AIDS and Male-to-Male Sex in Latin America: Vulnerabilities, strengths and proposed measures

Perspectives and reflections from the point of view of public health, social sciences and activism


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First Edition (Spanish): June 2002

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AIDS and Male-to-Male Sex in Latin America: Vulnerabilities, strengths and proposed measures - Perspectives and reflections from the point of view of public health, social sciences and activism. UPCH/UNAIDS, 2002. xxx pages.

HOMOSEXUALITY/BISEXUALITY/MSM/HIV/AIDS/HOMOPHOBIA/VULNERABILITY/RESEARCH/THEORY/ACTIVISM/LATIN AMERICA

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ISBN:
Depósito Legal:

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Printed in Perú
To Herbert Daniel, Francisco Galván, Henry Ardila and Luis Gauthier,
for their vital contribution to the fight against AIDS
and social exclusion in Latin America.
This book is the result of several years of effort. In 1998 UNAIDS funded an initiative to collect information on research on HIV/AIDS in populations of men having sex with men (MSM) in the region. That initiative led to a first meeting of researchers and activists in Lima in 1999. The outcome of this project was a catalogue of research and a directory of researchers, revealing -surprisingly perhaps- that a significant amount of studies had been done during the 1990s in different parts of the region. Therefore, the challenge was -and is- to bring those works together, disseminate them, make good use of their findings, and engage communities, grassroots activists, and decision makers in fruitful dialogue. Accordingly, towards the end of 2000, UNAIDS provided further support for the next stage of the initiative, making it possible to update the catalogue and leading to the publication of this book.

Currently there are more than 1.8 million adults and children living with HIV in Latin America and the Caribbean. As we know, there are considerable differences in terms of propagation of the epidemic and transmission trends both between and within countries in the region. Having said that, it is, nonetheless, necessary to underline that unprotected male-to-male sex is a mode of transmission present in every Latin American country; in fact it is the principal cause of transmission in Mexico, the Andean region, and other regions and countries. Furthermore, it is clear that HIV prevalence in MSM is very high: several different urban centres in the region report a figure of more than 5%. For example, as the 2001 AIDS Epidemic Update (UNAIDS, December) noted, recent seroprevalence studies conducted in Mexico show that a little over 14% of MSM are HIV positive.

In short, the data show that male-to-male sexual transmission of HIV remains a core factor in the spread of the epidemic, particularly bearing in mind the youth of those newly infected with the virus.

AIDS and men who have sex with men - Technical update, published by UNAIDS in May 2000, recalls that «Male-to-male sex exists in most societies. It frequently involves anal sex. Unprotected penetrative anal sex carries a high risk of HIV transmission,
especially for the receptive partner.» However, the document adds, HIV prevention programmes for men who have sex with men (MSM) are hindered by several obstacles. For example, denial that sexual behaviour between men takes place; stigmatisation or criminalization of men who engage in sex with other men; inadequate or unreliable epidemiological information on HIV transmission through male-to-male sex; the difficulty of reaching many of the MSM; inadequate or inappropriate health facilities, including sexually transmitted disease (STD) clinics; lack of interest among donor agencies in supporting and sustaining prevention programmes among men who engage in same-sex behaviour; inexistence of programmes addressing male sex workers; and a lack of focus on the needs of MSM in national AIDS programmes.

The obstacles mentioned are many and varied. Tackling them requires, among other things, comprehensive and reliable information, as well as adequate and meaningful analyses. This book is an effort in that direction. It summarizes research that, despite considerable difficulties, tries to contribute to a more focused and realistic understanding of what the epidemic entails.

Stigmatisation of sexuality, especially homosexuality, is encouraged by the historical tendency to reduce its visibility in society, and it helps, in turn, to perpetuate that invisibility. In connection to this, Awa Coll-Seck, former Director of the Department of Country Support, UNAIDS, and current Minister of Health of Senegal, has said that «men who have sex with men are a vulnerable group and the cultural, sociopolitical and religious factors that lead to the denial of male-to-male sex increase their vulnerability» (Regional consultation on HIV/AIDS prevention, care and support programmes in Latin America and the Caribbean for men who have sex with men, UNAIDS, 1999).

Overcoming the vulnerability factor of social invisibility is a need that must be pursued simultaneously on the individual, social, personal and political levels. As part of that process, another way of encouraging discussion of issues regarded as taboo is to include them in the legitimate agenda for research, production, and socialization of knowledge. The fact that universities, research institutes, and international organizations, in conjunction with communities, encourage research on gay and other MSM is an important step against the invisibility and, therefore, the vulnerability of this population group.

The epidemic continues to spread and responses to it need increasingly to be robust and comprehensive. At UNAIDS our aim is to support initiatives that assume such commitment, and the recently formed Task Force on MSM and HIV/AIDS in Latin America and the Caribbean is an example of this.
More than 20 years have passed since the outbreak of the epidemic. If there is one thing we have learned it is that the only way to act effectively against the propagation of the virus and to improve the quality of life of people living with HIV/AIDS is to adopt a more realistic perspective in our work, so that population groups and communities where the epidemic resides are targeted within a framework of absolute respect for their rights. We hope that this book can contribute to this shared undertaking.

Dr. Pedro Chequer
UNAIDS
Acknowledgements

This book is the result of several years of effort in Latin America which, happily, are set to continue. This initiative is aimed, first, at combining the perspectives of theory and research (from the fields of public health and the social sciences) with those of practice and activism in discussions on action needed to more effectively confront the HIV/AIDS epidemic among gay and other ‘men who have sex with men’ (MSM). Second, it seeks to make this dialogue of views and lessons learned available to those officials and authorities of the State and cooperation agencies who are responsible for decision making on health programs, policies and spending; as well as, naturally, to sectors more traditionally interested in such discussions, namely researchers, activists, and health professionals.

The Research Network on Sexualities and HIV/AIDS in Latin America, responsible for this effort, is a collective of social scientists and public health researchers who have worked in the areas of sexuality, sexual health, and HIV/AIDS in permanent contact with community-based organizations; as well as activists, who, having worked in gay organizations or in AIDS services organizations, have forged links with researchers, either by collaborating with them, or commenting on, disseminating, or using their research findings. The group is committed to the task on the basis of a shared experience of initiatives to confront the epidemic at various levels, and conceives research as a way to address people’s needs. In this view, research must respond to the problems of individuals and communities, and its findings must be placed within their reach, since it is utilization which makes research a legitimate endeavour.

In a region where MSM have been so severely affected by the epidemic, recognition is owed to the decision of UNAIDS to address a potentially sensitive issue and support, since 1998, a series of initiatives designed to enhance both the participation of the region’s civil society actors involved in work on AIDS with this population (academics, activists, and health staff), and to encourage the resolve of policy makers and health program directors in the implementation of measures aimed at controlling the epidemic in the region.
With respect to this network, we thank the initial invitation of Werasit Sittitrai for our initial steps (1998-1999), followed by the valuable help of Calle Almedal and Luiz Loures to start the second phase (2001-2002), which in subsequent phases was supported by Pedro Chequer and Mario Pecheny. Mario is also a member of this network, besides his role as UNAIDS consultant for the Task Force on MSM and HIV/AIDS in Latin America (of which this network is one of the constituents). Additionally, through the timely mediation of Paloma Cuchi, the English version of this book was made possible by a grant from the Spanish Agency of International Cooperation (AECI) and the Spanish Ministry of Health.

Others who have played an invaluable role in bringing this project to a successful conclusion and to whom we are sincerely grateful are: Percy Fernández Dávila, who helped in organization and communications, and translated the original version of the research catalogue into Spanish; Julio Cuadros, who designed the program that enables easy access to the regional research catalogue (on CD-ROM); Jesús Martínez, who helped with style correction and editing in the original Spanish version; Gaby Cáceres, who helped in communications; Simon Walter, who translated this book and the updated catalogue into English; Ana María Rosasco, Pablo Anamaría, Rubén Mayorga, Manuel Zozaya, Antonio de Moya, Rodrigo Vargas and Henry Ardila, who collaborated in the preparation of the first version of the catalogue; and the member NGOs of ASICAL – Equidad (Ecuador), SIGLA (Argentina), LCLCS (Colombia) and LetraEse (México) – which helped to update the catalogue. The English version of this book was made possible by a grant the Spanish Agency of International Cooperation (AECI) and the Ministry of Health of Spain. We want to thank Paloma Cuchi (PAHO/UNAIDS) for her support of this collaboration (February, 2003).

Finally, we must of course pay tribute to Henry Ardila, the physician and activist who founded the Colombian League against AIDS. He was the pioneer of community-based work on AIDS in his country and for many years the leading civil-society spokesman in dealings with the government. At the regional level he participated in the first stage of the research network project with UNAIDS, and later played a very active role in the creation and initial activities of ASICAL. Through these lines we would like the possible users of this book to learn about the contributions of Henry and other campaigners who are no longer with us, such as Herbert Daniel from Brazil, Francisco Galván from Mexico, and Luis Gauthier from Chile, who have been so valuable for the articulation of an adequate response to the AIDS epidemic in MSM in Latin America and the Caribbean (and, on a more general level, to the campaign for sexual rights and against the exclusion of those who are ‘different’). The memory of their legacy must reaffirm our loyalty to a tradition which was written with tenacity, generosity, and commitment.

Lima, May 2002

Carlos F. Cáceres
Research Network on Sexualities and HIV/AIDS in Latin America
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INTRODUCTION

CONFRONTING THE HIV/AIDS EPIDEMIC
IN GAY MEN AND OTHER MEN
WHO HAVE SEX WITH MEN
IN LATIN AMERICA AND THE CARIBBEAN

Carlos F. Cáceres and Mario Pecheny

As the HIV/AIDS epidemic in Latin America comes to the end of its second decade, a review of epidemiological information available reveals a situation that, despite its magnitude, has seldom merited the attention of the news media: In more than one-third of reported AIDS cases for which information was given about the probable mode of transmission, such probable mode was attributed to sexual transmission between men (PAHO, 2000), even though, ostensibly, men who have sex with men (MSM) account for a much smaller fraction of the population. Furthermore, the prevalence of HIV infection in MSM populations in most major cities in Latin America is between 5% and 20%, which, generally speaking, is much higher than in the general adult population (usually under 1%). By definition, therefore, most regional epidemics are mainly concentrated in MSM populations (see Chapter II).

A combination of passive acceptance of the notion that this epidemic among MSM is «to be expected» (in light of recent history and given the view that AIDS is the result of ‘promiscuity’), and ignorance of the cultural characteristics of MSM
Confronting the HIV/AIDS epidemic in gay and other MSM in Latin America and the Caribbean populations, together with the fact that in practice they are not regarded as persons with rights (even the right to health), probably led to a degree of indifference towards the figures mentioned above. Despite the long duration and magnitude of the ongoing epidemic in this group, it would not at all be fair to say that it is on the way to being controlled (PAHO, 2001).

This study, a joint effort by researchers and activists in Latin America and the Caribbean, seeks to boost - or strengthen - a regional response to this crucial issue. Having examined the experience of more than 20 years of anti-AIDS struggle, this group can say with certainty that successful public health policies are inextricably linked to the observance of rights, and that the one nourishes the other.

¿Why was this study necessary?

This study arises in response to the disparity between, on one hand, the scale of the epidemic among gay and other MSM in the region and, on the other, the social response to it (particularly at the level of governments). Ironically, this situation is partly the result of a worldwide movement launched at the end of the 1980's to «dehomosexualise» the epidemic, in order both to avert the stigmatisation of MSM and to convince others of the risks to which any sexually active person is exposed. This task implied confronting the myth that AIDS is a disease that affects «others». No consideration was given, however, to the fact that some of the assumptions that guided this strategic measure took it for granted that, a) sufficient effort had been invested in prevention in MSM; and, b) the epidemic among these groups was adequately controlled. However, there is no evidence to support either of these views. Although there were many programmes targeting MSM visible in the early days of the regional response to the epidemic, most of them were low-budget projects implemented by community-based organizations and designed without the proper technical support needed to ensure their impact. For their part, government programmes and initiatives played a minor role and, in any event, were late and insufficient.

There are several explanations for the inadequacy of government programmes. Probably the main reason, as mentioned, is that it was assumed that these groups were already receiving assistance from community-level initiatives and that the risks among them had already diminished. Other reasons we can cite include, a) the failure on the part of many AIDS control programme authorities in the region to properly understand the sexual cultures of MSM, in the context of a poor understanding of human sexuality in general, which limited their ability to see the
need for these programmes, or to design them properly when they realized their necessity; b) the view that the state should only concern itself with prevention in the general population; and, c) the difficulty to conceive MSM populations (and, by extension, other marginalised groups, such as male and female sex workers) as persons with rights, including the right to health.

In response to this situation, the main aim of this book is to provide persons who design, implement, or fund programs and projects in the area of public health and HIV/AIDS (as well as researchers and other interested individuals) with instruments to: a) better understand the sexual cultures of different groups of MSM in the region (including men with gay or transgender identities); b) better examine the dynamic scale of the HIV epidemic among them, and understand its roots in the social structure; and, c) implement better responses to the epidemic.

A Look at the Point of Departure

As stated above, the response to the epidemic affecting MSM populations in the region has been insufficient to achieve its control. That is not to say, however, that there has been no response; on the contrary, parts of this study, in particular Chapter VI, are devoted to examining it. Here we will limit ourselves to putting forward some general ideas that will enable us to understand the validity of our point of departure, and move on from there to ways to consolidate progress made and correct shortcomings and failures.

Activities designed to prevent HIV infection or to reduce its social impact have been implemented in most parts of the region, particularly in capital cities. These activities have been carried out by gay organizations, non-gay NGOs and, in some cases, government programs (Aggleton et al., 1998; UNAIDS/LCLCS, 1999). If we compare countries, we find that factors influencing the magnitude of the social response to the epidemic among gay men and other MSM have included: the relative incidence of AIDS among MSM; the view of AIDS as a public health problem; and, in particular, the level of civil-society involvement in issues concerning access to health and the status of sexual rights (Parker, Barbosa and Aggleton, 2000). Clearly, the Brazilian case is a ‘best practice’, given the energetic multi-sectoral response based on the perception of AIDS as a serious public health threat, and the political decision to earmark a significant portion of the budget at the federal, state, and local levels for prevention and care. Also worth noting is Brazil’s rich tradition of civic activism and the highest level in the region of integration of gay communities with mainstream society (The Lancet, 2000).
Very few comparisons have been made of the quality, sustainability, and coverage of these activities carried out at different times, in different countries, and with different stakeholders. Although narrative information exists on many of them, very few experiences have been documented or published, and even less have been formally evaluated, partly because most such activities have originated from the heroic enthusiasm and commitment of the community and have been carried out with very small budgets (Aggleton et al., 1998). These programs have been designed for implementation on several different levels: from those aimed simply to disseminate information or develop inter-personal capacities, to those that seek to change social norms or, in particular, to stimulate community organization with a view to consolidation of sexual citizenship (UNAIDS/LCLCS 1999). The community has been targeted with approaches that included promotion of HIV voluntary counselling and testing (VCT), group-level interventions, community mobilization, outreach on streets or shopping centres to distribute educational materials, educational theatre, and the promotion of peer leadership. It is encouraging that there is an increasing move away from traditional models based solely on information delivery or capacity building: these are progressively being replaced with structural interventions aimed at reducing vulnerability through community development and promotion of sexual rights (Parker, 1996).

With the exception of a handful of governments that have become involved in programs for MSM (notably, Argentina, Brazil, Colombia, Chile, Mexico, Peru and Dominican Republic), through either direct implementation or through the funding of activities of community-based organisations, most programs in this area have been funded by international cooperation agencies (e.g. UNAIDS, USAID, the Dutch Government), private donors (such as HIVOS, NOVIB, the International HIV/AIDS Alliance, the Ford Foundation) and humanitarian assistance organizations. All too often this has led to programmes with limited sustainability. The type of implementing agency also has a bearing on program coverage and quality, and the majority of successful programmes have been carried out by organisations that combine a reasonable level of technical capacity with well-established grassroots contacts in the community. Unquestionably, a crucial shortcoming of this response has been a lack of innovative and effective strategies aimed at reaching MSM subpopulations who do not identify themselves as gay and exerting an influence on the main structural factors of their vulnerability and that of their partners, both male and female (Aggleton, 1996; Parker, 1995).

Special mention should be made of regional initiatives on MSM and HIV. En 1997, a Special Consultation on HIV/AIDS Prevention, Care and Support Programs for MSM in the region organized by Joint United Nations Programme on HIV/AIDS (UNAIDS) (UNAIDS 1999), accomplished two things: a) A pledge to develop a Manual on Strategic Planning Guide for HIV/AIDS Prevention and Assistance Programs for MSM in the
region (published in Spanish with funding provided by UNAIDS) (UNAIDS/LCLCS 1999); and, b) a major effort in strategic planning of HIV/AIDS prevention programs targeting MSM, spearheaded by the Association for a Comprehensive Health and Citizenship in Latin America (ASICAL), with financing from UNAIDS and the Government of Brazil; this effort involved the participation of multi-sectoral committees from 13 countries in Central and South America (Meléndez et al., 2000).

The Research Network on Sexualities and HIV/AIDS in Latin America, which is responsible for this publication, has a similar background: In 1998 UNAIDS provided funds to support initial communication among researchers and researchers/activists involved in the issue of HIV/AIDS and sexual diversity in the region. This led to a Regional Meeting in Lima (February 1999) and the preparation of a Catalogue of Research on HIV/AIDS and MSM – sexual diversity-sexual rights – conducted between 1990 and 1999. Toward the end of 2000 a further grant from UNAIDS made it possible to update the catalogue and include it here for the benefit of policy makers in the region, in order to facilitate implementation of programs on HIV/AIDS in MSM populations. A new project, carried out with support from the Ford Foundation, on Sexualities, Health and Human Rights, will enable us to persevere with our efforts to build a networking forum for researchers and activists on these issues in the region, which will not only address the crucial matter of confronting the HIV epidemic, but also examine the epidemic in the light of the social exclusion of the people with alternative sexualities, which clearly is one of the core factors in its propagation.

Contents

This publication contains a collection of contributions prepared from different perspectives of disciplinary analysis, which aim to cover several relevant dimensions of the epidemic in a complementary manner. Although they basically reflect the views of their authors, they are part of a jointly-agreed publishing project and each helps in a different way to improve a common understanding of this and related problems in the framework of public health and human rights in Latin America and the Caribbean.

Chapter II describes the epidemiological context. Carlos Cáceres, a medical doctor and social epidemiologist from Peru sums up the situation and trends of the HIV/AIDS epidemic in the region, and shows the extent to which unprotected sex between men is a major cause of HIV transmission in practically every country. The author also criticizes certain categorisations and calculations that have hindered a proper analysis of the scale of the epidemic in MSM, and reviews an array of
options for organizing (or improving, where the groundwork has already been done) second-generation HIV epidemiological surveillance activities in MSM populations. Such review includes an analysis of ethical considerations, which, given the context, are an essential factor to bear in mind.

In Chapter III, Gabriel Guajardo, a Chilean anthropologist, describes and illustrates with examples the immense variety of situations and experiences encapsulated by an abstract category such as «men who have sex with men». If there is one common denominator in the practices, experiences and meanings attributed to sex and affective ties among men it is diversity. Any would-be effective preventive policy designed has to recognize that diversity and take stock of distinct symbolic worlds defined according to geography, age, social class, and cultural backgrounds. Cultural diversity entails, in turn, diversity in terms of capacities, resources and structural and symbolic vulnerabilities within a broader context of general hostility towards homosexuality.

In Chapter IV, José Toro-Alfonso, a psychologist from Puerto Rico, explores the issues of vulnerability and capacity from the perspective of the individual in a social context of homophobia; that is, a context in which sexual and affective ties between persons of the same sex are stigmatised. In particular, Toro examines this phenomenon in relation to the social construct of masculinity and exclusion of things that are different. This context produces a number of experiences linked to the creation of subjectivity that need to be recognized in order to ensure preventive practices that must be sustained in time.

In Chapter V, sociologist Hernan Manzelli and political scientist Mario Pecheny from Argentina, focus on HIV/AIDS prevention models targeting gay and other MSM. They start by describing three main theoretical prevention models and then describe concrete modalities in which they are applied to the diversity of practices and situations described in the preceding chapters. In this way the authors show the strengths and weaknesses that have emerged in their application.

In Chapter VI, the Chilean-American communicator and activist Tim Frasca summarizes and examines lessons learned from two decades of experience of prevention activities among gay men and other MSM in the region. The concrete daily efforts of activists and volunteers in the region yield lessons as to what works, what does not, and even what is harmful; those lessons are a key input for sound decision making in the future.

Finally, in Chapter VII, by way of conclusion, community health specialist and activist Veriano Terto from Brazil, discusses AIDS and the broader issue of the health of gay men and other MSM as we enter the third decade of the epidemic.
Annex I includes an introduction to the Catalogue of Research on HIV/AIDS and MSM conducted between 1990 and 2001 in Latin America and the Caribbean, a complete version of which is attached in an interactive CD-ROM in Spanish and English. The first part of the catalogue, covering the period 1990 to 1999, was the main product of the first project carried out by the Research Network with UNAIDS funding (1998-1999); the second part, which updates the research as far as 2001, was compiled by Mexican communicator and activist Alejandro Brito. Percy Fernández Dávila, a Peruvian psychologist, has combined the two parts into a single version.

Finally, Annex II contains an Executive Summary of this book prepared with the help of Peruvian writer Jesús Martínez.

**Overcoming exclusion and accessing health as a right**

We would like to conclude this short introduction by underscoring some of the ideas advanced in this book: the disproportionately high impact of the epidemic on gay male and other MSM populations should not be regarded as ‘to be expected’, thus making light of the enormous vulnerability of this group to this public health menace; that vulnerability cannot be reduced simply through individual behaviour changes, but depends to a considerable degree on altering the situation of social exclusion that curtails the quality of life and life expectancy of MSM, among other socially sidelined groups; like anyone else, MSM are entitled to the full exercise of their rights as citizens, which includes the right to health services for prevention and care; finally, we believe it is necessary to reiterate that government and society in general must act to curb the HIV epidemic that is seriously harming MSM populations in the region, in ways that are consistent with effective public health practices and with proper standards of protection for their human rights.
References


Introduction

As of December 2001, an estimated 1.82 million adults and children were living with HIV/AIDS in Latin American and the Caribbean, including 190,000 persons who had probably become infected during the previous 12 months (UNAIDS, 2001). By December 2001, 378,413 cases of AIDS and 156,228 deaths from AIDS had been reported in the region (PAHO, 2001a).

