

CHAPTER **V**

HIV/AIDS PREVENTION IN MEN WHO HAVE SEX WITH MEN

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Introduction

This chapter describes and examines a number of approaches to HIV/AIDS prevention among men who have sex with men (MSM) with a view to clarifying and providing precise information about issues that may interest officials in the area of public health and human rights, as well as activists in nongovernmental organizations, health professionals, people living with HIV/AIDS, and gay and bisexual men.

HIV transmission among MSM has particular characteristics linked to their sexual practices (such as anal and oral sex) and to the vast diversity of psychological, social, cultural, and political circumstances that determine the conditions for those practices. In short, the risks specific to MSM populations require specific prevention policies.

The chapter is arranged as follows: first we describe the main elements of some prevention approaches, progressing from a general overview to more specific aspects of AIDS prevention in MSM; second, we address those specific aspects and explore them in greater detail to provide an account of diverse situations; third, we stop to analyse to what extent access to treatment and drugs constitutes an essential component of a public health response to the epidemic; fourth, we advance a number of considerations with respect to articulation of public health policies and respect and promotion of human rights; fifth, we summarize the ground covered in a series of recommendations.

Prevention models

In schematic terms there are three identifiable theoretical models for tackling HIV prevention (*Parker 2000; Kornblit 2001; Cáceres 2001*).

- 1) The **epidemiological-behavioural model**: centred on individual high-risk behaviour, this model seeks to alter such behaviour by means of a cognitive intervention addressing information, risk perception, perception of control over one's behaviour, self-confidence, and the attitudes of different population groups to the disease.
- 2) The **anthropological-cultural model**: focusing on the meanings that individuals attach to their practices in given contexts, this model seeks to change the codes and values that heighten risks and impede preventive behaviours, and stimulates promotion of codes and values that lead to safe behaviour.
- 3) The **political-economic model**: based on community mobilization, this model aims to reduce social, rather than individual, vulnerability, starting from the premise that structural inequality, according to subdivisions of class, gender, subculture, lifestyles, etc., is at the root of the epidemic.

Summary of models

	EPIDEMIOLOGICAL-BEHAVIOURAL MODEL	ANTHROPOLOGICAL-CULTURAL MODEL	POLITICAL-SOCIAL MODEL
Conception of those affected	Risk groups	«All», according to differentiated cultural patterns	Most structurally vulnerable groups
Pathogenesis	Risk conduct	Subcultural norms	Structural vulnerability
Research model	Quantitative	Qualitative	Research-action
Measures proposed	Interventions targeting individual attitudes and conducts	Educational interventions targeting social groups	Citizen participation for excluded groups
Relationship with the field	Removed, objectivizing attitude	Solidarity on an affective level	Solidarity based on shared experience or empathy

Sources: Table adapted from Kornblit 2001:16

As Richard Parker (2000) says, these three models have been implemented in sequence and each incorporates a greater number of factors than the previous one; however, they are still implemented in parallel and respond to different areas of prevention.

The **epidemiological-behavioural model**, is based on the premise that all persons are rational individuals capable of considering the costs and benefits of alternatives and of making use of the information available to them. People weigh up the expected costs against the expected benefits or harm, and take those supposed decisions that are in their best interests and contribute to their well-being. As regards adopting safer sexual practices, this model considers that people measure the risks in a given a sexual relationship, make a judgment on the efficacy and cost of protection measures, and take decisions about what to do in such situation. The emphasis is placed on the beliefs and expectations of persons as regards the costs and consequences of engaging in preventive behaviour, in other words, on the mental processes underlying decision-making. The interventions will be aimed at measuring

these attitudes, behaviours, and beliefs, and the proposed prevention measures well seek to bring about changes at the individual level. In the «health belief model» (Becker 1974; Rosentock 1975), for instance, emphasis is placed on the perceived risk (or lack thereof) of individuals, which will promote safer behaviour. Among similar models (see Kornblit and Mendes Diz 1995; and Parker 2000) we can also mention the «self-efficacy theory» (Bandura 1986 and 1989), the «theory of planned action» (Ajzen and Madden 1986), the «stages of change model» (Prochaska and DiClemente 1983; Prochaska, DiClemente and Norcross 1992), the «level of effort required for behaviour change model» (Bagozzi, Yi and Baumgartner 1990), the «IMB model» (Fisher and Fisher 1992), and the theory of Van der Velde and Van der Pligt (1991).

The **anthropological-cultural model** focuses on the meanings that individuals attach to preventive and risk practices based on their links to specific cultural contexts. This model emerges in response to the inadequacy of the epidemiological-behavioural model to successfully bring about change from risk to safe behaviour. In this model social norms and values are taken into account and their particular configuration is examined in different cultures or subcultures. Included here would be those theories that entail a series of more complicated social and cultural questions that act as pivotal conditioning factors of behaviour change, such as the «social learning theory» (Bandura 1977) and specific applications of the «social action theory» (Ewart 1991). Most authors also place the «reasoned action theory» (Ajzen and Fishbein 1980; Fishbein and Ajzen 1975; Fishbein 1991) in this model because it takes into account the norms of «significant others» and the motivation to act according to those codes. However, authors like Perloff (2001) think that the reasoned action theory is more closely related to the first model due to the importance of its cost-benefit analytical component.

The **political and social model** is based on the idea that economic and social inequalities are at the root of the epidemic and that they constitute major structural obstacles for behavioural change towards safe conducts. This model replaces the idea of individual risk with the concept of the social and individual vulnerability. Preventive interventions will focus on activism at the community grassroots level mobilized for the defence of the rights of minorities and affected persons. The model leaves aside analysis of perceived risk in terms of individual behaviour, in order to focus instead on socially structured and conditioned vulnerability. This new conceptualisation also entails changes in responses to the epidemic -hitherto more technocratic- toward a fundamentally political response. Core aspects of this model, therefore, are «structural interventions» (Aggleton 1996; Sweat and Dennison 1995), «community mobilization» (Kelly, Lawrance and Stevenson 1992; Parker 1996a), and «social change and collective empowerment» (Kegeles, Hays and Coates 1996; Parker 1996b).

While the first model aims at modification or consolidation of knowledge, beliefs, and attitudes that influence individual behaviours, the second model recognizes that individuals are oriented by guidelines, codes, and norms, and by socially established «language games». The second model also entails cultural analysis of the symbols and meanings inter-subjectively constructed around sexuality, drug use, or gender relations in different contexts. The third model departs from evidence that individuals conduct themselves not only based on their individual attitudes and social norms, but also according to the structural resources available to them. These structural resources -material and symbolic- are unequally distributed among different social subdivisions.

In the specific case of homosexual persons, the combination of elements from these three models entails integrating questions on how homosexuality is lived at the individual level (in terms of practices, behaviours, attitudes, and even relations), how homosexuality is socially represented (in society in general or in gay or other subcultures), and, lastly, how the status of homosexuality as subordinate to heterosexuality, the latter considered the only legitimate expression of sexuality and love liaisons, is institutionally and socially reproduced.

However, it should be mentioned that since gay and bisexual men were among the first groups to be affected by the epidemic, practically all prevention models were applied or tested through projects targeting them (*Parker 2000: 93*). Furthermore, many of the lessons learned from the application of these particular prevention programs were incorporated in prevention strategies for other categories and for the general population¹.

The application of prevention programs in gay communities in industrialized countries showed the advantages and shortcomings of the approaches used in the epidemiological-behavioural model. Several studies guided by this model showed that perceived risk influenced the response of homosexuals to the appearance on the sexual scene of HIV; but when the behaviours were analysed of heterosexuals and of many MSM it was found that the levels of perceived risk of HIV did not influence their intentions with respect to adopting preventive measures. The search for an explanation for these differences led to the hypothesis that it was the gay group identity that enabled them to have greater relative success in the interventions carried out.

Within this first model, in addition to achieving individual changes in risk behaviour was the considerable challenge of ensuring the continuity in time of this safe behaviour. Furthermore obstacles also appeared for interventions with groups of

¹ For a review of the pioneer interventions and prevention programs see Parker, Rios and Terto, 2001.

MSM who do not identify themselves as gay or homosexual. In response, greater relevance began to be given to the anthropological-cultural model which, by penetrating different social and cultural contexts where risk practices occur, focused on implementing educational interventions with social groups.

MSM group prevention models were an important landmark in the conception of the political-social model, given that the work carried out with these groups highlighted the need to take into account the impact of stigma and discrimination in the configuration of AIDS vulnerability, and also the issue of relapses into unsafe sexual practices.

In the framework of the third model, «structural interventions», «community mobilization», and «collective empowerment» have in common a critical approach to the economic, political, cultural, and social causes that shape the dynamic of the HIV/AIDS epidemic. Individual risk is inserted in a structure that causes some groups to be more susceptible to infection than others. This differential susceptibility to the epidemic reflects the structural vulnerability of oppressed, stigmatised, marginalized and/or exploited groups. Therefore, the measures proposed under this approach are necessarily required to be long-range and broader in scope than those designed to bring about individual behaviour change, and will be designed to change, even through political mechanisms, the conditions of inequality and injustice.

The main aim of structural interventions is to change the conditions that influence behaviour change in both individuals and groups. An example of concrete application of this approach are the interventions designed to offer alternative work to male and female sex workers, programs aimed at improving the distribution logistics of condoms and lubricants, and the range of activities for reducing the risks and harm associated with drug use.

Community mobilization strategies seek to break the isolation of individuals belonging to vulnerable groups and to strengthen activism on the premise that community structures are important sources of support for reducing individual risk behaviours and for improving social responses to HIV/AIDS. In the specific case of prevention in MSM, the consolidation of gay communities was a central objective for many interventions. As Pollak (1993a: 77) says, the density of community networks and their organizational continuity, and the coordination of networks of more exposed groups with the public health authorities responsible for implementing public campaigns, are crucial elements when it comes to analysing the success of some prevention models and the failure of others. Furthermore, many individual behaviour changes were, in fact, the result of community mobilization processes rather than public health interventions or formal prevention programs (Parker 2000: 94-95; Pecheny 2001).



Community mobilization on HIV/AIDS in Santiago.
Archives of the C.Ch.P.S.

Finally, we shall mention so-called «empowerment» policies. Aimed at the recognition of the individual's bodily and psychic autonomy, the concept of empowerment arose mainly from studies on gender and has to do with a social action process that promotes the participation of individuals, groups, and communities in order to have control of their lives within the community and in society as a whole. The work of Brazilian researcher Paulo Freire (1994) on the pedagogy of oppression and social forms to defeat it, paved the way for the development of this concept. This approach seeks, through participatory learning techniques, to stimulate the capacity of individuals and groups to take action to deal with their particular circumstances and to explore and question their respective lives and realities. This critical questioning leads them to undergo training and a collective transformation that helps them to identify the choices open to them with respect to their oppressed situation. In the particular case of the HIV/AIDS epidemic, support groups, counselling and legal advice programs, and other types of interventions, are aimed at enabling vulnerable groups to become aware of the possibilities they have for confronting the forces that threaten and oppress them.

