Men who have Sex with Men and the HIV Epidemic in Latin America and the Caribbean

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Introduction

In the last few years, a re-emergence of international interest in the role of men who have sex with men (MSM) in HIV epidemics globally has become apparent. At least three recently published reviews and editorials have underscored the importance of refocusing prevention work on these populations in more sensitive ways [1-3]. This most likely results from a combination of reasons including: (a) alarming data from higher income countries where a new wave of infections among MSM is occurring, particularly among those who are younger [2]; (b) increasing numbers of studies from lower and middle income countries, where the higher burden of HIV among MSM is a common finding [3]; and (c) a higher recognition of the role of social exclusion and discrimination in determining lower access to adequate prevention and care and, more generally, increasing vulnerability to HIV among men who regularly or occasionally have sex with other men [4], regardless of their self and social identification. Such increased attention has resulted in the emergence of new settings for discussion and policy making: new publications, global and regional forums and networks, the possibility of addressing this issue more broadly within the UN system, and also new initiatives among funders.

By contrast to much of the developing world, since early in the epidemic in Latin America and the Caribbean MSM were recognized as a most-at-risk population. This stemmed from the fact that HIV seemed to have become concentrated among them in most of the countries, with studies suggesting prevalences over 5% in the majority of the largest cities (i.e. 7% in Buenos Aires, 21% in La Paz and Santa Cruz; 20% in Bogotá; 22% in Lima, 17% in Montevideo, 13% in Asunción and other cities in Paraguay) [5]. In fact, only two countries in the region, Bahamas and Haiti, are affected by generalized epidemics. Argentina, Brazil, Uruguay and Paraguay experience HIV epidemics which are concentrated on both MSM and injection drug users, and Suriname and Guyana seem to have epidemics concentrated on both MSM and female sex workers. All other countries (i.e. Mexico, Central America and the rest of South America and the Caribbean) appear to have HIV epidemics concentrated on MSM [52, 59].

The male:female ratio remains approximately at 2 to 3 male AIDS cases per female AIDS case reported each year. Around 50% of all infections in Latin America and the Caribbean are assumed to result from unprotected sex between men [6]. According to available data, this proportion is higher in a few countries such as Chile, Ecuador, Mexico and Peru, and lower in Central America and the Caribbean. However, a more careful analysis of information from Central America and the Caribbean has suggested that the MSM epidemic component in those sub-regions may be underestimated [6]. Moreover, a high proportion of MSM also is sexually active with women and/or is united to women. As we will illustrate below, this is another important fact that usually remains unchecked [22-25].

It is not clear why, in spite of the clarity of these figures, the notion that the epidemic focus was shifting away from this population towards generalization has often influenced public policy in the region, so that efforts to confront the epidemic in this group have remained sensibly insufficient [54].

Methodological Limitations and Data Availability

Clearly, research and surveillance on male same-sex relations and HIV faces many methodological and social challenges. While the use of the category ‘MSM’ underscores the common aspects of biological males having sex with other biological males (i.e. regardless of sexual/gender identity), it also overshadows their diversity and hampers adequate planning for prevention and care [7]. Moreover, the term ‘MSM’ has at least two additional, more specific yet opposite uses which add to

misinterpretation: (a) some planners use 'MSM' as a technical descriptor of gay/homosexually identified men; (b) some others in fact use 'MSM' to refer to non-gay identified men only.

In much of the world, most MSM also have sex with women, and the low prevalence of condom use among them in sex with both their male and female partners may lead to an underestimation of transmission from men to their female partners [8]. Another difficulty stems from the fact that HIV prevalence data is usually estimated from samples of MSM selected from high-risk sexual networks, and therefore may not represent the larger MSM population [9]. Similarly, the existence of male-to-female transgender persons implies the use of a more complex framework to describe male-to-male sex, with consequences for the ways in which sex questions may be asked and interpreted in surveys; and this is all the more important given the much higher HIV prevalence observed among transgenders [9]. Moreover, legal frameworks criminalizing same sex behavior, homophobia, discrimination and human rights violations not only pose particular challenges for the scaling up of interventions and services towards universal access, but for the validity of surveillance and research as well. [10].

While Latin America has produced a sizable amount of data about MSM populations over the past two decades [9], the generation of quality data has declined in the past few years except for a few countries [11]. Conversely, data on MSM from the Caribbean (except for the Dominican Republic and Cuba) remains as scarce as before. Existing information suffers from limitations, reflecting poor understanding of the reality of these populations; and much of collected data remains underutilized due to a lack of systematic analysis, particularly with regard to behavioral variables.

MSM – who and how many are they?

