology toward the use of the term men who have sex with men, or MSM, in an attempt

to separate sexual *identity*, which has nothing to do with HIV risk per se, and sexual risk *behavior*. Although this new terminology has been useful for addressing much of the stereotyping and stigmatization inherent in earlier risk group language and avoids the assumption that all homosexually behaving men can be glossed as *gay*, it is not a label with which individual men can identify and may therefore alienate them from HIV/AIDS interventions (Muñoz-Laboy, 2004). Perhaps more importantly, the new term has tended to perpetuate the erroneous assumption that the highly diverse groups of MSM subsumed under this label share certain broad features that would warrant their categorization as a single vulnerable population. It therefore presumes that the complex social and cultural meanings of sexual identity are universal to all those who participate in same-sex behavior, a notion that is at least partially based on the heterosexist premise that the social complexity of the LGBT experience is somehow reducible to sexual behaviors (Young & Meyer, 2005). Yet this entirely neglects the broad range of meanings, behaviors, social contexts, and identities associated with different subgroups of LGBT persons and across cultural settings, a diversity that is even more striking when placed in global perspective. For example, a growing ethnographic literature on homoeroticism—and perhaps most significantly on Latin American homoeroticism—now exists to conclude that a significant proportion of men who engage in homosexual acts do not identify themselves as *gay*, and their needs are rarely addressed by prevention approaches designed for gay-identified men (Parker, 1987, 1992, 1996, 1999; Alonso & Koreck, 1993; Carrier, 1995; Cáceres, 1996; De Moya & Garcia, 1996; Díaz, 1998; Carrillo, 2002; Cáceres & Stall, 2003; Padilla, 2007, in press).

Some analogous definitional problems have limited the creation of appropriate responses to the HIV prevention and treatment needs of what has come to be termed women who have sex with women (WSW). Partly because of the widespread assumption that lesbians face less risk of HIV infection than men, most studies and public health interventions exclude WSW who do not consider themselves lesbians, as well as the range of structural risks for HIV faced by many of the subgroups of women included in this broad category (Arend, 2005). For example, some of these women—most notably those who are marginalized because of class or race—bear much higher risks of exposure to violence, homelessness, sex work, and intravenous drug use (Arend, 2005). There is also a lack of information about other sexually transmitted diseases among lesbians, such as human papilloma virus (HPV) infection, gonorrhea, syphilis, vulvitis, vaginitis, and cervicitis, that can be transmitted among women (Eiven, 2003). Additionally, some of these women engage in sexual relations with men, realities neglected by generic categories that erase the diversity of behavioral patterns characteristic of certain subgroups of WSW (Young et al., 1992; Eiven, 2003). Lesbians are therefore invisible for many researchers, providers, and health professionals; and their rights to health are ignored or subsumed under the umbrella of reproductive health, a category of health services that is notoriously heterosexist (Eiven, 2003).

An additional complexity obscured by catch-all categories such as MSM and WSW is that transmission of HIV in these broad populations is subject to significant regional and cultural variation. For example, whereas there is now significant (and growing) evidence that MSM are an important population vulnerable to HIV infection everywhere in the world (Turner et al., 1993; McKenna, 1996; UNAIDS, 2002), prevalence levels and the behavioral epidemiology of HIV among MSM is quite variable. In Latin America, despite growing levels of heterosexual transmission in some countries, prevalence levels among MSM have ranged from 20% to 35% in major cities of large countries such as Argentina, Brazil, and Mexico and from 5% to 10% in provincial areas and in small countries such as Costa Rica (Izazola Licea, 2001). Whereas in Mexico and Brazil, the homo/bisexual category of HIV transmission accounts for 56% and 35%, respectively, of all AIDS cases reported (PAHO/WHO, 2002), official interpretations of surveillance data in the adjacent Caribbean region are quite distinct, where the epidemic is described as predominantly heterosexual (Camara, 2001). Surveillance data on cases of HIV/AIDS in the Caribbean estimate that somewhere between 76% and 80% of infections are currently due to heterosexual transmission, with homo/bisexual transmission accounting for around 12% (PAHO/WHO, 2002). The relatively low proportion of HIV infections attributed to same-sex activities in the Caribbean therefore contrasts rather sharply with some other countries in the region, despite the fact that the Caribbean is immediately adjacent to these countries and there is considerable and continuous interchange of populations between them. It is unclear to what degree these differences are reflections of true distinctions in the epidemiology of HIV in these regions and to what degree they are consequences of social or cultural distinctions in the organization of same-sex desire and behavior—differences that are not captured by epidemiological categories.

