

where the incidence of HIV-1 infection is monitored by means of follow-up of a cohort as well as by detuned assay (The Serologic Algorithm for Recent HIV Seroconversion¹⁷ is currently being used in order to better evaluate the dynamics of transmission in this population). Data obtained during the course of these studies will allow us to assess more reliably trends in HIV infection in this group and establish effective prevention programmes to curtail the HIV epidemic.

Acknowledgements

This study was partially supported by the US Naval Medical Research Center Detachment (NMRCD)-Lima, Peru (Work Unit 62787A S17 B0002), through a grant with the Pan American Health Organization (PAHO) and by PICT 98 05-04763, Argentina. The opinions and assertions contained herein are the private ones of the signing authors.

References

- ¹ AIDS epidemic update. UNAIDS. *Joint United Nations Programme on HIV/AIDS. July 2002*. Available at: http://www.unaids.org/epidemic_update/report_dec01. Last accessed 20 November 2002.
- ² Boletín sobre el SIDA en la Argentina. Ministerio de Salud. *Unidad Coordinadora Ejecutora VIH/SIDA y ETS*. August 2002.
- ³ UNAIDS. *Report on the Global HIV/AIDS Epidemic*. UNAIDS, 2002.
- ⁴ Leynaert B, Downs AM, de Vincenzi I. Heterosexual transmission of human immunodeficiency virus: variability of infectivity throughout the course of infection. European Study Group on Heterosexual Transmission of HIV. *Am J Epidemiol* 1998;**148**:88–96.
- ⁵ Padian NS, Shiboski SC, Glass SO, Vittinghoff E. Heterosexual transmission of human immunodeficiency virus (HIV) in northern California: results from a ten-year study. *Am J Epidemiol* 1997;**146**:350–57.
- ⁶ Misegades L, Page-Shafer K, Halperin D, McFarland W. Anal intercourse among young low-income women in California: an overlooked risk factor for HIV? *AIDS* 2001;**15**:534–35.
- ⁷ Koblin BA, Torian LV, Guilin V, Ren L, MacKellar DA, Valleroy LA. High prevalence of HIV infection among young men who have sex with men in New York City. *AIDS* 2000;**14**:1793–800.
- ⁸ Valleroy LA, MacKellar DA, Karon JM *et al*. HIV prevalence and associated risk in young men who have sex with men. *JAMA* 2000;**284**:198–204.
- ⁹ Mejia A, Ardila H, De la Hoz F, Calderon J, Velandia M. *HIV Prevalence Among Men Who Have Sex With Men (MSM), Bogota, Colombia*. The first IAS Conference on HIV Pathogenesis and Treatment. July 8–11 2001. Buenos Aires, Argentina. Poster LB-P32.
- ¹⁰ Cahn P, Perez H, Casiro A, Scaglione C, Muchnik G. Análisis de la demanda espontánea de un consultorio externo de SIDA en la Ciudad de Buenos Aires. *Medicina* 1998;**48**:125–31.
- ¹¹ Boxaca M, Belli L, Casco R *et al*. *Anti-HIV Antibodies in Outpatients From a Sexually Transmitted Disease Clinic in Buenos Aires City*. IV International Conference on AIDS, Stockholm, 6/13–14, Poster 5085, 1988.
- ¹² Muchnik G, Fay O, Cahn P *et al*. *HIV Seropositivity in High Risk Groups in Argentina: Future Impact on Heterosexual Transmission*. IV International Conference on AIDS, Stockholm, 6/13–14, Poster 5062, 1988.
- ¹³ Cahn P, Ben G, Bloch C, San Pedro M, Gonzales S, Perez H. *Who is Knocking on the Door for HIV Testing: Study of 9959 Cases*. XI International Conference on AIDS, Vancouver, 7/7–14, Poster Mo.C.1422, 1996.
- ¹⁴ Rein MF. The interaction between HIV and the classic sexually transmitted diseases. *Curr Infect Dis Rep* 2000;**2**:87–95.
- ¹⁵ Blocker ME, Levine WC, St Louis ME. HIV prevalence in patients with syphilis, United States. *Sex Transm Dis* 2000;**27**:53–59.
- ¹⁶ UNAIDS. *AIDS and Men Who Have Sex With Men*. UNAIDS, Technical update. Available at: <http://www.unaids.org>. Last accessed: May 2000.
- ¹⁷ Janssen RS, Satten GA, Stramer SL *et al*. New testing strategy to detect early HIV-1 infection for use in incidence estimates and for clinical and prevention purposes. *JAMA* 1998;**280**:42–48.