Sexual transmission of HIV accounts for approximately 78% of all reported cases of AIDS in Latin America and the Caribbean for which a probable transmission category has been provided (PAHO, 2001a). In the context of sexual transmission, male homosexual transmission has been and continues to be central in the region (PAHO, 2001b), since, although the number of cases reported as probably due to heterosexual transmission is similar to the number of cases reported as caused by heterosexual transmission, the former is alarmingly high when one considers that men who have sex with men (MSM) comprise a minor fraction of the general adult
population. Similarly, studies on seroprevalence in MSM show levels significantly higher than those of sentinel heterosexual populations (U.S. Bureau of the Census, 2001). Early in the epidemic, it was said that Latin America displayed a combination of the old I and II patterns, in which there were a significant number of cases in MSM and injectable drug users (IDU), as well as a heterosexual component (Cáceres and Hearst, 1996). According to UNAIDS, in most Latin American countries the epidemic is concentrated in MSM populations and, in some cases, in IDUs. (UNAIDS, 2000). Latin America has the highest number of HIV/AIDS cases in MSM outside the United States (McFarland and Cáceres, 2001).

Figure 1: Latin America and the Caribbean divided into 7 sub-regions based on geographical proximity.
Far from being operationalized, the concept of «homosexuality» refers to a series of constructs and categories such as orientation of sexual desire, sexual behaviour, sexual identity and sexual socialization (Stein, 1992; Herdt, 1997; Aggleton, 1996), none of which is binary. For instance, while sex between men is fairly common in the region, male homosexual behaviour usually does not imply a homosexual or bisexual identity (Parker, 1991; Cáceres and Rosasco, 1999; Carrier, 1995; Lancaster, 1995). Without overlooking diversity or an interrelation as complex as that which exists between identity, desire, behaviour and gender roles, as well as the political implications of sexual identities in a region where homosexuality is still a source of stigma, discrimination and human rights abuse (McKenna, 1996), a behavioural category such as «MSM» is used arbitrarily in HIV epidemiology to the extent that it includes, in theory, all sexual interaction situations between two males. That assumption would have greater validity if one departed from the hypothesis that all MSM share similar levels of risk. However, that is refuted by research findings, since the only sexual practice clearly connected with HIV/AIDS transmission among men is unprotected anal insertive and receptive penetration (Cáceres and van Griensven, 1994), and, given that not all MSM engage in that practice, or do so selectively, the levels of risk are diverse. On the other hand, it is essential to recognize that preventive interventions and community organizing should consider culture, identity and politics (Dowsett, 1996), and, therefore, must distinguish between MSM with different identities, contexts and experiences.

In the first part of this chapter we will examine epidemiological information available on this public health problem in Latin America and the Caribbean. In the second part we will put forward a number of observations and recommendations

«According to UNAIDS, in most Latin American countries the epidemic is concentrated in MSM populations and, in some cases, in injection drug users (UNAIDS, 2000).»


1 Studies to date have not found systematic evidence of transmission via oral sex, or fellatio, even when semen is swallowed (Page-Shafer et al., 2001). Anal penetration with routine condom use is regarded as low risk (Cáceres and van Griensven, 1994).
for improving the quality and depth of information on HIV in this population in the region, in particular through organization or enhancement of epidemiological surveillance practices.

Latin America has the highest number of HIV/AIDS cases in MSM outside the United States (McFarland and Cáceres, 2001).

Epidemiological Situation, according to information available

This section was prepared using the following information sources:

- Statistics on accumulated incidence of AIDS cases in the region reported to PAHO/WHO by each country and published periodically by PAHO/UNAIDS (PAHO, 2001a).
- Epidemiological studies on MSM populations recorded by three sources: a) HIV/AIDS Surveillance Database of the U.S Bureau of the Census (U.S. Bureau of the Census, 2001); b) publications and summaries of studies conducted in several countries in South America with participation of the US Naval Medical Research Center, Lima (Russell et al., 2000a,b); and c) information furnished by the National Bureau on STD/AIDS of the Ministry of Health of Brazil.
The limitations affecting the information available for carrying out this task are numerous:

- Epidemiological surveillance in the region is not of a uniform quality, and in many countries a significant proportion of AIDS cases cannot be diagnosed; furthermore, reporting may be delayed or not occur at all for a variety of reasons.

- Similarly, there are problems with transmission categories, particularly those linked to stigmatised behaviour; for instance, the label «homo-sexual transmission» (like that of IDU) is not applied consistently. In many situations, health providers may, to avoid embarrassment to themselves and the party concerned, prefer not to draw up a sexual history, and may simply assume that the cause is heterosexual transmission. For many the discrepancy between an allegedly predominant pattern of heterosexual infection in Central America and a male:female ratio of nearly two to one in that region (PAHO, 2001a) suggests that a high proportion of homosexual transmission is reported as heterosexual.

- Certain dilemmas have to do specifically with situations where there are multiple risk factors present, since many surveillance systems do not allow a margin for recording multiple risk conditions and use hierarchical classifications, which gives rise to arbitrary decisions on the most likely form of infection in each case; as a result, misclassification leads to error. The Brazilian AIDS/STD Control Program examined the impact of classification policies on case reports to determine the potential variability of figures according to criteria used to determine order of priority, in statistics, of transmission mechanisms present in each case (see Table 1), when there is more than one mechanism present (Ministry of Health of Brazil, 1999).

- Furthermore, very few seroprevalence studies have been conducted on representative samples of individuals. (The situation is much more serious in terms of seroincidence studies.) The above is probably the result of restrictions in funding and institutional (academic and governmental) support for epidemiological studies on MSM, as well as the marked complexity of appropriate research approaches with this vulnerable population (McFarland and Cáceres, 2001).
Table 1: Comparison of AIDS case reporting figures according to two different classifications of modes of transmission (i.e. hierarchical vs. concurrent) for AIDS cases recorded by the National Bureau on STD/AIDS of Brazil for 1980 to 1999.

<table>
<thead>
<tr>
<th>HIERARCHICAL CLASSIFICATION</th>
<th>CLASSIFICATION BY CONCURRENT CATEGORIES</th>
<th>NUMBER OF CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Homosexual</td>
<td>31,669</td>
</tr>
<tr>
<td></td>
<td>Homosexual/IDU</td>
<td>28,410</td>
</tr>
<tr>
<td></td>
<td>Homosexual/haemophiliac</td>
<td>2,805</td>
</tr>
<tr>
<td></td>
<td>Homosexual/transfusion</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Homosexual/IDU/haemophiliac</td>
<td>335</td>
</tr>
<tr>
<td></td>
<td>Homosexual/IDU/transfusion</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Bisexual</td>
<td>17,221</td>
</tr>
<tr>
<td></td>
<td>Bisexual/IDU</td>
<td>13,751</td>
</tr>
<tr>
<td></td>
<td>Bisexual/haemophiliac</td>
<td>3,054</td>
</tr>
<tr>
<td></td>
<td>Bisexual/transfusion</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Bisexual/IDU/haemophiliac</td>
<td>327</td>
</tr>
<tr>
<td></td>
<td>Bisexual/IDU/transfusion</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Heterosexual</td>
<td>40,115</td>
</tr>
<tr>
<td></td>
<td>Heterosexual/IDU</td>
<td>40,115</td>
</tr>
<tr>
<td></td>
<td>Heterosexual/haemophiliac</td>
<td>16,224</td>
</tr>
<tr>
<td></td>
<td>Heterosexual/transfusion</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>Heterosexual/IDU/haemophiliac</td>
<td>923</td>
</tr>
<tr>
<td></td>
<td>Heterosexual/IDU/transfusion</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Injection Drug User (IDU)</td>
<td>32,819</td>
</tr>
<tr>
<td></td>
<td>IDU</td>
<td>16,067</td>
</tr>
<tr>
<td></td>
<td>IDU/haemophiliac</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>IDU/transfusion</td>
<td>218</td>
</tr>
<tr>
<td></td>
<td>Haemophilia</td>
<td>1,109</td>
</tr>
<tr>
<td></td>
<td>Transfusion</td>
<td>3,070</td>
</tr>
<tr>
<td></td>
<td>Perinatal</td>
<td>4,630</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>39,442</td>
</tr>
<tr>
<td></td>
<td>Haemophilia</td>
<td>988</td>
</tr>
<tr>
<td></td>
<td>Transfusion</td>
<td>2,147</td>
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<tr>
<td></td>
<td>Perinatal</td>
<td>4,630</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>39,442</td>
</tr>
</tbody>
</table>

HIV/AIDS Case Reporting to PAHO/WHO/UNAIDS

**Cumulative Relative Incidence.** Table 2 shows the proportion of the cumulative number of cases reported in each geographic stratum that were classified as the result of homosexual transmission. The central column includes cases classified as of probable mode of transmission not reported, while the right-hand column excludes them. As we can see, the Andean Region and Mexico remain the areas with the highest proportion of cases attributed to male-male sexual transmission with around 50% of cases, with one assigned transmission category. After them come Brazil and the Southern Cone, with approximately one-third of the total, followed by Central America and the Caribbean which list only 13% of cases in this category.

**Table 2:**
Proportion of cases reported as pertaining to MSM in Latin America and the Caribbean (total number of cases reported to date). Source: PAHO, 2001a.

<table>
<thead>
<tr>
<th>SUB-REGION</th>
<th>MSM CASES AS A % OF TOTAL</th>
<th>% OF TOTAL CASES KNOWN TO BE OF MSM TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central America</td>
<td>12.3</td>
<td>13.6</td>
</tr>
<tr>
<td>Andean Region</td>
<td>42.6</td>
<td>48.3</td>
</tr>
<tr>
<td>Brazil</td>
<td>26.7</td>
<td>35.0</td>
</tr>
<tr>
<td>Non Latin Caribbean</td>
<td>10.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Latin Caribbean</td>
<td>9.0</td>
<td>13.8</td>
</tr>
<tr>
<td>Southern Cone</td>
<td>31.5 (n.a.)</td>
<td>32.9</td>
</tr>
<tr>
<td>Mexico</td>
<td></td>
<td>54.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>35.2</td>
</tr>
</tbody>
</table>

2 The statistics for Latin America are provided by PAHO/WHO in six and sometimes seven geographical strata or areas: the Andean Region (including Bolivia, Colombia, Ecuador, Peru and Venezuela); Brazil; the Southern Cone (including Argentina, Chile, Paraguay and Uruguay); Central America (Belize, Guatemala, Nicaragua, Honduras, El Salvador, Costa Rica and Panama); the Latin Caribbean (including Cuba, Dominican Republic and Haiti); the English- and Dutch-speaking Caribbean (which includes 19 islands); and Mexico (See Figure 1).

3 Except for Mexico, because the source does not have the information available, which prevents estimation of a regional total.

4 It also excludes cases resulting from risks considered “infrequent”; in other words, other than homo/bisexual, heterosexual, injectable drug use, hemoderivatives, transfusion, and perinatal.
Upon closer examination of the details for each geographical stratum, three patterns emerge. In the first pattern, the Andean Region has an epidemic in which 48.3% of reported cases are classified as pertaining to MSM (Figure 2a), with heterosexual transmission accounting for 47.5% of cases (a similar figure). Injection drug use is almost nonexistent, and cases resulting from perinatal transmission and other modes of blood transmission are rare. Similarly, in Mexico (Figure 2b) 54.5% of cases are classified as MSM, compared to 38.9% in the heterosexual category. Here, it should be noted that the Notification Report of December 2001 does not provide-for Mexico- the proportion of cases without information on probable mode of transmission; however, in the Report of May 2000 this figure was around one-third of total cases (PAHO, 2000). For the Andean Region and Mexico, the male:female ratio highlights the high frequency of MSM cases.

**Figures 2a-h**: AIDS cases distributed by mode of transmission among 7 sub-regions of Latin America and the Caribbean (2a-g); and in the region overall (2h). Excludes cases attributed to transmission via «other risk factors» and cases without probable cause attributed. Source: PAHO, 2001a.
A second pattern is visible in the Southern Cone and Brazil. In the Southern Cone (Figure 2c), approximately 58% of reported cases are due to sexual transmission, of which almost three in five are classified as MSM cases. However, the new element here is injection drug use, which accounts for one-third of reported cases. Perinatal cases represent 6% of total cases.
Equally, in Brazil (Figure 2d), around 70% of AIDS cases with information about probable mode of transmission are placed in the sexual transmission category, and 50% of those are listed as occurring among MSM. Another 24% are classified as corresponding to injection drug users. It should be noted that in Brazil, a quarter of cases are listed in an unknown risk category (a fact not shown in Figure 2d).

A third pattern becomes clear in Central America and the Caribbean. In Central America (see Figure 2e), the proportions as regards probable mode of sexual transmission reported are inverted, and heterosexual transmission, which accounts for 79% of total cases, is six times more frequent than homosexual transmission. Perinatal cases are also more common. Similarly, in the English- and Dutch-speaking Caribbean (see Figure 2f) heterosexual cases are 6.5 times more frequent than homosexual cases and account for 79.5% of cases with information about probable infection category. Here, however, the proportion of cases whose transmission category is given as unknown comes to 17%. In the same way, in the Latin Caribbean (Figure 2g) reported heterosexual transmission is also 5.5 times higher than homosexual transmission, and accounts for 76% of cases with information about mode of transmission. In this region, again, the proportion of cases listed as of mode of transmission unknown is very high (35%). In all of the last three areas the proportion of cases attributed to injection drug use is very low.
AIDS and Male-to-Male Sex in Latin America: Vulnerabilities, strengths and proposed measures

Figure 2e

Figure 2f

Figure 2g
Based on this diversity of situations, we find that sexual transmission at the regional level accounts for 78% of cases with information about probable mode of transmission (Figure 2h), and that heterosexual and homosexual cases represent 55% and 45% of that figure, respectively. Injection drug use represents 16% of cases in the region, and perinatal and other forms of blood transmission account for 6%.

Historically, throughout the 1990’s, the proportion of AIDS cases categorized as MSM has decreased due to an increase in the number of female cases. However, the total number of MSM has remained steady; in other words in relative terms their number may have diminished, but in absolute terms it has not.

The largest increase has been among injection drug users in Brazil and, most particularly, in the Southern Cone. The escalation of the epidemic in injection drug users is creating bridges to the heterosexual population more effectively.
than the epidemic in MSM. The result has been a slight to moderate rise in the proportion of perinatal cases. Conversely, a reduction in the proportion of blood borne cases is consistent with much improved prevention strategies at health facilities.

**Cumulative Male:Female Incidence Ratio.** Figure 3 shows the ratios for number of reported male cases to number of reported female cases for each sub-region and for Latin America as a whole, by year, from 1995 to 2001 (according to PAHO, 2001a). The chart highlights the difference between, on one hand, Mexico and the Andean Region, whose ratios, though descending, remain above three; and, on the other, Central America and the Caribbean, where the ratios are

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* Information is incomplete due to delayed notification.

** Cumulative ratio for the Latin Caribbean does not include Puerto Rico.
around two. Despite these differences, and perhaps with the exception of Honduras, Belize and the Dominican Republic, it is worth drawing attention to the fact that the Central American countries, in addition to Cuba (in the Latin Caribbean), have male:female ratios of nearly three, which is not congruent with the markedly heterosexual epidemiological patterns suggested by the case reporting. This discrepancy implies, once again, that many cases that have probably resulted from homosexual transmission in these countries have been reported as heterosexual cases.

**Young MSM Risk.** We do not have a demographic breakdown of cases among MSM in the region. However, while in countries like Peru AIDS is diagnosed in MSM between adolescence and old age; most cases occur in the 25-34 year-olds. It follows, then, that many such cases are the result of infections that probably occurred towards the end of adolescence, which leads us to underline two points: a) there are MSM of all ages, and all may be at risk (in fact, many MSM in the region become infected before reaching majority of age); and b) when we refer to «youths» we tend to assume that they only have heterosexual relations; however, it is important to recall that many also engage in homosexual relations, and some even identify themselves as homosexuals.

**HIV Seroprevalence Data**

We can make a rapid assessment of the historical impact of the epidemic on a population and its health services by analysing reported cases; however if we want to gauge the current and future impact of the epidemic on a given group and on the health system we must examine the data provided by seroprevalence studies. Table 3 contains the available seroprevalence data for MSM in the region. It is difficult to determine how comparable the data are, in that there is limited information on the conditions under which many studies were carried out, particularly with respect to sample selection. Having said that, the information suggests prevalences that vary between 5% and 20% for MSM in most capital cities in the region, a clear indication of an epidemic concentrated in MSM.
### Table 3: HIV Seroprevalence among MSM in Latin America and the Caribbean.

<table>
<thead>
<tr>
<th>Location</th>
<th>Description of Population</th>
<th>Sample Size</th>
<th>HIV Prevalence</th>
<th>Sample Year(s)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANDEAN AREA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td>«Homos./bisex.»</td>
<td>48</td>
<td>14.6</td>
<td>99/00</td>
<td>Russell, 2000b</td>
</tr>
<tr>
<td>Colombia</td>
<td>«Homos./bisex.»</td>
<td>63</td>
<td>20.4</td>
<td>99/00</td>
<td>Russell, 2000b</td>
</tr>
<tr>
<td>Ecuador</td>
<td>«Homos./bisex.»</td>
<td>14</td>
<td>17.9</td>
<td>99/00</td>
<td>Russell, 2000b</td>
</tr>
<tr>
<td>Peru</td>
<td>«Homos./bisex.»</td>
<td>98</td>
<td>14.2</td>
<td>99/00</td>
<td>Russell, 2000b</td>
</tr>
<tr>
<td>Venezuela</td>
<td>«Homos./bisex.»</td>
<td>20</td>
<td>9.0</td>
<td>99/00</td>
<td>Russell, 2000b</td>
</tr>
<tr>
<td><strong>BRAZIL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>167</td>
<td>6.6</td>
<td>99/00</td>
<td>Viana, 1996</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos. IDU»</td>
<td>570</td>
<td>9.0</td>
<td>99/00</td>
<td>Carneiro, 2000</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>313</td>
<td>9.2</td>
<td>99/00</td>
<td>Surratt, 1996</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>59</td>
<td>9.2</td>
<td>99/00</td>
<td>Surratt, 1996</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>753</td>
<td>11.0</td>
<td>99/00</td>
<td>Surratt, 1996</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>550</td>
<td>10.0</td>
<td>99/00</td>
<td>Surratt, 1996</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>453</td>
<td>13.9</td>
<td>99/00</td>
<td>Surratt, 1996</td>
</tr>
<tr>
<td>Brazil</td>
<td>«Homos./bisex.»</td>
<td>1082</td>
<td>10.8</td>
<td>99/00</td>
<td>Surratt, 1996</td>
</tr>
<tr>
<td><strong>CARIBBEAN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuba</td>
<td>«Homos./bisex.»</td>
<td>710</td>
<td>5.2</td>
<td>99/00</td>
<td>Galbán, 1989</td>
</tr>
<tr>
<td>Cuba</td>
<td>«Homos./bisex.»</td>
<td>560</td>
<td>7.7</td>
<td>1984</td>
<td>Tabet, 1996</td>
</tr>
<tr>
<td>Dominica</td>
<td>«Homos./bisex.»</td>
<td>230</td>
<td>7.7</td>
<td>1984</td>
<td>Tabet, 1996</td>
</tr>
<tr>
<td>Grenada</td>
<td>«Homos./bisex.»</td>
<td>495</td>
<td>7.7</td>
<td>1984</td>
<td>Tabet, 1996</td>
</tr>
<tr>
<td>Haiti</td>
<td>«Homos./bisex.»</td>
<td>495</td>
<td>7.7</td>
<td>1984</td>
<td>Tabet, 1996</td>
</tr>
<tr>
<td>Jamaica</td>
<td>«Homos./bisex.»</td>
<td>11.7</td>
<td>15.0</td>
<td>1985-86</td>
<td>Murphy, 1988</td>
</tr>
<tr>
<td>Martinique</td>
<td>«Homos./bisex.»</td>
<td>17.0</td>
<td>14.0</td>
<td>1985-86</td>
<td>Chot, 1988</td>
</tr>
<tr>
<td>St. Lucia</td>
<td>«Homos./bisex.»</td>
<td>15.0</td>
<td>14.0</td>
<td>1985-86</td>
<td>Chot, 1988</td>
</tr>
<tr>
<td>St. Vincent</td>
<td>«Homos./bisex.»</td>
<td>15.0</td>
<td>14.0</td>
<td>1985-86</td>
<td>Chot, 1988</td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>«Homos./bisex.»</td>
<td>30.0</td>
<td>40.0</td>
<td>1985-86</td>
<td>Chot, 1988</td>
</tr>
</tbody>
</table>

**Notes:**
- Referenced studies are based on adult samples.
- Mean age: 29 years.
- HIV+ Contacts.
### Table 3: (continued)

<table>
<thead>
<tr>
<th>SUBREGION</th>
<th>COUNTRY</th>
<th>LOCATION</th>
<th>DESCRIPTION OF POPULATION</th>
<th>HIV PREVALENCE</th>
<th>SAMPLE SIZE</th>
<th>YEARS</th>
<th>REFERENCE</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTRAL AMERICA(^1)</td>
<td>Costa Rica</td>
<td>San José</td>
<td>«Homo./bisex.»</td>
<td>4.9</td>
<td>143</td>
<td>1994</td>
<td>Bonifati 1994</td>
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<tr>
<td></td>
<td>Honduras</td>
<td>Tegucigalpa</td>
<td>«Homosexual»</td>
<td>14.0</td>
<td>n.s.(^2)</td>
<td>1989/92</td>
<td>Nuñez 1993</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Panamá</td>
<td>Panamá city</td>
<td>«Homosexual»</td>
<td>3.1</td>
<td>287</td>
<td>1984/86</td>
<td>Reeves 1988</td>
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<tr>
<td>MEXICO</td>
<td>México</td>
<td>Nationwide</td>
<td>«Homo./bisex.»</td>
<td>15.5</td>
<td>973</td>
<td>1991-96</td>
<td>Magis 1997</td>
<td>Epidemiological surveillance</td>
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<td>México</td>
<td>C. de México</td>
<td>«Bisexual»</td>
<td>2.6</td>
<td>884</td>
<td>1993-95</td>
<td>Terán 1996</td>
<td>CONASIDA Test center</td>
</tr>
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<td>C. de México</td>
<td>«Homosexual»</td>
<td>31.6</td>
<td>1,444</td>
<td>1993/95</td>
<td>Terán 1996</td>
<td>CONASIDA Test center</td>
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<tr>
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<td>México</td>
<td>Guadalajara</td>
<td>«Homosexual»</td>
<td>29.2</td>
<td>267</td>
<td>1990</td>
<td>Preciado 1991</td>
<td></td>
</tr>
<tr>
<td></td>
<td>México</td>
<td>Nationwide</td>
<td>«TSM»(^3)</td>
<td>13.6</td>
<td>712</td>
<td>1991-96</td>
<td>Magis 1997</td>
<td>Epidemiological surveillance</td>
</tr>
<tr>
<td>SOUTHERN CONE</td>
<td>Argentina</td>
<td>Bs. Aires</td>
<td>«MSM»</td>
<td>13.3</td>
<td>724</td>
<td>1990</td>
<td>Russell, 2000b</td>
<td></td>
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<tr>
<td></td>
<td>Argentina</td>
<td>Rosario</td>
<td>«Homo./bisex.»</td>
<td>11.2</td>
<td>659</td>
<td>1987-89</td>
<td>Rubio et al., 1989</td>
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<tr>
<td></td>
<td>Argentina</td>
<td>Not specified</td>
<td>«Homo./bisex.»</td>
<td>12.8</td>
<td>1,020</td>
<td>1991</td>
<td>Fay et al., 1991</td>
<td></td>
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<tr>
<td></td>
<td>Paraguay</td>
<td>Asunción</td>
<td>«Homosexual»</td>
<td>8.8</td>
<td>182</td>
<td>1987-90</td>
<td>Cabello et al., 1991</td>
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</tr>
<tr>
<td></td>
<td>Uruguay</td>
<td>Montevideo</td>
<td>«Bisexual»</td>
<td>3.2</td>
<td>252</td>
<td>1996</td>
<td>Barriolo 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uruguay</td>
<td>Montevideo</td>
<td>«Homosexual»</td>
<td>2.6</td>
<td>154</td>
<td>1996</td>
<td>Barriolo 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uruguay</td>
<td>Montevideo</td>
<td>«MSM»(^3)</td>
<td>13.4</td>
<td>187</td>
<td>2000</td>
<td>Russell, 2000b</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uruguay</td>
<td>Montevideo</td>
<td>«MSW»</td>
<td>17.8</td>
<td>241</td>
<td>1999</td>
<td>Russell, 2000b</td>
<td></td>
</tr>
</tbody>
</table>

Sources: HIV/AIDS Surveillance Database, U.S. Bureau of the Census; publications of NMRCD, Lima; National Bureau on STD/AIDS, Brazil.

