HIV among gay and other men who have sex with men in Latin America and the Caribbean: a hidden epidemic?*

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Objectives: To assess the epidemiological and social/cultural context of, and the social response to, the HIV epidemic among gay and other men who have sex with men (MSM) in Latin America and the Caribbean.

Methods: A review of epidemiological surveillance reports to the Pan American Health Organization/UNAIDS; published studies on HIV prevalence/incidence among MSM in the region; social/cultural studies on homosexuality; documents analysing risk and vulnerability among MSM and publications documenting the social response to the MSM epidemic.

Results: The regional HIV epidemic is concentrated in MSM populations in most urban centres (HIV prevalence 5–20%). Incidence rates (1.5–3.3 in Brazil and Peru) are still moderately high, and call for continued programmatic action. Transmission from bisexual men to women is increasingly observed, demonstrating that the neglect of intervention will fuel co-existent epidemics. MSM in the region are culturally diverse, with mediation of social class, sex, and ethnicity. Around core gay subcultures, non-gay identified MSM interact with them and frequently exchange sex for goods. Examples are shown of sexual meanings affecting prevention messages focused on individual risk, as well as of the role of structural vulnerability on potential exposure to infection, calling for programmes beyond individual rational decision-making. The social response to the AIDS epidemic has, in most countries, included programmes oriented to MSM, usually from civil society organizations, and has strengthened gay organizing.

Conclusion: Renewed, imaginative efforts are needed from governments and community organizations to strengthen culturally sensitive prevention work, and integrate it into community empowerment and the promotion of sexual rights.

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Introduction

As of December 2001, in Latin America and the Caribbean (LAC), it was estimated that 1.82 million adults and children were living with HIV, including 190 000 individuals who probably became infected over the past 12 months [1].

Sexual transmission of HIV accounts for approximately 59% of all reported AIDS cases in LAC (i.e. 76% of

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cases of known risk category [2]). Within sexual transmission in general, male homosexual transmission seems to be as important as heterosexual transmission. Early in the epidemic, Latin America was considered to follow a mix of the old epidemiological patterns I and II, which described the importance of cases among men who have sex with men (MSM) and injection drug users (IDU) as well as a heterosexual component [3]. Currently, UNAIDS considers that most countries in Latin America show epidemics concentrated in MSM and, in some cases, also in IDU [1].

Far from being a simple definition, homosexuality refers to a series of constructs and ideas such as the orientation of sexual desire, sexual behaviour, sexual identity, and sexual socialization [4–6], none of which is binary. For example, although sex between men is rather frequent in the region, male homosexual behaviour does not usually imply homosexual or bisexual identities [7–10]. Without losing track of diversity and of such complex interrelationships between identity, desire, behaviour and sex 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 violations [11], a behavioural category such as 'MSM' is arbitrarily used in HIV epidemiology to the extent that it includes, in theory, all situations of male-to-male sexual interaction (in the presumption that they share similar levels of risk). Conversely, it is crucial to recognize that preventative interventions and community organizing must take culture, identity and politics into consideration [12].

In this review, some of the epidemiological, social and cultural aspects of the HIV epidemic among MSM in Latin America and the Caribbean, as well as the community response to it, will be analysed.

Methods

This review utilized the following sources of information: AIDS case reporting to the Pan American Health Organization (PAHO)/WHO, as published periodically by PAHO/UNAIDS [2]; epidemiological studies on MSM populations from two sources: (i) as referenced in the HIV/AIDS surveillance database of the US Bureau of the Census [13], and (ii) studies implemented in six southern American countries with participation of the Naval Medical Research Centre Detachment, Lima, Peru [14]; studies on the social and cultural aspects of homosexuality; contributions on behavioural risk, sexual meanings, and structural vulnerability; and information on social responses to the HIV epidemic among MSM in the region.