The political-economic prevention model, by shifting the focus from individual risk to social vulnerability, produces a broader and longer-term response to the HIV/AIDS epidemic, encouraging social change capable of acting upon the structures

of inequality. Under this approach, proposed measures are not confined to information, education, and communication campaigns (though these are included), but incorporate strategies aimed at bringing about the necessary social transformation so that the most vulnerable communities can fight against the structural conditions that cause their vulnerability. Therefore, from this perspective, the social reaction to this epidemic should be aimed to change gender relations in society that make women more vulnerable to HIV/AIDS infection, to reform an economic structure in which AIDS is increasingly tied to poverty and marginalized groups, to stop the exclusion of drug users, and to confront the stigmatisation of homosexuality that makes MSM more vulnerable to the epidemic.

Below we will describe specific features of AIDS prevention in MSM in terms of target group, modalities, and implementation.

Specific prevention: «Men who have sex with men» (MSM)

Epidemiological studies, both in Latin America and in other regions, show that not everybody who desires and practices sex with persons of the same gender regard themselves as homosexual – or gay, or lesbian, or bisexual, etc. Those who consider that their homosexuality is central to their personal identity are known as «identity homosexuals». In principle, this trait entails self-acceptance, which may lead to a «coming out» process, depending on contexts and interlocutors (*Kornblit et al., 1998*).

In order to be able to encompass the diversity of identities, epidemiologists have proposed using the category of «men who have sex with men» (MSM), since it is unprotected sex -in this case between men- what can transmit HIV, not the fact of subscribing or not a given identity. In some cultures, for example, the man who plays the active role is not socially considered to be homosexual - or some equivalent term; something similar occurs with those who engage in homosexual relations for money. Therefore, the dissociation between practices and identities helps create what are termed «imaginary protections» against HIV (*Mendes Leite 1995*). The term «imaginary protections» refer to the fact that many people feel that they have little or nothing to fear from HIV because they do not recognize themselves or their sexual partners as belonging to a risk group (in this case, the homosexual constituency). Therefore, the expression MSM attempts to define a category of people according to a behavioural option and not the cultural identity of a social group or an individual. At the same time, the expression attempts to acknowledge

the lack of uniformity and includes diverse identities, socio-demographic characteristics, social roles, and sexual experiences with women.

Many gay activists question the category MSM since the heteronormativity in the way it is defined is seen as a form of domination². However, to suppose that the gay or any other identity is a destiny that is chosen or desired by all those who do not conform to heterosexuality overlooks the fact that in many cases identity has nothing to do with sexuality, and also the fact that very diverse practices may be ascribed to a given identity. And there is no reason why the analytical category of MSM should interfere in the social or political assumption of sexual or generic identities defined in relation to aspects that have more to do with subjectivities.

Studies carried out in every region of the hemisphere show that, with respect to men who have sex with men -a practice susceptible to transmit HIV-, a very broad variety of situations exists: the urban middle-class homosexual men who have been adopting the gay identity model based on the assertion of their need to live their homosexuality openly and happily; those who conceal their homosexual preferences; the bisexual who, married or not, also seeks homosexual relations; transvestites who dress up as women, either to satisfy their personal desires or to meet a demand into the prostitution market; butch gigolos who live in the same world of male prostitution as transvestites, without necessarily acknowledging themselves to be homosexuals, etc. In short, *not all men who recognize themselves as homosexual or gays are at risk of contracting HIV; and not all those who run the risk of contracting HIV (or who have already done so) through sex with other men admit to being homosexual or gay*.

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² For example, according to R. Duranti et al. (2001:1-2), of Grupo Nexo in Buenos Aires, «reducing the possibilities of a man's erotic relations by limiting, with that expression (MSM), the object of his erotic desire to another man, is nothing more than an over-simplification of the rich diversity of -in this case, supposedly homosexual- sexualities where an extremely rich form of bonding is reduced to a mere act, disregarding the entire gamut of affective possibilities that a relationship between two people entails, regardless of whether or not they happen to be of the same sex.» Furthermore, «one of the best prevention tools that exist for any target group, in this case so-called sexual minorities, is to construct an identity of belonging that enables them to form groups in which they identify positively both with themselves, and with their sexuality and the practices that derive therefrom [...]. Any person who cannot refer to themselves positively will always be destined to be an object of alien desire, making it difficult for them to insist on use of protection in a sexual encounter. Their first line of protection is to know who they are and the basis of their ties, since all acts need a subject to be carried out. «

AIDS prevention in MSM covers several aspects:

On one hand, the information component on risks, harm, and the physical and social consequences of contracting the disease may target these people in the same way as it targets the rest of the population. We will not go further into this generalist aspect of prevention here. Suffice it to say, that it is worth remembering that MSM, insofar as they are not a separate group in society, are also on the receiving end of generalist prevention policies. These policies should include them, since there is no division -social or epidemiological³- between MSM and the rest of the population.

Furthermore, many aspects of this type of prevention are specific; and these aspects refer both to the practices susceptible to transmit HIV or prevent HIV transmission, and to the social, cultural, and psychological conditions in which those practices occur.

As we mentioned, the specifics of prevention are concerned in first place with the avenues of sexual HIV transmission in MSM populations: unprotected receptive anal sex, unprotected penetrative anal sex, and the still disputed issue of unprotected oral sex. On this point, there is no need to reiterate that prevention mechanisms refer to the systematic use of condoms and water-based lubricants for penetrative sex.

In many parts of the hemisphere, and this is something that is worth reiterating, not only is access to condoms and lubricants not guaranteed and facilitated, but also it is expressly hindered or prevented on legal, moral, and even commercial grounds («it is not profitable»). Accordingly, as in other areas of Public Health, the State has an inescapable role to play, and its activities should be orchestrated in intervention networks with nongovernmental actors and civil society organizations (targeting places like bars, discotheques, and 24-hour pharmacies, STD clinics, gay groups, NGOs, medical services). Experience has shown that the State must be involved in prevention programs, either to ensure a sustainable supply of resources over time, or to enable the possibility of combining prevention with care; and non-governmental actors (NGOs, services, even commercial establishments) are necessary channels for reaching inconspicuous and non-mainstream populations outside of their specific environments.

One particular issue which we will address has to do with risk places, connected with the widespread practice of anonymous sex and sex in public or semi-public places. In several countries prevention measures were successfully implemented in bars, saunas, and pick-up places through interventions with people who frequent such places; they were provided with information (fliers with pro-prevention

³ Many MSM have sex with women and/or have a female partner. For instance, a 1995 study on 400 MSM in Fortaleza, Brazil, found that 40.5% had had sex with women in the previous 12 months. The sample included men who were married or cohabiting with women and men who engaged in paid sex (Kerr-Pontes et al. 1998: 75).

messages and contact addresses where interested people could turn for help), condoms, and lubricants.

In addition to such measures is the policy of promoting voluntary HIV testing. This is a comprehensive program that includes free and easy access to confidential testing, as well as to information, psychological and material assistance when the blood sample is taken, during the waiting period, upon delivery of results, and immediately after learning the result; and the offer of concrete steps to follow for potential treatments and care. Indeed, as experience has shown, knowledge of a clear possibility of being able to access treatments encourages testing, which improves the quality and life span of people living with HIV/AIDS, reducing costs for their care, and reducing exposure to opportunistic diseases and hospitalisation, which is very costly both for the patient and health systems.

One specific aspect of the testing issue has to do with the particular situation of many MSM: on one hand, stigmatisation of homosexuality carries with it several specific issues connected with anonymity and confidentiality as regards not only HIV/AIDS, but also sexual orientation, in the sense that it may be feared that infection will reveal practices undertaken discreetly and/or clandestinely.

If, in spite of good information programs, high-risk sex between men remains widespread, one reason is that «wild sex» serves to satisfy the psychological needs of many homosexual men. As *Perloff (2001: 46)* mentions, some of these needs have to do with «sexual validation», «emotional intimacy», «compensation for feelings of inferiority», and, «escape from stress». «Sexual validation» refers to gay men who attach great importance to their physical appearance and sexual performance, and for whom the number of sexual conquests and the variety of situations in which they occur provides excitement, adventure, and



Educational material produced by the Homosexualities Project. Brazil. Archives of ABIA.

novelty, to the extent that «sexual adventure is what enables them to go on» living (47). As for «emotional intimacy», as with heterosexuals, the practice of safe sex seems to prevent complete intimacy in the couple. The «sense of inferiority», resulting from homophobic socialization, leads many to place more importance on sexual and affective union than any other consideration, in the sense that condom use should not take priority if such proposition can jeopardize the relationship itself. Finally, «escape from stress» has to do with the fact that unsafe sex, in this case an explicitly rule-breaking behaviour, provides a means of escape from the tensions produced by having to live within rules. In our opinion, these psychological needs discussed by this author do not reside or are explained at the unconscious or biological level; on the contrary, they are the result of past and present social conditions to which persons are subjected who must negotiate in a manner never free from tensions their relationship with sexuality and affective ties. For these reasons, overcoming such «psychological obstacles» goes beyond psychology to include social and political changes which Model 2 (which takes into account the other meanings) and Model 3 (which takes the broader social context into account) seek to address.

One peculiarity of some MSM is the practice of sex in public or semi-public places, such as parks, train stations, bars, discotheques, dark rooms, saunas, baths, cinemas. According to research carried out (*Schifter 2000*), these places are frequented by gay men (self-identified homosexuals), as well as by «discreet homosexuals and bisexuals», and criminals and sex workers, whose roles, Schifter says, sometimes overlap; in addition there are policemen. As the above study carried out in Costa Rica shows, the reasons that lead these people to have sex in public places, has to do not only with the impossibility or difficulty of having sex in more comfortable surroundings, but also with the fantasy and enjoyment associated with the risk, the novelty, and the anonymity (having sex «with strangers»). This aspect seems to be connected with the positive perception of sex dissociated from affective ties, with the efficacy and speed with which the sexual act is consummated, and with the compulsion always to meet new people. The most common sexual practices in encounters of this sort are oral sex and mutual masturbation.

Another issue has to do with the risk of violence associated with stigmatisation, exclusion, and self-exclusion connected with homosexuality. These risks derive from situations such as going to strangers' homes or receiving strangers at home, not introducing sexual partners to social acquaintances, and anonymous sex; all of these are situations that heighten the risk of HIV/AIDS, violence, extortion, robbery, etc.