\(^1\) There was no information available on HIV prevalence among MSM from Belize, El Salvador, Guatemala, and Nicaragua, in Central America; from Chile in the Southern Cone; and from Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, British Virgin Islands, Cayman Islands, Dominica, Dutch Antilles, French Guiana, Grenada, Guadeloupe, Guyana, Haiti, Montserrat, St. Kitts and Nevis, St. Lucia, Suriname, St. Vincent and the Grenadines, and the Turks and Caicos Islands in the Caribbean.

\(^2\) Not specified.

\(^3\) Male sex workers.
In the Andean Region, studies on several populations, including MSM, have recently been conducted in Bolivia, Colombia, Ecuador and Peru by the US Naval Medical Research Center, Lima, in cooperation with local institutions (Russell et al., 2000b). Studies on MSM mostly show prevalences that range from 5% (in the provinces of Peru) to 28% in Guayaquil, Ecuador. The prevalence was 15% in La Paz, Bolivia (n = 48), 20% in Bogotá, Colombia (n = 643), 11% in Quito, Ecuador (n = 244), and 14% in Lima, Peru (n = 4883).

In Brazil, baseline surveys for three cohort studies carried out in Rio de Janeiro, Sao Paulo and Belo Horizonte found prevalences of 9 to 11% between 1994 and 1996 (Ramos et al., 1999; Carvalheiro et al., 1998; Carneiro et al., 2000). In the Caribbean, the best data come from the Dominican Republic, where the prevalence was 8 to 12% for 1994 (Tabet et al., 1996). In Central America, the most recent data we have is limited. The prevalence in Costa Rica was estimated at 5% in 1994 (Bonifati, 1994), and was reportedly as high as 14% in a sample in Tegucigalpa, Honduras (Núñez, 1993).

In Mexico, the most significant data come from sentinel studies in the framework of a nationwide epidemiological surveillance program. Prevalences were reported of 16% for homo/bisexual men and 14% for male sex workers for 1991 to 1996 (Magis et al., 1997). Finally, in the Southern Cone, the US Naval Medical Research Center, Lima, has also conducted studies in Argentina (the HIV prevalence was 13% in a group of 724 MSM in Buenos Aires) and Uruguay (on 241 male sex workers in Montevideo, with an estimated prevalence of 18% in 1999) (Russell et al., 2000b). We have no relevant data for Chile or Paraguay.

Comparing seroprevalence in MSM populations with that found in heterosexual populations. The seroprevalence data in Table 3 may be compared with available data for heterosexual populations or with those for the subpopulations typically used to assess the situation of the heterosexual population. For instance, the results of studies on pregnant women in several countries in the region listed in the HIV/AIDS Surveillance Database (U.S. Bureau of the Census, 2001), showed that in most countries (except Brazil, Dominican Republic, Jamaica, Honduras, and a few others with figures of 2% or 3%) seroprevalence figures are below 1%. This fact suggests that in the majority of the countries the epidemic cannot be considered generalized, and is concentrated in MSM populations (and, in countries like Argentina, Brazil and Uruguay, also in IDUs).
HIV Seroincidence Data

Information on HIV seroincidence is available for Brazil and Peru only (see Table 4). In Brazil, three cohort studies were implemented in the cities of Rio de Janeiro (Praça Once Cohort [Ramos et al., 1999]), Sao Paulo (Bela Vista Cohort [Carvalheiro et al., 1998]) and Belo Horizonte (Horizonte Cohort [Carneiro et al., 2000]) from 1994 to 1999. The estimated incidence densities were 3.1 per 100 persons-year for the study in Rio (in a cohort of 753 men), 1.51 in Sao Paulo (in a cohort of 1,028 men), and 1.99 in Belo Horizonte (in a cohort of 470 men). In Peru, 1,140 men monitored in the Alaska Cohort from 1998 to 2000 showed a seroincidence density of 3.3 per 100 persons-year of observation (based on 5,166 persons-month) (Sánchez et al., 2000). The estimated incidences in the four studies suggest moderately high HIV transmission rates in MSM in these countries, which underlines the need for continuous and more effective programmatic action.

Table 4: HIV seroincidence density among MSM in Latin America and the Caribbean

<table>
<thead>
<tr>
<th>SUB-REGION</th>
<th>COUNTRY</th>
<th>LOCATION</th>
<th>DESCRIPTION OF POPULATION</th>
<th>DENSITY INCIDENCE</th>
<th>SAMPLE SIZE</th>
<th>YEAR(S)</th>
<th>REFERENCE</th>
<th>OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANDEAN</td>
<td>Perú</td>
<td>Lima</td>
<td>«MSM»</td>
<td>3.3</td>
<td>1140</td>
<td>98/00</td>
<td>Sánchez et al, 2000</td>
<td>Alaska Cohort</td>
</tr>
<tr>
<td>BRAZIL</td>
<td>Brazil</td>
<td>Rio de Janeiro</td>
<td>«MSM»</td>
<td>3.1</td>
<td>752</td>
<td>95/97</td>
<td>Ramos et al, 1999</td>
<td>C. Praça Once Cohort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sao Paulo</td>
<td>«MSM»</td>
<td>1.51</td>
<td>1028</td>
<td>94/99</td>
<td>Carvalheiro et al, 1998</td>
<td>C. Belavista Cohort</td>
</tr>
</tbody>
</table>

* Number of new cases per 100 persons-year of observation.
Generating better data: Strategies for HIV surveillance among MSM

In order to monitor the emergence and evolution of the HIV epidemic among MSM populations in Latin America, to have an idea of behavioural patterns that may increase transmission of the virus from MSM to other populations, and to have a record of the impact of future interventions, it is very important to improve access to quality information. Consequently, building on the logic proposed by UNAIDS for the development of second-generation epidemiological surveillance systems, we put forward guidelines for organizing epidemiological surveillance of HIV in MSM populations, in particular for the consideration of countries in the region that do not already do so or that do not obtain the necessary information from the systems in place.

Formative Research

It is not possible to implement a standardized surveillance system without first conducting formative research to identify variety and diversity of behaviours, determine points of access, and establish partnerships with organizations and individuals that are trusted by significant MSM populations. Therefore it is necessary to apply ethnographic approaches designed to provide a better understanding of the complexity of the sexual cultures of MSM. Such research typically includes observation, discussion groups, and in-depth interviews with key informants. Members of MSM communities should be involved at all stages.

«It is also essential to build key partnerships with institutions and individuals who can help facilitate access to MSM populations»

The ideas mentioned here have been summarized and adapted from a section of Surveillance among men who have sex with men; McFarland, W, and Cáceres, C.. AIDS 2001, 15 (suppl 3): S23-S32 [15].
Since classic ethnographic research requires a lengthy time frame, the use has been popularised of rapid assessment procedures (RAPs) to generate information at the pace that public health measures demand. These procedures, which are fairly narrowly targeted, combine adapted standard anthropological techniques (interviews, observation, discussion groups) with small-scale surveys and secondary analysis of quantitative data. In preparation for HIV surveillance among MSM, RAPs are particularly helpful for reaching the community and also make it easier to design more representative surveys.

Formative research also makes it possible to identify a «universe» of points of access to MSM populations. This universe of social spaces (e.g. bars, discotheques, saunas, libraries, video clubs, public meeting areas, magazines catering for MSM, and internet web sites and chat rooms) can be used to prepare a sampling frame for probabilistic quantitative studies. It is also essential to build key partnerships with institutions and individuals who can help facilitate access to MSM populations (e.g. activists, gay and lesbian rights organizations, owners of commercial establishments frequented by MSM, AIDS services organizations and other community-based organizations, sexual health services, health authorities, and local governments).

**HIV/AIDS Case Reporting**

AIDS case reporting is obligatory in almost every country in the region. The same is also true throughout most of the region for reporting cases of HIV infection that do not meet AIDS diagnosis criteria. However, many of these systems are, in practice, passive, due to a combination of low prioritisation and limited resources. Detection of HIV infections that do not qualify for an AIDS diagnosis occurs in a very small proportion of cases, for which reason it is not reported to any significant extent. As AIDS is diagnosed far more frequently, and because it is attributed greater importance, the value of case reporting statistics is higher; nevertheless, such value is limited to indications of very long-term trends in HIV transmission. Case reporting provides a numerator (AIDS cases) without a reference denominator. Improving reporting forms so that they can provide better information about probable mode of transmission would be ideal, as would be training those who diagnose or record cases to notify the health authorities, so as to avert a tendency toward either under- or over-diagnosis.
Sentinel Surveillance

‘Sentinel surveillance’ refers to the implementation of reproducible, serial cross-sectional serosurveys on populations (in this case at risk from HIV), generally with samples selected on the basis of convenience (for example, STD clinic users). Frequently such surveys are anonymous, that is, they do not identify the participant, and are generally conducted on samples obtained in other studies in order to reduce biases resulting from the self-exclusion of some persons (for example, those who assume they will test positive and do not want to know the result). However, such strategy is considered unethical by those who think that HIV testing should not be conducted without providing counselling to participants before and after they receive the results. Linked (i.e. non anonymous) studies, on the other hand, make it possible to acquire information on sexual behaviour. It is generally assumed that samples included in sentinel studies belong to populations (in this case MSM) at risk from infection, and that monitoring them helps characterize trends in the general MSM population.

Seroprevalence studies

The problems with finding suitable institutional forums for conducting sentinel studies with MSM, together with the difficulties of establishing the condition of MSM in such a way as to ensure the freedom and security of interviewees and interviewers, make it important to conduct baseline studies on HIV seroprevalence at the community level, with broader and/or more representative samples, aimed at validating estimates made using less expensive techniques; although the cost of these studies means that it is possible to carry them out only at certain intervals. Diverse sampling strategies may be used: convenience sampling (in accessible populations that are prepared to participate, although they may not be the most exposed to risk); snowball sampling (of persons referred by previous participants, particularly when homosexual behaviour is very stigmatised, or with very marginalized target groups); quota sampling (when the target group is segmented into significant subgroups and a fixed or minimum number of persons is used); venue-based sampling (which involves mapping places where MSM may be sampled sequentially or systematically); or random time-place sampling (in which the time variable is combined with the previous method if the ‘typical’ population varies according to day, week or time of
day). Population-based sampling, which contacts households in person or by telephone, has been designed for ‘gay’ neighbourhoods in North America but is not possible with MSM in the region because such neighbourhoods do not yet exist with the necessary population density, or the social climate in them does not permit generation of sufficiently valid information to justify the investment.

Seroincidence studies

The interpretation of serial cross-sectional data (in other words, data which come from successive prevalence surveys) assumes that prevalence trends reflect recent trends in transmission, and that the relative prevalence of infection determines the relative risk of its acquisition. Frequently, these assumptions are not mirrored in MSM populations, making it necessary to measure infection incidence over time. The classic epidemiological research method for measuring incidence is the cohort study, which requires recruitment of large numbers of individuals at-risk, together with periodic serological follow-up to detect seroconversions. Obviously, owing to their high cost and the complex logistics involved, such studies are not very common. Fortunately, more and more alternative techniques are becoming available that enable acceptable incidence estimates, including testing of samples stored over time provided by groups of individuals (secondary retrospective cohorts: for example, samples collected for evaluation of reactivity to syphilis); joint analysis of samples collected from specific individuals over time at voluntary HIV testing centres (individually identified in an unambiguous manner, for example, with initials and date of birth); and, above all, detuned testing, which combines two enzymatic immunoabsorbent assays (EIA or Elisa) of different sensitivities, so that the less sensitive one (usually an older generation EIA) does not detect lower levels of HIV antibodies typical at the start of seroconversion, while the more sensitive one detects both older and recent infections. The estimated number of new cases makes it possible to calculate incidence. Despite its limitations and the fact that large numbers of samples are needed, this assay permits cross-sectional incidence estimates that have been validated in cohort studies.
STI surveillance and behavioural surveillance

Sexually transmitted infections (STIs) are an ‘objective’ indicator of sexual risk, as well as a facilitating factor for HIV acquisition and transmission. Accordingly, measuring their incidence serves various purposes as regards monitoring the epidemic. STI surveillance has not been adopted as standard by most countries in the region, and when it is carried out information about sexual orientation is not usually requested. An HIV surveillance system among MSM could consider recording gender of the partners of persons who seek care for STIs, as well as better exploration of the possibility of rectal STIs and the inclusion of STIs in epidemiological studies carried out with MSM. In addition, in the framework of second-generation surveillance, monitoring sexual behaviour trends, particularly those connected with risk practices, sexual partner recruitment patterns, and condom use, is a valuable source of information that, even in the absence of laboratory data, can make it possible to determine with a degree of accuracy the risk levels in a community.

Estimating the size of the MSM population

The validity or broad applicability of surveillance data is limited when the size of the MSM population at-risk or of specific subpopulations is not known. The reason is that since the population denominator is unknown the scale of the phenomenon remains uncertain and, for the same reason, since the
subpopulation denominators have not been identified, it is hard to determine an appropriate proportion for each of them in the sample in order to arrive at a realistic estimate. Unfortunately, the social exclusion of homosexuality and the self-censorship it still implies, together with the diversity of identities and practices, and factors like migration and high mortality, make it enormously difficult to estimate the size of this population. In spite of that, there are a number of useful approaches that have been used in North America and northern Europe: a) the assumption that MSM constitute a fixed proportion of the adult male population, according to data from population studies on sexual behaviour that study homosexual experience; b) the capture-recapture method, which for specific locations (for example, the streets of a particular area of a city) uses two independent samples in which the proportion of coincidences (individuals contacted in both surveys) depends in part on how big the population is, making it possible to estimate its size; c) methods that combine various sources of data, such as the Holmberg component model, which included a census of homes inhabited by single male couples, epidemiological surveillance data on MSM living with HIV/AIDS; MSM who seek counselling and antibody testing services, number of services provided for the gay population, epidemiological surveys and expert opinion polls; (4) inclusion of this objective into broader random household surveys.

Ethical concerns

Despite its enormous importance, the generation of information on the HIV epidemic in MSM and other socially excluded populations should take into account their vulnerability and avoid causing negative repercussions to them as individuals (for example, physical, emotional, or legal consequences as a result of the loss of privacy) or in the community (for example, political repression resulting from publication of ethnographies of sexual activity in public spaces, or the limitation of resources to ‘punish’ MSM populations for their ‘promiscuity’). For both ethical and technical reasons the health authorities should always bear in mind the potential repercussions of their activities, particularly their media...
policy. Furthermore, if promises were made in order to gain access to a population, honouring them is crucial to ensure the legitimacy and sustainability of surveillance among MSM populations. It is necessary to look beyond the academic interests of research at social responsibility, in order to improve the epidemiological situation described here. Therefore, information should be shared with all those who can use it to implement positive interventions, starting with the communities directly involved.

Special ethical considerations are required with particularly vulnerable MSM, such as minors, ethnic minorities and migrants, prison inmates, transvestites and transsexuals, sex workers, and drug users.

Efforts should also be made to offer individual participants benefits to reward them for their service to society (for example information, counselling, treatment of HIV infection and associated illnesses). Given that in much of the region universal access to highly active antiretroviral treatment (HAART) does not exist, consensus should be reached with local MSM communities to establish the standards of treatment that should be available to those who find out about their infection through their participation in surveillance programs. Special ethical considerations are required with particularly vulnerable MSM, such as minors, ethnic minorities and migrants, prison inmates, transvestites and transsexuals, sex workers, and drug users. In areas where the legal framework does not adequately protect their human rights, measures should be avoided that might expose them to any undesirable situation.
Conclusions

- Analysis of the HIV epidemic in MSM in Latin America and the Caribbean points to a complex scenario in which stigma and social exclusion have fuelled an epidemic which, given the proportion of this population that has become infected, developed AIDS, and died, could be fairly described as devastating. Gay men and other men who have sex with men have been the group most severely affected by this pandemic in the region, and they remain the most vulnerable to HIV infection and the disease and death that are the secondary consequences thereof. Despite being a minority they have accounted for a high number of AIDS cases and there are firm indications that many cases reported as the result of heterosexual transmission were probably caused by male homosexual transmission.

- The HIV epidemic, defined by UNAIDS as concentrated in MSM populations in the majority of urban centres, with prevalences ranging from 5% to 20% and still high incidence rates that fluctuate between 1.5 and 3.3 infections per 100 persons-year of observation (in the countries for which such data are available), urgently requires a clear, effective, and concrete response. Moreover, failure to implement a timely intervention to deal with the epidemic in MSM may permit synergies to develop with parallel HIV/AIDS epidemics (particularly among female partners of some MSM).

- There is very little reliable information about HIV prevalence and incidence, STIs, and, in general, about sexuality, risk, and vulnerability in this population. All of this points to the need to continuously generate more and better information based on rigorous and culturally appropriate research conducted in accordance with the recent UNAIDS recommendations on second-generation surveillance. Such information would make it possible not only to monitor trends in the epidemic, but also obtain a better idea of the circumstances that favour its expansion and collect evidence of the impact of any interventions carried out.

- Epidemiological surveillance should be organized on the basis of proper formative studies. It is also essential to involve the community in the surveillance. Furthermore, recognizing the limited value of case reporting (which, at any rate, requires review and improvement), it is
necessary to use sentinel studies and, where possible, seroprevalence studies that are more representative; it is also important to explore the option of measuring HIV incidence (especially if the possibility exists of employing new techniques that use cross-sectional methods to obtain estimates), and to incorporate components of STI monitoring and surveillance of behavioural trends.

• Any surveillance measures should, however, avoid causing harm at the individual or community level as a result of the stigma associated with homosexuality or HIV, and their legitimacy should be ensured by using the information produced to take action in concert with MSM communities. Where possible, individual benefits should be offered to participants, including an acceptable standard of care for HIV infections detected by the system (in countries where no universal treatment exists), with special care taken with the more vulnerable MSM groups.
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G a b r i e l   G u a j a r d o   S.

I n t r o d u c t i o n

This chapter offers a global description of the socio-cultural construction of relations and practices among gay and other «men who have sex with other men» (MSM) in Latin America, chiefly in urban contexts, since the outbreak of the HIV/AIDS epidemic.

This chapter aims to cover a wide geographical area in the region; however, the reader should be aware that the diversity of civil society actions, the inconsistent fashion in which they have been recorded, and the limited dissemination of specialized publications on this subject, undermine any pretension at a truly exhaustive study, and it is highly likely that there is information that has been overlooked and which will have to be included later.

In every country in the region there are published studies and ongoing research on the issues of gender identities and sexuality -particularly since the end of the 1980's- which constitute a source of material for literary research.

The search for analytical background information on the situation of homoerotic relations and practices in various databases was hampered by the absence of up-to-date syntheses of national or regional data and, furthermore, by the use of a wide range of methodologies and theories to address the issue. The foregoing severely hampered the comparability of aspects of the private and public lives of individuals and groups identified in a broad gamut of male and female homosexualities.
An exhaustive exploration of the issue in this chapter is also impossible because homosexual relations and practices may be examined from a multitude of perspectives. The above is particularly true when one considers that in Latin America HIV/AIDS research has not covered a number of important areas of clinical and epidemiological study. In particular, socio-cultural studies have played a peripheral role in the scientific response to the AIDS epidemic, even though this situation is changing with respect to promotion of socio-cultural research on sexuality in the 1990’s, thus altering the previous position (Cáceres and Rosasco, 2000).