The limitations of the information available to perform this task are numerous: epidemiological surveillance in the region is of uneven quality, and in many countries a substantial proportion of AIDS cases may not be diagnosed, or their notification may be delayed or may not happen at all. Conventional transmission categories are problematical, particularly those linked to stigmatized behaviours: the label of 'homosexual transmission' is not assigned in a consistent fashion, even within single locations. In many situations both the client and the health provider will prefer to avoid the discussion of homosexuality, and report a case as 'heterosexually transmitted'. For many, the lack of consistence between a supposedly predominant heterosexual pattern of infection in central America and a male : female ratio still close to 2 in that region [2] still reveals a high proportion of homosexually transmitted HIV that is disguised as being of heterosexual origin. In other cases, conversely, the provider may even assume that this condition is present in a client, and will not ascertain it at all. Additional problems emerge in situations in which multiple risk factors seem to be present, because many surveillance systems do not allow for the registration of multiple risk conditions, and utilize hierarchical classifications that imply arbitrary decisions on the most likely way of infection per case, thus leading to some misclassification.

Similarly, sound seroprevalence studies in representative samples of individuals, not to mention seroincidence studies, have been very limited, probably as a result of restrictions in funding and institutional (i.e. academic and governmental) support for epidemiological studies in this population, and also because of the significant complexity of adequate research approaches to this 'hidden' population [15].

Finally, useful studies of social/cultural issues relating to the HIV epidemic among diverse groups of MSM are not numerous, in connection with funding limitations and methodological challenges intrinsic in the study of marginalized populations, the lack of adequate theoretical frameworks, and ethical/practical problems derived from stigma, such as the risks for confidentiality and police harassment in the research setting. Even reports or evaluations of programmes and interventions are almost non-existent, because such activities have usually been launched with limited funding by organizations based on voluntary work [16].

Epidemiological surveillance and prevalence/incidence estimates

HIV/AIDS case reporting to PAHO/WHO/UNAIDS

Statistics for Latin America are generally provided in six or even seven geographical strata or areas, as follows

(see Fig. 1): the Andean area (including Bolivia, Colombia, Ecuador, Peru and Venezuela); Brazil; the English and Dutch-speaking Caribbean (which includes 19 small islands); Central America (that is, Guatemala, Nicaragua, Honduras, El Salvador, Costa Rica and Panama); the Latin Caribbean (including Cuba, the Dominican Republic and Haiti); Mexico; and the Southern Cone (including Argentina, Chile, Paraguay and Uruguay).

On the basis of the May 2000 PAHO/UNAIDS regional surveillance report [2], Table 1 shows the proportion of total AIDS cases cumulatively reported in each geographical stratum that were classified as MSM. The middle column includes cases classified as of unknown transmission route, whereas the right column excludes them. As can be observed, the Andean area and Mexico remain the areas with the highest proportion of cases attributed to male-to-male sexual transmission, with approximately 50% of cases with an assigned transmission category. In those countries, the second most frequent transmission route is heterosexual transmission, and injection drug use is reported as almost non-existent.

Table 1. Proportion of AIDS cases who are reported to be men who have sex with men in Latin America (among total number of cases reported to date).

Area	% Total cases who are MSM	% Cases with known transmission category who are MSM
Andean area	42	54
Mexico	35	45
Brazil	29	37
Southern Cone	32	42
Caribbean	9	12
Central America	12	15
Latin Caribbean	8	10
Total	28	36

MSM, Men who have sex with men.
Source: STD-AIDS/PAHO [2].