In this chapter we do not discuss the sociological or psychosocial reasons that different authors advance to explain the phenomenon we are describing (*Pollak 1993b*). We are simply interested in mentioning here that sex in public places poses specific obstacles to the adoption of preventive behaviours, given the largely anonymous

and fleeting nature of sexual encounters, which, for that very reason, present specific challenges for prevention activities. Nevertheless, such activities are being carried out in the region thanks to the articulation of formal and informal networks with gay organizations and activists. In particular we should mention the alliance with owners of business establishments where these sexual practices take place, either officially or unofficially, in order to distribute condoms and lubricants and to put up posters bearing pro-prevention messages; in saunas in some countries, for example in France, they even have a room that at predetermined times serves as an anonymous consulting room on matters to do with HIV/AIDS and other STDs.

Another core aspect is broad political discussion on the abolition of legal and social barriers to the adoption of safer sexual behaviour. In particular we refer to explicit or implicit prohibitions on access to condoms in closed institutions; to the issue of youth, for whom the recognition of active sexuality is refused; and to the absence of protection against discriminatory attitudes to sexual orientation and/or HIV/AIDS in the workplace, at home, and -by no means uncommon- among health professionals.⁴

Finally, it would not be remiss to reiterate that the adoption of preventive behaviours among male homosexuals was due to the construction and social mobilization of the gay community. In some cases, during the 1980s, it was the incipient gay organizing that spearheaded early anti-AIDS activities, and in other cases it was the struggle against the virus itself that prompted socio-political organization around the issue of sexual orientation (*Pollak 1993a; Roberts 1995; Pecheny 2001*). The activities to combat AIDS in MSM implemented by these organizations have a three-fold objective: to reduce HIV incidence; to provide assistance to those living with the virus; and to encourage acceptance and recognition of sexual diversity within sexual-minority subcultures and in society as a whole. To that end, they carry out activities in the areas of research -bringing together academic, political, and community activists-, prevention, assistance, and political organization and lobbying, thereby drawing attention to the close link that exists between public health and citizenship.

Young MSM

Adolescence is a pivotal period of change in which individual behaviour with respect to social gender patterns is enhanced. In this passage from childhood to adulthood they progressively incorporate behavioural codes that have an effect for

⁴ The data collected on a sample of health workers (n= 377) in Buenos Aires reveal a negative attitude towards homosexuality in 46.9% of those interviewed and a positive one in 5.7% (*Kornblit and Mendes Diz 1995: 132*).

the rest of their lives. Many researchers hold that as a period of flux it is easier to modify attitudes, behaviours, and habits during adolescence than it is in adulthood. For this reason, it is considered that prevention policies should target this sector of the population as a priority, since the impact on them would be far greater than that of programs targeting older populations. Much has been written in Latin America about adolescents and indeed about sexuality during adolescence, particularly with respect to adolescent pregnancy, reproductive health, sexual behaviours, and contraceptive use in adolescents. However, research on the sexuality and reproductive health of adolescents has all but ignored the non-heterosexual population (*Pantelides and Manzelli, 2001*)⁵.

«Any prevention strategy aimed at adolescent and young MSM should encourage a social transformation of educational institutions and incorporate cross-sectional contents in all areas with respect to different possible forms of sexuality.»

In addition to the prevailing stigma on homosexuality in the Latin American region, adolescent MSM have to contend with the added problem that the behaviours, attitudes, and feelings they exhibit have only been partially legitimised in the majority of these societies, and exclusively among adults. The focus of the better known aspects of the gay and lesbian culture are adults, and there are legal, social, financial, and political barriers that block any adolescent involvement in them. For adolescent MSM who do not identify themselves as gay or homosexual, the outlook seems much darker. Adolescents who engage in alternative sexual behaviour to heterosexuality are utterly shunned. Despite the scant information that we have on this population there are a number of important issues to bear in mind for the purposes of prevention activities.

The majority of the institutions in which adolescents grow up denigrate any form of non-heterosexual behaviour or identity. As is normally the case for young people, their political, economic, and social expression is restricted by their age. However,

⁵ Cáceres (2000) was one of the pioneers in incorporating these groups in research. Among the objectives of his study is to describe the sexual behavior of adolescents and youth in Lima in the 1990s and to identify particular sexual and reproductive health risks in this group. In a sample of young adult MSM the sexual initiation pattern that emerged was of partners somewhat older than themselves who were distantly related (for example loose acquaintances or simply strangers), mainly in public places, mirroring patterns of behaviour associated with male prostitution. As regards adolescent MSM, for their part, although their sexual initiation patterns were less traditional, involving sexual relations in particular with persons close to them (friends, colleagues, cousins) and of the same age, they revealed an alarmingly low prevalence of condom use in their sexual initiation.

in the particular case of adolescent MSM there is the added factor that schools, the family, the church, and peer groups deny and stigmatise behaviours, feelings, ideas, and desires associated with homosexuality. Educational institutions have a track record of hostility towards sexual minorities, and any non-heterosexual behaviour is censured in schools curricula and reading materials. In many institutions sex education is just another subject at the secondary-school level, an age when adolescents usually have their first sexual encounter. An HIV/AIDS prevention campaign that promotes condom use but fails explicitly to recognize the existence of sexual relations between males (or between females) exclusively targets the heterosexual population. Any prevention strategy aimed at adolescent and young MSM should encourage a social transformation of educational institutions and incorporate cross-sectional contents in all areas with respect to different possible forms of sexuality.

Furthermore, several studies find that young people, more than any other age group, are prone to generate homophobic violence (*Masters, Johnson and Kolodny 1992; Greer 1986; in Unks 1995: 6*). Therefore, it should be borne in mind that another of the factors that contribute to the exclusion of, and consequent adoption of risk behaviour by, adolescent MSM is their lack of a sense of group membership. It is necessary to design strategies that seek to breach the isolation of these individuals based on the «community action» theories that hold that stronger community structures are important sources of support for reducing individual risk behaviours. Counselling programs and support groups are useful and necessary tools for helping these young people become aware of the options available to them for dealing with social discrimination.

Sex workers

The practices in which sex workers engage on a daily basis make them more exposed to HIV/AIDS infection than the rest of the population. These levels of risk vary according to their patterns of sexual behaviour. It is difficult to speak of male sex workers as a well-defined and uniform group due to their variety and different self-perceptions as sex workers. Included in this category are identities as varied as those of transvestites, macho male prostitutes, gigolos, people who prostitute themselves on an occasional basis, and a variegated series of denominations that express «*intransferable peculiarities that vary from place to place*» (*Perlongher 1993*). However, in proposing intervention strategies for HIV/AIDS prevention it is essential to work with all of these groups and subgroups of people because of the high levels of risk that they face. For the sake of explanation, we believe it useful to adopt the

differentiation used by Néstor Perlongher between macho male prostitutes, transvestite prostitutes, and other types of homosexual prostitutes⁶.

Discussing male sex work involves addressing strict taboos because it entails a series of transgressions of social conceptions of gender, sexuality, and desire (Córdova Plaza 2001). The few academic studies carried out in Latin America on male prostitution all agree that exclusion and discrimination appeared to be connected with the adoption of unsafe sexual practices. From these studies it is possible to identify a number of features to bear in mind for the design of intervention strategies for HIV/AIDS prevention.

Although in theory the services of macho male prostitutes are intended for both sexes, the majority target men. As Perlongher (1993) says in his study on macho male prostitutes in Sao Paulo, «*in street prostitution the proportion of female clients is insignificant. However, heterosexuality seems to be invoked far more than it is actually practiced*». In his study, on macho male prostitutes in Xalapa, Mexico, Rosío Córdova Plaza (2001) finds that the bulk of clients are men.

Furthermore, macho male prostitutes generally do not regard themselves as homosexuals, and transfer «*the social burden of the stigma on to their homosexual partners. The fact that they do not abandon masculine forms of discourse and gestures makes the use of such resources possible*» (Perlongher 1993: 12).

The physical locations in which these activities take place largely coincide with those of the gay scene: bars, discotheques, saunas, and pornographic cinemas. Also included are street settings, where large numbers of people dwell (plazas, street corners, public conveniences, stations, etc.), as well as private apartments, escort services, and massage parlours or clinics. These services can be promoted in classified advertisements in newspapers and on web sites, where arrangements can be made to meet in the street and other public places.

Unlike transvestite sex workers, organization networks among macho male prostitutes appear to be less common and rather weak.

Studies also reveal the existence of an indeterminate number of young men who occasionally have sex with other men in exchange for some form of payment in kind, which may take the form of gifts or even an invitation to consume alcohol or drugs. Córdova Plaza says that «*this population is difficult to identify and quantify*

⁶ The study uses the term 'macho male prostitution' (*prostitución viril*) to distinguish the sexual services offered by male prostitutes «who make an exaggerated show of their masculinity to the client» from those provided by transvestite prostitutes «who charge men for their artificial representation of their femininity», and other forms of homosexual prostitution, such as the camp prostitute who sells his body or the gay prostitute (Perlongher 1993: 10).

precisely because they do not believe that there are engaging in any kind of commercial sex and, not being aware of the practices in which they are involved, they are also unaware of the risks they may run of contracting AIDS or some other type of sexually transmitted infection. « (Córdova Plaza 2001: 8).

Transvestites, one of the most vulnerable sexual minorities from any perspective, deserve a separate mention. Exposed to physical mistreatment, with little or no prospect of socioeconomic advancement and of being able to exercise their rights, many transvestites in the region resort to sexual work (Villa-Real, 2001). Research in a number of cities in Brazil and Argentina shows that socio-political organization of transvestites and transsexuals is possible, just as it is for women prostitutes. Transvestites of limited means are extremely vulnerable to police and other forms of violence, in which AIDS is just another risk to be confronted and is sometimes regarded as no more pressing than others. One study says transvestites who engage in sexual work in Buenos Aires says that *«there is a strong risk of infection, in particular because they let it be understood that the client determines the kind of sex to be performed. Far from a form of empowerment, it is the clients that control their situation.»* (Vujosevich et al. 2001: 15).

In designing intervention strategies for HIV/AIDS prevention it is necessary to take into account the heterogeneous nature of this group and the different levels of self-perception of these individuals with respect to being a sex worker or not. Córdova Plaza is conclusive when she states that *«the more they regard themselves as sex workers, the greater their apparent awareness of the importance of condom use and of rejection of high-risk sex»* (Córdova Plaza 2001: 11). Therefore, it is necessary to take into account that the adoption of risk practices accounts for the exclusion and clandestine situation of sex workers. It is necessary, then, to design interventions that specifically target this group with a view to raising their awareness of exposure to risk situations and ways of preventing infection.

M_{SM} living with HIV/AIDS

One of the tasks for AIDS control is primary prevention; that is, targeting the population not infected with the virus. Prevention concerns two intimately related aspects: the health aspect (risk behaviours and ways of averting HIV transmission), and the humanitarian aspect (since being well-informed is the basis for an attitude of solidarity and non-discrimination with regard to people living with the virus).