Sexual Diversity in Latin America

Western societies have sought to universalise their hostility or antagonism towards persons of a homosexual, bisexual or lesbian orientation, by treating them, until near the end of the last century, as if they suffered from a psychiatric complaint (until 1973, when it was eliminated from the Diagnostic and Statistical Manual of Mental Disorders (DSM)), or by criminalizing such behaviour. In fact, each of the terms of identification mentioned has a connotation that is currently recognized, and they do not pertain to mere technical descriptions of behaviour nor are they appropriate in all cultures and countries.

Some countries in the Americas still impose legal and non-legal prohibitions on non heterosexual sexual and emotional expressions. However, increasingly, cultural definitions and standards in the area of sexuality, reproduction and man-woman gender relations, are changing or being discussed publicly. In this framework, towards the end of the 20th century, in different countries in the region there were a number of indications of change in the social and academic visibility of homosexual practices and relations in the population: for instance, the abolition of laws in Ecuador and Chile that made it a crime for persons of the same sex to engage in sexual relations (International Gay and Lesbian Human Rights Commission - IGLHRC), 2000); an increase in the publication of studies on sexuality and gender relations (Balderston and Guy, 1998); the inclusion of the issues of sexual diversity and the HIV/AIDS epidemic as matters for debate in public agendas; the emergence of civil society organizations that began to publicize the existence of ways of experiencing same-sex sexuality and affection that do away with tradition, culture, and legal restrictions; and the implementation of community AIDS prevention programs and support for people with AIDS (Whitlock, 1992).
Studies have been conducted to examine different factors that explain this change in favour of public expression of forms of homosexuality, bisexuality and lesbianism not only at the regional, but also at the international level (Castells, 1999). In this framework, local and generalizing labels such as «gay», «homosexual», «bisexual» and «sexual minorities» appear to be part of the mass phenomena of western societies, in that they propose a distinction with respect to the sexuality and affections of individual and groups belonging to the «majority». That distinction suggests the impossibility of autonomy for the «sexual minorities» category - or for others that presuppose a incomplete person - and the existence of a «majority» in society, the latter understood as the whole that determines the conduct of the individual and arises from the relationship between the cultural, economic, social, and political systems, all contained within territorially and legally conceived borders. In this perspective, social and political dimensions eclipse opportunities for civil visibility of sexual diversity given their aims for nationwide scope and their legal frames of reference.

However, increasingly, the notion of society as the frame of reference for establishing uniform, separate, or fixed identities is questioned by social scientists in the region, particularly since the combined effect has been felt of globalising processes that extinguish the sense of borders and endogenous centres of decision making and negotiation. This change has been attributed to two factors connected with the economic globalisation of the hemisphere that have altered the cultural map of Latin America: social and political opening-up in the domestic sphere, and integration processes undertaken by the region’s countries in order to compete in the new world market, suggesting articulation between market developments and national states. One of the most significant changes that has resulted from this is the demographic movement from rural to urban areas. This process has created a heterogeneous urban cultural weft composed of a dense multicultural assortment of threads which, despite the differences in ways of life and of thinking, in structures for feeling and narration, communicate very well with each other. It is a multicultural assortment that challenges the frames of reference and understanding forged from clear-cut, deep-rooted, and clearly segmented identities» (Martín-Barbero, 2000).
In the area of cultural studies it has become clear that that articulation between state and market fuels rising inequality in Latin America, which led to social fragmentation, undermined mechanisms of social and political cohesion, and eroded the symbolic and emblematic representations of nationhood. Those spaces of collective representation contained strong gender biases and discriminatory public expressions on sexual diversity, and their break-up has permitted the inclusion of innovative imagery and meanings that have not necessarily originated within the country itself but from a process of integration and exclusion brought about by globalisation (García Canclini, 1995; Brunner, 1998).

Research is needed throughout the region on the globalisation of communications, especially as regards the relationship between the media and information technologies and gay/lesbian people and groups. Recently this has resulted in a fruitful use of information technologies by these groups, reinforcing processes of change in sexual, social, political, and other imageries and representation forums, as well as leading to the creation of gay cybercommunities with multiple interests and options for communication that share a temporal proximity even if physically distant. One feature of the cultural globalisation processes is deterritorialization and a change in the conception of time (Ortiz, 1994). This situation enables rapid communication, especially through the media of cultural phenomena from the global level to the local or regional level. Thus, in the latter, shared and unifying traditions and frames of reference, such as, for instance, sexual ideologies and religious precepts are confronted, investigated or questioned by the media, with a view to discussing comparatively the basis of their value and their validity, beyond the specific contexts of time and place of origin (Brunner, 1998).

The relations between the media (television, radio, and print) and gay/lesbian organizations tend to be contradictory to the extent that the genuine presence of the issue of homosexuality in terms of its codification and symbolic transgression is questioned; and yet, at the same time, it is an increasingly profitable media commodity in the entertainment or fiction genres. In Peru, Angélica Motta says that in the 1990’s the cultural construction of the «gay scene» as a collection of networks of relations, social settings, dynamics and symbols pertaining to homosexual people in Lima, «has undergone quite dynamic growth and change, and very little is known about it from a social-science point of view. Mainly, it has been the media that has taken it upon itself to reveal, to some extent, part of its dynamic through talk shows, news programs and newspapers, as well as providing coverage whenever there is a raid by the police or municipal authorities on gay discotheques. However, such reporting is partial and biased due to the prejudice that exists towards a population that has been highly stereotyped and on which there is very little serious information» (1999:429).
Analysis of press coverage

A study conducted on the content of issues published between 1988 and 1991 of El Imparcial, one of the longest-standing and most widely read newspapers in the city of Hermosillo, Mexico, made it possible observe opinions on such issues as sexuality, pornography, homosexuality, marriage, sexual liberation, eroticism, prostitution and AIDS. The findings of the study revealed the existence of a discourse with strong religious and medical components used to organize censorship of desire, pleasure, and the body. This medium, embodies the representations and discourses found in families, the Catholic Church, media and civil society organizations, especially those with links to the Catholic Church, and they are materialized in codes and rules.

The main features of this discourse include affirmations that biological reproduction is the only legitimate reason for sexual intercourse and that sex is only justifiable within wedlock; a denial of sexual pleasure outside the context of reproductive sex; and a strong insistence on genitality as the natural rationale for heterosexuality as the norm. Accordingly, any practice not consistent with these principles is censured on moral and medical grounds; the morality that supports this position is steeped in Christian values and is advanced over the opinion of the majority as a core principle; homosexuality is associated with a «suspect nature», «personality problems», prostitution and crime; and love is only conceived as possible between heterosexuals.

The result is that the newspaper becomes a mouthpiece for the dominant discourse on sexuality in the local culture, and, therefore, it is so rooted in conventional wisdom that it assumes that discourse to be logical and unquestionable. From what the researcher has observed, dominant representations generate a «panoptic» effect because they are always observing, censoring and punishing any «excess». This device is activated when the newspaper addresses the issue of homosexuality, producing representations that focus on public presence or private invisibility. Thus, it calls discreet homosexuals those who (...) keep up a heterosexual appearance, from whom one would expect chastity, and brazen homosexuals those who try to stand out or be conspicuous, transvestites, drag queens.

This ideological process makes male homosexuals particularly critical of information on AIDS and it is the permanent backdrop for any evaluation of the virus and its transmission (Torres, 1997:24). This critical posture has been strengthened by their impression of the media's handling of such information, particularly television in its role as the shaper of social reality; thus, homosexuals currently «do not exist» as a stricken population.

This perception held by gay men that the media conceal homosexuality and negate their existence is consistent with the opinion of the heterosexual population that appearances of homosexuals on television are unacceptable. A FLACSO survey in 1998 found that around 60% of the population (men and women) over the age of 18 in Santiago, Chile, thought it unacceptable for prostitutes and homosexuals to be interviewed on television. However, technically, the way the survey findings are presented makes it hard to tell precisely if that percentage refers to homosexuals, prostitutes, or both; it also leads one to wonder about the criteria that permit collection of those data without reproducing social stereotypes or prejudices (FLACSO, 1998).

In broad terms, the enormous variety of socio-cultural practices and intra-regional overlaps in Latin America create a panorama so complex that it is impossible to examine the day-to-day existence of men and women in the region from a cultural perspective. On the other hand, social science research has stressed the importance of understanding human sexuality, which is no longer a product «...of our biological nature but of the cultural and social schemes that mould not only our sexual experience, but also the ways in which we interpret and understand that experience. This vision of sexuality and of sexual activity as social constructs draws attention to the inter-subjective nature of sexual meanings, (and) their collective and shared qualities, not as belonging to isolated individuals, but to social persons integrated
in the context of a variety of different sexual cultures. From that perspective, the subjective experience of a sex life is understood, literally, as a product of the inter-subjective meanings and symbols associated with sexuality in different social and cultural situations» (Parker, 1996:15).

Identities, behaviours and cultures

The emergence of homosexuality or gay styles as a sexual category in the 1980’s and 1990’s in Latin America, cannot be be interpreted to mean the non-existence of complex subcultures in urban areas that, as mentioned in the case of Brazil, have a historical depth that harks back to the beginnings of the 20th century (Parker, 1998). We talk about a «gay world», which encounters, on one hand the sex and gender relations and system at the popular level, and, on the other discourses on rationalized sexual identity, as well as incorporates the diverse contexts of the urban universe and, increasingly, commercial establishments that cater to the homosexual population and provide places for them to meet and recognize one another, as well as containing a host of connotations connected with the ritual of consumption. In some cities an industry has developed, providing entertainment and private premises for homosexual men and women, such as bars, dance halls, restaurants and cinemas.

Realization of the recent expansion of forms of representing identity in the realm of sexual diversity and the multicultural depth of the region’s countries, has led us to question the use of the main categories of sexual identity in the Latin American cultural context – homosexuality, bisexuality and heterosexuality– especially in the framework of HIV/AIDS prevention campaigns and the different fields of epidemiological research. These categories do not necessarily represent in any meaningful way homoerotic identities and practices in given national, economic, socio-cultural, or linguistic contexts, but may come to embody, at an interpersonal level, other definitions and experiences (Rodríguez, 2000).

Adherence to these and other categories that assume a direct causal relationship between sexual desire, sexual behaviour and identity has been cast into doubt since the transcultural study began of male homosexual interactions, which revealed the diversity and complexity of, and discrepancies between, behaviour and alternative sexual identity (Parker, 1996). Other categories were similarly questioned; for instance, the term «lesbian», which covers a galaxy of affective and sexual identities and experiences in women that may be alien in certain cultural or
linguistic contexts (Rosenbloom, 1997). This also concerns those cultural generalizations about the «Latin American man» or «Latin macho», which blur the differences, complexities and subtleties of masculinities and men’s day-to-day experiences (Ramírez, 1993; Gutmann, 1996).

Several research efforts draw attention to the complex relationship between meanings of sexual roles, gender roles, and identity, in particular in the case of male transvestites, who experience a «dissidence of identity». In other words, identity is not only moulded from univocally codified elements of a paternal male culture, but also from the fluid, uncodified subjectivity of the feminine (Facuse, 1998). A study in Costa Rica observed men who professed to be heterosexuals and sought the services of transvestites in order to have in penetrative sex, and who want «a man who is 100% man», regardless of other manifestations of masculinity (Schifter, 1998).

This identity dissidence from the «binary» macrocodes (for example, passive/active) is found in the world of male prostitution, which is weakly institutionalised compared to that of heterosexual female prostitution, «occupying an indistinct,
intermediate space between axiomatic obedience to the rules of the code and a certain pseudolibertinistic nomadism that moves through the meanders of the 'cities of the night'.» (Perlongher, 1999:221).

In certain contexts there is a very visible association between sexual roles («passive» and «active») and sexual and personal identities. A qualitative study in Nicaragua found that in the opinion of homosexual men those who played the penetrative role in sexual intercourse were not homosexuals. The rules on sexual roles and behaviours tend to be strict, to such an extent that the term «rechivuelta», which alludes to those who adopt both a passive and active role in sexual intercourse, is the worst insult for a homosexual man (Aráuz, 1997). In Mexico, for its part, some studies reveal that a man who plays the receptive or passive partner in sex «is no better than a woman» and is treated accordingly (Carter, 1995). By contrast, in some countries, the younger sex workers do not regard certain sexual practices among males (like anal or oral sex) as a sign of homosexuality (Vásquez and Ruiz, 1990).

It is precisely the homoerotic experiential order that refers to situational contexts that are not merely socio-cultural or political in nature, to use the daily language concept developed by Halliday (1986). This appears to make possible identity, relational and behavioural codes, which, though they may be repeatedly updated, are permanently exposed to the possibility of discrepancies, uncertainties and risks. A specific situation that concerns MSM occurs in the case of institutions where men are confined together without the possibility of having sexual or affective encounters with women, such as prisons or the armed forces. In these organizations cultural and psychosocial processes take place that give meaning and shape to homoerotic experiences, in which the sexual cultures of the population become mixed amid resistances and complex changes, and HIV/AIDS prevention measures are hindered by not only institutional but also socio-cultural barriers (Schifter, 1997).

Based on a review of literary material on the situation of the HIV/AIDS epidemic among men who have sex with other men in Latin America and the Caribbean, Cáceres and Chequer (2000) say that the studies focusing on men identified as gay sought to summarize explanations advanced for the «unsafe» behaviour that continued to be reported despite the large amounts of technical information available to the study subjects:

- HIV/AIDS prevention messages lost sight of the complexity of the reasons that lead people to engage in sex, as well as the emotional meanings that are attached to it.
• It would be frequent to feel that suggesting condom use might be either offensive or too difficult because of the complex interpretations which that might give rise to.

• It would appear that unprotected sex is regarded as allowing greater closeness between couples and for that reason it is thought that it should be the «norm» with the steady partner («steady partner» is also a hazy category, and for many one week is sufficient to qualify in that regard).

• The potential risk of partners can apparently be determined from their «healthy» or «unhealthy» appearance. This approach appears to follow traditional aesthetic categories and is used by many to decide with whom unprotected sex is possible.

• Unrealistic views have spread with respect to the absence of risk connected with insertive, as opposed to receptive, anal sex.

• Some people appear to have misunderstood the purpose of HIV testing and to think it is a preventive measure that is virtually an alternative to protected sex, rather than a source of auxiliary information.

• Low self-esteem associated with inner conflict over acceptance of sexuality, coupled with a clandestine form of sexual experience, particularly if facilitated by alcohol or other recreational drugs, could hamper the cognitive and emotional capacity of the subject to take preventive measures.

• Given the long natural history of HIV infection, the risk it poses is apparently seen as more applicable to those persons who feel they have more to protect and attach greater importance to health in their lives in general.

• In all local societies, many men feel, to a greater or lesser extent, that they have a social duty to marry, regardless of their sexual interests, which appears to lead to situations of forced bisexuality, clandestine sexual experiences, and low self-esteem.

• Many of the physical environments where men engage in clandestine homosexual intercourse (i.e., streets, parks, cars, cinemas, saunas) would appear to make it difficult to include condom use, given that there are other risks present; furthermore speed of action is viewed as a necessity. Therefore, it may be necessary to create alternative settings, ideally with information on prevention available.

• Perceived social standards regarding the «obligatory nature» of preventive recommendations are apparently important in determining whether or not an individual feels comfortable with following them.

• Educational strategies should consider the experiential and socio-cultural diversity of MSM, and, in particular, the fact that some are ready for direct messages, while other might require an elliptical approach.
The creation of gay communities and in general, cultural settings designed to enable development of positive homosexual identities from an early stage would help MSM to develop better outlooks on the value of their lives and, therefore, lead them to make a greater effort to preserve them.

Educational material produced by the Homosexualities Project (Brasil), which addresses bisexuality. Archives of ABIA.

The dichotomies of gender and sexual identity in bisexuals in Mexico, can apparently be explained by the importance of a family-based culture where the possibility of not getting married and having children is inconceivable for most men due to rigid social principles (Carter, 1995). In the Dominican Republic, a bibliographic review of the state of research in 1996 (De Moya and García, 1996) concluded that bisexuality, bisexual behaviour, and bisexuality seem to be intrinsic to the social construction of masculinity and of gender roles among many Dominican males, although public recognition as the receptive partner in homosexual sex carries a strong stigma.
In the sexual identity development process many young men experience a conflict of approach/rejection that confuses bonding with competition between, and domination of, members of their own sex, and tends to encourage among men a considerable amount of impulsive clandestine behaviour, leading them to deceive their female partners and to be unfaithful to male ones, in practices that generate fleeting ties of affection, guilt, and denial. These local ideologies on masculinity and stereotypical gender relations appear to encourage male homosexual prostitution in Santo Domingo by strengthening relations of domination in the exchange of sex for money (De Moya and García, 1998).

This discrepancy between homoerotic practices and identities is reflected by the understatement of male homo/bisexual practices in national sexual behaviour surveys, given the answers provided to the question about self-identification as homosexual, bisexual or heterosexual. There is a lack of congruity with epidemiological data on HIV transmission in the area of sexual exposure category, which, in 1999 in Chile, for instance, suggested that homo/bisexual men accounted for 71% of cases (Government of Chile – Ministry of Health, 2000).

An illustrative example of the invisibility and variety of homoerotic practices can be seen in certain stereotypically male job categories where the prevalence of sex among men has been investigated. Studies on male-to-male sex among long-distance truck drivers in Central America, for example, found prevalences ranging from 3.6% in Honduras to 11% in El Salvador (Madrigal, 1998). Studies on subregions of Latin America have not provided detailed reports of movements between rural and urban areas, or between countries; however, in the Dominican Republic a high incidence of sex tourism between cities was observed in a sample of 188 men aged 17 to 47 (Ramah, 1992).

As male-to-male sex is one of the determinants of the epidemic’s configuration at the regional and international level, «...the dominant social representations of homoeroticism and the way in which they interact with specific sexual practices are fundamental. In a ‘macho’ setting male status has constantly to be confirmed, and anything that threatens it symbolically is crudely stigmatised. Social exclusion of homosexuals (typified by homophobia), supported by society as a whole has only recently begun to undergo reversion, thanks to the increasing dissemination of values promoting respect for difference and sexual diversity, which are changing the official line but not the more entrenched attitudes, including those of institutions. The health system is a key example of the latter because it turns a social stigma into an obvious barrier to its services.» (Cáceres, 2002).
Homoerotic experience and homosexual sociability

In the specialized literature on the subject, homoerotic experiences and practices in certain contexts have received more attention than modalities of coexistence, such as construction of ties of friendship, partner relationships, the homosexual family, employment, or citizenship.

For example in discussions in political and academic circles on the family, the existence of a homosexual family is located at the point of coalescence of issues such as the sex/reproduction divide; the fact that the married life is no longer based on a relationship dependent on economic and social reproduction conditions; and the questioning of the belief that kinship requires procreation and that «non biological» ties should be shaped according to a biological model. One of the results of this type of family is the construction of non-procreational sexual identities and the image of blood as a biogenetic symbol of procreation, to which the notion of «choice and creativity» is opposed (Bestard, 1998).

Furthermore, a number of studies indicate that male-to-male sex in public places in the cities of Latin America, is among the practices that entail the highest levels of disguise, repression and discrimination, and little is known about it in the social sciences. This practice combines elements of transgression of moral codes and public sexual discourses (Mendoza, 1998), and reflects hierarchies and relations of domination associated with hegemonic gender constructs (Schifter and Vargas, 1998). In such practices, the conflictive association between gender identities and sexual behaviours is not found to be what some studies indicate; such is the case of an exploratory study based on participant observation and a survey of sex workers in the steam baths of Mexico City, which concludes that none of the men interviewed reported conflict between their identity and their sexual behaviour; nor did any describe himself as homosexual or bisexual. They reported that their place of «initiation» of sex with men had been the steam baths, sometimes at the encouragement of close friends or relatives (Hernández, 1997).
According to a study conducted in Peru (Cáceres and Rosasco, 1997), there is a consistent connection between sex in public places, such as streets, parks and other locations and high risk sexual behaviour. In the study the report on sex in public places consistently predicted the presence of high-risk behaviour according to two indicators: (a) unprotected receptive anal sex, and (b) a risk behaviour index based on number of sexual partners in practices of varying risk levels.

FONOSIDA is a free and anonymous service created by the Ministry of Health of Chile in order to facilitate people's access to information, orientation and personalized support regarding HIV/AIDS and its prevention.

A study of calls received during 1999 determined a total of 54,042, with a monthly average of 4503 calls completed. On the basis of data provided by the hotline users, 75.4% of them are heterosexual (67.9% of men and 91.2% of women); 6.4% are bisexual (7.4% of men and 3.1% of women), and 20.2% are homosexual (24.6% of men and 5.8% of women).

Information is requested on ways of HIV transmission, HIV prevention, HIV testing, use of condoms, and AIDS symptoms. Most men call when they perceive themselves at risk for HIV or when they are HIV positive, while most women call because they distrust their partners, or because they live in proximity to somebody living with HIV/AIDS.

Risk Practices

Practices that pose risk for HIV infection (particularly unprotected vaginal, anal and oral sex, which represent 68% of sexual practices reported by hotline users) are frequent. Sex with strangers is reported by 55% of men and 21% of women.
The most important sexual practice among self-reported homosexual persons is anal penetration, while among self-reported bisexuals it is anal sex followed by vaginal sex, and among heterosexuals it is vaginal sex. Similarly, the study uses an index to relate high- and low-risk practices for all those practices in which using a condom can reduce risk. According to such index, 3.5 unprotected episodes of vaginal sex occur per act of protected vaginal sex, while the figures are 2.9 for anal sex and 17.5 for oral sex.