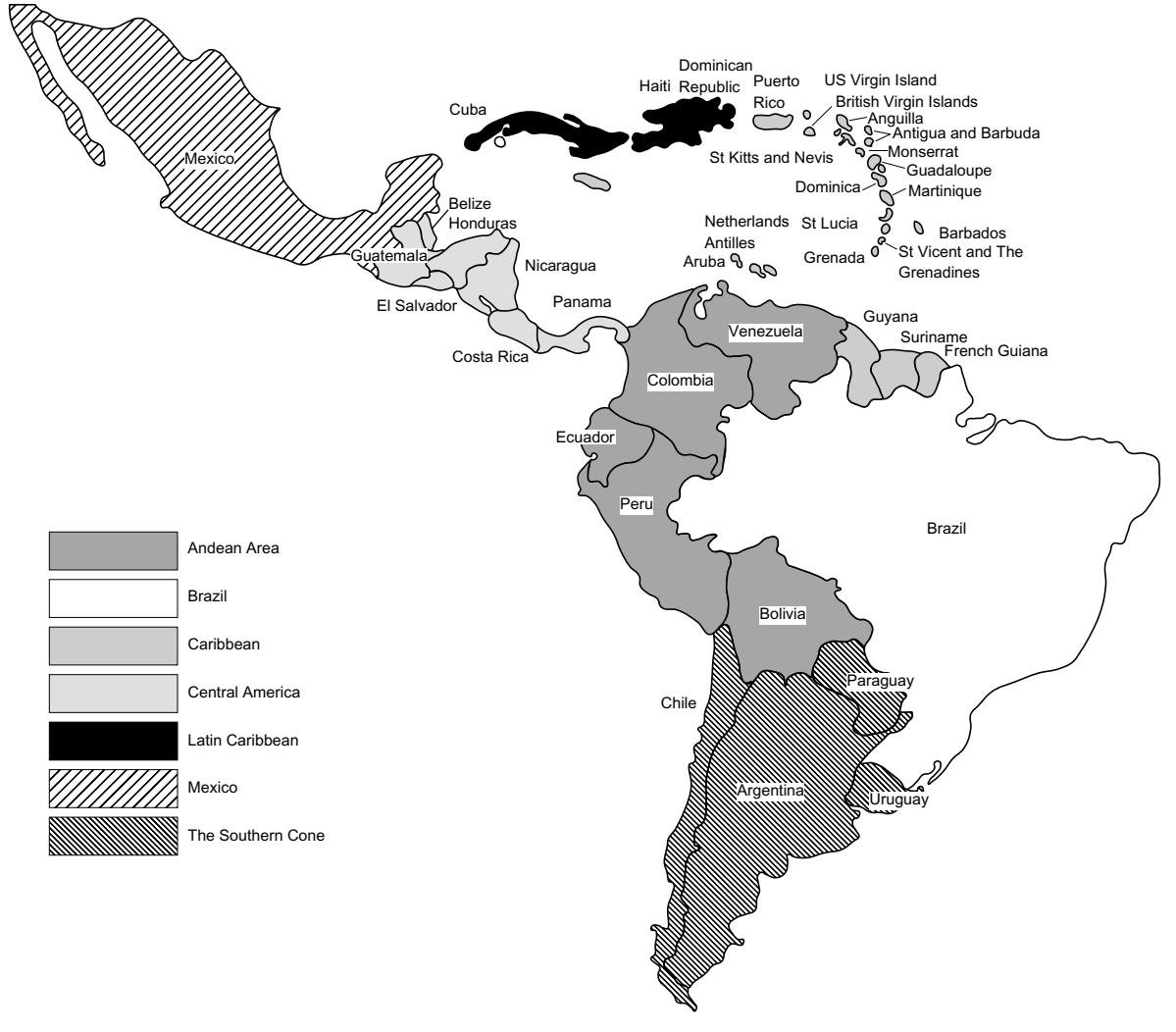

Fig. 1. Latin America and the Caribbean, divided into seven sub-areas on the basis of geographical proximity.

In Brazil and the Southern Cone, approximately 40% of AIDS cases are accounted for by male homosexual transmission, whereas approximately a third of cases are supposed to occur among IDU who share their equipment.

Finally, Central America and the Caribbean list only 10–15% of their cases in this category. In Central America, the balance with regard to sexual transmission is reversed, and heterosexual cases, which are supposed to account for 73% of cases, are reported to be six times as frequent as homosexual cases. Similarly, in the LAC region heterosexual cases are reported to be six times as frequent as homosexual cases.

From this diversity of situations in the region, Figure 2 shows that, for the region as a whole, sexual transmission accounts for 59% of AIDS cases, and that the numbers of heterosexual and homosexual cases are similar. Injection drug use represents 13% of regional cases, and perinatal and other blood-borne cases account for 5%, whereas 23% are still listed as of unknown origin.

Historically, throughout the 1990s, the proportion of AIDS cases classified as MSM decreased as a result of an increase in the number of female cases, but the total numbers of MSM cases have remained steady. When focusing on changes in transmission routes, however, the most important increase has occurred among IDU, although it is limited to Brazil and especially the Southern Cone. In all other areas it is clear that more diverse populations of MSM, many of whom also have sex with women, are becoming infected, so that the epidemic is increasingly reaching their (usually steady) female partners.

HIV seroprevalence data on men who have sex with men

Available data on HIV seroprevalence among MSM in the region are shown in Table 2 [17–47]. It is difficult to establish the comparability of data, because information from many studies is limited and assessing the quality of data, particularly from the viewpoint of sample selection, is cumbersome. However, available data suggest prevalences ranging between 5 and 20% for MSM in most capital cities in the region, which signify an epidemic concentrated on MSM.