Prevalence and incidence data for MSM are less available for countries in Asia and Africa, where a clearly defined *gay* identity seems to be less common than in the United States, Europe, or even Latin America and where the widespread denial of sexual activity between men may have resulted in a lack of research attention to these hidden populations (McKenna, 1996). Throughout Asia, however, behavioral surveys of men generally have reported high levels of bisexual behavior, and male–male sex has been responsible for an important part of reported HIV infections. For example, in a study of military conscripts in Thailand, although male–male sex was reported by only 7% of the sample, it was associated with 13% of the HIV infections in this population in 1995 (UNAIDS, 2002). The diverse and dynamic nature of these behavioral patterns is further highlighted when we consider the emergence and growth of LGBT identities and sexual politics in Asia, which may have influences on hidden populations and transform the meaning of HIV-related risk practices. For example, a growing literature based on ethnographic research now exists that documents the emergence of increasingly complex LGBT communities and movements in Thailand (Jackson, 2000), Indonesia (Boellstorff & Oetomo, 1996; Oetomo, 2000; Boellstorff, 2004, 2005), India and Bangladesh (Khan, 1994, 1998; Nanda, 1999; Reddy, 2004), and the Philippines (Tan,

1993, 1995). Such movements and politics are directly applicable to the shape of vulnerability to HIV infection as well as institutional representation from which to engage in HIV prevention activities for LGBT populations in the region.

In sub-Saharan Africa, where denial of male homosexual behavior has been described as especially strong, social and behavioral studies by African researchers have increasingly begun to call this denial into question, suggesting that in many countries largely hidden homosexual practices may in fact be far more common than previously reported (Cameron & Gevisser, 1994; Gevisser & Cameron, 1995; Murray & Roscoe, 1998; Teunis, 1998; Phillips, 2000, 2004; Lorway, 2003), and that levels of male–male transmission may be hidden in the HIV prevalence estimates for supposedly uniformly heterosexual men (Murray & Roscoe, 1998; Padilla, 2007, in press). Undoubtedly, part of the problem here derives from the fact that categories such as *homosexuality* fail to describe adequately the diverse forms of traditional male–male sex in many African societies, even though closer study of the contexts within which male–male sex occurs has revealed that male same-sex practices occur throughout the world but are rarely defined as homosexual or gay (McKenna, 1996; Parker & Terto, 1998). Yet even in sub-Saharan Africa, historical and ethnographic research carried out over the course of the past decade has emphasized the existence of multiple forms of hidden same-sex interactions in traditional cultures (Murray & Roscoe, 1998; Lorway, 2003), in the institutions and economies of colonial and early postcolonial societies, such as the mines of southern Africa (Moodie & Ndatshe, 1994; Morrell, 1998; Niehaus, 2002; Phillips, 2004), and most recently in the rapidly changing societies of contemporary Africa (Preston-Whyte et al., 2000; Lorway, 2003; Phillips, 2004).

The emerging literature on homosexuality in such settings suggests that lack of available data on HIV/AIDS and MSM in some regions is itself probably a result of official denial feeding into the limitation of HIV/AIDS research agendas. These limitations have almost certainly masked important forms of vulnerability to HIV infection that have been hidden or even mystified in epidemiologic reports on the epidemic. Recent work coming out of sub-Saharan Africa, for example, suggests that homosexual transmission among men is often incorrectly interpreted as heterosexual transmission due to the inability of researchers, physicians, and public health officials to recognize hidden homosexual relations (Teunis, 1998; Lorway, 2003; Phillips, 2004; Padilla, 2007, in press). Equally perverse, studies now suggest that some women in sub-Saharan African societies who are primarily active in sexual relations with other women (and often self-identified as lesbians) may also be at high risk of infection due to social pressure to be heterosexually active, and may even experience male violence and rape employed in the service of compulsory heterosexuality (Lorway, 2003).