Now, twenty years since the outbreak of the epidemic, it would be fair to say that prevention targeting people living with HIV/AIDS (secondary and tertiary prevention)

is without doubt the most neglected area of prevention. This type of prevention is important both for preserving the quality of life of affected persons -by preventing reinfection, opportunistic diseases, depression, and low immune levels- and for stimulating in them responsible attitudes towards others.

«...prevention targeting people living with HIV/AIDS (secondary and tertiary prevention) is without doubt the most neglected area of prevention.»

Secondary prevention also includes health and humanitarian aspects, since behaviour that is safe both for themselves and for others depends on adequate information levels, self-esteem, peer support, and recognition of rights. Studies carried out on persons living with HIV/AIDS (*Green and Sobo 2000, Pecheny and Manzelli 2001*), show that the transition from anger and fear -characteristics of the first phase after a positive HIV test result- to «fighting the disease» involves a kind of decision to take charge of one's life. In particular, this entails changing the social circles in which one moves; in other words, distancing from those who may adopt attitudes of rejection or indifference, and moving closer to others where one will find support, including persons living with the virus. Among homosexual men, this is particularly significant for two reasons: first, letting other people know that they are infected with HIV/AIDS may lead to the disclosure of a homosexual lifestyle experienced more or less discreetly - a revelation that would result in a redefinition of their liaisons with the other meaningful, non-gay persons in their life; such a redefinition may lead to a strengthening of ties with family and friends, or the reverse. Second, for many gay men, knowing that they are HIV positive helps them finally to come to terms with their homosexual or gay identity, leading to a tightening of their relationship with their gay partner, who might also be living with AIDS. All of these aspects need to be taken into consideration when designing prevention or assistance campaigns.

NGOs play a very important role in this area by offering programs for affected persons: they provide information, as well as medical, pharmacological, psychological, and legal assistance. There is a clear mindset that biomedical, psychological, and legal aspects are inseparable: the way a person's life with the disease evolves is determined by emotional reactions - which have immune effects-

to real or potential rejection on one hand, or to solidarity and affective support on the other. NGOs publicize scientific progress in treatments and drugs, and demand that the State guarantees access to them. As political actors, their role is crucial for ensuring that the State recognizes the priority of the anti-AIDS struggle and acknowledges the existence of people living with the disease.

As with other chronic patients, becoming a member of informal networks of people living with the same pathology- in particular, but not only, gay men- helps considerably to improve quality of life. This is revealed in the processes by which such people become experts in the interpretation of symptoms, knowledge of available drugs and treatments, information on addresses and places to turn to for support, names of doctors «who understand you», and, above all, learning the tricks for overcoming bureaucratic and information obstacles that hinder access to good services and drugs (*Pecheny and Manzelli 2001*). These networks of gay men living with HIV can also be a source of support for coming to terms with the frequent psychological stress that follows a positive test result. In addition to this is the role of formal or informal multipliers that gay men living with HIV can play in the promotion of safer sex and early detection among peers who move in the same circles as them.

Prevention in persons already living with HIV/AIDS is crucial, both as regards promotion of self-care and diligent continuation of treatment, and as regards protection of others. According to our research, most HIV positive people expressed concern regarding the possible infection of their sexual partners, but very often do not know what it is that they should avoid, and, above all, what it is they can do with little or no risk. In this connection, peer campaigns and/or campaigns implemented by NGOs are crucial, since at this level it is necessary to provide a great deal of explicit detail about «what they can't» and «what they can» do sexually, bearing in mind different sexual practices and the different context of those practices; for instance, sex in public places.

As we know, people living with HIV/AIDS are confronted daily with the issue of whether or not to tell other people who are affectively or socially important to them (the «other meaningful people» in the sense of G. H. Mead) that they are HIV positive. In particular, we would like to mention here the issue of sharing this information or secret with sexual and/or affective partners, which poses various dilemmas and potential crises. According to various studies carried out on people living with HIV/AIDS (*Green and Sobo 2000*), the nature of the relationship is a determining factor when the possibility arises of sharing this information. Paradoxically, sometimes social distance reduces the tensions associated with confession, as in the case of those with whom a relationship is formed precisely because they are living with HIV (for example health workers).

The actual and/or expected reactions of partners and/or lovers of MSM living with HIV/AIDS determines not only the quality of life and the mood of such persons, but also their inclination to adopt risk or safe behaviour. It is for that reason that prevention policies increasingly focus on the «couple» as a unit, and address diverse issues, such as: knowing the serological status of both members of the relationship; ensuring that those not infected remain uninfected, and avoiding reinfection of those who already have the virus; and providing psychological and practical support aimed at keeping the relationship together if there is serodiscordance or both partners are HIV positive -the latter applies to steady partners. In the case of people with an active sex life but no steady partner, it is also necessary to tackle the issue of whether, how, and when to disclose the fact that they are living with HIV. In particular, one message with which to target seropositive individuals, enabling them to protect themselves from uncertainty and their possible partners to protect themselves from HIV, is for them simply to say to their partners that *safer sex* is for their benefit and that they are more comfortable with it, without offering any further explanation; and if and when the moment arrives, they can mention the issue of HIV then. Many of those interviewed during our research (*Pecheny and Manzelli 2001*) say that this has worked well for them, and even that, when the moment of greater confidence arrived, they each learned that the other was seropositive. However, other interviewees said that they present the «deal» and that if the other does not want to protect himself then that is his problem and, therefore, safe sex ceases to be a priority. In the latter cases, although they appear to be the exception, it would be necessary to think of ways to incorporate *safer sex* as a routine practice, for example by including prevention messages in information on the risk of reinfection and communicable opportunistic diseases, together with non-moralizing ethical considerations. Finally, as Green and Sobo (*2001: 139*) point out, «*while the risk to the physical health of the partner and, in some cases to oneself (e.g. through cross infection) is taken into consideration, the social risks of not engaging in unprotected sex are seldom recognized.*» This brings us back to the analyses and proposals contained in Models 2 and 3 above.

Access to treatment and drugs

Over and above the ethical considerations regarding recognition of the universal right to health, it is necessary to recall here that access to treatments and drugs in itself constitutes a prevention policy (primary, secondary, and tertiary). In purely economic terms, even though treatments are costly, the savings in terms of hospitalisation and medical care, as well as in indirect costs, justify the decision to make available the drugs that delay the advance of HIV infection (*Beloqui 1998*).

On the other hand, lack of access to treatment and/or explicit or implicit closed-door policy to MSM on the part of health services (as occurs to a large degree with drug users) encourages a lack of preoccupation with knowing one's serological status, dealing with the disease, and protecting oneself and others.

Public health and human rights

Historically political debate on prevention of epidemics has centred on the defence of the health of the community versus upholding individual freedoms. However, for the first time in history, prevailing epidemiological policy places an emphasis on the notion of personal risk management, thereby reconciling the ideas of collective prevention and individual rights. In this sense, what is new about this epidemic is the fact that the public-health imperatives seem to demand respect for human rights (*Herzlich and Adam 1997: 9*). According to Peter Piot of UNAIDS, «*Public health appears increasingly to be a new imperative reason for protecting human rights, even if observance, protection, and realization of such rights is already warranted by their very nature. In the context of HIV/AIDS, an environment in which human rights are taken into account reduces vulnerability to the pandemic, enables people affected by HIV infection or AIDS to live with dignity, free from discrimination, and attenuates for individuals and society the consequences of infection with the virus*» (*United Nations 1998:v*).

The anti-AIDS campaign gave rise to different debates about how the struggle might best be waged. On debate pits the «curative» approach against the «preventive» approach. The «curative» approach deals with the epidemic by trying to tackle the infection and the disease in individual terms, while the «preventive» approach attempts to influence the behaviours (individual and social) that enable the propagation of the virus. Very often, governments have pursued a single approach, with dire consequences: for example, the Argentinian government, for many years focused on treatment of infected people, arguing that the population was sufficiently well informed on modes of HIV transmission and that, in a context of limited resources, these should be allocated to providing care to those already infected. Other governments in the region refused for years to acknowledge the reality of the epidemic and accorded priority to generalist prevention campaigns, very often on the assumption that AIDS was a disease that affected «others». However, thanks to growing awareness and domestic and external pressure, the governments of the region came to realize that the curative and preventive components are inseparable.

During the 1980s, people with HIV/AIDS were unprotected, legally speaking, against acts of discrimination. The state turned a blind eye, and it was the incipient anti-AIDS movement, together with the gay movement and a number of health professionals, that took the first initiatives. Anti-AIDS associations were not only pioneers in providing assistance to the ill and launching prevention campaigns, they were also the first to denounce discriminatory attitudes (even among governments and health ministries) and to set in motion anti-discrimination campaigns.

As a result, in the 1990s, a genuine non-governmental anti-AIDS movement evolved in the region, composed of two types of NGOs. On one hand, NGOs or foundations connected with health institutions, implementing centralized assistance and prevention programs; and on the other, small NGOs, and mutual assistance and self-help groups that engaged more in localized prevention, providing support to patients, and combating discrimination. All of these organizations have set up networks that very often have seriously questioned government programs.

In particular, these associations have been helping to redefine the social, political, and legal context with respect to AIDS: they help persons living with HIV to comply with health, administrative, and judicial procedures; improve medical care and hospital infrastructure; keep an eye on the state, health institutions, and doctors; create forums that help people living with HIV/AIDS to avoid isolation and loneliness; and ensure the social visibility of persons whose plight society had dramatized and at the same time denied; and, lastly, they encourage less negative attitudes towards the disease⁷.

The response of governments was, generally speaking, late in coming and ambiguous. In response to domestic and international pressure, many countries adopted laws designed to ensure observance of the rights of people living with the virus, giving them precedence over considerations allegedly reached in the name of public health.

The priority accorded to the rights of the individual makes prevention primarily the responsibility of the infected individual and each member of the community, based on principles, such as:

- Respect for freedom of choice, that is, each individual has the right to make their own life decisions, guaranteeing informed consent for the performance of tests and treatments.

⁷ Having mentioned this hard-fought progress, we should, nevertheless add that 20 years on from the start of the epidemic, it is time for a critical evaluation not only of the external obstacles that this movement encountered, but also of the a number of questionable aspects of its internal development as regards excessive bureaucracy, mercantilistic attitudes, and accountability.

- Confidentiality, which signifies doctor-patient privilege and coding of test results.
- Non-discrimination against HIV carriers.
- Information and education on all aspects of the disease and its transmission.

Since the end of the 1990s, some ministries in the region have been financing AIDS prevention campaigns through NGOs, included among which are a number of gay organizations. In some countries, furthermore, the Ministry of Health assumes responsibility for supplying drugs to those who demonstrate that they cannot afford them, even though the continuity of distribution and the quality of the drugs distributed are occasionally called into question.