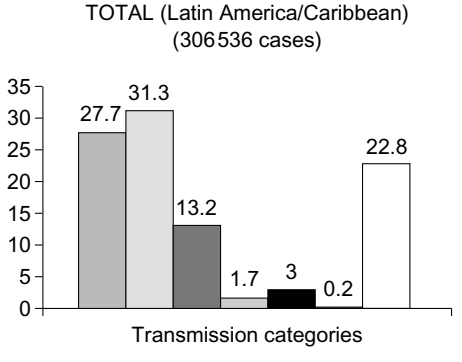

Fig. 2. AIDS cases distributed by route of HIV transmission in Latin America and the Caribbean. ■ Homo/bisexual; □ heterosexual; ■ injection drug user; ■ other blood; ■ perinatal; ■ other risk factor; □ unknown. Source: STD-AIDS/PAHO [2].

In the Andean area, studies on various populations, including MSM, have recently been implemented in Bolivia, Colombia, Ecuador and Peru by the US Navy Medical Research Institute Detachment in Lima, in collaboration with local institutions [17]. Studies on MSM mostly show prevalences ranging from 5% (from the provinces in Peru) up 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, the initial waves of three cohort studies in Rio de Janeiro, São Paulo and Belo Horizonte obtained rates of 9–11% between 1994 and 1996 [18–20]. In the Caribbean, the best data come from the Dominican Republic, and reached 8–12% for 1994 [21]. In Central America, limited data are available for the most recent period. The prevalence seemed to be approximately 5% in Costa Rica in 1994 [22], and was reported to be 14% in a sample in Tegucigalpa, Honduras [23].

In Mexico, the most significant data come from epidemiological surveillance at the national level. Prevalences are reported to be 16% for homosexual/bisexual men and 14% for male commercial sex workers for the period 1991–1996 [24]. Finally, in the Southern Cone, studies facilitated by the US Navy have also been conducted in Argentina (HIV prevalence was 13% in 724 MSM from Buenos Aires) and Uruguay (in 241 male commercial sex workers in Montevideo, yielding a prevalence of 18% in 1999) [17]. No relevant data were available for Chile or Paraguay.

HIV seroincidence data

Data on seroincidence are only available from Brazil and Peru (see Table 3) [18–20,48]. In Brazil, three cohort studies were implemented in the cities of Rio de Janeiro (Praça Once Cohort [18]), São Paulo (Bela Vista Cohort [19]) and Belo Horizonte (Horizonte Cohort [20]) between 1994 and 1999. The incidence densities calculated in each of these cities were 3.1 per 100 person-years for the study in Rio (in a cohort of 753 men), 1.51 in São Paulo (in a cohort of 1028 men), and 1.99 in Belo Horizonte (in a cohort of 470 men). In Peru, 1140 men followed-up in the Alaska Cohort between 1998 and 2000 yielded a seroincidence density of 3.3 per 100 person-years of observation (based on 5166 person-months) [48]. Incidence esti-

Table 2. HIV seroprevalence among men who have sex with men in Latin America and the Caribbean.