As Parker and colleagues have argued, the result of denial and neglect in HIV/AIDS research has been the reproduction of denial and neglect in the development of AIDS-related programs and services for LGBT populations: "Virtually no official governmental or intergovernmental programs have prioritized men who have sex with men, even

in regions where homosexual transmission has been pronounced, such as in Latin America and parts of Asia" (Parker et al., 2000, p. 529). This persistent neglect, related to the stigmatization of LGBT more generally, has been clearly documented in a study carried out by the Panos Institute in association with the Norwegian Red Cross (McKenna, 1996). A targeted survey was conducted with national AIDS programs, AIDS-service organizations (ASOs), nongovernmental organizations (NGOs) involved in AIDS-related work, and gay groups and individuals in countries around the world to document both the extent of same-sex behavior and the kinds of programmatic and prevention responses that had been generated in response to HIV among MSM in the developing world. Data were collected from more than 40 national AIDS programs, more than 100 ASOs and NGOs, and more than 50 gay organizations in countries throughout Africa, Asia, and Latin America. Only 25% of national AIDS programs listed MSM as a target group for AIDS prevention, and only 9% reported programs for male sex workers (in contrast to 84% targeting heterosexual adults, 78% targeting adolescents, and 69% targeting female sex workers) (McKenna, 1996). These results were confirmed when national AIDS programs were asked if any AIDS-related services were available to MSM in their countries: again, a large number, 74%, stated that no such services were available; only 24% reported some services available. When asked what kinds of services, 23% reported counseling services, 18% information and education programs, 16% condom distribution, 12% outreach work, and 9% HIV testing or treatment for MSM (McKenna, 1996).

Throughout the developing world, in the absence of meaningful governmental programs, primary responsibility for HIV prevention has depended on community-based NGOs (McKenna, 1996; Parker et al., 1998). Thus far, the most limited efforts for MSM still characterize sub-Saharan Africa (Gevisser & Cameron, 1995; McKenna, 1996; Murray & Roscoe, 1997, 1998; Parker et al., 1998; Lorway, 2003). In a number of southern and southeastern Asian countries, important programs oriented toward MSM and to the newly emerging gay communities found in many countries have now been initiated (WHO, 1993; Boellstorff & Oetomo, 1996; Kahn, 2003), as is the case in Latin America where gay and AIDS activist organizations have taken the lead in developing programs largely aimed at community mobilization and HIV prevention (Schifter & Madrigal, 1992; Parker et al., 2001). Given their limited scale, however, it is no surprise that such programs have had a relatively small impact on slowing the epidemic, which is exacerbated by the fact that these programs have almost never been systematically evaluated through the use of rigorous research designs; nor have they provided the kind of empirical information base that would ideally be available to programmers and policy makers seeking models to replicate in developing prevention programs for homosexually and bisexually active men (Parker et al., 1998). Indeed, one of the clearest conclusions from the available literature is the urgent need for rigorous intervention and evaluation research on the structure, process, and outcomes of prevention programs designed for MSM in developing countries.