Since the mid-1990s governments in the region have shown a strong reluctance to implement HIV prevention programs targeting MSM (and injection drug users - IDU), for a variety of reasons: negation of, or indifference to, the existence of sex among men (or of injection drug use); stigmatisation and/or criminalization of such practices; difficulties with collection of reliable epidemiological information; alleged difficulty of reaching MSM (and IDU); limited health services infrastructure and lack of awareness among health professionals of the peculiarities of these vulnerable groups; absence of economic incentives to finance targeted prevention programs; and the priority given to prevention in the general population.



A demonstration in Chile demanding better AIDS policies and respect for the rights of persons living with HIV/AIDS, including access to treatment.
Archives of the C.Ch.P.S.

Based on this combined effort, both on the domestic front -driven by the anti-AIDS movement sometimes in conjunction with the gay movement- and the external front, governments are beginning to take seriously the epidemiological data provided by the health Ministries in each country. Consequently, they are beginning to plan prevention programs that target MSM (and IDU) with the added aim of reducing discrimination and stigmatisation (*Rossi 2001*).

Recognition of the need for prevention as the principal mechanism for confronting the epidemic, raises discussion about the modalities and contents of campaigns: generalist or targeted, and abstentionist or aimed at risk reduction. During the early years, two factors led governments to prefer generalist campaigns. On one hand, the fear that the epidemic would spread very rapidly through the general population via heterosexual and perinatal transmission; and, on the other hand, the aim to tackle not only the risk of HIV transmission, but also social panic, and to show public opinion that «the Government is doing something» about it. It has quickly become clear that generalist campaigns are inadequate for modifying risk behaviours, since they depart from the assumption of a socially and culturally homogeneous public. Targeted and proximity campaigns, by contrast, are justified on health and ethical grounds: they are more effective and better recognize the different types of exposure to the risk of contracting HIV. Proximity and targeting makes it possible to take into consideration specific risks and to deal at the same time with secondary and tertiary prevention, as well as encourage the social inclusion of individuals excluded from the health system.

Even today, AIDS carries a powerful social stigma compounded by the far older social rejection linked to homophobia.

Stigmatisation (*Goffman 1989*) is a unique form of social discrimination. Stigma is a given physical, behavioural, and/or identity trait of an individual or a group thereof that sets them apart and diminishes their value in the eyes of society. As a result of this stigma, society and the milieu in which the individual exists regard him or her as being in some way inferior, contemptible, dishonourable, or dangerous. However, it is society that creates the stigma, which makes a particular feature have such effect. Stigmatisation leads to questioning of the stigmatised persons' dignity and a partial or total loss of their rights. Even today, AIDS carries a powerful social stigma compounded by the far older social rejection linked to homophobia. Given that AIDS is a problem in which health aspects are intermingled with social and legal ones, it is simultaneously a public health and a human rights issue.

Studies have shown the extent to which people living with the virus lose their rights or the possibility of exercising them as a result of being seropositive. Therefore, people living with HIV/AIDS claim rights in three areas:

- The right to health and to life, which implies access to treatments and drugs, as well as a reformulation of the rights of patients in general and of the patient-doctor-health establishment relationship.
- Connected with the right to privacy, which affects almost every aspect of a sufferer's life, is the right to confidentiality of test results and treatments, as well as respect for the right to informed consent for conducting tests and treatments.
- In connection with the right to equal protection, when an individual is found to be HIV positive the apparent consequence is that he or she loses their «right to have rights», since very often HIV positive or sick individuals lose their fundamental rights, including the rights to employment, to dignity, or to a home.

The main problem with AIDS is not legal discrimination against persons living with HIV/AIDS, since formally coercive measures are the exception in the region. The problem has to do above all with the social conditions for the exercise of formally recognized rights; such conditions worsen in contexts of homophobia. When a young seropositive man is the victim of discrimination -for instance, arbitrary dismissal- the law protects him, but social and family discrimination against AIDS make the conditions for application and use of the law impossible. This discrimination may be real or perceived (referred to as anticipated discrimination). In any event, perceived discrimination and fear of rejection by one's family or affective surroundings work as an efficient self-exclusion factor. The situation is made doubly difficult when revelation of seropositive status also entails the revelation of practices pursued in a non-public manner, in particular, homosexuality or drug use.

In short, we have sought here to present an argument in favour of a synergic integration between effective public health policies and respect for human rights:

- On one hand, discrimination and exclusion contribute to the spread of the epidemic, which, in turn, contributes to the decline in the quality of life and the exercise of rights of many individuals and groups.
- On the other hand, recognition of human rights -including the right to health and to free expression of sexuality- makes it possible to improve implementation of primary, secondary, and tertiary HIV/AIDS prevention, and such prevention, accompanied by universal access to drugs and treatments, does nothing if not respect the universal and inalienable nature of human rights.



Two views of a gay rights demonstration in Santiago de Chile, where the AIDS agenda was clearly established. Archives of the C.Ch.P.S.



Conclusion

In this chapter we have examined the main prevention approaches and the way they are applied to the HIV/AIDS epidemic. We have also mentioned some of their shortcomings and strengths in the area of programs for men who have sex with men.

The three theoretical models we described depart from different supposed ontological premises and, consequently, focus on different areas of prevention. However, despite their differences, an effective prevention campaign should, of necessity, include a combination of the elements contained in these models. Interventions aimed at modification of beliefs, knowledge, and attitudes that influence individual behaviour have had little success because they fail to take into account the meanings that subjects attach to preventive practices and risk. Furthermore, in addition to individual behaviours and social values, especially those on which the subjects construct meanings, economic and social inequalities are what largely determine the subject's possibilities for action. HIV/AIDS prevention strategies that apply a combination of elements from these three models are by definition aimed at bringing about social change to alter the structures that make some groups more vulnerable to HIV infection than others.

In this chapter, we underline the importance of prevention that targets people who are living with HIV or AIDS (secondary and tertiary prevention) and the scant attention that has hitherto been given to this aspect. In this framework, access to treatments and drugs constitutes a core theme of any prevention campaign, be it primary, secondary, or tertiary.

In conclusion, we wish merely to say that an invitation to individuals to act responsibly as the cornerstone for prevention of HIV transmission and, therefore, for the anti-AIDS struggle, requires freethinking individuals. According to the classic principle of citizenship, if the state requires individuals to accept responsibilities and obligations to the community, this is done in exchange for the guarantee of each individual's rights and freedoms. Accordingly, freedom from discrimination and recognition of rights are a necessary condition for any health policy.

Recommendations for specific prevention work oriented to gay and other MSM:

- Include messages oriented to MSM and to MSM living with HIV/AIDS in the general campaigns.
- Integrated primary, secondary and tertiary prevention.
- Implement specific campaigns:
 - Recognizing heterogeneity of situations among MSM.
 - Guaranteeing access to resources necessary for adopting low-risk behaviours (e.g. use of condoms and lubricant), including venues where cruising or semi-public sex takes place.
 - Working with members of the gay community who enable access to such settings
 - Incorporating commercial establishments frequented by gay and other MSM to prevention activities, either through voluntary invitation or through regulations.
 - Promoting community and official activities of self-support and counselling, through hotlines and workshops, with a focus on HIV testing (e.g. interpretation of test results; resources to consider after receiving a positive diagnosis; and ways to deal with privacy when seropositivity and homosexuality are not lived publicly).

All this should be done:

- Integrating interventions with epidemiological and social science research, in order to improve our understanding of specific situations and to evaluate their impact.
- Training health providers and peer educators in the recognition of sociocultural specificities of gay and other MSM.
- Consolidating the intervention networks formed by government programmes, NGOs, gay activists and organizations of persons living with HIV/AIDS:

- Think of HIV as integrated with other health problems, such as sexually transmitted infections (STD), hepatitis, and mental health problems.

- Respect people's rights and avoid discrimination:
 - Ensuring legal protection against discrimination on grounds of HIV infection, sexual orientation, or sexual identity.
 - Recognizing the associative and expression rights of sexual minorities, whose organizations are key actors in HIV prevention and care.
 - Promoting sex education in all educational levels, with a focus on discouragement of homophobia and intolerance.
 - Recognizing the sexual and emotional rights of those who do not embrace heterosexuality, by respecting the principles of liberty and equality for all citizens, regardless of sexual orientation.
 - Recognizing the rights of persons living with HIV/AIDS, including the universal right to effective access to health care and antiretroviral treatments.

- Recognizing the heterogeneity of situations usually implies:
 - Proposing prevention activities oriented to adolescent gay men and the youngest MSM, since it is at this time of life when many of them become infected with HIV.
 - Proposing specific campaigns for bisexual men united to women, who suspect or know they are infected, so as to help them address this subject with their partners and potentially assume the need to fight the disease.
 - Addressing HIV prevention of prison inmates and minors living in reformatories, so that their life conditions can be improved, included access to HIV testing and treatment.
 - Addressing HIV prevention and life conditions of transvestites and transsexuals.
 - Through members of the gay community, addressing prevention in settings where public, or semi-public sex, occurs.

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CHAPTER VI

LESSONS LEARNED FROM ACTIVITIES AND PROGRAMS TO PREVENT AIDS AMONG MEN WITH HOMOSEXUAL PRACTICES

Tim Frasca

Introduction

From the very beginning of the AIDS epidemic, HIV was strongly identified with male homosexuality. The first warnings from the U.S. government about the new pathology labelled it «GRID» or «Gay-Related Immune Disorder.» For cultural and political reasons, even health authorities in developed nations were slow to respond to the new disease that seemed to be easily transmitted through homosexual relations. This initial indifference and unconcern was particularly common in Latin America (*McKenna 1997; CChPS 1997*). In some countries, such as Colombia and Ecuador, gay groups had to conduct their own studies on HIV seroprevalence because of the state's inaction.

At the same time, throughout the region the importance of homosexual transmission in national epidemics was often minimized. In some cases government officials concerned about the epidemic were afraid of weakening political support for their efforts; in others, there was simply little concern for the health and welfare of men who engaged in homosexual practices.

According to one U.S. observer, the historic pathologization of homosexuality by the medical profession and the resulting distrust homosexuals felt towards doctors and public health institutions hindered prevention work in the first crucial decade

of the epidemic and, indeed, played a role in its rapid spread (*Rosser, et al., 1993*). Nevertheless, the same negative factors reinforced feelings of group solidarity among those affected which later would facilitate the development of educational activities. In many respects Latin America is experiencing a delayed version of this same process.

Those directly affected by AIDS in the region often were the first to address the need for public education. Although these initiatives were isolated at first, they gradually attracted a growing level of cooperation and support from other sectors, including governments. However, many of the first preventive efforts lacked rigour or consistency, and very few were systematically evaluated. Of particular importance in this process was the early participation of organized gay communities in their own prevention activities. What is now known as «peer education» was not originally conceived as such; rather, it was simply a reaction on the part of those afflicted or endangered, frequently without specialized training, to an emergency that was having a direct impact on their lives. With the eventual contributions from educators and the social sciences, the field of prevention among gay and other homosexually active men became a rich source of information about not only methods and experiences but also complex social processes.