The Social Organization of Male Same-sex Sexuality in Latin America and the Caribbean

A broad literature has described the social organization of sexual practices among biological males in Latin America (including the Spanish-speaking Caribbean), regardless of sexual/gender identity [12-15]. Generally speaking, male-male sexuality covers a broad range of social arrangements which may coexist in any particular city of the region. In more 'modern' arrangements, usually associated with higher educational levels, and higher assimilation to cultural views of the Global North, sociomedical categories of sexual orientation (i.e. as homo/bisexual) and alternative sexual cultures (i.e. gay, queer) are predominantly seen among MSM, who simultaneously show sexual role versatility (i.e. assume both insertive and receptive roles in penetrative sex); a significant proportion of men in those settings, however, are behaviorally bisexual, heterosexually or bisexually identified men who choose to pass as heterosexual and conceal their encounters with other men. Some of the latter may be men who decide to conform to the heterosexual norm given strong family/peer pressure, while others may be men who choose to explore sex with other males without questioning their heterosexual family arrangements. [16]. Clearly, these men are not a regular component of gay networks and are not willing to be targeted by health services oriented to MSM.

In more 'traditional' contexts associated with lower education and lower assimilation of global views of sexuality, male-male relationships reflect a gender-based pattern, where a masculine partner plays the insertive role with a more receptive partner. The insertive partner usually identifies as heterosexual, often has a (regular) female partner and does not see his sexual activity with feminine gay men and travesties as posing a risk to his masculinity especially if pecuniary compensation is obtained [16, 17]. The receptive partner, conversely, often identifies as a feminine gay man or a *travesti*/transgender (18, 19). Once a stereotype of homosexuality, *travesti* lifestyles are at present considered and expression of gender identity. Given the emergence of a new political identity in this group (i.e. as transgender, or simply *trans*) they are (and demand to be) regarded as a separate group, outside the label of MSM.

Studies about sexual diversity in the Anglo-Speaking Caribbean are, conversely, almost non-existent, reflecting the still prevailing assumption that this group is very small in that region. A similar

assumption in Sub-Saharan Africa, largely derived from the stigma of homosexuality as a Western practice (or vice), prevented the study of MSM populations and their HIV epidemics for a long time, until their importance became apparent [20].

While these sexual cultures are evolving quickly, particularly after the advent of the internet, traditional and modern patterns co-exist in the region, and their importance should not be underestimated. Now, the fact that only a minority of MSM self-identify (or are socially identified by others) as part of a non-heterosexual constituency, constitutes a key obstacle for MSM-oriented HIV prevention that is channeled through gay community networks only. The large number of MSM who may, occasionally and secretly, have sex with other men while regularly living a heterosexual life, may be completely missed by prevention efforts. This should be carefully considered by prevention programs, since reaching non-gay identified MSM is as challenging as it is necessary to offer a comprehensive response in epidemics concentrated among MSM [21].

Estimating the numbers of men who have sex with men

While estimating the population size of adult males who have sex with other males is an important epidemiologic and demographic question, population-based studies (e.g. demographic and health surveys) have overlooked this enquiry. Table 1 shows a few recent (2003-2007) studies that address this concern. Responses to this question are likely to differ according to the period of reference (e.g. lifetime vs. last *n* months) or sexual practice (oral vs. anal vs. any sexual practice). In Latin America, reported lifetime prevalences among adult males of any sexual practice with other males cover broad ranges, between 3 and 20%, while last-year figures for this indicator vary between 1 and 14%. According to a review which covered a longer period [9], lifetimes prevalences ranged from 6 to 20%, while prevalence for the past year was roughly half of that figure (6-7%). In either case, such figures suggest that lifetime same-sex sexual activity among men is not a rare event. These studies did not inquire about sexual identity, although such figure should likely be lower than prevalence of sex with other males during last year.

Table 1: Proportion of Males who report Sex with Other Males in LAC, 2003-2007

	Prevalence sex with men, ever No. of studies (Range)	**Prevalence sex with men, last year No. of studies (Range)**	**References**
Pooled Latin America	4 (3-15%)	2 (1-14%)	22-25
Argentina	1 (4%)	ND	22
Peru	2 (15%)	ND	23, 25
Brazil	1 (10.6%)	ND	24
Caribbean	ND	ND	

MSM and their relationships and sexual practices with women

Studies exploring heterosexual practices among men who have sex with men show how misleading the presumption may be that these men have exclusively homosexual practices. Consistently, between one and two thirds of these men reported sex with women (according to country), and somewhat lower figures for the past two months. A sizable proportion reported that they were married to women (See Table 2). Again, these estimations provide a basis for considering male same-sex sexual activity not as the definition of a distinct population, but as a characteristic of many men who are socially recognized as part of the 'general population'.

Table 2: Heterosexual Sex/Relationships among MSM in LAC; 2003-2007

	Prevalence heterosexual sex among MSM, ever	**Prevalence heterosexual sex among MSM, last year**	**Prevalence marriage among MSM**	**References**
El Salvador	34%	31.4%	1.7%	26-29, 33
Nicaragua	32%	20.5%	10.1%	26-29, 33
Perú	34%	29% *	ND	31
Dominican Republic	78%	ND	41%	37

*Last 3 months.