Sub-area/country	City/location	Description of the population	HIV prevalence	Sample size	Year(s)	Reference	Comments
Andean area							
Bolivia	La Paz	MSM	14.6	48	1999–00	[17] (2000)	
Colombia	Bogotá	MSM	20.4	643	1999–00	[17] (2000)	
Colombia	Bogotá	Bisexuals	15.8	NS[b]	1994	[25] (1996)	
Ecuador	Quito	MSM	10.7	244	1999–00	[17] (2000)	
Ecuador	Guayaquil	MSM	28.4	102	1999–00	[17] (2000)	
Perú	Lima	Homo/bisexual	11.2	98	1985	[26] (1986)	Mean age 29 years
Perú	Lima	Homo/bisexual	6.5	124	1988	[27] (1991)	January–April 1988
Perú	Lima	MSM	13.3	2158	2000	[17] (2000)	
Perú	Lima	MSM	14.2	4883	1999	[17] (2000)	
Perú	Provinces	MSM	5.5	3101	2000	[17] (2000)	
Perú	Provinces	MSM	4.9	1413	1999	[17] (2000)	
Venezuela	Isla Margarita	Gay men	25.0	NS[b]	1994	[28] (1996)	
Venezuela	Not specified	Homosexuals	30.8	315	1992(2)	[29] (1992)	
Brazil							
Brazil	B. Horizonte	Homo/bisexual	6.6	167	1994	[30] (1994)	18–59 years October 1994
Brazil	B. Horizonte	Homo/bisexual	9.0	570	1994	[20] (2000)	Baseline prev. in cohort study
Brazil	R. de Janeiro	Homo/bisexual	9.2	98	1996(?)	[31] (1996)	18–50 years
Brazil	R. de Janeiro	Homosexuals	8.9	313	1996	[32] (1996)	18–50 years to June
Brazil	R. de Janeiro	Homo IDU[c]	32.2	59	1996	[33] (1996)	
Brazil	R. de Janeiro	Homo/bisexual	11.0	753	1995–97	[18] (1999)	Baseline prev. in cohort study
Brazil	Salvador	Homo/bisexual	10.0	550	1989–90	[34] (1993)	Jan 1987 to Nov 1990
Brazil	São Paulo	Homosexuals	13.9	453	1990–94	[35] (1996)	August 94–May 96
Brazil	São Paulo	Homo/bisexual	10.8	1082	1994	[19] (1998)	Baseline prev. in cohort study
Caribbean[a]							
Cuba	National	HIV+ contacts	5.2	710	1986–88	[36] (1989)	
Dominicana	Sto. Domingo	Bisexuals	7.7	234	1994	[21] (1996)	Nov–Dec 1994
Dominicana	Sto. Domingo	Homosexuals	11.7	77	1994	[21] (1996)	Nov–Dec 1994
Jamaica	Not specified	Homo/bisexual	15.0	100	1986	[37] (1993)	
Jamaica	Kingston	Homo/bisexual	9.6	125	1985–86	[38] (1988)	17–70 years Aug 1985–Jan 1986
Martinique	Not specified	Homo/bisexual	39.1	23	1988	[39] (1989)	
Trin. & Tobago	Not specified	Homo/bisexual	40.0	100	1983–84	[40] (1987)	
Central America[a]							
Costa Rica	S. José	Homo/bisexual	4.9	143	1994	[22] (1994)	18–50 years Jan–March 1994
Honduras	Tegucigalpa	Homosexuals	14.0	NS[b]	1989–92	[23] (1993)	1989 and/or 1992
Panamá	C. de Panamá	Homosexuals	3.1	287	1984–86	[41] (1988)	
México							
México	National	Homo/bisexual	15.5	973	1991–96	[24] (1997)	Epidemiological surveillance
México	C. de México	Bisexuals	22.6	884	1993–95	[42] (1996)	CONASIDA testing centre
México	C. de México	Homosexuals	31.6	1444	1993–95	[42] (1996)	CONASIDA testing centre
México	Guadalajara	Homosexuals	29.2	267	1990	[43] (1991)	
México	National	MCSW[d]	13.6	712	1991–96	[24] (1997)	Epidemiological surveillance
Southern Cone[a]							
Argentina	Buenos Aires	MSM	13.3	724	1999–00	[17] (2000)	
Argentina	Rosario	Homo/bisexual	11.2	659	1987–89	[44] (1989)	
Argentina	Not specified	Homo/bisexual	12.8	1020	1991	[45] (1991)	
Paraguay	Asunción	Homosexuals	8.8	182	1987–90	[46] (1991)	
Uruguay	Montevideo	Bisexuals	3.2	252	1996	[47] (1996)	18–65 years 1 April–30 June
Uruguay	Montevideo	Homosexuals	2.6	154	1996	[47] (1996)	18–65 years 1 April–30 June
Uruguay	Montevideo	MCSW[d]	13.4	187	2000	[17] (2000)	
Uruguay	Montevideo	MCSW[d]	17.8	241	1999	[17] (2000)	

Source: HIV/AIDS Surveillance Database, US Bureau of the Census.
[a]Information on seroprevalence among men who have sex with men (MSM) was not available from: Belize, El Salvador, Guatemala and Nicaragua, in Central America; Chile, in the Southern Cone; and Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, British Virgin Islands, Cayman Islands, Dominica, Dutch Antilles, Guiana Francesa, Grenada, Guadeloupe, Guyana, Haití, Montserrat, St Kitts and Nevis, St Lucia, Surinam, San Vicente y Granadinas, and Turks and Caicos in the Caribbean.
[b]Not specified.
[c]Homosexual intravenous drug users.
[d]Male commercial sex workers.