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A broad spectrum of interventions, methodologies and perspectives has developed in the course of nearly two decades of efforts to halt the advance of HIV among gay and other homosexually active men. The accumulated evidence suggests that the best approach for an overall prevention strategy is a combination of actions aimed at overcoming obstacles at the individual, group and societal levels, each of which require multifaceted strategies.

As these interventions and strategies developed, the results gradually revealed the weaknesses of each perspective or approach; activists perceived new factors influencing individual and group behaviors that they had previously ignored or overlooked. These discoveries often led groups to change direction and restructure

or broaden their interventions. Therefore, any discussion of the lessons that have been learned cannot simply offer a list of activities or methodologies but must consider as well the processes by which new knowledge was obtained.

This chapter summarizes the state of prevention practices directed toward gay and other homosexually active men so that the activities of individuals or groups interested in carrying out similar work may be strengthened. Clearly, there is no single course of action appropriate for all circumstances, and each organization will elaborate its plans based on the conditions, capacities and interests of its members. However, general guidelines based on the reported successes and failures of others may be of use.

Descriptive terms for the population

Many men around the world have incorporated into their languages the term «gay» to describe and identify themselves on the basis of their sexual orientation and/or practices. In addition, they are frequently members of communities or social circles that share this identification. However, early on in the course of AIDS prevention work, a problem arose on how to classify the many men engaging in homosexual or homoerotic practices who do not consider themselves to be «gay» nor associate these practices with any other aspect of their identities. In statistical reports on HIV/AIDS, the category was described as «men who have sex with men» or similar variations, eventually abbreviated to «MSM.» This inclusive term was utilized for epidemiological purposes to assure better calculations of the predominant means of transmission, given that many heterosexual-identified males were acquiring HIV through homosexual relations.

However, the term *MSM* does not adequately describe the community of gay men who have publicly or privately assumed their sexuality as a cultural expression that affects their attitudes, friendships, lifestyles or living arrangements. Given the importance of the shared gay male identity for the success of many HIV prevention programs, this chapter will use each term as appropriate. For example, the term *gay* will be used when referring to activities designed to strengthen shared norms among communities of self-identified homosexual men. On the other hand, if the activity is aimed at reaching men in public sex venues, the term *MSM* is apt. Semantic incoherencies, such as *MSM communities*, will be avoided.



A gay rights demonstration in Mexico City. Archives of Letra S.

Levels of prevention work

HIV educational interventions among populations of gay men and MSM operate at different levels, depending on the particular methodologies utilized and the circumstances being addressed. These interventions can be grouped in four categories, each with its own advantages and limitations (Aggleton, et al., 1991).

- (A) **Provision of information** about HIV/AIDS, modes of transmission and prevention methods;
- (B) **Individual skill- and capacity-building** activities, such as training in condom use, negotiation and erotization of safe sex, or individual services such as voluntary HIV test counseling;
- (C) **Socio-cultural interventions**, such as promotion of group or community codes of behavior, and;
- (D) **Social transformation**, including mobilization to combat the epidemic, gay rights activism, lobbying, promotion of legal or administrative reforms, or formation of local, national and regional alliances.

A. Provision of information

The first actions aim to inform the target group about HIV/AIDS and provide people with the basic knowledge they need to avoid infection. This approach was particularly prevalent at the beginning of the epidemic when the need to publicize the new disease and confirm that it was sexually transmitted was urgent. Although most educational work inevitably begins with providing the basic facts about HIV/AIDS, ideally this initial approach will be accompanied by strategies to connect individuals in the target population to other services or related activities, given that mere information delivery does not lead to sustained preventive behaviours.

In gay circles, activists often emphasized that AIDS had first appeared among homosexual men and that their sexual practices implied certain risks. The fact that this information came from members of their own community was of particular importance and strengthened its credibility; previously, nearly all information was filtered through the news media, replete with alarmist and

homophobic tendencies or outright misinformation. The tone of the early news media coverage practically guaranteed its rejection by gay men and strengthened their natural desire to deny the existence of a danger that promised to further complicate their lives.

Flyers distributed at bars, saunas or parks, gay meetings, information talks or videos, and advertisements in gay publications were all used to raise awareness among gay men and other MSM about the risks to their health and well-being. Initially, due to a lack of clarity with respect to modes of transmission, these messages did not contain many guidelines for self-care. Later, messages specified which practices entailed a greater or lesser risk and encouraged people to take the necessary precautions, normally within a context of individual reflection and conscious decision-making.

- The «emergency»

However, these first educational efforts tended to ignore the emotional impact and meaning of human sexuality, as well as the particular elements of secrecy, discrimination and family or psychological conflicts facing gay men. The information suggested that they would have to «repress» what had cost them so much to assume and live (Shernoff & Bloom, 1991). Moreover, much of the material failed to treat sexual acts with sufficient frankness. A typical pamphlet published by a state health department in the United States, «What gay and bisexual men should know about AIDS» (Virginia State Health Department, 1984), limited itself to warning of the risk of «sexual contact» without indicating how HIV was transmitted. Using extremely discreet drawings and a final suggestion to «take measures that could help prevent the spread of HIV,» the pamphlet managed to raise an issue that was of great interest to the targeted group without ever addressing it.

Other informational material used fear of disease and death to underline the gravity of the situation. Such messages appeared repeatedly in official campaigns in the early stages of the epidemic in a bid to communicate its seriousness to the general population. Some gay groups imitated these fear-based campaigns in their own material, using images of death and pictures of sick people, unaware that aggravating the fear surrounding AIDS was both ineffective and counterproductive.

By contrast, other groups used everyday language and even coarse slang aimed at establishing frank and direct communication with gay men. While this

language might have been offensive in other contexts, it sought to create a sense of collusion and appeal to the brotherhood of the threatened group. A 1987 Australian flyer encouraging condom use announced that «*Everyone´s doing it,*» and affirmed that the shift in practice was «*an important move for the entire community.*» The use of such language indicates early awareness of the need to connect information about HIV/AIDS and self-care measures to feelings of community solidarity and the concept of self-protection as a group norm. (Shernoff & Bloom, 1991) (Parker, 2000)

- From information to education

After the «emergency» period, material began to aim at educating rather than merely delivering information. Activists seeing the reactions of the target population to the earlier educational materials began to demand that more care be used in both the written and the graphic content of these publications. They questioned the use of flat, non-erotic language to encourage changes in men´s sexual practices. «*Sexual marketing is used to sell many products in Western culture,*» wrote a team of researchers in 1993, but «*rarely is it seen in traditional educational campaigns on HIV.*» (Rosser, et al., 1993)



Group-based educational workshops have represented a key strategy in the response to AIDS. Archives of the C.Ch.P.S.

Attention to information, education and communication (IEC) quickly increased as government concern grew about the epidemic. While these campaigns for mass audiences rarely addressed homosexual practices, the communications techniques, including research to specify the central messages and to validate the efficacy of the material, filtered through to groups that were aiming their efforts at more specific populations.

For their part, after the first attempts to communicate about the existence of AIDS, gay groups began to produce an enormous variety of didactic materials, sometimes with considerable creativity and aesthetic value. Comics, magazines, erotic postcards, pamphlets, flyers and calendars appeared, along with key rings, matchboxes, coasters, napkins, swizzle sticks — in short, any object that could serve as an information vehicle.

- Telephone hot-lines

Telephone hot-lines were established in many capitals in the region in a bid to respond to the need for information about AIDS. Modeled in part on hot-lines set up to help rape victims, people suffering from depression and other types of consultation services where anonymity is important, these services inevitably combined an informative function with other roles. They might provide crisis intervention or refer users to other services, offer advice about sexuality issues, family conflicts, relationships or other concerns. The early gay organizations sometimes found that their office telephones were converted into impromptu hot-lines as anxious callers besieged them for information.

As these services were formalized, groups established and maintained timetables for calls, trained operators to provide basic information and counseling and built a network of contacts with other organizations and services. Many eventually added a registry of incoming calls in order to keep a record of the questions asked and the results of the call. These records became important sources of statistical and anecdotal information about the evolution of the epidemic and social reactions to it.

Dissemination of these telephone services was not always easy. The best vehicles were city telephone directories, specialized guides, referrals from other hot-lines or organizations, posters or adhesive stickers in gay venues, or newspaper and magazine articles. Over time, some hot-lines began to concentrate on certain kinds of calls and to refer people to other entities better prepared to deal with issues such as AIDS treatments, drug use, problems related to sexual identity, bereavement, medical services or other specific problems.

However, the groups that operated these hot-lines soon realized that information alone rarely would result in the desired reduction of HIV infection risk among

individuals. Although the hot-lines were important for providing anonymous advice or orientation, the initial contact needed to be complemented with other services and interventions that could reinforce the risk-reduction process.

Government IEC campaigns or highly publicized incidents related to HIV typically sparked a significant increase in the demand for hot-line services. By including the telephone numbers of the available hot-lines in these campaigns and articles and assuring that the hot-lines are staffed by personnel trained to receive calls from gay and other homosexually active men, educators were able to reach an important number of men vulnerable to homosexual transmission.

- Links with gay commercial establishments

Most large cities have bars or clubs frequented by a predominantly gay clientele, and these are obviously key to reaching the maximum number of gay men. Many of the owners of these establishments, while initially reluctant to permit educational activities about AIDS out of fear of losing business or «bothering» their patrons, eventually became allies for AIDS prevention. Educators quickly learned that materials that were erotic and even festive, rather than those containing dire or threatening messages, overcame both owners' and clients' resistance.

Some organizations try to reward the more cooperative owners with periodic public recognition. Others use agreements obtained with some owners as an example to convince others to participate, as failing to do so would demonstrate a lack of solidarity with the community that keeps them in business.

- Visits to public sex sites

Another type of intervention frequently used to contact gay men and MSM are visits to public sex sites, semi-clandestine meeting places where men go to meet potential sexual partners or to engage in sex on the spot. This strategy sometimes combines providing information materials or condoms in a bid to establish a relationship of trust and identification with the prevention organization, thereby reaching men who are more socially isolated or who tend to conceal their homosexual practices.

Educational interventions in these sites require considerable skill and experience, both to establish contacts with users as well as to avoid assault or unwelcome attention from the police. Informing police and health authorities and explaining the rationale of these interventions can reduce the hazards for educators.

The codes of communication utilized in these sites tend to be non-verbal, given that men of any orientation, as one manual says «*generally do not talk about sex with their sexual partners.*» (Beckstein, 1990) The best educators tend to be men who themselves know and frequent the places selected although this can cause difficulties in separating their educational work from their private activity. Programs of this type should establish procedures and norms to avoid possible confusion and loss of confidence among beneficiaries.