Commentary: The human immunodeficiency virus/AIDS epidemic among men who have sex with men in Latin America and the Caribbean: It is time to bridge the gap

Carlos F Cáceres¹ and Ron Stall²

The paper by Pando *et al.*,¹ published in this issue of the *International Journal of Epidemiology*, underscores the need to

focus on the human immunodeficiency virus (HIV) epidemic among men who have sex with men (MSM), which until now has not received attention proportional to its magnitude. The fact that this is the first study of its kind in Argentina also highlights the paucity of sound epidemiological information on which HIV prevention and control in Latin America could be based. Interpretation of this paper might be better achieved if it is put in the context of the larger HIV/AIDS epidemic among

¹ School of Public Health, Cayetano Heredia University, Lima, Av. Armendáriz 445, Miraflores, Lima, Peru. E-mail: ccaceres@upch.edu.pe

² Prevention Research Branch, Division of HIV/AIDS Prevention—IRS, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, Atlanta GA, USA. E-mail: rstall@cdc.gov

MSM in Latin America. This commentary outlines the extent of the HIV/AIDS epidemic among MSM in this region, describes some of the prevention response to it, and suggests a set of actions that could be taken to help prevent the further spread of HIV in the region.

The extent of the epidemic among men who have sex with men in Latin America

As of December 2001, as the HIV/AIDS epidemic in Latin America and the Caribbean entered its third decade, an estimated 1.82 million adults and children in this region were living with HIV/AIDS, including 190 000 people who had probably become infected during the previous 12 months.² By December 2001, in this same area, 378 413 cases of AIDS and 156 228 deaths from AIDS had been reported. 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.³

In 35% of reported AIDS cases for which information was given about the probable mode of transmission, such probable cause of infection is attributed to sexual transmission between men.³ Sadly, most of the news media attention to AIDS among MSM has not emphasized this factor, nor has it contributed to action *vis-à-vis* the severe epidemic in this population. Furthermore, as the study by Pando *et al.* shows for Buenos Aires, 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%).⁴

UNAIDS maintains that in most Latin American countries the epidemic is currently concentrated in MSM populations and, in some cases, in intravenous drug users.² Latin America has the highest number of HIV/AIDS cases in MSM outside the US.⁵ Clearly, any attempt to limit the spread of HIV in this region must focus to no small degree on sexual transmission between men.

The extent of the response to this epidemic in its first two decades

In most countries of the region, particularly in the capital cities, HIV prevention activities have been launched by gay organizations, non-gay community-based organizations (CBO), and, in a few cases, governmental programmes.^{6,7} Taking countries as units of comparison, the social response to the HIV epidemic among MSM has been more extensive in countries with larger MSM epidemics, that is, South American countries and Mexico have shown a stronger response, as compared with Central America and the Caribbean. Additionally, the general consciousness about AIDS as a national public health problem, and, especially, the level of civil society involvement in health-related issues, as well as the status of sexual rights, have played a role.⁸ Clearly, a success story in this regard is Brazil, with a strong, multi-sectoral response, resulting from the perception of AIDS as a major national problem, the political decisions of expending large budgets at the federal, state, and local levels in prevention and care, a rich tradition of civil activism, and the highest level of integration of gay communities into the larger society in the region.⁹

The quality, sustainability, and coverage of these diverse activities have been far from homogeneous across time or country. While anecdotal information exists on many prevention programmes, very few have been documented and published, and even fewer have been formally evaluated.⁶ The lack of a strong evaluation of community-based prevention work is a situation that exists in many regions of the world. Programmes have been designed at various levels, from the simple provision of information or the development of interpersonal skills, to the promotion of change in social norms to community organizing for an enhanced sexual citizenship.⁷ People have been reached through approaches ranging from individual counselling and testing, and small group interventions, to street- or club-outreach with distribution of educational materials, educational theatre, peer leadership, and community mobilization. The increasing replacement of traditional models based solely on information or skills building, by structural interventions that address vulnerability through community development and sexual rights promotion, is clearly promising.¹⁰

Aside from the few cases where governments have become involved in activities oriented to MSM (particularly Argentina, Brazil, Colombia, Chile, Mexico, Peru, and the Dominican Republic) most prevention programmes have been funded by international agencies, private donors, and charities. This has resulted in low sustainability of many such programmes. Most successful programmes have been launched by institutions combining reasonable levels of technical capacity with an important community basis. A key limitation in this response has been the unavailability of innovative, effective strategies to reach the various constituencies of non-gay identified MSM and act upon the structural factors that make them vulnerable to HIV.^{11,12}