Homosexuality as a minority experience in Latin America

There has been significant progress in the construction of social movements and of an institutional structure composed of NGOs, welfare organizations, and grassroots gay groups in Latin America, providing a foundation for sociability and promotion of recognition and citizenship experiences. However, there is still considerable mainstream rejection against the public presence of gay men and lesbians and, in some countries serious violations of their human rights, according to Amnesty International (1994), in particular extrajudicial executions and forced disappearance of persons identified as homosexuals. These grave violations of fundamental rights are closely connected with police control and repression measures in places of recreation, such as discotheques or bars, which are frequently reported in various countries in the region without the victims being afforded clear opportunities for their defence (Montalvo, 1997).

In Chile, various opinion polls and qualitative studies have shown that the majority of the population tends to reject homosexual men involved in culture-reproducing institutions, such as schools, the armed forces, television, and politics (Guajardo, 2000). In a 1997 study to measure tolerance and discrimination among members of the Chilean public over the age of 18, the chief object of intolerance and discrimination was homosexuality, coming before ethnic discrimination, the death penalty, and other issues (Fundación Ideas, 1997). In Argentina, a substantial segment of the population of Buenos Aires stated their rejection of homosexuality, citing both personal feelings and moral, socio-political and even medical and psychological considerations (Kornblit, Pecheny, Vujocevich, 1998).

The experiences of belonging to a sexual minority and of discrimination or social intolerance unite individuals with their own bodies in a relationship of self-aggression and self-inflicted violence. Thus, in a hostile social environment suicide may legitimised in the homosexual experience because it is represented not as a source of life but as a generator of death. One example of this can be seen in the positive view taken of suicide by some 30% of lesbians and bisexual women in Costa Rica, according to a 1999 study made by the International Gay and Lesbian Human Rights Commission (IGLHRC).

Given the cultural legitimacy of the death of certain persons due to their extreme corporalisation, it is fair to say that the body is always inscribed in an experience that forms part of the identity of the person and can attain articulation in the reflexive unification of the multiplicity of elements of the life of an individual (Pérez Cortes, 1991). Non-alienating exercise of corporality entails having access to
items of reference that place bodies in a context where they can find formulae for survival, independence or subversion, instead of using generalizing examples or labels that limit the plurality of human life.

Despite its considerable presence in the region, however, depending on social background, homophobia creates different reactions in the population, owing to different ways of understanding homosexuality (Cáceres and Rosasco, 2000). «In the middle class world it is viewed from a traditional medical or psychiatric perspective, under which any sexual contact between men implies homosexuality; in that context, many homosexually oriented men from such a background choose to marry and engage in homosexual sex sporadically or concomitantly; and in connection with the clandestine nature of that activity some have acquired HIV/AIDS and transmitted it to their female partners. By contrast, low-income urban sectors have tended to cling to a traditional stance towards homosexuality based on gender roles under the Herdt classification (1997): in that framework, homosexuals would be interpreted as men who renounce their masculinity and behave like women, which is why they ‘naturally’ want to have sex with (real) men.» (Cáceres, 2002).

In low-income sectors, that fact that a man should have sex with another man in exchange for various kinds of payment does not undermine their masculinity (Motta, 1999). «This model, then, leads to a high prevalence of bisexual behaviour among men who do not identify themselves as bisexual\(^1\) nor feel diminished as «men»; the frequency with which these exchanges occur with alcohol present, as well as the low acceptability of condoms results in a stream of HIV infections from «homosexual» men to these men who engage in bisexual behaviour and to their female partners.» (Cáceres, 2002).

According to the assessments mentioned there are trends in the countries of the region towards increased visibility of homoerotic identities, relations and practices and towards the universal legalization of male homosexuality and, to a lesser degree, female homosexuality.

Laws have not necessarily assured peaceful and respectful coexistence with homosexual persons and groups in the region’s countries, and there is a need for educational, communicational, and legal strategies aimed at restoring their dignity as persons and full citizens. To the contrary, there are illegal arrests and harassment, as well as the persistence of stereotypes and social restrictions that prevent the possibility of instituting legal action in defence against acts of discrimination and defamation committed against gay men or lesbians (Ahumada and Sánchez, 2000).

\(^1\) Which unquestionably has a bearing on the language used in prevention campaigns.
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CHAPTER IV

VULNERABILITY OF GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN TO THE HIV/AIDS EPIDEMIC IN LATIN AMERICA: THE OTHER SIDE OF MASCULINITY

José Toro-Alfonso

Introduction

The HIV/AIDS epidemic has had a disproportionately heavy impact on gay men and other men who have sex with men (MSM). Epidemiological data for most Latin American countries indicate that these groups are the most severely affected. Despite the fact that countries like Honduras, the Dominican Republic, Puerto Rico and Brazil report a spiralling rise in cases of heterosexual transmission, the male homosexual population continues to represent a very significant proportion of people infected with the virus (UNAIDS, 2001a).

Bearing in mind that homosexuality is not accepted in many countries in the region, it is not difficult to see why, even in countries that have reported fewer cases among MSM since the start of the epidemic, the HIV/AIDS epidemic might increase the consequences of publicly coming out of the closet. The inescapable fact remains that throughout the world the homosexual, bisexual and transgendered population has been exceptionally affected by this epidemic.
This is one of the reasons why at the start of the epidemic the connection was made between AIDS and the gay lifestyle. Consequently, idea arose that homosexual people had not only their own lifestyle, but now their own particular diseases as well¹.

Furthermore, the disease was clearly having a powerful impact on the gay community and an effective response was needed to this situation. Led by members of the gay community, different groups were organized to raise funds for research, implement educational programs, and provide support to people with the disease. Doubtless this was one reason why the disease continued to be associated, either exclusively or predominantly, with homosexuality.

Ironically it was the epidemic that helped the world recognize the diversity of homosexual cultures. Important celebrities and public figures told the news media that they were infected with AIDS and had been homosexual all their lives.

Now, at the beginning of the 21st century, the epidemic continues to be the most important cause of death among MSM (including many young people) throughout the hemisphere. Despite the enormous amount of research carried out to understand the human immunodeficiency virus (HIV) epidemic and its infection and transmission mechanisms, the disease remains present across broad sectors of our society (Izazola, Astarloa, Belloqui, Bronfman, Chéquer and Zacarias, 1999).

A whole array of factors makes the homosexual population an ongoing and almost favoured target of this epidemic. In terms of biological makeup, there are no conditions that make MSM particularly predisposed to HIV infection. Therefore, we should be looking at other factors that make this population vulnerable. Understanding and taking account of these vulnerabilities could be the answer for implementing intervention programs that will succeed where the millions of dollars invested to date have not.

¹ As we know, for a time, AIDS was referred to as the «gay plague» or the «pink plague».
Individual vulnerability

Numerous research efforts on HIV vulnerability among men who have sex with men have identified various individual factors, such as levels of self-esteem, internalised homophobia, intimacy problems, among others (Schifter, 1998).

Without going into the structural factors that cause these vulnerabilities, we cannot overlook the fact that there are individual factors that can contribute to an increase in risk behaviour among gay men and other men who have sex with men. Several studies mention sexual abuse during childhood as an element that may contribute to difficulties establishing boundaries and the necessary intimacy in relationships (Carballo-Diéguez, 1996). In the United States some studies have found that (particularly Hispanic) men who said that they had unwanted sex during childhood have a higher frequency of high-risk sexual behaviour as adults, a larger number of sexual partners, greater involvement in sex work, and problems with alcohol and drug abuse (Dilorio, Hartwell and Hansen, 2002).

Furthermore, the establishment of relations of power and control with co-dependence indicators has also been identified as an individual vulnerability factor in some MSM sectors (Schifter, 1998; Toro-Alfonso, 2000).

Another important aspect in the personal processes of MSM is the impact of their own perception of their sexuality. Some authors say that homophobia can be an enormous obstacle in the development of safe sexual behaviour (Toro-Alfonso, 1997). Levels of internalised homophobia may be related to a person’s comfort with their sexuality and establishing proper relationships (Pharr, 1997; Schifter, 1998).

People with low self-esteem tend to try to seek acceptance in indirect ways. It is very common for many gay men to invest of lot of time trying to please others, listening, and acting as counsellors, therapists, mediators, and defenders of their family. It has been found that individuals who engage in safer sex have higher self-esteem, experience less anxiety or depression and fewer behavioural problems, and consume smaller quantities of alcohol than those with unsafe patterns of conduct (Rotheram-Borus, Rosario and Reid, 1992).

Other studies have identified factors such as low perceived individual risk, health-related beliefs, and negotiation skills as important elements in individual HIV vulnerability in MSM.
Mays and Cochrane (2001) identified a high level of psychiatric morbidity in a sample of homosexual men taken in a representative national survey of adults in the United States. Homosexual participants reported greater discrimination than their heterosexual counterparts; 42% percent of them related discrimination to sexual orientation. The researchers found that perceived discrimination was associated with a low quality of life and with high levels of psychiatric morbidity.

**Structural vulnerability**

Herek and his collaborators (1999; 1997) have conducted multiple studies relating the stigma associated with the disease and the vulnerability of this sexual minority to the epidemic. The issues of discrimination against and stigmatisation of MSM lead us, therefore, to other dimensions of vulnerability: not individual fragility but the social implications of sex between men and their impact on individual lives.

Right from the very start of the epidemic many organized groups of gay and MSM developed intervention models to deal with the impact of the epidemic on their community. Many of these interventions were aimed at reducing individual vulnerability. Despite the positive results of these interventions and early research efforts, it soon became clear that these vulnerabilities were contained in a structural dimension that had not been taken into account (Parker, 2000; Parker, Easton & Klein, 2000). Indeed, a relapse was detected in HIV incidence in those communities where individual interventions were implemented at the beginning of the epidemic.

"These recent developments have offered important new insights that have helped us to rethink the kina of oversimplistic oppositions that have traditionally characterized the cross-cultural analysis of homosexuality and gay life. In particular, they have moved us forward by breaking down earlier, monolithic, notions of «gay (and lesbian) community» in the Anglo-European world. By focusing on questions of internal difference, gender power, race and ethnicity, social class, and so on, such approaches have thus pushed in the direction of more dialectical understanding of the relationship between local contexts and cultures, on the one hand, and the broader social and historical processes, on the other." (Parker, 1999, p.9)
It was at that point that the examination of structural factors that cause, heighten, or influence the vulnerability of these communities became important. It was noted that one of the most significant factors is poverty (González-Block & Liguori, 1992). In many countries where the epidemic has had a disproportionately heavy impact on the MSM community a clear connection has been found between the spread of the epidemic and variables such as high levels of poverty, limited access to information and health services, and prevalence of the sex trade (UNAIDS, 2000).

We cannot overlook the social construction of sexuality that supports a heterosexual norm that excludes all other sexualities. Discrimination sustained by a univocal vision of masculinity and the way in which men should relate to each other forces men who have sex with men into individual and social exclusion. The very force of the hegemonic masculinity becomes the main cause of vulnerability in Latin American men who have sex with men.

**Hegemonic masculinities and power**

There is no doubt that gender transects a multiplicity of social relations, such as those of social class, race/ethnic background, and education. Gender as a way of organizing social practice is superimposed on the fate of biology for the precise reason that biology does not determine the social dimension (Connell, 1987). Social practice, on the other hand, is creative but not independent. It responds to specific situations and is generated within structures defined in the interior of social relationships.

These relationships are built on the central pillar of power relations that sustain female subordination and male dominance. This relationship structure paves the way for the imagery of a hegemonic masculinity, which no man really lives but from which we all obtain dividends. Hegemonic masculinity may be defined as follows:

> "At any given time, one form of masculinity rather than others is culturally exalted. Hegemonic masculinity can be defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees the dominant position of men and the subordination of women." (Connel, 1995 pag. 87)

The debate on hegemonic masculinity places us in the dilemma of determining if in social relationships there are different masculinities or if they are all manifestations of the same one. And if, even though we might examine the supposed differences of, for instance, the masculinity of the labourer compared to that of the foreman, or that of the white man in relation to that of the subjugated man, all we will find are the same manifestations of male hegemony that is forcibly imposed on women based on their gender and their social position, regardless of their social category.

Violence as a manifestation: The vulnerability of power

And how are these manifestations imposed? Clearly through intimidation and violence. «A completely legitimate hierarchy would have less need to intimidate.» (Connell, 1987, p. 45). Masculinity betrays its illegitimacy when imposed individually and socially as it has been for centuries.

The intimidation of women is achieved starting with the wolf whistle of supposed admiration in the street, progressing to harassment in the office, and culminating with rape and domestic battery. In each instance men achieve their aim of imposing their will slowly but surely, and, on occasions, with violence and brutality. After all, violence is the business of men... wars, murders, urban violence, youth gangs, among other examples. Everything would seem to indicate that living according to the codes of masculinity entails high-risk and violent self-destructive behaviour (Ramírez, 1999).

Others believe that, as there are few men who can claim to live a hegemonic masculinity, the result is high anxiety and a sense of impotence. They also say that the force of hegemonic masculinity as a male stereotype is the result of a biased view of men, since it does not permit displays of suffering on their part and they may succumb to the weight of imposed masculinity (Rivera-Medina, 1991). The fact is that the dominant position is created in power relations, and in that balance of resources and benefits those who suggest that they act from this position are more often than not given the benefit of the doubt. We are very often accomplices to this fact by showing that we have no intention of righting the balance of gender power relations.

The moment that hegemonic masculinity excluded any trace of homosexuality in its constitution, it made it socially acceptable to emotionally and physically abuse gay men and other MSM. As part of the power games, the hegemony is protected through aggression towards and even elimination of those who threaten it.
In the United States studies have produced highly important data for the healthy psychological and social development of young people with a different sexual orientation (D’Augelli and Garnets, 1995). They show the vulnerability of this population to aggression and mockery in society. According to D’Augelli and Garnets, gay and other men who have sex with men reported that 75% of them had been verbally harassed, 25% had been threatened with physical violence at least once, 22% had been persecuted, 5% had been spat at least once, and 17% had had their property damaged. Gay men are more frequently the target of verbal abuse than lesbians; more than half have made some adjustments to their daily lives to avoid harassment; 64% of young gay men and lesbians fear for their lives, and the majority of young men and women interviewed regard it as «normal» and «expected» to harass gays and lesbians; a fact that does not seem strange to them, nor are they interested in rejecting it.

The paradoxes of masculinity: Homoerotic desire

Hegemonic masculinity also occurs in sex between men. The subject of homosexuality and of homosexual behaviour in our culture brought up directly or as the subject of social debate is greeted with silence or rejection, particularly when the speaker is a man (Guajardo, 2000; Bohan, 1996). It is interesting that the need for HIV/AIDS prevention has broken that silence and has forced us to speak openly on the issue despite the stigma. See the discourse of Costa Rican men in the social imagery presented by Schifter (1999) and Schifter and Madrigal (1998); in the essays of Kormblit, Pecheny & Vujosevich (1998) in Buenos Aires, of Cáceres (1996) in Lima, Parker (1999) in Brazil, Guajardo (2000) in Chile, and Carballo-Diéguez (1994) on Puerto Rican men in New York.

Geographic contexts may vary but the social school attended by the men is essentially the same. The contradiction between identity and behaviour proposes a different analysis of the question of homosexualities. Castañeda (1999) tells us that «the homosexual is not always homosexual; the heterosexual is.» The heterosexual has been formed as such and is more consistently heterosexual. The author explains that homosexual persons become «conscious» of their sexual orientation as they go through life and probably define their sexual orientation based on their heterosexuality. However, the boundaries between homosexuality and heterosexuality have become less clear (Broido, 2000; Madrigal, 1998), resulting in hybrid identities, as Carrillo calls them (1999).
Much has been said about bisexuality as an innate characteristic suggesting that sexual orientation is not a biological given, but is shaped in the course of the individual’s personal and social history. Though this might seem an attractive idea, it has generated a series of debates on the origin of sexuality. In addition, there has been a proliferation of simplistic explanations for homosexuality. Efforts have multiplied to identify uniquely homosexual hormonal or genetic traits. Some researchers have found that if a man is homosexual and has an identical twin brother, there is likelihood that he too will be homosexual. Indeed, Ardila (1998) says, «Fifteen years ago we were stressing the importance of learning factors, while at the end of the century we are putting the emphasis on genetic and hormonal factors.» The fact is that hormonal and even cerebral differences are not universal. When some researchers suggest that the size of certain brain parts is different in homosexual men, and that their size is similar to that of women, the suspicion arises that such an interpretation, rather than having anything to do with the essence of brain structures, is related to the social construction of heterosexual masculinity, which seems to imply that everything about men is big and efficient (Hammer and Caplan, 1994).

We cannot deny that the essentialist thesis of the biological origin of homosexuality is located next to power in the discourses of minorities. And within those discourses they expect the fragile acceptance and social recognition for which homophile movements have struggled since the beginning of the last century. The argument here is that gays should be accepted not because they are free to choose their sexual identity but because they have no choice other than to be so.

Furthermore we consistently see that ethnographic studies conducted on populations of men who have sex with men in Latin America describe the rhetoric of interviewees in the context of the confluence of sexual orientation and gender. Cáceres (1999) tells us about the people of Lima, González and Liguori (1998) about Mexico, Schifter (1998) about Costa Rica, De Moya (1998) about the Dominican Republic, Parker (1997) about Brazil, and Ramírez (1996) about Puerto Rico. In all we see the discourses of men on homosexuality within the context of effeminateness and sexual passivity. Whether we call them cacheros, bugarrones, fletes, bugas..., the individuals described as such are men who have sex with men but who keep their allegiance to hegemonic masculinity by limiting themselves to active penetration and domination.

The literature on homosexuality in some developing countries describes in detail the gender-based polarization that we observe in sexual behaviour between men (Harding, 1998) even in the context of the sex industry (Perlongher, 1999). Murray (1995) provides a detailed description of sexual conduct between Latin American men as founded on traditional sexual roles where the «man» penetrates and the
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«woman» is penetrated. The same thesis has been advanced by Carrier (1971; 1985) and Díaz (1997) regarding the impact of homophobia on the development of identities. Latin American literature has also examined sexual roles, social class, and homosexuality, as seen in the works of Bejel (2001), Parker (1999), Navarro and Stimpson (1999), and Parker and Gagnon (1995). Thus, the essence of urban and Anglo-Saxon homosexuality is reproduced in the imagery of the globalized ghetto, while at the core of our society we observe and describe other sexual cultures that govern the lives of other men who have sex with men (Fernández-Alemay & Sciolla, 1999; Murray, 1998; Schifter, 1997; Schifter & Madrigal, 1996).

It looks as if the conflict between essence and constructed identity will keep us occupied for quite some time to come because the force of hegemonic masculinity socially encumbers us and prevents us from looking at sexuality from the subjective point of view of the interlocutor. And for that reason the secret is an open secret, like the rumours about Doña Herlinda's son in Jorge Humberto Hermosillo's classic film. The social participation model, the desire to belong and to be the same as the rest of society, has led the movement to put aside the struggle against compulsive heterosexuality and institutionalised homophobia in order to lobby for pro-equity laws to protect the rights of homosexual persons to equal economic participation through marriage or domestic relationships, legal adoption, and in some countries, access to military institutions.

Vulnerability of gender transgression

Within this constellation of sexual identities we come across people who resist the biological script that fate imposed upon them. For example, some men who are born with male biological structures construct themselves as women and elect to face society as gender transgressors. Transgender is the umbrella concept used to describe any person who defies traditional sexual roles. The concept also applies to the full range of gender expressions seen in various fashion expressions as well as in drag queens, androgyns, transvestites, transformists, intersexuals, and transsexuals (Bocking, Robinson & Rosser, 1998).

In part reaffirming the heterosexual norm and in part recreating identities, transsexual men play with the rules of gender in such a way that it becomes a strange source of vulnerability for them (Rodríguez Madera and Toro-Alfonso, 2002).

There is ample evidence of the particular vulnerability to HIV infection of the transgendered and transsexual male population. This vulnerability is more evident
in populations of men who have sex with men in Latin America or in immigrant populations in the United States (Bocking, et al, 1998; Parker, 1999; Schifter, 1999; Sykes, 1999; Toro-Alfonso, 1995). Ethnic background and gender combine in such a way as to place men who have sex with men at greater risk of HIV infection (Díaz, Ayala, Bein, Henne and Marín, 2001).

Vulnerability on the social margins

Relegation to the social margins generates vulnerability. The exclusion and marginalization by society of men who have sex with men paves the way towards disease and need. Recent research has shown that, more than individual fragility, what generates vulnerability is the perception of social isolation, lack of social support, and fragility or non-existence of political organization and social

Never before in an epidemic has the need been so urgent to rescue vulnerable populations from the social margins so that they can take control of their health and lives. Community-based organization and social empowerment are a crucial strategy for addressing the issue of public health in the face of the HIV/AIDS epidemic (Altman, 1994; Bianco, 1999; Kalichman, Somalí and Sikkema, 2001; Vangorder, 1995). The United Nations Joint Programme on HIV/AIDS has recognized that «HIV infection rates among MSM have diminished mainly as a result of the activities of gay organizations « (UNAIDS, 2000, p. 6), thus underscoring the advantages of being organized for tackling the epidemic (UNAIDS, 2001).

Therefore, the challenge of prevention lies in strengthening support networks and structures for men who have sex with men. Social exclusion and criminalization of homoerotic desire and behaviour only bring harmful consequences. On the other hand, inclusion of diversity and social recognition are both characteristics of the best public health interventions (Ugarte, 1999).

On the fringes of society sex becomes a commodity. The need to survive turns the intimate relationship into a commercial transaction. Such interactions may be money or particular favours (Aráuz, Ortells, Morales, Guevara & Shedlin, 1997). Furthermore, alcohol and drugs become party companions, partly to enliven sexual encounters and partly to deaden feelings of remorse and the pressures of the sex industry. It is possible that alcohol and drugs may be necessary to enter an altered state of consciousness and thus be able to handle the pressures of daily life and the sex trade (Schifter, 1997).

Police persecution as well as discrimination and harassment on the part of judicial institutions, combined with the dangers and risks of the commercial ghetto, are part of the fate of many men who have sex with men. Prison, the courtroom, and police repression are well known in these circles. In most Latin American countries there is no official criminal penalty for sexual intercourse between men; however, the reality is that the rules on sodomy are maintained in the social imagery. «The absence of a legal penalty neither removes, nor has anything to do with the social penalty, which makes people terrified and neurotic, deforming them» (Ugarte, 1999, p. 78).