Table 3. HIV seroincidence density data for Latin America and the Caribbean.

Sub-area/country	City/location	Description of the population	HIV incidence[a]	Sample size	Year(s)	Reference	Comments
Andean area							
Peru	Lima	MSM	3.3	1140	1998–00	[48] (2000)	Alaska Cohort Study
Brazil							
Brazil	Rio de Janeiro	MSM	3.1	753	1995–97	[18] (1999)	Praça Once Cohort Study
	São Paulo	MSM	1.51	1028	1994–99	[19] (1998)	Belavista Cohort Study
	Belo Horizonte	MSM	1.99	470	1994–99	[20] (2000)	Horizonte Cohort Study

MSM, Men who have sex with men.
[a]Number of new cases per 100 person-years of observation.

mates in all four studies still suggest moderately high HIV transmission rates among MSM in those countries, and call for continued, more efficient programmatic action.

Social/cultural context

As explained, probably a large proportion of MSM in the region do not identify as gay or bisexual [49]. Diverse forms of 'gay' identities (i.e. from local/traditional forms of homosexuality to newer, 'globalized' patterns that share meanings and language with counterparts in North America and Europe) exist in larger urban areas [8,10,50]. Such identities normally emerge from, and help consolidate, 'gay' subcultures in these places. These subcultures do not determine unitary constituencies of 'gay' men (and lesbians) in each locality; rather, they are heavily influenced by general social stratification in relation to class, age, and ethnicity, which mostly replicate the power relations existing around those categories outside the subcultures [5]. In addition, erotic value is assigned to physical beauty and to sex roles (e.g. looking more or less 'manly'). In Peru, and probably elsewhere in Latin America, transvestites embody at the same time the old paradigm of 'homosexuals' and a segregated minority-within-the-minority, as they are blamed by other MSM for the stigma shed on homosexuality in general [8].

Members of these core 'gay' subcultures interact sexually among themselves and with men who do not share a 'gay' identity in any of its forms. The latter also constitute a diverse group with differences around class, age and ethnicity. In many popular-class settings in Latin America, hegemonic male identities do not exclude sexual exchanges with other men, as long as distinct sexual roles are unambiguously assigned [51–53]. Men are raised knowing that 'gay' men or transvestites will naturally show sexual interest in them. It will be acceptable to exchange sex with these men for some kind of good (i.e. money, a gift, a glass of beer, a haircut, or just sexual relief), as long as only hegemonic male roles (insertive oral or anal sex) are practised with them. Whereas almost all these men also have sex with women, only a few will call themselves 'bisexual', because this category is either unknown at all or is understood as 'role-versatile' (which they would avoid at all costs) [54]. This sexual script is the source of an important proportion of sex between gay men and men not identified as gay in Latin America.

This understanding of male-to-male interactions in the popular classes is less common in the middle classes, because therein gay-identified men usually embrace a globalized gay lifestyle in which interactions occur only with other gay men (or, at least, outside the 'real man–gay man' dichotomy) [50]. Often they try to pass as non-gay or masculine-looking; thus they do not seek supposedly heterosexual men of their class for sex. Conversely, middle-class MSM not identified as gay are usually men who like other men but remain outside the gay scene, limiting their interactions with gay men to the sexual arena, and living this dimension of their experience as a double life, of which they seldom speak to anybody. In their official lives, they may have girlfriends, fiancées or even wives, or pretend they do not have a sex life at all. Often they will articulate this experience as 'bisexuality' [8].

The intense use of alcohol (heavily promoted in leisure contexts in the region as a facilitator of social interaction, and even signifying 'normal' male behaviour) is as much an excuse for the expression of feelings, particularly sadness, weakness and affection for other men, as it is a relatively well-accepted explanation for homosexual interactions across all classes [7].

Compensated sex (offering or getting sex in exchange for some sort of good) is important among men of all sub-groups. Transvestites will often sell sex to men in

the popular or lower-middle classes who pretend they mistook them for women or recognize that they like their femininity and sexual expertise. Some working-class men will depend more heavily on the financial aid they get from an older gay friend, or on the product of more formal sex work with more affluent gay men [51–54].