Men who frequent public sex environments generally react favourably to systematic concern about their health and welfare. Coupons that can be exchanged for condoms or other goods at the organization's headquarters may attract new users to other existing services or awareness-raising activities. Educators can also provide other information of interest, such as material on other STDs, how to use the sites themselves, handling the police, or safety tips for these meeting places.

- Outreach

In order to establish and maintain links with gay men or MSM, many groups place an emphasis on the need to seek out potential beneficiaries rather than to wait for them to visit the organizations. «Outreach» implies a permanent presence in places where gay people meet, including both commercial and informal settings: bars, parks, saunas, discos and public sex sites. This work implies a cooperative relationship with owners, as well as gay-oriented periodicals, hospitals with HIV/AIDS programs, and any other types of formal or informal circles where gay men and MSM meet.

- Limitations of informational work

After a great deal of effort to inform the gay community about the HIV/AIDS risk, some activists and researchers began to warn about the apparent inefficacy of these actions. They discovered that not only had the infection rate failed to decline in certain groups but that those receiving the information had not altered their risky practices. Many of the studies indicated the persistence of risk behavior in men fully aware of the dangers involved. (Myers, 1993; Parker, 1995; Díaz, 1998)

These researchers and observers suggested that the factors that lead gay men and MSM to expose themselves to HIV infection were much more complex than they had thought. They insisted that deeper interventions were needed, based on new knowledge and considerations of sexual experiences and meanings.

BARRIERS TO SAFER SEX

1. Machismo

- An extreme and almost exclusive focus on penetrative sexual practices to the extent that sex without penetration is not considered sex;
- Perceptions of low sexual control, where a state of high sexual arousal («estar caliente», being hot») is used as a socially accepted justification for unprotected sex and surrender of reflective/regulatory control in sexual encounters;
- A perception of sexuality as a favored place to prove masculinity, where the possibility of losing penile erection is avoided at all costs.

2. Homophobia

- A strong sense of personal shame about same-sex sexual desire, so much so that fear of rejection in sexual encounters takes precedence over health concerns;
- Serious problems in self-identification as a member of a group at risk, with consequent denial of personal vulnerability to HIV;
- Feelings of anxiety about same-sex sexual encounters, leading to an increased use of alcohol, drugs and/or other intoxicants in preparation for sexual activity.

3. Family Cohesion (in the context of close personal involvement with homophobic families)

- Closeted lives with low levels of identification with and/or social support from a peer gay community;
- Minimal influence of normative changes in the gay community on sexual behavior because families are seen as the main social-referent group;
- A forced separation between sexuality and social/affective life of relationships that promotes anonymous, hidden encounters in public cruising places.

4. Sexual Silence

- Problems in talking openly about sexuality, resulting in difficulties with sexual communication or safer sex negotiation in sexual encounters;
- Increased sexual discomfort with all matters pertinent to sexuality;
- The psychological dissociation of sexual thoughts and feeling, decreasing the likelihood of accurate self-observation within the domain of sexuality.

5. Poverty

- Decreased sense of personal control over one's life, leading to fatalistic notions regarding health and personal well-being;
- Increased unemployment, drug abuse and violence, undermining the consideration of HIV infection as a major, central of priority concern;
- Situations of financial dependence such as living with families, explorative relations with older men, and/or prostitution where the personal power for self-determination and self-regulation is seriously undetermined.

6. Racism

- Increased personal shame about being Latino, with serious negative consequences on self-esteem and personal identity.
- Lack of participation in the mainstream gay community and its activities. Racist and classist values regarding personal looks, financial power, and educational achievement, highly prevalent in the mostly White and middle-class gay community, conspire against feelings of belonging and social recognition for gay men of color;
- Racist stereotypes about Latino men as being «passionate, dark and exotic» creating pressure from non-Latino White gay men to practice risky sex.

Rafael Diaz and George Ayala (2001) *Social discrimination and health: The case of Latino Gay Men and Risk for HIV Infection*. Washington: National Gay and Lesbian Task Force.

B. Individual skill- and capacity building

The sense of an urgent need to provide widespread public information on AIDS rapidly reached a crisis point. Activists saw that information and warnings about the dangers of HIV infection were not having a significant impact on people's sexual habits. Gay activists began to cast around for more sophisticated methods but first had to understand something of the psychological and group dynamics operating in their communities.

- Perceived risk

One important discovery was that while many people theoretically acknowledged the existence of risk for their peer group — in this case gay men — this recognition did not necessarily imply awareness or belief in personal risk for *themselves*. Studies often indicated that many people were guided by arbitrary criteria to determine whether or not their potential sexual partners might have the virus, based on physical appearance, length of acquaintance, social class, supposed sexual history, or level of intimacy in the meeting place. (CChPS, 1997; Shifter & Madrigal, 1997)

On the other hand, many gay men who had formed romantic partnerships, even of quite recent origin, were opting to leave prevention methods aside as a sign of fidelity and trust within the relationship or out of a vague association of HIV with «promiscuity,» psychologically distant from their current monogamous practice.

Exploring these situations gave rise to methodologies that sought to stimulate new levels of awareness among participants about their reactions and reasoning processes and to provide them with certain skills, including the mechanics of condom use or more interpersonal skills, such as negotiation within the sexual relationship. They used role-playing and other exercises to uncover and explore participants' feelings and reactions.

A classic example of this type of technique is the safe-sex workshop, which has become popular around the world in a variety of formats (Shernoff & Bloom, 1991). These workshops bring together 10 to 20 participants who share their experiences and concerns through conversations, games and directed exercises. The facilitator introduces basic information about AIDS while promoting self-observation and individual and collective reflection. Many Latin American groups carry out activities of this type. (Cáceres and Rosasco, 1993; Shifter and Madrigal, 1997; Almeida, 1997; Parker and Terto, 1998)

Safe-sex workshops are useful for starting conversations among peers about sexuality and for encouraging the development of group norms among gay men. Outside of these settings, many participants have few opportunities to discuss sexuality issues that are of serious concern for them. Without attempting to be a panacea, workshops of this type overcame some of the limitations of strictly information-based approaches by creating a collective learning experience in which each participant simultaneously experienced the process and witnessed it in others. In evaluations, participants in these meetings frequently comment that the workshops provided them the first opportunity ever to speak frankly about their sexuality, even years after first joining in gay social circles.

Workshops can be used not only to teach preventive sexual practices but also for dealing with conflicts related to sexual orientation («coming out»), partner relationships, family problems, sexual abuse, racism or other issues, all of which affect decisions about sexual practices.

The incorporation of the workshop modality marked an important step forward in preventive strategies for gay men. These experiences incorporated psychosocial aspects and used the group process as an integral part of their method. Implicitly, those organizing these workshops recognized that information and even good intentions were not enough to guarantee that individuals adopted habits of self-care and prevention; instead, they recognized that group and societal processes were involved as well.

At the same time, materials produced by gay men's organizations began to incorporate messages reflecting these multiple influences and the subtle forms of self-deception that had been discovered. «Don't assume anything,» said one flyer from the U.K.-based Terrence Higgins Trust (1987), referring to the tendency of many gay men to believe that their sexual partners were free of the virus based on their silence, their apparent good health, or their preferences for certain sexual practices.

A 1998 postcard from the French group AIDES illustrated the risk of interpreting what is left unsaid in the context of sexual intimacy. Two men appear in the midst of a sexual encounter: one is thinking in silence, «He didn't ask for a condom, so that means he must be HIV-negative like me.» Meanwhile, the other muses, «He didn't put on a condom, so he must be HIV-positive like me.»

These later-generation materials also reflected an awareness of the importance of sex to the target population: messages became more erotic, defending the benefits of a satisfactory sex life. Images included different gay sexual styles and tastes, from romantic to leather, drag and S/M, along with varied language to include

men with different educational levels. As safe-sex workshop pioneers explained, «Messages with a hint of moral rigidity tend to have the negative effect of inviting this population to challenge them precisely because they recall moral or religious prohibitions they experienced as children.» (Shernoff & Bloom, 1991)

Other flyers used typical phrases taken from research interviews to illustrate situations that complicated prevention, such as drug and alcohol use, fear of rejection, or emotional commitments. However, even with these improvements, not everyone was convinced that perceived risk was crucial for prevention. A Canadian study found that this perception «*was not a significant variable*» compared with other aspects such as the self-perception of control or the ability to assume preventive practices. (Canadian AIDS Society, 1993)

- Voluntary HIV testing and counselling

Another innovation for the promotion of prevention among gay men was the recognition of the importance of a comprehensive HIV testing service that would allow people to talk frankly about their sexuality and their lives.

Many gay men suffered discrimination or insensitive treatment when seeking the HIV test, especially when the result was positive. In the first years of the epidemic, medical personnel responsible for these tasks, accustomed to detecting cases of syphilis or gonorrhoea or «screening» sex workers, did not have the skills to respond to gay men who were concerned about the possibility of acquiring HIV. Services often failed to use the test as an educational or care opportunity; many gay men diagnosed with HIV recall receiving the news like a death sentence, accompanied by warnings and advice about how to reorganize their lives.

Today, the HIV test is known to be capable of leading to risk reduction in a significant percentage of the people who seek it. Crawford, et al., (1996) found that a higher percentage of gay men who were tested supported safe-sex strategies than those who were not tested, regardless of the results. The massive U.S. five-city RESPECT study (Kamb, et al., 1998) confirmed that new cases of STDs fell among clients who received adequate counselling before and after the HIV test.

For men engaged in homosexual practices, expressions of concern and understanding regarding their sexual and emotional lives during the HIV testing process can have a direct impact on their future attitude toward prevention and their own health. As the decision to take the test indicates a recognition of the

risks that have already been run, proper handling of the situation can open a door to reflection about sexual practices and constitute a decisive moment for change.

By contrast, if the service provided is insensitive, an important opportunity may be lost; furthermore, there is considerable evidence that a negative result can encourage additional risk behaviour in some people. (*HIV Counsellor Perspectives, 1997*)

Counselling during an HIV test (normally through the ELISA technique) usually consists of a confidential and private conversation between the patient and a professional or volunteer counselor. While providing basic information about HIV transmission and the procedures involved in the exam itself, counselors invite the client to explore why he is taking the test and what sexual risk practices

«For men engaged in homosexual practices, expressions of concern and understanding regarding their sexual and emotional lives during the HIV testing process can have a direct impact on their future attitude toward prevention and their own health.»

are involved. In many institutions, questions are included about the impact of a possible positive test result, an outcome the consultant may not have fully considered. Other services attempt to encourage each client to formulate a personal risk reduction plan that can be immediately implemented and later evaluated with the counselor when the results are delivered.

Test counselling offers a series of advantages for prevention work among gay men and MSM. Many people seek this service, often without prompting of any sort, and sensitive handling of their concerns can create a favourable environment for prevention messages. At the same time, the service can provide an opportune moment to refer the individual to other activities and services such as workshops, individual psychological care, or social or clinical services. In the case of a positive result, the client can receive both immediate support and be connected promptly with all other services available in the community.