From exclusion to full citizenship

It is impossible to develop health promotion and HIV risk reduction programs in a context of exclusion and violation of human rights. Clearly, in this framework sexual rights are human rights.
Exclusion, poverty, lack of access to health services, and lack of recognition of the diversity of identities (situations that can even occasionally lead to murder) violate the rights to full citizenship of gay men and other men who have sex with men (Díaz, Ayala & Marín, 2000). Violations of citizenship are constant and widespread in our countries and the harsh reality is that these situations barely affect the rest of the community. Even in countries where protection of sexual diversity is supposedly guaranteed by the Constitution, men who have sex with men recognize their own vulnerability and levels of risk for social aggression.

In many cases emigration represents a way out, not only from profound poverty, but also in the quest for the fantasy of a social environment of supposedly greater tolerance and permissiveness (Carballo-Díéguez, 1998). Unquestionably «the quasi-criminal and certainly marginal image of men who have sex with men should be corrected for the sake of the dignity of persons whom society recognizes as valid in their chosen professional, working, and creative fields» (Ugarte, 1999, p. 90). Full citizen participation and freedom of choice are essential elements of any successful HIV/AIDS prevention effort.

**Conclusion: from vulnerability to strength**

Only when consideration is given to the structural vulnerability endured by gay men and other men who have sex with men will we be able to move ahead with the implementation of appropriate interventions to halt the HIV epidemic once and for all. Public health interventions should be aimed not only at tackling individual vulnerability, but also at dealing with the challenge of strengthening the organizations that represent these communities, in order to guarantee access to health services and observance of their human rights.
Even on the sidelines and in their vulnerability the homosexual population has a history of collective struggle that dates back to the beginnings of the epidemic. Through personal and organizational experience, gay communities know what it means to fight AIDS. In many countries, such as Brazil, Argentina, and Mexico, nongovernmental organizations created by and for the gay and lesbian population have implemented prevention and care initiatives for people living with HIV for more than 20 years (Lumsden, 1991; Parker & Terto, 1998; Daniel & Parker, 1993; Ministry of Health of Brazil, 2000). In Latin America the first anti-AIDS mobilizations involved nongovernmental organizations set up by homosexual and bisexual groups. This experience should be recognized and provided ongoing support, as it could even serve as an example for, and help contribute to the efforts of, other socially marginalised and excluded segments.

Every person has the right to lead a full life, and diversity of sexual orientation and identity should not be an obstacle to happiness. It is imperative to curb police interventions and the permissiveness and complacency that enable the majority to harm and marginalize MSM. Governments and their institutions provide a poor service to the community when they fail to recognize their duty. It is important to acknowledge that «men who have sex with men face social, cultural, and occasionally, legal and economic discrimination because of their sexual behaviour. HIV/AIDS prevention, care, and support programs should be accompanied with activities to promote equality and non-discrimination» (UNAIDS, 1999, p. 9).
Strengthening public health means ensuring that vulnerable populations have access to decent jobs, preventive health services, and freedom to express their sexuality. The recommendations submitted to UNAIDS (1999) at the Regional Consultation on HIV/AIDS Prevention, Care, and Support Programs in Latin America and the Caribbean for Men who Have Sex with Men remain valid.

The reality of MSM in Latin America and the Caribbean is a slap in the face for us. The pillars of vulnerability to HIV infection are set in exclusion and stigma. It is essential for governments and civil society to concoct development and solidarity plans aimed at providing assistance to one of the most vulnerable sectors of our population.

It is crucial to develop the legal conditions necessary to strengthen the exercise of full citizenship for gay men and other MSM. Health professionals need to be educated in order to make them sensitive to the reality and particular needs of this sector. Community-based organizations should receive sufficient assistance to enable ongoing implementation of programs by and for the MSM community. Strengthening community organizations and social support networks is an important and unavoidable public health challenge.

«When HIV programmes aimed at MSM are operating, it is vital that they should be maintained. There have been cases, including in developed countries, where programmes had their funds reduced, or even stopped, after the project was declared to have been «successful», or when it was thought that the risk to men engaging in same-sex behaviour had declined. (UNAIDS, 2001, p.7)
Sexual oppression as a vulnerability factor for HIV infection was recently addressed in symposia and publications, as this cover page of the ABIA bulletin shows (January-March 2000). Archives of ABIA.
References


CHAPTER V

HIV/AIDS PREVENTION IN MEN WHO HAVE SEX WITH MEN

Hernán Manzelli and Mario Pecheny

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.
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 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, Ríos 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).
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 heteronomy in the way it is defined is seen as a form of domination. 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.

«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.»

3 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 epidemiological- 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 nongovernmental 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

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1 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 perform-
ance, 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

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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).
HIV/AIDS Prevention in Men Who Have Sex with Men

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).

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,

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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.» (Vujosevic 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.

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 disease.

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.

1 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 (STI), 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.
Lessons learned from activities and programs to prevent AIDS among Men with homosexual practices.

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.
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 calientes”, 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.
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
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 per-
sonal 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)

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 «legitimisation 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.


Lessons learned from activities and programs to prevent AIDS among Men with homosexual practices


Shifter y Madrigal (1997) *Ojos que no ven...psiquiatría y homofobia*. San José, Costa Rica: Editorial ILPES.


Terto, Parker, Quemmel, Guimaraes & Sant’Ana (19—). *AIDS Prevention for MSM in Rio de Janeiro and Sao Paulo*. Rio de Janeiro: ABIA.

Conclusion

This chapter describes some of the challenges raised by the AIDS epidemic for those involved in health promotion for men who engage in homosexual practices, as well as for social research into male homosexuality. The issues addressed cover both formulation of public health policies for this population (in particular regarding AIDS), and reflections about health, homosexuality and AIDS.

In the 20th century, the relations between homosexuality and health sparked debate and controversy, both in the area of medical science and within social movements. During this period, homosexuality itself was considered a «disease» and individuals who engaged in homosexual practices were treated as if they were suffering from a pathology or disorder that was considered biological or genetic or associated with the individual's inadequate psychological development.

The emergence of AIDS at the beginning of the 1980s made these relations even more complex and served to refuel prejudices against homosexuals. In fact, male
homosexuality itself became synonymous with AIDS. Initially this association reached a point where the recently discovered disease was dubbed GRID (Gay-related immune deficiency) in scientific circles and «gay cancer», «gay plague,» or «pink plague» by the press and public opinion (Daniel and Parker, 1991).

Twenty years later, AIDS continues to be a serious problem in the daily lives of gay men. The social representations that identified them either as villains or as victims of AIDS remain in place. As a result, these men continue as individuals to suffer the stigmas and prejudices implicit in the association of AIDS with homosexuality and they continue to be at risk from HIV infection if they fail to adopt safe-sex practices.

Collectively, the epidemic is still a problem that demands a response from different government sectors as well as significant mobilization to guarantee resources and ensure that they are used for prevention and assistance, so that discrimination and prejudice might be denounced and punished and human rights respected. The following example is indicative of the complex relationship between homosexuality and health care policies: In Brazil, homosexuals (if they identify themselves as such) are barred from giving blood at blood banks because, under Ministry of Health regulations, they are classified as a «risk group» for AIDS and other sexually transmitted infections (STIs). This practice is hotly opposed by the homosexual movement and NGOs that work with AIDS due to its discriminatory nature, since it may actually harm the population rather than help to control the epidemic and STIs.

The impact of AIDS on gay and other MSM assumed catastrophic dimensions in Western countries. Early in the 1980s, either as individual leaders or as gay organizations, they were the first to directly confront the challenges imposed by the epidemic, not only for the homosexual population but also for other specific groups as well as the general population. This mobilization produced responses such as the creation of diverse non-governmental organizations to fight AIDS, the production of the first manuals on safer sex, and the promotion of human rights and solidarity as basic principles of prevention work, among others (Terto Jr., 1997).

While some of these responses may have contributed to stabilize the number of new cases in some countries, such as Brazil for example, the association between AIDS and homosexuality continues to be the subject of debate and analysis, both among those researching sexuality and health and activists and experts involved in combating the epidemic. At the beginning of the third decade of life with AIDS,

\[\text{\footnotesize For an analysis of the lessons learned based on these efforts see chapter VI.}\]
new challenges have compounded earlier ones⁴. Among the most recent: when the issue of the health of gay men is brought up, immediately reference is made to AIDS, as if this were the only possible health problem affecting this population or as if HIV status were the only indicator of their state of health (Tuller, 2001).

This tendency demonstrates the dimension of the impact of AIDS on the lives of gay and other MSM and how the «AIDS-homosexuality» association refuses to go away and may in fact be creating a barrier against prevention and care initiatives for this population. At the same time, it could also be making it more difficult to understand how AIDS and other health problems affect different populations of men who have sex with men. The tendency to assume that the health problems of this population are confined to AIDS can make it difficult to evaluate the real health needs of this population and possible ways to adapt health services in order to ensure their capacity to meet such needs.

Below we discuss some of the challenges that need to be tackled over the coming years regarding the relationship between homosexuality, health, and AIDS. These challenges fall into three fields: epidemiology, prevention, and assistance. I hope, in outlining these challenges and questions, to contribute to debate and research both in academic circles (and above all in the field of Social Sciences), and in the areas of public services and gay activism.

**Epidemiology**

In the area of epidemiology⁵, few qualitative studies (most of which have not been widely disseminated) have addressed the issue of homosexuality in depth, or helped to understand how the epidemic affects different MSM populations and to identify other health problems that these populations face. Carrying out more studies could improve our understanding of the change in the relative incidence of AIDS cases in certain groups of the population: the increase in the proportion of heterosexual cases and a concomitant reduction in the proportion of homosexual cases.

In recent years, homosexuality as a social category has been the object of research and debate that has clarified different processes regarding how social and political

⁴ One example of how old prejudices that link AIDS to male homosexuality remain, can be seen in an article published by the Folha de Sao Paulo on March 3, 2000, which said that «in order to contract AIDS it is sufficient to have sex with homosexuals» (Source: Folha de Sao Paulo, 3/3/2000, cited by Mott and Cerqueira, 2001).

⁵ For a detailed analysis of the epidemiology of AIDS among MSM in the region, see chapter II.
identities are formed based on a sexual desire for people of the same gender. (Heilborn, 1996; Parker, 1992; McRae, 1990). In the area of epidemiology, the definition of homosexuality as an epidemiological category has been problematic and the focus is complex and difficult. For example, homo-bisexual transmission does not always occur among people whose social and sexual identities define them as homosexual; in fact they may describe themselves as heterosexual. In Brazil, 18% of AIDS cases in men are still reported as of «transmission by unknown cause», and problems understanding who they are and what happens to them could stem from limited epidemiological instruments and the complexities of trying to define the homosexual universe epidemiologically. It could be that this 18% includes men with heterosexual social identities who engage sporadically or constantly in homosexual practices. (Brazil, 2001). 

If there has been a decline in the number of cases of homo-bisexual transmission or if the incidence of new cases is tending to stabilize, it would be interesting to determine why and to see if these changes are occurring in different segments of the homosexual population, based on factors such as age, ethnicity, social class, and geographic area, among others. Some claim that the incidence of AIDS is concentrating among increasingly younger and poorer populations. (Pimenta et al., 2001). Young men who engage in homosexual practices have been identified as especially vulnerable to HIV and could contribute to a new rise in AIDS incidence in the male homosexual population. Before new stigmas are created or older ones reinforced, it is important to conduct studies to analyse these trends and their correlates, in order to guide preventive measures and help define the health needs of men who engage in homosexual practices. This includes not only those related to HIV/AIDS but also those linked to other health problems and exposure factors.

Prevention

It is estimated that less than 5% of total resources allocated to prevention in Latin America has been used for HIV/AIDS prevention in the homosexual population. While in Brazil and other countries this proportion may be higher, it certainly does not reflect the importance of homosexual transmission in the profile of the epidemic in the region. Meanwhile, some studies have been demonstrating that the MSM population is among those that most consistently practice safer sex and who are

4 For a more in-depth discussion, see chapters III and V.
best informed about STDs and AIDS, which certainly helps explain why, in general terms, there has been a decline in the number of cases among this population, although this is not necessarily uniform. (Brazil, 2001b). As I mentioned previously, incidence of HIV infection among segments of the younger population living in situations of poverty, sexual oppression, or family and police violence, is alarmingly high and deserves more attention from prevention initiatives. (Pimenta et al., 2001)7.

The difficulties faced by prevention efforts in these populations are related to the sense of shame and blame that still marks the way homosexuality is addressed in prevention and even care initiatives. (Warner, 1999). This shame and blame may justify the representations according to which all homosexually active men are potentially infected with HIV and responsible for spreading the virus to other segments of the population. It may also serve to sustain the images of homosexuality in the media and prevention campaigns, gay men’s fear of getting tested, and the emotional crisis they tend to experience if the end up with a positive result, since they consider themselves or are considered as to blame for becoming infected.

Blame and shame may also be implicit in prevention messages, when they recommend safer sex as if it were a commandment to be practiced without exception, without the right to make mistakes; and when that commandment is not kept it is regarded as the result of irresponsibility or negligence or simply viewed as the failure of the individual to negotiate or practice safer sex. Prevention initiatives should take into consideration the fact that negotiating safer sex is subject to a series of factors and circumstances that vary throughout the individual’s history. For now, it is important to understand these variations and circumstances rather than strengthen the codes and control messages that preventive messages may contain and which, at the same time, give rise to feelings of guilt and shame each time so-called «risk» sexual practices occur.

Another challenge to prevent HIV in MSM is the selection of appropriate methodological approaches. Up to the second half of the 1990s, behavioural models and theories were the most commonly used in prevention initiatives (Parker, 2000)8. In recent years, these models are being criticized and reformulated because they prioritise behaviour change as if HIV risk could be avoided through the use of recommended and adopted technical standards «that regulate the consistent practice of safer sex». These traditional behavioural models, which concentrate on one aspect of the individual –behaviour change– ultimately overlook other elements that tend to fall in the social and cultural sphere, which have also been revealed to be important in successful initiatives in the prevention field. In this sense, other models have been orienting intervention towards emphasis

7 Risk and vulnerability are a central theme of Chapter IV.
8 For a more in-depth discussion of this point, review Chapter V.
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on structural questions such as socio-economic situation and respect for civil rights, and towards factors such as sexual oppression, family and police violence, racism, and education levels, among others, which in an isolated or synergic fashion also determine vulnerability to HIV/AIDS and other health problems.

Behavioural models were important at a time of emergency, for providing people with more information about risk, individual prevention measures, and the urgent need to change certain behaviours. They demonstrated how, by avoiding certain practices and adopting others, it was possible to maintain an active sex life, even with HIV/AIDS present. However, perhaps due to those special conditions, excessive importance was placed on HIV/AIDS to the point where this became the only conceivable health indicator when dealing with MSM. In the same way, priority was attached to standards and technical aspects, which focus on the individual’s effective management of prevention techniques and end up presenting safer sex as the new standard in the framework of social control over sexuality, without taking into account other aspects of their lives, such as the quality of the sexual experience, pleasure and happiness.

The shortcomings of these behavioural models were also revealed when attempts were made to apply them to other social segments. For many, the adoption and maintenance of safer practices are intimately related to changes in vulnerability factors such as those already mentioned. In this case, we can mention oppressed ethnic groups or population living in poverty. As a result, the protection of human rights (as well as recommendations for behavioural change) are fundamental for HIV/AIDS prevention and health promotion.

In the next few decades, models must be created and used that have a more integrated and holistic perspective as regards health. It is not enough to consider HIV alone. To the contrary, it is essential to identify other needs, prevent other health problems, defend human rights, confront sexual and social oppression and, in particular, promote happiness as an attainable objective in the search for collective and individual health. (Ayres, 2002).

Care

In general, the category sexual orientation is not considered in clinical epidemiological research on risk factors for different problems that could affect men (or women). As a result, the medical profession does not always recognize the health problems and needs of the population with different sexual orientations (Tuller, 2001). This has been one of the greatest obstacles in the area of care for the
health needs of men who engage in homosexual practices. Problems of mental health, including substance abuse and violence, or other problems such as STDs, have been barely studied from the point of view of the relationship between their occurrence and sexual orientation, which reveals a gap in health research programmes. It would be interesting to study how sexual diversity (and the experience of sexual minorities) relates to vulnerability to diseases such as Hepatitis C or HPV (Human Papiloma Virus), which can cause cervical cancer in women and anal cancer in men, among other sexually-transmitted viral infections; or to prostate cancer.

Regarding mental health, the effects of stress on the physical and psychic health of gay men and lesbians due to having to live in a homophobic society have not been explored in depth. In this sense, studies should be carried out to determine how depression, self-destructive tendencies, and drug use, among others, are related to the difficulties of living with a different sexual orientation.

Homophobia, which is still found in health services, is another obstacle for access to these services and for the development of appropriate treatments. Unlike the United States or Western Europe, where there are health services headed by health professionals who are homosexual themselves, the reality in the Latin American region is very different, as is that of health programs that target the homosexual population, since, if they exist at all, they tend to focus on specific populations (for example young people, women, migrants).

Without disregarding prevention and treatment efforts, the aim of this article is to draw attention to strategies that can strengthen such efforts and help to reach an increasing number of MSM. Regarding care, the possible inclusion of sexual orientation in clinical studies on different diseases may increase possibilities for more integrated health care, including HIV/AIDS. Understanding the different health conditions and needs of the homosexual population, taking into account their diverse identities, expressions and policy projects, is a way to recognize them socially and to break the image of the disease that has so far prevailed in the majority of thinking on homosexuality and health. This will certainly permit a level of care that is less impersonal, stigmatising, and disrespectful of difference.

One of the lessons learned in health care for marginalized social groups refers to the importance of including the idea of «care» in the notion of «treatment,» which, according to Ayres (2002) would broaden the approach so that, in addition to the treatment of symptoms, care will also take into account the background and future plans of the individual. Such treatment would make it possible not only to suppress clinical symptoms but also to develop such life projects by encouraging people's inclusion in society and self-realization.
Conclusion

The challenges examined above underline the importance of an interdisciplinary approach in different fields of study, solidarity between researchers and activists, and the need for integrated prevention and care measures for the control of HIV/AIDS and other health problems experienced by gay men and other men who have sex with men. Epidemiological studies should be consistent with research on homosexuality, including an understanding of social vulnerability to HIV, so that the analysis of the impact of the epidemic will be more explicit and the definition of prevention policies, thus, better oriented. Clinical studies could also consider the question of sexual orientation for a better understanding of the epidemiology of other health problems that affect MSM as well as the contexts of vulnerability determined on the basis of those associations.

Prevention and care should be integrated in order to guarantee a more complete approach that has individual and collective happiness as a goal. In every population group, in particular socially excluded groups, prevention should be oriented not toward the imposition of disciplinary norms regarding what is correct and what is not, but toward the promotion of measures aimed at emancipation and happiness. In this sense, the promotion of human rights should be a fundamental part of this series of measures and interventions in the health care field.

Relations between homosexuality and health, both in medical-science circles and in public opinion, as demonstrated in the case of AIDS, has originated social representations of homosexuals that still have to be addressed, at both the individual and the collective level. Such prejudices and discriminatory practices have been an obstacle for the construction of more positive identities and life plans that might permit homosexual men and women to lead a less traumatic existence, and have created difficulties for the implementation of health policies that truly respond to individual needs. At the beginning of the third decade of life with the epidemic, the lessons learned and the challenges to be confronted, show that it is time for these relations to be radically altered so that they are no longer defined purely on the basis of prejudice or a notion of «disease», but are approached increasingly in terms of solidarity and the promotion of happiness.
Declaración de Derechos de Personas viviendo con VIH/SIDA.

Promotional material developed in the context of an advocacy campaign for the rights of persons living with HIV/AIDS in Chile. Archives of the C.Ch.P.S.
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References


APPENDICES
I. Executive Summary

This book is a multi-disciplinary compilation of experts' analyses of the AIDS epidemic in gay men and other men who have sex with men (MSM) in Latin America. A group of experts from different parts of the region examine the situation from various angles, so that socio-cultural perspectives are combined with public health approaches, and vice versa. The book is divided into seven chapters - apart from this executive summary - and an appendix that is exceptional for its comprehensiveness and variety: a catalogue that encompasses most of the research carried out in the continent on the subject. First, the introduction by Carlos Cáceres and Mario Pecheny places the book in the context of the epidemic in Latin America and the social response to it. Chapter II, also written by the Peruvian epidemiologist Carlos Cáceres, makes a comparative analysis based on figures and statistics of the current status of the disease in the region and, in doing so, advances a number of recommendations to improve the quality of available information. In Chapter III, the Chilean anthropologist Gabriel Guajardo describes the socio-cultural construction of male homoerotic relations and practices. In Chapter IV, José Toro from Puerto Rico looks at the social vulnerability of MSM and the risk it poses for becoming infected and ill with HIV. From Argentina, Mario Pecheny and Hernán Manzelli examine in the fifth chapter the theories and models used to develop prevention programs, particularly in MSM. Added to this research is that of US journalist Tim Frasca, who in chapter VI looks at the most important «lessons learned» from prevention and social change programs. Finally, and by way of conclusion, the Brazilian psychologist and activist Veriano Terto broadens his analysis and ends with an examination of comprehensive health of MSM and other problems that should not be lost from sight.

This book has come about in response to the striking discrepancy between the scale of the epidemic in gay men and other MSM in the region, and the social response to it (particularly on the part of governments). Ironically, this situation is partly the result of the worldwide movement launched at the end of the 1980's to «dehomosexualise» the epidemic, in order both to avert the stigmatisation of MSM and convince others of the risks to which any sexually active person is exposed, and to confront the very stigma affecting AIDS as a disease of «others». The fact
has been ignored, however, that some of the assumptions that guided this strategic measure took it for granted that a) sufficient effort had already been invested in prevention in MSM; and b) the epidemic among these groups was adequately controlled. However, there is no evidence to support either of these perspectives. Although there were many programs targeting MSM visible in the early days of the regional response to the epidemic, most of them were low-budget projects implemented by community-based organizations and designed without the proper technical support needed to ensure their impact. Government programs and initiatives played a minor role and, in any event, were late and insufficient.