The fact that most governments have generally failed to address adequately the nuances and local realities of the HIV/AIDS epidemic among LGBTs is a clear illustration of the ways that social stigma is expressed in political institutions and economic structures. Where government policies and programs should have sought to reduce the social inequalities that fuel the HIV/AIDS epidemic, they have often chosen to ignore the record of research and programs demonstrating the importance of reaching out to marginalized groups, building communities capable of providing supportive structures, empowering LGBTs to take action on their own behalf, and ensuring their human rights and dignity in the face of persistent stigma and discrimination in the wider society (Parker et al., 1998). Ironically, institutionalized discrimination in the form of the systematic neglect of such programmatic needs only contributes to the cycle of stigma and vulnerability that fuels the epidemic. As shown in a growing number of studies in the developed world, experiences of stigma and discrimination among LGBT persons may in fact be primary factors contributing to high risk behavior. Understanding the precise structural, social, and psychological bases for these connections is a crucial area of future research for LGBT health (Lang, 1990, 1991; Savin-Williams, 1994; Meyer, 1995; Díaz, 1997, 1998; Diaz et al., 2000). Nevertheless, although we might suspect that this synergistic relation between social stigma and HIV/AIDS vulnerability will have analogous expressions in the developing world, their specific manifestations depend on local cultural definitions of nonnormative sexuality, the nature and intensity of social and institutional oppression, and the role played by the state in mitigating the negative consequences of discrimination against LGBT persons. Unfortunately, most governments are far from understanding and addressing these linkages in their specific cultural settings.

Finally, when considering the relationship between institutional and political contexts as they relate to HIV/AIDS among LGBTs, it is important to mention what we might call the epistemologic barriers that often hinder the ability of public health programs to address effectively the HIV prevention and treatment needs of LGBT populations. What is particularly clear from the international anthropological literature on AIDS is that there are vast cultural differences in definitions of what constitutes a *homosexual*, and these definitions have consequences for at least two factors that influence the delivery of appropriate HIV/AIDS services to LGBTs: (1) Such definitions affect how accurately epidemiologists and public health officials interpret patterns of morbidity and mortality among specific LGBT populations; and (2) they influence how effectively public health interventions are specifically designed to address the *broad range* of same-sex identities and practices in the local culture. Unfortunately, only in rare cases are epidemiologic or behavioral data pertaining to HIV/AIDS (or any health-related phenomenon significantly affecting LGBTs) analyzed and interpreted in reference to the local meanings and practices that define homoerotic experience in specific cultural settings. Once again, behavioral bisexuality serves as a useful example. A number of researchers

have described the invisibility of bisexual behavior in many parts of the world as being due to the fact that certain homoerotic behaviors are not locally understood to be homosexual, much same-sex desire and behaviors are hidden to avoid social stigma, or private inversion of the sexual norm is considered erotic (Aggleton, 1996b). For example, in his discussion of male bisexuality and HIV in Peru, Cáceres argues that the typical epidemiologic construction of AIDS as essentially a homosexual plague with bisexuality serving as a "bridge connecting an infected (and infectious) constituency to the general population" serves to falsely essentialize sexual behaviors in a manner that has little relationship to the actual behavioral epidemiology of HIV in Peru (Cáceres, 1996, p. 137).

As has been articulated also in Parker's work in Brazil (1987, 1990, 1992, 1996, 1999), another implicit assumption behind much HIV prevention is that all or most men who engage in homosexual sex will be successfully reached by programs targeting the *gay* or *homosexual* community. This perspective—fostered in some settings by the overgeneralization and somewhat uncritical exportation of standard approaches to HIV prevention among urban, white, middle-class, gay-identified men in the United States—has therefore tended to conflate a gay sexual identity with homosexual behavior, a conflation that does not reflect the psychosocial reality for some (perhaps most) men who regularly engage in same-sex sexual behavior in many areas of the world. It is only gradually, and still in a limited number of (relatively well resourced) settings, that what might be described as emerging gay communities have begun to articulate their own hybrid (indigenous yet also globally engaged) responses and program designs for HIV/AIDS prevention and mitigation (Parker & Terto, 1998).

In sum, when viewed from the global and cross-cultural perspective, the HIV/AIDS epidemic among LGBT populations is far from a unitary phenomenon. The interpretation and analysis of local epidemics requires recognition of the mounting evidence showing that although LGBT populations are vulnerable to HIV/AIDS in all settings, the nature and expression of this vulnerability is dependent on numerous contextual factors. To be successful, future programs must recognize the diversity of both identity and behavior in LGBT populations and their distinct HIV prevention and sexual health needs. Furthermore, intervention approaches must recognize that in many cultures concepts such as homosexuality, bisexuality, or gay may have little meaning, and that even in societies in which such categories are present many men who have same-sex relations may not consider these practices to be definitive of their sexual identities. Finally, programs must recognize the importance of mobilizing communities and developing community support structures to reach LGBT persons and to provide them with both social and psychological support for adopting and sustaining safer sexual practices. Such collective empowerment, in the face of otherwise widespread stigma and discrimination, is a key element of all interventions for so-called MSM and WSW; and it is only with widespread state support for basic human rights among all LGBTs that a social climate can be created to reduce the impact of HIV/AIDS among

the broad range of LGBT communities as well as the so-called general population.