In times of globalization in Central and South America, options for a homosexual experience are diversifying rapidly, and traditional arrangements now co-exist with or are being replaced by new lifestyles and identities [50]. In this context, the emergence of strong activist initiatives is contributing to the constitution of new sexual communities, which are both fighting structures of sexual oppression and helping construct the notion that the states must protect the health and rights of all, irrespective of their sexual preferences.

'Risk behaviour', sexual meanings and social vulnerability

It has become quite clear that situations leading to the sexual transmission of HIV should not any longer be seen primarily from the narrow perspective of 'risk behaviour' [55]. Although HIV is in fact transmitted as a result of unprotected sex, causal models used for explaining such behaviour have gone far beyond the rather limited concepts of 'lack of knowledge', 'inaccurate susceptibility estimations' or 'lack of responsibility'. New understandings have evolved in at least two directions: First, they recognize the fundamental role of sexual meaning [56]. Not only risk perception and the protection of self guide individuals' judgements of specific sexual practices. Affection and eroticism also impose values on, for example, the 'exchange of fluids' and the decision not to use condoms as signifiers of intimacy, trust and sharing [57] or, alternatively, as an arousing move because of their transgressive content [58]. Negotiating non-penetrative sex, frequently presented as a safer sex variant, is usually out of the question among heterosexual couples who have learned that sex between a man and a woman implies penetration [59]. Although this is not implied in sex between men, for many men who eroticized penetration early in their sexual lives, non-penetrative sex is also probably not 'real' sex at all.

In Latin America, the meanings of the penetrative and receptive sexual roles, manliness and sexual identity are usually intertwined in complex ways, with clear implications on HIV risk perception and message interpretation, which is crucial in preventative interventions [60,61]. For example, the old myth of AIDS as a gay disease made many men believe for a long time that they were not at risk [62]. Similarly, many well-informed gay men could neglect using condoms when having sex with men they saw as heterosexual [63]. More generally, many men assess risk with a new partner on the basis of physical stereotypes of health and disease. Additional examples of social meanings impeding 'behavioural change' are the difficulty of interiorizing the notion of HIV risk *vis-à-vis* the long natural history of HIV disease and, more recently, the availability of highly active antiretroviral therapy, which has dramatically raised the life expectancy and quality among individuals living with HIV [64].

Second, they enter the social structures into the equation. It is key to recognize that all kinds of individual relationships with other people (including sexual interactions) are permeated by power relations resulting from structural differences [55]. Moreover, it is crucial to view sexual activity as a human practice frequently, if not mostly, resulting from subjective and intersubjective phenomena distant from rational decision-making. As much as sex inequities affect, or even exclude, the option of safer sex negotiation between heterosexual partners in Latin America and other parts of the world, class and educational differences affect factors as diverse as access to information, assertiveness derived from one's ability to express and defend an idea, the capacity to buy condoms, or the need to sell/capacity to buy sex, and the relative control of conditions in which sexual services are provided [65]. Wherever it still occurs, ethnic segregation enhances these barriers. Even attributions of differential manliness and differential sexual roles among MSM in the region, endowed with symbolic value, influence their ability to negotiate sexual practices and use protection. Moreover, the limited exercise of citizenship among various groups of excluded MSM, which results in, and perpetuates, the lack of a strong community based on solidarity, autonomy and a feeling of belonging in the larger society, leads to an even weaker access to information, healthcare and condoms, not to mention self-denial and low self-esteem [50,57]. These structural determinants of individual and collective risk are referred to as social vulnerability [66].

Social response

In most countries of the region, particularly in the capital cities, activities oriented to the prevention of HIV infection or the mitigation of its social impact have been launched by gay organizations, non-gay Community Based Organization, and in a few cases, governmental programmes [16,67]. Taking countries as units of comparison, a key determinant of the social response to the HIV epidemic among MSM has been the relative importance of MSM epidemics in each context. In consequence, southern American countries

and Mexico have shown a stronger response, compared with Central America and the Caribbean. In addition, the general consciousness about AIDS as a national public health problem, and especially, the level of involvement of the civil society in health-related issues, as well as the status of sexual rights, have played a role [55]. Clearly, a success story in this regard is the Brazilian case, 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 regional context [68].