A special mention should be made of regional initiatives around MSM and HIV. In 1998, a Special Consultation on HIV/AIDS Prevention, Care and Support Programmes for MSM in the region was convened by UNAIDS.¹³ Commitments made on that occasion resulted in two products: A manual for strategic planning on HIV/AIDS programmes for MSM in the region, published in Spanish,⁷ and a major strategic planning exercise on MSM-oriented AIDS programmes involving multi-sectoral commissions of countries in Central and South America.¹⁴ Similarly, UNAIDS funded a networking effort involving epidemiological and social researchers on HIV and sexual diversity which has recently updated a catalogue of regional studies on MSM and HIV, as well as produced a document oriented to decision-makers,¹⁵ in which the complexities of the MSM epidemics in the region have been addressed. Other agencies are considering supporting the development of stronger links between research and action with regard to HIV (and, more generally, sexual health and sexual rights) in this population. Finally, after a valuable UNAIDS initiative, a multi-sectoral Task Force on MSM and HIV in Latin America and the Caribbean was established in April 2002 to strengthen the regional response to the epidemic in this group. National and regional chapters of this Task Force are currently being formed.

What remains to be done

In spite of the actions just described, a clear disparity exists between, on one hand, the scale of this epidemic in the region

and, on the other hand, recognition of the need to effectively and consistently respond to it, particularly in governmental programmes. The inadequate response to the AIDS epidemic among MSM may be due to several factors, such as: (1) the assumption that MSM were already receiving assistance from community-level initiatives and that the epidemic was already controlled; (2) inadequate understanding of human sexuality (including male-to-male sexual cultures) in the design of prevention policies and programmes; (3) the view that governments should only be concerned with prevention in the general population; (4) resistance to acknowledging that MSM populations (and, by extension, other marginalized groups, such as male and female sex workers) have rights, including the right to health; and (5) the assumption that epidemics among MSM and heterosexuals are mutually independent.

It is, however, time for an honest recognition of the mistakes of the past and of the urgency to organize a strong and thoughtful response to this severe epidemic that is unequivocally respectful of the human rights of MSM populations. Failure to confront this epidemic in the region may permit synergies to develop between it and parallel HIV/AIDS epidemics (particularly among female partners of some MSM). An adequate response should:

- Take into account the very high HIV prevalence (from 5 to 20% in urban centres) and incidence (1.5–3.3. infections per 100 person-years of observation) observed at present in these populations;⁴
- Understand the ways in which stigma and social exclusion have driven vulnerability to HIV among MSM;
- Recall that MSM in the region are characterized by their cultural diversity, which is characterized by differences in social class, gender, ethnicity, and educational attainment, and has implications for preventive interventions. Groups of non-gay identified MSM interact with core gay male subcultures in various ways, including forms of compensated (transactional) sex;
- Understand that interventions should go beyond traditional models oriented to individual behavioural change through the provision of knowledge or the development of skills, and address cultural meanings and structural barriers in creative ways which respect individual autonomy and rights;
- Understand that the epidemic cannot be contained without special attention devoted to helping HIV-positive MSM maintain sexual safety for long periods of time. Such work should include designing HIV testing programmes so that MSM will feel motivated to find out their status, and specialized HIV prevention programmes to help HIV positive men cope with the additional stigma of HIV seropositivity in their social lives, protect their sexual partners, and access treatment for HIV infection.
- Consider the need to monitor trends in the epidemic, identify the circumstances that favour its expansion, and assess the impact of any interventions carried out at the individual, community, or structural levels. There is very little reliable information about HIV prevalence and incidence, sexually transmitted infections, and, in general, about sexuality, risk, and vulnerability in this population. All of this points to the need to continuously develop rigorous and culturally appropriate research, and to share new knowledge with community-based

organizations which can amplify an evidence-based response. The recent UNAIDS recommendations on *second-generation surveillance*,¹⁶ and other documents available⁵ suggest an array of research approaches for varying conditions;

- Recall that any surveillance measures should avoid causing harm at the individual or community level as a result of the stigma associated with homosexuality or HIV. The legitimacy of surveillance activities 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;
- Incorporate the recommendations of the United Nations Special Session on AIDS¹⁷ regarding the need to integrate prevention and adequate care, with particular reference to access to highly active antiretroviral treatment;
- Understand that effectively controlling the severe MSM epidemic in Latin America implies confronting the social exclusion of MSM communities, through an overt recognition of their human rights, including their sexual rights and their right to health. This implies not only talking clearly about sexuality and MSM, but also confronting stigma and discrimination.¹⁸

The very high proportion of MSM in Latin America who have become infected, developed AIDS and died over the past 20 years can only be described as catastrophic. Responses to this situation have not as yet been proportionate to the need imposed by the AIDS epidemic among MSM in Latin America. We hope that these few observations about the state of the epidemic in this region, in combination with studies like the one by Pando and colleagues in this issue, can help governments, communities, CBO, and individual citizens work in more effective ways toward controlling this epidemic among MSM in Latin America.