5 Incarceration and LGBT Health

The fact that LGBT persons are often criminalized by institutionalized sexual discrimination has at least two consequences for considerations of LGBT health in prisons and detention centers. First, because of such discriminatory laws and policies—supported by social prejudices—LGBT persons are at very high risk of incarceration and/or persecution by the authorities. A number of studies in international settings, particularly studies focusing on HIV/AIDS prevention, have demonstrated that prisons can be harmful environments in terms of epidemics and public health (Sagarin, 1976; Moss et al., 1979; Douglas et al., 1989; Wiggs, 1989; Carbajal et al., 1991; Guerena Burgueno et al., 1992; Ducos et al., 1993; Anonymous, 1998; Odujinrin & Adebajo, 2001; Chen et al., 2003; Green et al., 2003). Thus, if LGBT persons are at high risk of exposure to prison environments, they are similarly at high risk for exposure to the various risks associated with being incarcerated. The epidemiologic significance of this is emphasized by the fact that prison environments, although often considered marginal institutions disconnected from the rest of the society, are part of a continuous flow of people between prison environments and the "outside world" that can contribute significantly to epidemiologic patterns of infectious diseases in the larger society (Wiggs, 1989). Thus, LGBT persons may be implicated in epidemiologic relationships that link incarcerated settings with outside settings, an argument that has been made frequently in the context of HIV infection and transmission to women among African American populations in the United States (Peterson, 1997; Lichtenstein, 2000; Lemelle & Battle, 2004).

The second consequence of the institutionalized discrimination faced by LGBT persons is that once they are placed in prison environments they are vulnerable to additional abuses by both fellow inmates and the prison staff. In terms of nonconsensual sex, violence in prisons is a complex phenomenon not only occurring between and among inmates but also wielded as a form of institutional violence committed by the authorities in charge of the prison (Moss et al., 1979; Aubrey & Christiaan, 1995). Many studies report high numbers of men who report having been coerced into having sex at some point during their imprisonment (Green et al., 2003), and in some cases this violence results in the victim's suicide (Wiggs, 1989).

In the case of HIV/AIDS, the situation is made worse by the fact that there is often a common cultural opposition to providing condoms in prison, often because this service would represent institutional recognition of active homosexual behavior among inmates (Anonymous, 1998). In Malawi prisons, for example, prison inmates are not allowed access to condoms because of the belief that such an intervention could encourage homosexuality, which is illegal in the country (Zachariah et al., 2002). In his analysis of South African prisons, Achmat (1993)

argued that biomedical and other hegemonic discourses about sexuality seek to neutralize the subversive and destabilizing effects of same-sex sexuality in all-male environments such as compounds and prisons. In this sense, efforts to provide condoms to prisoners confront strong opposition from politicians and government officials, who frequently share the view that introducing condom in prisons is an invitation to (or an acknowledgement of) forbidden homosexual practices. An additional problem is that many programs for preventing HIV infection in prisons emphasize the idea of mandatory HIV testing as a way of preventing the spread of the disease, rather than offering voluntary programs with emphasis on education and counseling (Andrus et al., 1989). In the context of societal discrimination against HIV-positive persons, such mandatory testing programs could add another layer of discrimination and abuse, as inmates may be forcibly tested and their HIV status exposed.