In response to this situation, the main aim of this book is to provide persons who design, implement, or fund programs and projects in the area of public health and HIV/AIDS (as well as researchers and other interested individuals) with instruments to a) better understand the sexual cultures of different groups of MSM in the region (including men with gay or transvestite identities); b) better examine the dynamic scale of the HIV epidemic among them, so as to understand its roots in the social structure; and, c) implement better responses to the epidemic.

• Epidemiology

Carlos Cáceres' article sums up the situation and trends of the HIV/AIDS epidemic in the region, and shows the extent to which unprotected male-to-male sex is a major cause of HIV transmission in practically every country. The author also discusses certain categorisations and calculations that have hindered a proper analysis of the scale of the epidemic in MSM, and reviews an array of options for organizing (or improving, where the groundwork has already been done) a modern (i.e. second-generation) HIV epidemiological surveillance system in MSM populations, without neglecting ethical considerations, which, given the context, are essential to bear in mind.

Status of the Epidemic. As of December 2001 it was estimated that at least 1.82 million adults and children were living with HIV/AIDS in Latin America and the Caribbean, including 190,000 persons who had probably become infected during the previous 12 months. Sexual transmission accounts for 78% of all reported cases for which a probable cause of transmission was provided. Of that total, male-to-male sexual transmission of HIV accounts for 35.2% of total cases reported with a probable cause of transmission. Furthermore, HIV prevalence studies in MSM show levels of above 5% in all the main urban centres in the region. It is estimated that male-to-male sexual transmission is the cause of over
half the total adult male cases, which is exceedingly high considering that men who have sex with men comprise a small fraction of the general adult population.

However, this is not the case in every country in the region. The HIV/AIDS epidemic in Latin America is remarkable for its lack of uniformity, with differences between and within countries. We find three clear patterns in Latin America.

1. The Andean Region and Mexico are the areas with the highest proportion of cases attributed to male-to-male sexual transmission (approximately 50% of cases with an assigned transmission category);
2. In the Southern Cone and Brazil approximately 36% of reported cases are due to probable male-to-male sexual transmission, although here a new and critical factor is transmission among injectable drug users: between 25% (Brazil) and 33% (Southern Cone) of cases appear to be caused by transmission associated with injection drug use (IDU);
3. The third pattern is in Central America and the Caribbean, where between 5.5% and 6.5% of cases reported as caused by heterosexual transmission are presumed to be the result of male homosexual transmission (accounting for between 10% and 12% of total cases).

**Recommendations for epidemiological surveillance.** There is very little reliable information about HIV prevalence and incidence, STIs, and, in general, sexuality, risk, and vulnerability in this population. All of this points to the need to continuously generate more and better information based on rigorous and culturally appropriate research conducted in accordance with UNAIDS recommendations on second-generation surveillance. Such information would make it possible not only to monitor trends in the epidemic, but also obtain a better idea of the circumstances that favour its expansion and collect evidence of the impact of any interventions carried out. Epidemiological surveillance should be organized on the basis of proper formative studies. It is also essential to involve the community in the surveillance. Furthermore, recognizing the limited value of case reporting (which, at any rate, needs to be reviewed and improved), it is necessary to use sentinel studies and, where possible, seroprevalence studies that are more representative; it is also important to explore the option of measuring HIV incidence (especially if the possibility exists of utilising new techniques that provide cross-sectional estimates), and to incorporate components of STI monitoring and surveillance of behavioural trends. Any surveillance measures should, however, avoid causing harm at the individual or community level as a result of the stigma associated with homosexuality or HIV, and their legitimacy should be ensured by using the
information produced to take action in concert with MSM communities. Where possible, individual benefits should be offered to participants, including an acceptable standard of care for HIV infections detected by the system (in countries where no universal treatment exists), with special care taken with the most vulnerable MSM groups.

• Socio-cultural Context

In order to be able to analyse or simply discuss the AIDS epidemic it is essential to bear in mind the role and importance of different notions of community, and how they operate. The enormous plurality of situations and experiences encompassed by a category as abstract and as vast as «men who have sex with men» requires flexible responses in order to cope with that diversity. If there is one thing that truly distinguishes the behaviours, conduct, and perceptions of sex and affective ties among men it is precisely the multiplicity of their manifestations. If the aim is to implement an effective prevention policy it is impossible not to explore that geographic, cultural, and social diversity. Guajardo’s article provides «a global description of the socio-cultural construction of relations and practices among gay and other «men who have sex with other men» (MSM) in Latin America, particularly in urban contexts, since the outbreak of the HIV/AIDS epidemic». The author warns us at the same time that the diversity and disparity of the measures adopted by civil society, as well as the scant dissemination of specialized publications on the epidemic in MSM, «severely hampers the comparability of aspects of the private and public lives of individuals and groups identified in a broad array of male and female homosexualities.»

The magnitude of the geographic area necessarily entails a diversity of methodologies. Added to this is the hostile atmosphere in which gay and other MSM lead their lives. There is visible rejection of their overt presence on the part of general public, and in some countries, according to the claims of Amnesty International (1994), there have even been serious violations of the human rights of lesbians and gay men, in particular, extrajudicial executions and forced disappearance of individuals identified as homosexuals. Guajardo illustrates these observations with examples from Chile and Argentina, where very often «the main object of intolerance and discrimination» is homosexuality. However, homophobia should be examined from various perspectives, for instance social class or culture, due to the alternative ways that exist of understanding homosexuality. Different perceptions come into play: the meanings attached to homosexuality by low-income and middle-class sectors are clearly different. But however much interest there is, however many studies have been conducted,
and in spite of the trend in the region towards increased visibility of homoerotic identities, relations and practices and towards the universal legalization of homosexuality, laws do not necessarily ensure peaceful and respectful coexistence for and with homosexual individuals and groups. To the contrary, there are reports of illegal arrests and harassment, as well as of the persistence of stereotypes and social restrictions that prevent the possibility of instituting legal action to provide protection from acts of discrimination and defamation against gay men or lesbians.

**Risk and Vulnerability**

Generally speaking, structural vulnerability is the lack of protection afforded to a group of persons (sexual or ethnic minorities, migrants, women, etc.) from possible threats or harm to their basic needs and rights (in the areas of health, education, or employment, for example). This precarious situation translates into increased vulnerability for such excluded groups to epidemics like AIDS. These vulnerable groups, which, by and large, live in poverty, tend to be caught up in social dynamics of trade in which sex is a unit of exchange or in which they have less control over their sexual activity. In such a framework it is not hard to see how exclusion and poverty might increase vulnerability to HIV infection and encourage the spread of the disease. To better explain this point José Toro-Alfonso says that, «Only when consideration is given to the structural vulnerability endured by gay men and other men who have sex with men will we be able to move ahead with the implementation of appropriate interventions to control the HIV epidemic once and for all.» He adds that to achieve this requires strengthening the organizations that represent these communities, in order to guarantee access to health services and observance of their human rights. However, it is not just a matter of strengthening public health; above all, «It is essential for government and civil society to concoct development and solidarity plans aimed at providing assistance to one of the most vulnerable sectors of our society.» In summing up, Toro concludes with the recommendation that it is necessary to ensure «that vulnerable populations have access to decent jobs, preventive health services, and freedom to express their sexuality». Only then will MSM in Latin America and the Caribbean, whose reality is built on exclusion and stigma, be able to confront the challenges posed by the epidemic.
• Prevention Theories and Models

Knowledge has progressively increased over time with respect to the most effective prevention strategies, selection of target groups for prevention programs, and the most effective and powerful treatment methods. However, there are significant discrepancies between this knowledge and government action. Currently, in Latin America and the Caribbean the HIV epidemic is mainly concentrated in large cities and, there, in groups that engage in high-risk practices; lesser epidemics have also been detected in other sectors of the population (for example, women). Mario Pecheny and Hernán Manzelli formulate diverse strategies for responding to the HIV epidemic in the region: carry out interventions targeting groups whose practices represent the greatest exposure to risk, such as, for example, certain men to have sex with other men, in particular younger ones; implement prevention programs targeting persons living with HIV and AIDS, and increase the limited attention that has so far been given to this dimension; plan strategies specifically designed for male and female sex workers and their clients, as well as for injection drug users and their partners; and promote health in the media, with particular attention to young people with no or very few risk practices. This chapter describes and examines a number of approaches to HIV/AIDS prevention among MSM, and the authors specify that they do so «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 non-governmental organizations, health professionals, people living with HIV/AIDS, and gay and bisexual men». In short, «the risks specific to MSM populations require specific prevention policies». To that end the authors examine the main prevention approaches and the way they are applied to the HIV/AIDS epidemic, as well as mention some of their shortcomings and strengths as regards programs for men who have sex with men. The article describes three theoretical models that depart from different ontological premises and, consequently, focus on different areas of prevention. The authors’ recommendation is that an effective prevention strategy «must, of necessity, include a combination of the elements contained in these models» making it possible to achieve the necessary social change «to alter the structures that make some groups more vulnerable to HIV infection than others.» Clearly, the above should take place in a legal framework that recognizes «the sexual and affective rights of non-heterosexuals,» and respects «the principles of freedom and equity for all citizens without distinction on the basis of sexual orientation.»
• Lessons Learned

How does one successfully expand or launch a major community-based mobilization to reduce the epidemic in Latin America and the Caribbean? How does one stir and maintain the interest of the community in combating HIV/AIDS among the most-poverty stricken population sectors in the region? Are the capacities developed by the various persons responsible for national programs, NGOs leaders, and others lasting and sustainable over time? What are the concrete lessons to be learnt from the daily work of so many activists and volunteers in the region? Have there been negative factors that have obstructed the progress of educational activities? In sum, Tim Frasca asks: What has worked? What has not worked? What has proved harmful? Before posing these questions, Frasca first notes that the importance of homosexual transmission in national epidemics was minimized. He alleges many reasons for this, such as, for example, the fear of the authorities (sanitary and political) that they would lose the political support necessary for other aspects of their work, or, worse still, lack of concern for the health and welfare of those men who engage in ‘marginal’ sexual practices. These and other obstacles at the individual, group and societal level raise the need for complex and multi-faceted strategies. However, a discussion of lessons learned cannot be confined simply to a presentation of a list of methodologies; rather, it must also examine the processes experienced. Thus Frasca reviews the state of prevention practices among gay men and other men with homosexual behaviour, recognizing at the same time the debates and discrepancies that still exist in their regard. This enables him to ascertain that few of the organizations involved in prevention work with gay men and MSM in Latin America have solid institutional foundations in place before embarking on their activities, which has made the learning curve, set in a framework of discrimination and social exclusion, a steep one. In addition to taking on the considerable technical challenges of halting the epidemic, these organizations have had to find new, original and dynamic ways to ensure that the prevention message does not fade from sight. At the same time they have had to keep in mind the importance of harnessing individual expertise, in order to be able to «open the field to new actors» and thus keep sight of the most important aim, namely to ensure that the progress made endures.

• Conclusion

By way of conclusion, in an article on gay men and other MSM, Veriano Terto Júnior identifies a number of the challenges posed by the AIDS epidemic.
According to him, «the epidemic is still a problem that demands a response from different government sectors as well as significant mobilization to guarantee resources and ensure that they are used for prevention and care». Thus, we learn that despite all the work of experts, activists, governments, institutions, organizations and the private sector, things do not end there. As the author shows, there is interaction between transmission of sexually transmitted infections and HIV transmission. However, insufficient attention and inadequate resources have been devoted to the prevention of these diseases in Latin America and the Caribbean, and few qualitative studies (most of which have not been widely disseminated) «have addressed the issue of homosexuality in depth, or helped understand how the epidemic affects different MSM populations and identify other health problems that these populations face.» Accordingly, Terto recommends carrying out more epidemiological studies in order to improve «our understanding regarding the change in the relative frequency of AIDS cases: the relative increase in the number of heterosexual cases and a relative concomitant reduction of homosexual cases». He also examines prevention and care, which, in his view, should be combined in strategies that strengthen each other and ensure that campaigns reach increasingly large numbers of MSM. Finally, he underlines «the importance of an interdisciplinary approach in different fields of study», as well as the need to forge ties of solidarity among researchers and activists, whose ultimate aim should be increasingly to foment, on the basis of solidarity and the promotion of happiness, efforts to ensure the «search for collective and individual health» for gay men and other men who have sex with men.

• Appendix: A regional catalogue of studies on HIV/AIDS and MSM

While research has played a role in the facilitation of programs oriented to the prevention of HIV infection in MSM populations in the region, such role has not been as important as it could, or should, have been. This is due, in first place, to general problems of the insertion of research into the social practice in the region, and, in second place, to the problems connected to the study of homosexuality, either in conjunction with, or regardless of, HIV/AIDS. Both homosexuality and AIDS are stigmatised topics, and research focused on them may not necessarily enjoy academic legitimacy. In spite of this, the catalogue here presented shows that a diverse set of initiatives has been accomplished in the region in the past fifteen years (1987-2001). The amplitude of perspectives
and contributions characterising such initiatives, despite the numerous obstacles, illustrates the importance of individual and collective commitment in the response to the epidemic.

In a CD-ROM attached, this catalogue is presented in English and Spanish, in an electronic version with options for bibliographic search. A first period of studies (1987-1998) was inventoried in 1999 by a research team formed by Carlos Cáceres, Ana María Rosasco and Pablo Anamaría (Peru) and Veriano Terto (Brazil). The second period (1999-2001) was inventoried in early 2002 by Alejandro Brito (Mexico). The catalogue includes work from 13 countries: Argentina (12 studies), Brazil (27), Chile (9), Colombia (7), Costa Rica (8), the Dominican Republic (12), Ecuador (1), El Salvador (1), Guatemala (2), Mexico (37), Nicaragua (1), Peru (18) and Puerto Rico (6). This adds up to 21 studies from the Southern Cone, 27 from Brazil, 26 from the Andean Region, 12 from Central America, 18 from the Latin Caribbean and 37 from Mexico, making a total of 141 records. For each record, authors’ names and institutional affiliations are included, together with a thematic descriptor, the status of progress at the time of record preparation, publication availability and reference, a summary, and a critical comment. For two meetings in Lima (1999 and 2001) and the elaboration of the catalogue, the Research Network on Sexualities and HIV/AIDS in Latin America received two grants from UNAIDS.
II. Inventory of Research on HIV/AIDS in MSM Populations in Latin America and the Caribbean (1987-2001)

PRESENTATION

Mario Pecheny and Carlos Cáceres

As this volume has shown, unprotected sex between men has been, and continues to be, a major cause of HIV transmission throughout the region. Until the mid-1990s, the governments of the region had been reluctant to implement HIV prevention programs targeting MSM for a number of reasons (UNAIDS 1997): denial of the existence of sexual practices between men; stigmatization and even criminalization of such practices; limited epidemiological information about homosexual transmission of HIV; difficulty of access to most MSM; lack of health services infrastructure in particular in the area of STD; lack of awareness among professionals regarding the peculiarities of STD among men; absence of financial incentives to fund prevention programs targeting MSM and sex workers; and priority placed on the general population by the vast majority of National AIDS Control Programs.

In this context, even though research has had a part in facilitating prevention measures for this population, the contribution it made could, and perhaps should, have been greater. This is due, in first place, to generalized problems regarding the harnessing of research for social practices in the region (for example, lack of funding for research; absence of strategic planning for research activities that would ensure
their feasibility, its relevance to problems felt by others, and its usefulness; limited dissemination of finished research; and absence of the systematic practice of using research in the design of programs; and, in second place, to specific problems of carrying out research on homosexuality, whether it has to do with AIDS or not. Both homosexuality and AIDS are stigmatized issues, and they may not automatically be regarded as legitimate research subjects from an academic point of view. Furthermore funding for research on this population can be hard to come by, and the feasibility of the studies requires, given the social exclusion of the group, points of entry ensuring reasonably sustainable contact with that group. Finally, when research initiatives originate from community groups, technical barriers can limit the acceptability of their findings in scholarly or bureaucratic circles.

In spite of the above, the inventory below shows what a varied collection of initiatives pursued by several actors has managed to achieve in the region over the past 15 years (1987-2001). The breadth of their approaches and contributions, in spite of the constraints described, demonstrates the importance of individual and collective commitment to the struggle against the epidemic, and justifies our faith in future contributions of research (academic and/or community-based) to the fight against AIDS and for the health and sexual rights of sexual minorities in Latin America and the Caribbean.

A bout the Inventory

The inventory contained in the CD-ROM attached is based on an initial review of research conducted in Latin America between 1987 and 1998 on different aspects of HIV in MSM populations. The review was carried out in early 1999 by a research team composed of Carlos Fernando Cáceres, Ana María Rosasco, Pablo Anamaría (from Peru) and Veriano Terto Júnior (from Brazil). A supplementary inventory of research carried out between 1999 and 2001 was prepared by Alejandro Brito (from Mexico) in early 2002.

The information for preparing the first part of the inventory came from focal points in ten countries in the region: Argentina (Mario Pecheny), Brazil (Veriano Terto), Chile (Timothy Frasca), Colombia (Henry Ardila), Costa Rica (Rodrigo Vargas), the Dominican Republic (Antonio de Moya), Guatemala (Rubén Mayorga), Mexico (Manuel Zozaya), Peru (Carlos Cáceres, Ana María Rosasco and Pablo Anamaría), and Puerto Rico (José Toro). In February 1999 a meeting attended by the above people was held in Lima. Also at the meeting were Fernando Seffner (Brazil) and Jeff Stanton (ASICAL-Colombia). The information for the second
part of the inventory came from the same focal points for Argentina, Brazil, Chile, Peru, Guatemala, Mexico and Puerto Rico, and from the following member organizations of ASICAL: Colombian League against AIDS (Colombia); SIGLA (Argentina); OASIS (Guatemala); EQUIDAD (Ecuador), and Letra S (Mexico). Based on the information collected most of the authors included were contacted, and summaries of papers presented at international conferences on AIDS were consulted.

The inventory consists of 141 records containing the following data: information about the authors and their institutional affiliation, the status of the research at the time it was recorded (1999 or 2002), availability and publication reference, summary, and critical commentary. We received assistance from UNAIDS (Department of Policy, Strategy and Research) for the meeting in Lima and for preparing the inventory as part of a grant for the creation of an HIV/AIDS and MSM research network in Latin America and the Caribbean (1998-1999) awarded to Cayetano Heredia University in Lima.

Based on the information contained in the catalogue, we have prepared a systematic summary, enabling us to form a preliminary assessment of the status of the issue (Pecheny 2000).

The sample is composed of studies from 13 countries: Argentina (12 studies), Brazil (27), Chile (9), Colombia (7), Costa Rica (8), Dominican Republic (12), Ecuador (1), El Salvador (1), Guatemala (2), Mexico (37), Nicaragua (1), Peru (18) and Puerto Rico (6). In other words, 21 studies from the Southern Cone, 27 from Brazil, 26 from the Andean region, 12 from Central America, 18 from the Caribbean, and 37 from Mexico.

In order to present in simplified form the main features of the collection of studies, we came up with the following analytical categories: (1) objectives; (2) discipline; (3) methodology; and (4) institution (research headquarters).

**Objectives.** We established four main categories for the principal research objectives:

1. **HIV/AIDS AND SEXUAL PRACTICES**: KAP surveys on HIV/AIDS; sexual practices, including high-risk and preventive behavior; biomedical studies, and studies on HIV seroprevalence.
2. IDENTITY, CULTURE AND RIGHTS: Studies on the everyday life of gay people and other sexual minorities, including the issue of politics and human rights, gay culture, construction of gender images, identities, living with HIV/AIDS, etc.

3. PAID SEX: Studies on people who work as prostitutes or in other areas of the sex industry, including transvestites and sex workers.

4. INTERVENTION: Studies directly associated with intervention, prevention, psychological assistance, etc. (including education of couples, and evaluation of programs and of the impact of campaigns, etc.).

The graph below shows the distribution of research studies that comprise the sample, according to the principal objective of each. This categorization grossly oversimplifies the issues investigated, just as compartmentalization very often overlooks the fact that issues and approaches are intertwined. However, we think that this method of classification provides a general idea of the focuses of research on MSM and HIV/AIDS in the region. The Item «Other» covers, for instance, studies on religion and homosexuality, homophobia, and prejudices.

Partly because of the very definition of the study subject «homosexuality» (or «sexuality»), and partly because unprotected sexual activity is an avenue for HIV transmission, one of the main focuses of these studies is knowledge of sexual practices; in fact it is addressed in more than one third of them. This issue can be tackled in connection with HIV/AIDS, and in association with knowledge on modes of HIV transmission and of prevention methods, of attitudes and beliefs, and of behaviors connected with HIV/AIDS. This is the
predominant approach used in the KAP surveys; most of them are descriptive, and some of them explain the connection between good information and high-risk practices. It is also the predominant approach adopted in the seroprevalence studies. Furthermore, a little over a third of the studies, analyze sexuality in the broader framework of identity and culture, and examine the question of rights. Sex workers and different forms of paid sex are addressed as a separate issue in 10% of the studies. They are regarded as possible means of HIV transmission between socio-demographic sectors with different types and degrees of vulnerability. Another 10% deal with studies on interventions designed to change behaviors, and aimed at prevention of infection.

**Disciplines.** Graph Nº 2 shows in a simplified manner the different disciplines that address the issues of sex between men and HIV/AIDS, divided into four main disciplinary groups: sociology, anthropology, epidemiology, and psychology.

1. **SOCIOLOGY:** including sociology, political sciences, and history.
2. **ANTHROPOLOGY:** including anthropology, ethnography, and literary criticism.
3. **EPIDEMIOLOGY:** including epidemiology, sexology, clinical studies, and interventions.
4. **PSYCHOLOGY:** including psychology and social psychology.