The quality, sustainability and coverage of these diverse activities have been far from homogeneous across time, country or actor. Whereas anecdotal information exists on many of them, very few have been documented and published, and even fewer have been formally evaluated, which partly results from the community basis of most such interventions [16]. 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 or, especially, the promotion of community organizing for an enhanced sexual citizenship [67]. People have been reached through approaches ranging from individual counselling and testing, and group dynamics, to street or club outreach, with distribution of educational materials, educational theatre, peer leadership, and community mobilization. The increasing abandonment of traditional models based solely on information or skills building, and their replacement by structural interventions that address vulnerability through community development and sexual rights promotion is clearly promising [69].

Besides the few cases in which governments have become involved in activities oriented to MSM (particularly in Argentina, Brazil, Colombia, Chile, Mexico, Peru and the Dominican Republic), either through direct implementation or the funding of external agencies, most of these programmes have been funded by international cooperation agencies (e.g. UNAIDS, USAID, the Dutch government), private donors (e.g. the private Dutch donors HIVOS and NOVIB, as well as the International HIV/AIDS Alliance, the Ford Foundation) and charities (e.g. religious organizations) (J. Izazola, personal communication). As is frequently seen, this has resulted in the low sustainability of many such programmes. Types of implementing agencies play, in turn, a key role in programme coverage and quality, and 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 affect the structural determinants of their own, and their (male and female) partners' vulnerability [6,70].

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 [71]. 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 [67], and a major strategic planning exercise on MSM-oriented AIDS programmes involving multi-sectoral commissions of countries in Central and South America [72]. Similarly, UNAIDS funded a networking effort involving epidemiological and social researchers on HIV and sexual diversity, which is currently updating a catalogue of regional studies on MSM and HIV, as well as a document oriented to decision-makers in which the complexities of an adequate focus on the MSM epidemics in the region will be addressed (P. Chequer, personal communication). 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.

Conclusion

An analysis of the epidemic among MSM in the LAC region, and of the social response to it, suggests a complex, challenging reality in which stigma and social vulnerability have fuelled a devastating epidemic over the past 15 years. It also suggests that public consensus for the assumption of responsibility can, in certain cases, contribute to the elaboration of an expanded multisectoral response, whereas in others such a response can be disproportionately small and lack any impact. This experience provides valuable lessons not only for the analysis of MSM epidemics in other developing areas, such as Asia, but also of epidemics in other populations in the developing and 'developed' worlds.

Gay and other men who have sex with men have been one of the constituencies most affected by HIV in the region, and continue to be one of the population groups most vulnerable to infection and death related to HIV. Concentrated in MSM populations in most urban centres, with prevalences varying between 5 and 20%, and still moderately high incidence rates ranging from 1.5 to 3.3 (in countries for which these data exist), this epidemic calls for continued programmatic action.

Far from sharing a unitary sexual culture, MSM in the region are characterized by their cultural diversity, which is heavily permeated by social class, age, ethnicity and educational attainment. Around core gay subcultures sorted by social class, groups of non-gay identified MSM interact with them in various ways, including forms of compensated sex.

Individual risk must be understood in the context of sexual meanings, including affection and erotic value, and of determinants of social vulnerability. Consequently, interventions should go beyond traditional models oriented to individual behavioural change through the provision of knowledge or the development of skills, and address meanings and structural barriers in creative ways that respect individual autonomy and rights.

Few reliable data are available on HIV, sexually transmitted infections and, in general, sexuality, risk and vulnerability in this population, calling for more information based on sound, culturally sensitive research, which should opportunely inform programmatic action.

The social response to the AIDS epidemic has, in most countries, included prevention programmes of some sort oriented to MSM, usually from civil society organizations, and has contributed to strengthening the processes of gay organizing. The quality and impact of such programmes have importantly depended on the involvement of all sectors and, especially, on the diversification of funding resources, which have both shown a clear relationship with the incorporation of MSM communities into the larger society and the degree to which a citizenship consciousness among them finds its way. Brazil provides a good example of such an expanded response that has increased options of prevention and care, including the exemplary international campaign to force pharmaceutical companies to reduce antiretroviral prices in order to maintain their universal treatment programme.

Renewed, imaginative efforts are needed from both governments and community organizations in order to maintain and strengthen HIV work in prevention and care with MSM in culturally sensitive ways, and to integrate it into a process of community empowerment and the promotion of sexual rights.

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