As in any other homosocial environments, highly diverse sexual cultures and practices occur in incarcerated populations. Indeed, imprisonment itself creates conditions for the exchange of intimacy and sexual experiences. Several studies show not only different forms of sexual behavior but also the constitution of new forms of social and sexual identities based on the daily life experience in prison (Awofeso & Naoum, 2002; Vásquez del Aguila, 2002). There may be a reconfiguration of eroticism in such settings, such that sexual identities are more fluid and express an array of sexual practice, such as sex between inmates and their male and female visitors (which are not always conjugal visitors); consensual homosexual sex among inmates; group masturbation; various forms of prostitution; sex between prisoners and prison staff; and rape and sexual violence among prison inmates (Awofeso & Naoum, 2002; Vásquez del Aguila, 2002).

Despite the strong potential for regulations on the use of illicit substances in incarcerated populations, prison life in the developing world may involve routine use of drugs, alcohol, and other substances as part of the daily life of the inmates. For example, in a study in Tijuana, Mexico, prisoners reported high rates of drug use even in comparison with several nonincarcerated populations (Guerena Burgueno et al., 1992). As many studies demonstrate in other contexts, the use of drugs can reduce the possibility of sexual negotiation and the incorporation of safe sex behavior, including the use of condoms. In this sense, the presence of drugs in prisons reinforces the inmate's vulnerability and increases the possibilities for the spread of sexually transmitted infections.

As Arnott (2001) states, it is necessary to incorporate a human rights approach in prisons with the assumption that these institutions are not a different world in which human rights and other international conventions do not apply. From a public health perspective, human rights in prisons include preventing the spread of HIV, which requires the provision of condoms, education, counseling, and access to health services. In fact, periods of incarceration may represent a unique opportunity to convey prevention messages that focus on high-risk behaviors outside the incarcerated setting (Wohl et al., 2000). Finally,

the LGBT approach to health advocacy has rarely been linked to protecting the sexual health of incarcerated populations; but given the vulnerability of LGBT persons to institutional abuse and incarceration—as well as the overlapping nature of prison homosexuality and the larger LGBT community—greater awareness of these linkages may serve to improve the health of both incarcerated populations and LGBT populations more generally.

6 Sexual Migration, Mobility, and Health

Migration is a regional or global movement of people who cross domestic and/or international boundaries for a variety of reasons, such as an economic crisis, the search for educational improvement, escape from political violence, and as may be the case for LGBT persons, the perception of greater openness to sexual diversity. Although the social scientific and demographic literature on migration and the process of acculturation has expanded significantly during the last few decades, few studies have addressed the particular issues faced by LGBT migrant populations (Carrillo, 2004). On one hand, decisions to migrate for LGBT persons may involve political and economic considerations similar to those of heterosexual persons, such as opportunities for employment, professional advancement, or escape from oppressive economic or political circumstances. On the other hand, this decision is shaped by other factors and considerations that are particular to LGBT persons, such as sexual identity, exposure to sexual stigma, and the perception of improved possibilities for sexual experiences or community building in other regions or countries (Carrillo, 2004). This problematizes traditional approaches to migration that presume that sexuality involves exchanges between male and female heterosexual partners, or that the meanings of family and kinship for migrants are necessarily the same for the wide range of genders and sexualities.

For many migrants, international migration is not a new experience but, rather, a continuum linking rural communities or small cities to urban or mega cities in their country of origin. Therefore to conceptualize migration among LGBTs as a process, it is necessary to consider the sexual and social situation of the immigrants prior to relocation, during migration, at the various migratory phrases, upon arrival in the new place of residence, and in many cases upon return to their country of origin (Carrillo, 2004). Migration from developing countries is not a homogeneous phenomenon; rather, it involves diverse patterns of separation from the homeland, transition, and so-called acculturation to the new social environment. Cultures vary enormously in how they approve or disapprove of sexual behaviors, and LGBT migrants therefore may encounter dramatic shifts in ideologies, sexual practices, social stigma, and sexual identities. Certain attitudes and behaviors that gay men perform in a new situation are not possible to imagine in their homeland owing to the stigma and discrimination these attitudes might engender, not only for themselves but also for their families and social networks (Bronfman et al., 1989; Bronfman & Minello, 1992).