References

- 1 de los Angeles Pando M, Maulen S, Weissenbacher M *et al*. High human immunodeficiency virus type 1 seroprevalence in men who have sex with men in Buenos Aires, Argentina: risk factors for infection. *Int J Epidemiol* 2003;**32**:735–40.
- 2 UNAIDS. *AIDS Epidemic Update, December 2001*. Geneva: UNAIDS, 2001.
- 3 Pan American Health Organization. *AIDS Surveillance in the Americas. Biannual Report, December 2001*. Washington DC: PAHO, 2001.
- 4 Cáceres C. HIV/AIDS among men who have sex with men in Latin America and the Caribbean: A hidden epidemic? *AIDS* 2002;**16**(Suppl.3):S23–S33.
- 5 McFarland W, Cáceres C. HIV surveillance among men who have sex with men. *AIDS* 2001;**15**(Suppl.3):S23–S32.
- 6 Aggleton P, Khan S, Parker R. Interventions for men who have sex with men in developing countries. In: Gibney L, DiClemente R, Vermund S (eds). *Preventing HIV Infection in Developing Countries*. New York: Plenum, 1998.
- 7 UNAIDS/LCLCS. *Estrategias y Lineamientos para la Acción en VIH/SIDA con HSH*. Geneva and Bogotá: UNAIDS and Liga Colombiana de Lucha Contra el SIDA, 1999.
- 8 Parker R, Barbosa R, Aggleton P (eds). *Framing the Sexual Subject. The Politics of Gender, Sexuality and Power*. Berkeley, Los Angeles and London: University of California Press, 2002.

- ⁹ Editorial. HIV in Latin America and the Caribbean. *Lancet* 2000; **355**:2087.
- ¹⁰ Parker R. Empowerment, community mobilization, and social change in the face of HIV/AIDS. *AIDS* 1996; **10**(Suppl.3):S27–S31.
- ¹¹ Aggleton P (ed.). *Bisexualities and AIDS: International Perspectives*. London: Taylor and Francis, 1996.
- ¹² Parker R. Behaviour in Latin American men: implications for HIV/AIDS interventions. *Int J STD and AIDS* 1995; **7**(Suppl.2):62–65.
- ¹³ UNAIDS. *Consulta Regional sobre Programas de Prevención, Atención y Apoyo en VIH/SIDA con Hombres que tienen Sexo con Hombres en América Latina y el Caribe*. Geneva: UNAIDS Best Practices Collection, 1999.
- ¹⁴ Meléndez G, Stanton J, Díaz A *et al*. HIV/AIDS strategic planning with gay men. Abstracts Book, XIII International Conference on AIDS, Durban, July 9–14 2000. [MoPpD1120].
- ¹⁵ Cáceres C, Pecheny M, Terto V (eds). *SIDA y Sexo entre Hombres en América Latina: Vulnerabilidades, Fortalezas y Propuestas para la Acción*. Lima: Cayetano Heredia University/UNAIDS, 2002.
- ¹⁶ UNAIDS/FHI. Meeting the behavioural data collection needs of National HIV/AIDS and STD Programmes. A joint Impact/FHI/UNAIDS workshop. Report and Conclusions. Geneva: UNAIDS/FHI, 1998.
- ¹⁷ UNAIDS. Summary of the Declaration of Commitment on HIV/AIDS. United Nations General Assembly, Special Session on HIV/AIDS, 25–27 June 2001, New York. Geneva: UNAIDS, 2002b.
- ¹⁸ Terto V. Conclusiones: La salud de los hombres gay y otros hombres que tienen sexo con hombres: Desafíos para la tercera década de la epidemia de VIH/SIDA. In: Cáceres C, Pecheny M, Terto V (eds). *SIDA y Sexo entre Hombres en América Latina: Vulnerabilidades, Fortalezas y Propuestas para la Acción*. Lima: Cayetano Heredia University/UNAIDS, 2002.