From the disciplines and the methodologies used it is immediately apparent that these studies have in common a trans-disciplinary and multi-methodological approach. This applies both to the theoretical approaches adopted and to practical work and fieldwork. For example, the epidemiological studies would be «empty» if they lacked the dimensions provided by qualitative sociology and ethnographic
work; similarly, socio-demographic studies on sexual behaviors had to include the dimensions of subjectivity afforded by psychological or psychosocial perspectives. From a broader standpoint, furthermore, most of the studies, including those conducted by universities and scholars, are directly or indirectly related to prevention- and assistance-oriented interventions, in the areas of program design, implementation, and evaluation. In this system of classification, the studies mainly had a sociological, anthropological, or epidemiological approach (each comprising approximately 30% of the studies); a psychological focus was used in the remaining 10%.

Methodology. The approaches employed in the studies were quantitative, qualitative, or a combination of both:

1. QUANTITATIVE: Surveys addressing socio-demographic variables, seroprevalence studies, epidemiological models, development of scales, etc.
2. QUALITATIVE: Participant observation, life histories, in-depth interviews, key informant testimonies, focus groups, literary analysis, etc.
3. COMBINATION: Combination of quantitative and qualitative techniques.
4. [Not applicable]: Category used in the case of historical studies, political analyses or others that do not fall into the above three categories.

For researching «sensitive» issues like sexuality, qualitative techniques seem to be the most efficient for overcoming stigmatization and winning the trust of participants (Lee 1993). On the other hand, a combination of qualitative and quantitative techniques provides at the same time an indication of the cultural diversity of practices and identities that exist behind categories and definitions, and allows us to attempt
to determine the degree of social (and geographic) representation of aspects we are trying to explore. No wonder, then, that over half the studies use a qualitative approach, and one quarter use a combination of qualitative and quantitative approaches. The purely quantitative studies made up 20%.

**Research headquarters institution.** With respect to the institution that acted as headquarters for the research, we find that in the area of HIV/AIDS and MSM collaboration seems to be the rule: universities and other academic centers, nongovernmental organizations, and governmental agencies have created -after more than a decade of cooperation and conflict- intervention and research networks. Perhaps the only issue remaining is the formation of such networks at the regional level in Latin America, as has happened, for example, with studies on women and gender, sexual and reproductive rights, and reproductive health.

1. UNIVERSITY: Public or private universities, academic and research centers.
2. NGOs: NGOs, AIDS service organizations, groups of people living with HIV/AIDS, gay institutions, foundations.
3. GOVERNMENT: National AIDS control programs, health departments, ministries.
4. UNIVERSITY plus NGOs.
5. UNIVERSITY and/or NGO plus GOVERNMENT.
6. OTHERS: Hospitals or health centers; independent actors.

Collaboration between governmental, non governmental, academic, and community actors very often stemmed from the need to combine knowledge and resources (for instance the need of researchers and governmental programs to reach more-or-less hidden populations by means of the «snowball» technique led...
them to contact and seek the support of gay organizations and people living with HIV/AIDS; conversely, the need for financial and technical resources led the latter to team up with universities and government officials). As a result, and not without foot-dragging, distrust, or conflict, different models of research-action and/or intervention-evaluation were tried out by mixed institutional networks. Analysis of the makeup of institutional affiliations shows that: 1) the university is most frequently the headquarters for these studies; 2) NGOs host almost one-quarter of research initiatives and are, therefore, an important alternative; 3) the growing importance of collaboration between universities and NGOs is clear; 4) governmental programs have emerged as research headquarters, either on their own (6%), or in collaboration with universities or NGOs (11%).

Epistemological status of research into HIV and MSM in Latin America

The struggle against AIDS has been the source of the majority of research initiatives on homosexuality carried out between 1987 and 1999. The sample that we analyze here is not representative of all the studies on homoeroticism in the region, since the main purpose of the inventory was to bring together studies that examine the link between HIV/AIDS and MSM. However, it is interesting to note that 76 studies (out of a total of 102) directly connect sex between men and HIV/AIDS, while seven do so indirectly; only 19 are concerned with homosexuality-related issues independently of the epidemic. It is also interesting that at least 50% of these research projects received foreign funding, either from international agencies or from North American or European universities (this is a conservative figure since the other 50% do not expressly mention their sources of financing).

A recurring epistemological and political path, with respect both to AIDS and to homosexuality, is to link sexual practices to individual sexual identity and to their socio-cultural and political contexts; hence the analysis of homophobia, discrimination, and claims for rights.

The needs to tackle the AIDS epidemic brought to the fore many questions regarding the epistemological status of homosexuality in Latin America.

- In first place, the will to adopt preventive measures with regard to MSM and to interact with fledgling gay organizations demonstrated the dearth of information -or misinformation- about the sexual

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1 This analysis is based on the 102 study records produced for the first part of the catalogue (1987-1998).
practices, identities, gender constructs, history, and subcultures of the region’s sexual minorities.

- In second place, the epidemiological imperative for HIV/AIDS prevention and assistance prompted KAP-type research designed to learn about the sexual practices of MSM: their risks, their safest behavior, transmission of HIV and other STDs among men and also to women. The epidemic also prompted studies -and action- in the areas of mental health, self-esteem, self-confidence, and sexual health of MSM and other sexual minorities. The issue of identity, thus, becomes unavoidable, as a decisive element in the adoption of preventive behavior, care and self-care measures, or of high-risk conduct. Finally, the study of the everyday existence of MSM and/or persons living with HIV/AIDS exposed the stigmatization, discrimination, homophobia, and other social exclusion mechanisms that constitute both violations of the most basic human rights, and propitious environments for the spread of the epidemic.

- In third place, research by government, academic, and community organizations soon brought to light a huge diversity of sexual practices and identities. Studies showed the complex relationship between risk and affection (depending on the context of interaction, for instance, affection sometimes encourages risk - since the use of a condom can seem like a sign of distrust- or, on the contrary, encourages safe behavior -since caring for one’s partner can appear to be proof of love); between risk and pleasure; and between risk and identity. What we have learnt from these studies is that it is impossible to establish universal correlations between sexual practices, sexual and gender identities, and safe or high-risk behavior. Furthermore, throughout the region practices and identities have proved neither very closed nor fixed.

- In fourth place, although AIDS served as a catalyst and a legitimate argument to justify the funding and institutionalization of studies on gay men and other sexual minorities, the inclination of most researchers was towards enhanced specificity with respect to the sexual issue of desire and amorous practices among people of the same sex, to the construction of sexual identities (gays, lesbians, etc.), and to the patriarchal order (which includes dimensions of heterosexism and homophobia), independently of the question of HIV/AIDS. Accordingly, research on aspects of everyday life, rights, and creation of social movements moved deeper in this direction.

As the Final Report of the Lima Meeting summarizes, the status of research on HIV/AIDS and MSM populations in the region is characterized as follows (Cáceres 1999:12):

- Research on MSM populations has been very limited in the region. In the 1980s there seems to have been a kind of «pact of silence» in the sense that so little information has been generated about the demographic segment worst hit by HIV/AIDS. This phenomenon has come about for two opposed reasons: on one hand, the stigma of homosexuality, which influenced many decision makers; and, on the other hand, the efforts of many professionals and activists to destigmatize gay men through the «dehomosexualization» of the epidemic.

- For many years the issues most studied in research on HIV and MSM have been those that concerned national AIDS control programs from a mainly epidemiological perspective (i.e., number of sexual partners; frequencies of specific practices; etc.), consolidating the notion of a risk group, which was borrowed from the field of epidemiology and progressively used in non-specialized contexts with negative connotations (in other words, «risk group» equated to «risky group»). The main players in research studies were the national programs, together with international agencies, and medical schools. In some cases NGOs participated, however, generally speaking, gay organizations were not taken into consideration, except for the recruitment of participants. Not all groups within the population of men who engaged in homosexual practices were taken into account, since the researchers themselves were not always clear about matters concerning the diversity of this population.

- Probably, it was only after 1992 that changes began to appear in the sense that a larger number of community organizations, including those set up by MSM, began to launch research initiatives, as biomedical research diminished. There was a direction change in issues toward themes connected with meaning and subjectivity, identity and vulnerability; and, increasingly, qualitative methods were adopted. In addition, more sophisticated approaches were used to describe the different realities that surround the existence of MSM populations.

- The information produced by research has been underutilized, in part because of the «pact of silence», but also because of scarcity of funds,
the legitimacy that research lacked as a necessary resource for program planning, and a shortage of regular publications on public health accessible to social sciences researchers.

- Community actors have made limited use of the information produced due to the perception that urgent action was needed, putting off systematization of research and experience. Furthermore, these actors began increasingly to lose interest in research as the information they generated was disregarded by decision makers. The «dehomosexualization» of AIDS (which was justified in part by the need to highlight the vulnerability of women) also led to a fall-off of interest in targeting AIDS research at MSM, and to less funding becoming available for the study of HIV/AIDS-related issues in this population. Even in the new area of studies on men and masculinity, issues about homosexuality are frequently left aside.

- In consequence, the information generated by research has not been put to any significant use by programs or interventions.

According to the participants at the Lima Meeting, the Priorities for Research on HIV/AIDS and MSM populations in Latin America are as follows (Cáceres 1999:13):

1. Role of research in the development of programs on AIDS prevention and on sexual health/citizenship in MSM in the region.

The HIV/AIDS epidemic and the research produced as a result have led to:

- A better understanding of homosexualities
- Legitimization of research on sexual diversity, which implies its acquisition of an epistemological status
- A focus on the issues of human rights and citizenship, including access to health.

On this point, social actors interested in MSM populations ought to undertake research aimed to:

- Identify, describe, and analyze the determinants of vulnerability and social intervention objectives
- Monitor public policies and access initiatives
- Move beyond the risks of infection and examine the issues of health access, exposure to violence, and family situations.
· Influence neighboring academic fields, such as sexual and reproductive health, sexual rights, and studies on gender/masculinity, so that they too might address sexual diversity concerns.
· Interact with and provide technical assistance to national programs.

2. Issues and subpopulations that should be made a priority

· Operational research geared to implementation and evaluation of interventions.
· Behavioral and cultural diversity of MSM populations (including sexual interaction with men of low-income and excluded sectors).
· Young MSM and the construction of identity, desire, and gender.
· Identification of the determinants of exposure to the risk of HIV infection, quality of health care, and discrimination.
· Living with HIV/AIDS in the region.
· Issues relating to the private lives of MSM (including gay couples, family life, the workplace, the market, and consumption).
· Homophobia and prejudice in the general population and in service providers.
· Alcohol and drug use among MSM.
· Seroprevalence studies.
· Sexual and epidemiological patterns in urban centers, ports, and rural areas.
· Incidence of STD and other diseases.
· Human and sexual rights.

3. Modalities of research planning and implementation that should be made a priority.

· Analysis of the state of regional research on MSM and HIV/AIDS in order to determine needs.
· Trans-disciplinary and inter-sectoral workshops to identify priority research strategies.
· Multi-center studies.
· Participatory research to encourage development and organization of MSM communities.
· Unorthodox approaches that move beyond the exclusive preoccupation with biomedical and statistical issues and include qualitative investigation.
· Meta-analysis of quantitative data.
AIDS helped issues like homosexuality (or sexuality alone on its own) to become not only a permanent item on public agendas, but also an issue of necessary consideration. The increased visibility of homosexuality and of gay men that came about with the emergence of AIDS has had the effect of breaking down the traditional order that relegated sex and love between persons of the same sex to the private sphere, and of acting as a catalyst for gay organizing, demands for sexual rights, and public discussion of the issue (Roberts 1995).

Paradoxically, therefore, the AIDS experience created an environment that encouraged the reassessment of the subordinate status of homosexuality as a stigmatized practice relegated to the discreet confines of the private sphere, and accelerated the entrance on to the public stage of the issue of discrimination against, and rights of, sexual minorities. AIDS brought about the public discussion of diverse forms of sexuality, not only in terms of sexual relations, but also in terms of love, public displays of love, of social and sexual rights, and of citizenship.
References


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**Puerto Rico**

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III. Glossary

- **Advocacy:** Promotion and defence of a cause (or of a group) among decision makers (for example, authorities) or stakeholders.

- **Antiretroviral treatments:** In this book, this term is generally used to refer to current forms of AIDS treatment because they target HIV (a human retrovirus). These treatments mainly involve combinations of two and sometimes as many as four drugs, usually of different types or «families».

- **Cohort study:** In epidemiology, a type of study in which a group of individuals is observed over time.

- **‘Coming out’ (of the closet):** A metaphor traditionally used to refer to the disclosure of homosexual identities, desires, or experiences that many men and women secretly conceal.

- **Construct:** A category defined when a theory is operationalised, usually with the subsequent development of an instrument (for example, a scale) to measure it. For instance, the construct «self-esteem» is proposed and a scale is later developed to measure it.

- **Gender:** Unlike sex (which alludes above all to the biological differences between men and women) this refers to the characteristics historically assigned by a society to men and women, in terms of types of behaviour, dress, sexual relations, etc. For example, men are (or should be) tough, emotionally inexpressive, strong, prone to conquer; women are (or should be) delicate, emotional, mildly flirtatious.

- **Hegemonic discourse:** The dominant view on a given issue imposed by tradition or a power group. For example, the view that heterosexuality is the «normal» form of sexuality is still part of the hegemonic discourse although the latter is in the process of changing.
- **Homophobia**: Rejection of anything related to homosexuality.

- **Incidence**: The number of new cases of a disease (for example, HIV infection) that occur over a given period of time (for example, one year) in a group of persons susceptible to its acquisition. Thus, if three out of a group of 100 susceptible persons become infected, the incidence is 3% per year.

- **Individual vulnerability**: Lack of protection for an individual against a public risk, partly for reasons inherent to the individual (for example, psychological characteristics), and partly because he or she belongs to a group that is overall the victim of structural vulnerabilities.

- **Machismo/Marianism**: A version of sexism considered typical of Latin America and Southern Europe, which enforces more rigid and marked behaviour patterns for men, clearly distinct from those of women, which are also rigid and marked in an opposing sense.

- **Masculinity**: Socially determined mode of male behaviour that varies with time and according to different societies and cultures. It corresponds to the male gender role and stands in counterpoint to femininity.

- **MSM**: Acronym that stands for «men who have sex with men», which alludes to all men who engage in such sexual practice, regardless of their identity. It includes, therefore, men with gay, bisexual, heterosexual and other identities.

- **Outreach**: Refers to searching for and meeting persons within a population, who are usually hard to locate (for example, male and female sex workers, drug users) generally to offer them some form of preventive or therapeutic intervention.

- **Prevalence**: In epidemiology, the concept that alludes to the proportion of persons within a sample or monitored group with a given condition or disease. For example, if five out of 100 persons under observation in a study present signs of gonorrhoea, the gonorrhoea prevalence in that population is 5%.

- **Primary HIV prevention**: Prevention of HIV infection.
Risk behaviour: In discussions on HIV/AIDS this term is used to refer to behaviour likely to increase the risk of acquisition or transmission of HIV. It generally alludes to risky sexual behaviour (essentially unprotected anal or vaginal penetration with partners who are seropositive or whose serological status is unknown). It can also allude to risk behaviour in the use of recreational drugs (essentially the sharing of needles and syringes with other persons).

Secondary HIV prevention: Prevention of the development of clinical problems after HIV infection has occurred.

Second-generation surveillance: In AIDS epidemiology, a new concept in epidemiological surveillance which emerged in the mid-1990s, and proposed diversification of information sources (in addition to case reporting data), for instance, including sentinel surveillance, seroprevalence studies, behavioural surveillance, and STI monitoring.

Sentinel surveillance: In AIDS epidemiology, a routine survey that is repeated over time, generally on a reproducible convenience sample (for example, clients of an STI clinic) to provide a broad idea of the progress of the epidemic in a reference group.

Sexual identity: Notion of oneself with regard to the sexual. From the point of view of sexual orientation, it normally refers to whether a person considers himself or herself as «homosexual», «gay», or other similar identities, or considers himself or herself «heterosexual» or «bisexual». Sexual identity, however, depends on the categories or types of identity that people in a given time and place see as possible or available to them. In certain working classes, for example, it is not frequent among men to define themselves as «heterosexual», since the distinction only exists between «man» and «homosexual».

Sexual orientation: Sexual preference for the opposite gender, for the same gender, or for both genders.

STD: Sexually transmitted disease.

STI: Sexually transmitted infection. The difference with STD is that «disease» specifically refers to symptoms and signs, while «infection» does not. Given that only a fraction of STIs lead to symptoms and signs (that is, disease), only a fraction of STIs are recognised as STDs.
Stigmatisation: The signalling of a practice (for example, anal sex), an experience (for example, seropositive status), or a group (for example, homosexuals) as negative, uncomfortable, or undesirable.

Structural vulnerability: Lack of protection for a group (that shares a stigmatised characteristic, such as, for instance, being a member of an ethnic, religious, or sexual minority) against a public risk, when that lack of protection stems from social exclusion.

Transgender / transsexual: a person who, having been born with one biological sex, leads her or his life, from the point of view of gender, in a way traditionally regarded as corresponding to the other sex. Such is the case of men who choose to dress and live in a manner which tradition reserves for women, and vice versa. On occasions, the differentiated use of the two words, as well as that of transvestite, is use to convey the difference in condition before and after a sex change. However, this differentiated use of such terms is not consistent.
About the authors

Alejandro Brito holds a history degree from the National School of Anthropology and History, Mexico City. He has worked as a journalist for more than 12 years. Currently he is the editor of Letra S, Salud, Sexualidad, Sida, a monthly publication produced by the newspaper La Jornada, for which he was awarded the National Journalism and Information Award. He is also director of the organization Letra S, Sida, Cultura y Vida Cotidiana A.C., which, among other activities supports the Citizens’ Committee against Homophobia-Related Hate Crimes, which is composed of prominent personalities and each year releases an annual report on crimes of this type committed in Mexico. Letra ‘S’ is also a member of the Association for Comprehensive Health and Citizenship in Latin America (ASICAL).

A medical doctor and social researcher in health, Carlos Cáceres obtained his doctorate in public health at the University of California, Berkeley. He is currently Professor of Public Health at Cayetano Heredia University, Lima, where he conducts research on sexualities, health and sexual rights, and coordinates the Masters Program in Gender, Sexuality and Reproductive Health. He is also a researcher at the Center for AIDS Prevention Studies at the University of California, San Francisco, and a member of the HIV/AIDS Epidemiology Network for Latin America and the Caribbean. With the support of UNAIDS, in 1998 he promoted the creation of the Research Network on MSM and HIV/AIDS in Latin America.
and the Caribbean, and has also been involved in community initiatives against AIDS and for sexual rights. He has been a consultant on health research and policy in national and international contexts, and is the author of numerous publications.

Timothy Frasca is a US journalist who has lived in Chile for the past 20 years. He helped to found the Chilean Corporation for the Prevention of AIDS, the first gay group to become involved in HIV/AIDS at the end of the 1980s (he was the executive director of the organization for seven years). He is currently researching a book comparing the social response to HIV/AIDS in nine countries in Latin America and the Caribbean. In 2001 he founded CIPRESS, an institution aimed at tackling the HIV/AIDS epidemic in women and promoting ties between the gay movement and the sexual and reproductive rights movement.

Gabriel Guajardo graduated from the University of Chile in 1986 with a degree in social anthropology. He is currently a research associate at the Latin American Faculty of Social Sciences (FLACSO-Chile) and a faculty member at the School of Psychology, Diego Portales University, Santiago, Chile. From 1998 to April 2002 he headed the evaluation and studies unit of the Chilean Corporation for the Prevention of AIDS, a community-based NGO devoted to the prevention of the epidemic in the homo/bisexual populations of Valparaíso and Santiago. In connection with this, together with the Chilean psychologist Isaac Caro, he conducted a study of cultural homophobia at FLACSO and, later, articles on the relationship between the social sciences, public opinion and homosexuality.
Hernán Manzelli is a sociology graduate from the University of Buenos Aires. He has completed postgraduate studies in Mexico and Costa Rica and is currently taking a masters degree in social sciences (health). He has worked at the Centre for Population Studies and the University of Buenos Aires since 1996. His areas of interest include gender, reproductive health and social policies on health.

Mario Pecheny holds a Ph.D. degree in Political Sciences from the University of Paris III. He currently lectures on Social Science Philosophy and Methods at the University of Buenos Aires. He is also a researcher at the Gino Germani Institute of the University of Buenos Aires, supported by the National Council on Scientific and Technical Research (Argentina). He is also UNAIDS' special consultant to the Task Force on MSM and HIV/AIDS in Latin America and the Caribbean. He has published the following books: *Gays y lesbianas: formación de la identidad y derechos humanos* (with Ana Lía Kornblit and Jorge Vujosevich), *Discriminación: Una asignatura pendiente* (with Ana Lía Kornblit and Ana María Mendes Diz) and *La construction de l'avortement et du sida en tant que questions politiques: le cas de l'Argentine, as well as numerous articles and contributions to other works on health, sexuality and human rights.*

Veriano Terto obtained a psychology degree from the State University of Rio de Janeiro (UERJ). Later, he obtained a masters degree in psychology at the Catholic University of Rio de Janeiro (PUC-RJ), and received a doctoral degree in collective health from the Institute of Social Medicine (IMS/ UERJ). Until May 2002 he was the General Coordinator of the Brazilian Interdisciplinary Association on AIDS (ABIA), where he has worked since 1989. He first became active in the Brazilian homosexual movement at the beginning of the 1980s.
and since 1989 he has been involved in the AIDS movement. With Richard Parker he organized the publications «Entre Homens: homossexualidade no Brasil» and «Solidariedade: ABIA na Virada do Milenio», as well as a number of other ABIA publications. He has also written numerous articles on homosexuality, AIDS and living with HIV.

José Toro-Alfonso is a Professor of Psychology at the School of Social Sciences of the University of Puerto Rico where he teaches sexuality, program evaluation and research ethics. He is Associate Director of the HIV/AIDS Research Training Program and of the Centre for Psychological Services and Studies, Psychology Department, University of Puerto Rico. He is also a consultant and evaluator of community HIV/AIDS prevention programs. As a researcher his interests include gender, masculinity, sexuality, domestic violence in gay couples, HIV prevention, stigma, support networks for people living with HIV/AIDS, and adherence to treatment. He was the founder of the Gay Awareness Collective of Puerto Rico and Executive Director of the AIDS Foundation for 10 years before joining the School of Social Sciences on a full time basis.