As suggested by recent critiques of the concept in public health, the notion of *acculturation* has often led to analyses that stereotype reality, reducing complex social phenomena to two ideal types that are seen to interact rather simplistically and in a somewhat linear fashion (Hunt et al., 2004). The reality of contemporary migration and mobility patterns questions analyses that depict a somewhat mechanistic assimilation to the mainstream society rather than dynamic processes, always in tension, conflict, negotiation, and resistance between the various migrant groups and the (often multiethnic) receiving society. Indeed, patterns of population movement are considerably more complex than the traditional *culture contact model* implies, illustrated by phenomena such as circular migration, global media communications, and the complex transnational kin structures that are everywhere in evidence today.

Interestingly, the notion of acculturation has been applied in a number of recent studies on the LGBT population to understand the relation between assimilation to a gay model and its relation to sexual health. For example, a significant amount of HIV/AIDS research on the acculturation process among Latino MSM has sought to determine whether greater incorporation into a gay-identified sexual system leads to greater or lesser rates of sexual risk behavior. A number of studies have argued that integration into the North American gay community is protective for immigrant Latino MSM, either because these men are able to learn safe sex norms espoused by gays or because they gain access to the social support of the gay community (Seibt et al., 1993; Turner et al., 1993; Kelly et al., 1995; Chng & Geliga-Vargas, 2000). Nevertheless, the presumed positive effects of gay acculturation are not universal findings. In a study of HIV-positive gay, bisexual, and heterosexual Latinos in Los Angeles, greater levels of acculturation were associated with greater rates of sexual risk disclosure but significantly higher rates of unprotected sex (Marks et al., 1998). Similarly, other investigators have found that men with higher connectedness to gay communities and organizations were *less* likely to disclose high-risk behavior or unprotected anal intercourse (Doll et al., 1994).

As with the wider literature on acculturation, we believe that studies of LGBT health need to move beyond reductionistic or stereotyped models of culture contact to examine the lived experiences of migration and the situational contexts of health for specific migrant populations. Transnational migration, rather than simple geographic movement of people from one country to another, is a dynamic and complex phenomenon related to social networks and transnational linkages that constitute important economic, emotional, and social exchanges between people's homelands and their new place of living (Hirsch et al., 2002; Hirsch, 2003). These complexities are further magnified for LGBT migrants because, in addition to cultural differences in the normative society, they are often moving within and between dramatically different sexual communities with quite variable consequences for social stigma, same-sex behavior, and discrimination. Furthermore, because of the often stark differences in the material and structural contexts of the various places migrants traverse, there may

be quite different material consequences for LGBT persons depending on where they are in their specific migration route, the legal rights (if any) for LGBT persons in each location, the willingness of the government and authorities to protect the rights of migrant LGBTs, and so on. Future research on health among migrant LGBTs should therefore seek to conceptualize not only the ways that cultural exchange occurs regarding the meanings of homoeroticism and the processes of sexual self-identification but also how structural factors are operating to influence health among LGBT migrants.

Tourism is not a form of migration but, rather, a particular combination of mobility, consumption, and leisure (MacCannell, 1976; Urry, 1995, 2002). Nevertheless, it may be closely linked to health among LGBT populations, particularly in geographic areas highly dependent on the tourism industry. Farmer, for example, pointed to the epidemiologic linkages between gay North American sex tourism and the AIDS epidemic in Haiti, arguing that despite epidemiologic data to the contrary, U.S. public health officials during the early 1980s depicted the island as an isolated reservoir of endemic HIV infection (Farmer, 1992). He argued that this rhetorical construction belies the extensive epidemiologic linkages between the United States and Haiti through the commercial sex industry, which provided the most likely route for the introduction of HIV from North America to Haiti: "Sufficient data now exist to support the assertion that economically driven male prostitution, catering to a North American clientele, played a major role in the introduction of HIV to Haiti" (Farmer, 1992, p. 145). Paralleling many aspects of Farmer's argument, a growing number of studies have emphasized the epidemiologic and historical importance of these regional nodes of international sex work in various parts of the Caribbean, such as Cuba (Leiner, 1994; Lumsden, 1996), Barbados (Press, 1978), and the Dominican Republic (De Moya et al., 1992; De Moya & Garcia, 1998; Padilla, 2007, in press). The need for interventions to improve sexual health among tourists and the locals with whom they have contact, including but not limited to sex workers, has been argued repeatedly, drawing on studies from a wide range of geographic and cultural contexts (Isaacs & McKendrick, 1992; Murray & Roscoe, 1998; McCamish et al., 2000; Visser, 2002; Padilla, 2007, in press). It remains a priority for future efforts to improve LGBT health to examine the intersection between tourism, sex work, and the health of LGBT populations and to prioritize programs to address the needs of both hosts and guests in the global tourism sector.