Counselling for the HIV test emerged in the face of a recognition of the dangers and inherent opportunities in what was previously considered a mere diagnostic procedure. In fact, private organizations, including gay groups, often were innovators in this area and provided important guidelines and experience to the medical systems' own diagnostic centers.

When this service emerged from within the community, it underlined a new degree of commitment and concern on the part of members for their peers. This factor was perceived as a new key element in the promotion of gay sexual health: the idea of shared norms of self-care and solidarity, concern about oneself and others as part of the community fabric.

Despite the positive results that can be gained through HIV-test counseling, the practice clearly does not guarantee preventive practices in the future among its beneficiaries. In 1997 in the city of Los Angeles, USA, nearly two-thirds (66%) of gay men who tested positive for HIV had been tested previously -- with a negative result. (*HIV Counselor Perspectives, 1997*)



Voluntary counselling and testing (VCT) constitutes a key example of approaches seeking to raise people's HIV risk perception. Image: www.uanl.mx/publicaciones

C. Socio-cultural interventions

In recognizing the social aspects that influence the construction of individual sexuality, some interventions also take advantage of the weight of certain community norms or the influence of other members of the reference group -- such as friends, spokespeople or natural leaders -- to establish models or habits to be emulated. In some cases an effort has been made to identify informal leaders to promote protective behaviors. An early study in small cities in the United States (*Kelly, et al 1990*) confirmed a 30 percent reduction in risk practices when the best-known patrons of gay bars were trained in HIV prevention techniques and encouraged to promote them among their closest friends.

For many people, merely encountering someone with a genuine interest in their health and welfare may have a surprisingly strong impact. Given that in Latin America the AIDS epidemic often gave rise to the creation of the first gay-emancipation organizations, their efforts in favor of the community's health were key to strengthening group solidarity and greater attention to prevention messages among the target population.

Like any group, gay men are heavily influenced by their immediate circle of friends and acquaintances. The preventive focus can multiply its impact if it consciously seeks to incorporate beneficiaries as agents of change among their partners. Parker, *et al.*, (1995) found a «*close relationship*» between HIV risk and «*social isolation and psychological conflicts caused by prejudice and discrimination.*» Therefore, the authors said, any response should attempt to incorporate men into support networks and to create permanent social environments, including a sense of community (Parker, Rios and Terto, 2000). Ekstrand and Coates (1990) found that young people with less developed social networks and who did not know people living with HIV were more likely to engage in risky practices.

However, this strategy raises the problem of the limits of «community»-based strategies as many individuals either do not feel part of a gay community or simply do not have the necessary contacts. If community ties — sometimes called *gay community attachment* (Crawford, et al., 1990) — are essential to promote prevention, what does this mean for men who do not have these connections? Men with heterosexual partners, other MSM or men who carry out their homosexual practices in more extreme secrecy remain outside these circles. Some ethnic minorities, economically disadvantaged men, sex workers, minors, older adults, or people who do not feel comfortable in a commercial gay environment may also be on the margin of prevention activities designed for «the community.»

«The preventive focus can multiply its impact if it consciously seeks to incorporate beneficiaries as agents of change among their partners.»

There are no easy answers for this situation although in recent years more projects and interventions have been developed to reach men in these circumstances, using a variety of techniques. Some projects use materials with little or no reference to gay identity, particularly when working in places used for more furtive sexual encounters.

D. Social Transformation

The above-described interventions reflect years of experience in different approaches to diverse gay and MSM populations. Even so and despite an enormous number of self-esteem workshops and trainings in sexual negotiation, many investigators suggest that deeply rooted discriminatory structures constitute nearly insurmountable barriers for AIDS prevention.

Carballo-Diéguez (1998) describes how police repression, Catholicism, homophobia and rigid gender roles in Latin communities undermine prevention and health interventions. *Díaz & Ayala (2001)* lobby for a perspective that goes beyond individual vulnerability or the lack of negotiating capacity to address homophobia, family pressures, poverty and machismo, all of which can easily sabotage individual intentions to guard against HIV infection.

In order to address these factors, organizations have no alternative but to emphasize their social criticism of sexism and homophobia. However, it is not always easy to leave behind the theoretic environment and use these concepts to design a prevention strategy.

One exception might be work to lobby for the basic rights of homosexual men in legal and social terms in the arena of public opinion. This work naturally coincides with more direct interventions related to health as it is possible to describe how types of discrimination and abuse have a direct impact on sexual risk-taking.

In this environment of political action to change the social conditions of gay men and MSM, work around AIDS has opened an important door for discussion. Many countries in the region have seen gay men organize a response to the epidemic, winning recognition and credibility with their prevention and care work and in some cases legal demands. In Ecuador and Chile the legal ban on homosexual practices has been eliminated, and in some cities in Brazil, Mexico and Argentina laws now exist against discrimination based on sexual orientation.

In addition to political-legal actions, the demands of public health and lobbying for gay civil rights are naturally intertwined in many other areas. Although the

process is certainly rife with contradictions, the visible presence of gay-oriented groups in HIV/AIDS work has produced a certain validation of these groups and their more political demands, what Altman (1988) calls «*legitimation through disaster.*»

In some countries efforts have been made to encourage coordination among gay groups linked to AIDS and other entities dedicated to parallel themes such as gender equity, sexual and reproductive rights, human rights, community health or the commercial sex industry. Some regional initiatives exist to promote greater government efforts toward traditionally marginalized populations and to challenge the persistent tendency to ignore them in official campaigns.

Some organizations establish relations with the medical services most often used by gay men in order to confront social prejudice or exclusion. Many gay groups that began to address the issue of HIV/AIDS rapidly saw the need to contact the hospital or clinic where men affected by HIV or AIDS were being treated. For example, the Argentine Homosexual Community decided to fund certain improvements in the Muñiz Hospital of Buenos Aires where people with HIV sought treatment. These links not only served to raise awareness among personnel about the needs of the gay and MSM clientele but also suggested that gay patients were supported by organized groups and could complain, if necessary, about discriminatory situations.

- Dehomosexualization of HIV/AIDS and the focus of actions

One very common phenomenon throughout the region is the tendency to minimize the extent of the homosexual epidemic and emphasize the vulnerability of other groups which generate more sympathy in public opinion, especially pregnant women and infected children. McKenna (1997) confirmed the slow response to the homosexual epidemic in developing countries despite its epidemiological importance (see also Parker, Aggleton & Khan, 1998).

Preventive interventions for gay men also can incorporate their analysis of structural obstacles in other ways. Diaz and Ayala, et al., (2001) suggest that organizations should shape their official discourses so that people who do not manage to systematically protect themselves can recognize and speak about their experiences, regardless of whether they could be considered prevention «failures.» If groups close ranks in the face of HIV and punish those who do not protect themselves, any possibility of openly discussing what is really happening in their lives is eliminated. Not even the men most militantly committed to

prevention always practice it. In recognizing the true weight of socio-cultural factors in the experiences of the target group, activities can provide better opportunities to discuss these experiences without judgment.

Some authors insist on the importance of integrating all aspects of health promotion in HIV-specific prevention work. The importance of a gamut of psychological issues — loneliness, guilt, aging, mourning for friends who have died from AIDS, social isolation, refuge in the «stable» partner and its attendant risks — all contribute to the individual and collective panorama of gay men and MSM and therefore have an impact on their sexual behaviour. (Canadian AIDS Society, 1994)

Summary of interventions

In summary, the activities described above for gay and MSM populations can be seen to operate within one or more of the four levels mentioned above: informational, skill-building, socio-cultural or political. (Terto, et al, 1998): (1) Research, especially that used to diagnose the situation before launching an intervention; 2) information, education and communication (IEC) designed for the specific population and sensitive to its codes, language and group norms; 3) outreach to gay and other homosexually active men; 4) permanent work with the owners of commercial gay establishments; 5) links with health services, especially those that have gay clientele; 6) workshops; 7) counselling; 8) condom distribution; 9) telephone hot-lines; 10) support for groups of people living with HIV or AIDS that have a significant gay presence; 11) political or institutional pressure to defend and support individuals´ rights and satisfy their needs, including demands to change laws and government policies; 12) alliances with other groups and movements. The authors add evaluation as an additional activity relevant to all the above-mentioned interventions.

Local or national governments must recognize the advantages of work with gay and other MSM, and their explicit support to them can become a clear sign of their care.

While the initial protagonists of these initiatives were almost exclusively gay organizations or those that had a strong gay presence, gradually there has been more academic interest in studying and evaluating this type of work. Local and national governments must recognize the advantages of work with gay and other homosexually active men; explicit support from officials is a significant sign of collective concern about this population.

Conclusions

- Few organizations dedicated to preventive work with gay men and MSM in Latin America had a solid institutional foundation prior to beginning their work. They have had to navigate a tortuous learning curve and acquire skills along the way, incorporating a permanent process of evaluation and analysis in the face of a changing epidemic and a background of discrimination and social exclusion.
- From providing information to recognizing the influence of complex psychological and subsequently socio-cultural factors in sexual conduct, the search for effective interventions to brake the steady expansion of HIV infection has been a considerable technical challenge, given the need to understand and react to multiple factors that guide the sexual and relational lives of the groups in question. As with all publicity, preventive messages require constant repetition but must also be novel and innovative. There is a need for modest but permanent activities and a variety of simple, constantly updated materials. Given the nearly universal presence of some degree of secrecy in the lives of Latin American gay men or MSM, gay meeting places -- legal, tolerated or clandestine — are key sites for establishing contact with them.
- While prevention work with gay and MSM populations has become more professional over the years, the contribution of people who provide basic information about transmission and prevention methods is invaluable. At the same time, some permanent participation on the part of the organization in services for people living with HIV/AIDS empowers the preventive message, even when care is not a priority objective of the group. Careful record-keeping is important in extracting maximum value from these diverse experiences in prevention and assistance, as well as a consistent emphasis on the need and relevance of systematic evaluations of them.

- In addition, attention should be paid to the needs of the work team itself, including volunteer participants. AIDS is a particularly troubling issue for gay men, who may be combining activism with stressful personal situations, including grief, partners or friends living with HIV, their own seropositivity or ongoing anxieties about their sexual practices.
- The incorporation of alliances with similar groups not only strengthens the potential impact of the work but also frequently serves to educate each group about the realities faced by the others. Sometimes these alliances are constituted in formal networks although these tend to be complex bodies that require a great deal of clarity about the goals.
- Gay groups also have had to decide on an appropriate balance of emphasis between combating gay discrimination and other political tasks versus AIDS prevention education and services for people living with HIV. In many cases, there has been a trend toward specialization to take advantage of each group's «expertise» and thereby avoid turf or representativity fights and to open the field to new participants. Above all, consistency and renewal are key in promoting prevention as the message of sexual health must not disappear from the gay environment.

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