In addition to tourism, it should be mentioned that in the contemporary globalized world cross-cultural contact and LGBT relationships are taking increasingly complex and varied forms, including configurations such as transnational relationships, partnerships between foreign expatriates and locals in the developing world, or circular migratory arrangements. In part, these emerging expressions of LGBT sexuality and identity are the product of different kinds of cultural contact and fluidity that characterize late capitalism itself (Harvey, 1990; Appadurai, 1996). Indeed, the structures of what has been called *flexible accumulation* may lead to different types of population flow that

also have implications for LGBT sexuality, identity, and health, as illustrated by the influence of multinational offshore modes of production on the sexual mixture of employees from various cultural backgrounds, or the increasing presence of expatriate aid workers in the developing world who now live for long periods in the South. Thus, the movement and flow of LGBT populations is quite complex in their contemporary capitalist expressions; and these flows, and the relationships they generate, are as important as the shorter, more clearly commodified relations typical of sex tourism. Research and interventions have only begun to address the ways that such processes influence LGBT health in specific settings, but they must be examined in future work on these issues if we are to improve patterns of morbidity and mortality in LGBT communities in the contemporary globalized world.

7 Conclusions

This chapter has sought to outline the existing ethnographic and social science literature relevant to LGBT health from a theoretical perspective that highlights both political-economic conditions and the structural violence LGBT populations confront, as well as the cross-cultural variations in the social norms and perceptions that shape LGBT vulnerability in specific locales. As described at the outset, we believe that such a dual conceptual approach is essential to the consideration of LGBT health in the contemporary world, given that both social inequality and the diverse meanings of nonnormative sexuality have an influence on the health-related vulnerabilities LGBT persons face. Unfortunately, there is a paucity of cross-cultural studies that specifically seek to examine LGBT health within such an analytical framework, requiring us to extrapolate ethnographic observations regarding the discrimination and health risks of LGBT persons from broader anthropological studies about nonnormative genders and sexualities in various developing countries. On the other hand, health-related research and public health programs targeting LGBT populations rarely consider health outcomes as the product of structural violence or social inequalities, resulting in a theoretical myopia that limits the ability of such work to address the larger social forces that shape LGBT health. We therefore advocate for the development of social science perspectives and intervention approaches that conceive of LGBT health as embedded in various social inequalities and that seek to understand the precise linkages between structural violence and sexual marginality in specific cultural settings.

In addition, we believe that the growing field of globalization studies has much to offer the examination of health issues among LGBT populations, as so many of the fundamental features of contemporary sexualities—from Guadalajara to Hong Kong—are embedded in transnational modes of production/consumption and the rapid flow of bodies, sexual identities, and sexual meanings. Although the latter aspects of globalization have been theorized in many of the cross-cultural studies of sexuality cited above, there has been relatively little

work done that places LGBT health at the center of the analysis, examining how global processes relate to health circumstances in specific places. This is perhaps related to the tendency for globalization to be conceptualized as a process primarily involving the flow of the meanings and identities related to LGBT sexualities, rather than the stark social inequalities and patterns of structural violence that are central to the experiences of globalization among many LGBT populations, particularly in the developing world. To conceptualize the multifaceted connections between global processes and the health risks and vulnerabilities experienced by LGBT persons, future work must combine these perspectives, examining how processes of globalization function to create new health risks for LGBT persons as well as considering ways that public health programs, structural interventions, political activism, and policy changes might function to mitigate these risks.

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