Table 3 summarizes HIV prevalence estimates for MSM and transgenders by country. A wide variation is also observed both in prevalence figures and in the number of studies across countries, so that estimates are presented by country. The prevalence of HIV among transgender persons is higher than among MSM, which shows the increased risk and marginalization of this group. Only one study reports HIV incidence among MSM at high risk in Peru in 2002, at 5.1 cases (95% CI: 3.1 to 8.3) per 100 person-years observed [31].

Table 3: Prevalence of HIV among MSM and Transgenders in LAC, 2003-2007

	Prevalence of HIV among MSM No. of studies (Range)	**Prevalence of HIV among Transgender No. of studies (Range)**	**References**
Argentina	5(9 – 51%)	ND	38-42
Bolivia	1 (21%)	ND	42
Colombia	1 (19.7)	ND	42
México	1 (15%)	ND	43
Paraguay	1(13%)	ND	42
Peru	3 (9.6 – 22.3%)	1 (32%)	31, 34, 35
Uruguay	1 (22%)	ND	42
Central America	1 (8-15%)	1 (24%)	33
Dominican Republic	1 (11%)	ND	37

Table 4 also shows prevalence estimates of preventive behaviors reported by MSM (i.e. condom use at last anal sex with a man, consistent condom use for anal sex with a man during the last year, and never having used a condom with a man). Roughly between 40 and 60% of MSM report consistently using condoms for anal sex with male partners, of which higher and lower end estimates refer to casual and steady partners, when the distinction is made. These figures suggest that prevention efforts among MSM based on condom promotion have been partially successful, but that there is still room for improvement and probably for focusing on the sustainability of preventive practice, given global trends towards lower condom use among MSM. They also show that MSM make a difference (as other men do) between regular and casual partners, which reflects that emotional ties and trust often justify the assumption of risks among many MSM. Prevention efforts should take this into account, not just condemning the lack of condom use with certain partners, but recognizing the agency of gay cultures in the development of complementary prevention strategies, such as negotiated safety, as has been described by studies mainly from Australia for a long time [44, 45]. Moreover, the trend towards lower condom use observed among MSM in higher income countries [46] should also support the surveillance of sexual practices among MSM in the region to assess whether this trend will take place and why, and to develop creative responses to it.

Table 4: Prevalence of condom use in LAC, 2003-2007

	Condom use last anal sex with a man	**Consistent condom use for anal sex with men, last year**	**Never used condoms during sex**	**References***
Argentina	91%	ND	ND	59
Central América	47% (stable partner) 61% (casual) 47-83%	ND	ND	33, 59
Chile	29%			59
Colombia	80%			59
Ecuador	63%			59
México	79%	64%	24%	43, 59
Panama	86%			59
Perú	54% (stable partner) 56% (casual) 47%	ND	ND	31, 34-35, 59
Cuba	55%			59
Dominican Republic	77%, 79%	54%	ND	37, 59
Trinidad and Tobago	47%			59

*Estimates from reference 59 in this table are taken from the reports on UNGASS Indicator 19, year 2007 (Annex 2, page 319).

Table 5 shows data for other STIs. In Latin America, syphilis prevalence was reported in 7 studies and ranged from 5.0 to 29%, with highest figures for Argentina (17%) and Peru (29%) [26-30, 35, 36]. Syphilis was shown to be highly prevalent in this population, and syphilis reinfection has also shown to be frequent [47]. These high figures warrant more detailed studies of the epidemiology of syphilis among MSM in Latin America, particularly given efforts to eradicate neonatal syphilis and the high prevalence of male bisexual behavior.

Only two studies were found with Chlamydia and gonorrhea prevalence estimates: Two from Honduras: onereporting 12% and 9%, respectively [27]; and the other one providing figures for Tegucigalpa, San Pedro and La Ceiba (see Table 5) [61]; likewise, another from Peru, reporting 2.4% and 0.0% respectively [35]. HSV type 2 infection was reported in eight studies (Guatemala, Honduras, El Salvador, Nicaragua, Panama and Peru, with prevalences ranging between 21 and 72% [33-35; 61]). Hepatitis B infection was assessed in 2 studies in Argentina (with figures between 22 and 38% [36, 39].

Table 5: Prevalence of other STI in LAC; 2003-2007

	Prevalence of Syphilis among MSM No. of studies (Range)	**Prevalence of Chlamydia among MSM No. of studies (Range)**	**Prevalence of gonorrhea among MSM No. of studies (Range)**	**References**
Latin America	7 (5-29%)	2 (2-12%)	2 (0-9%)	26-30. 33-36
Argentina	17%	ND	ND	36
Honduras	5% 4.4%	12% 6% (Tegucigalpa),	9% 1.1%	27,33, 61

	(Tegucigalpa), 11.3% (S. Pedro Sula), 0.3% (Ceiba)	2.8% (S. Pedro Sula); 1.7 (Ceiba)	(Tegucigalpa); 2.0% (S. Pedro Sula)	
Peru	2(12 – 29%)	2%	0%	34, 47

Social Drivers of Vulnerability to HIV

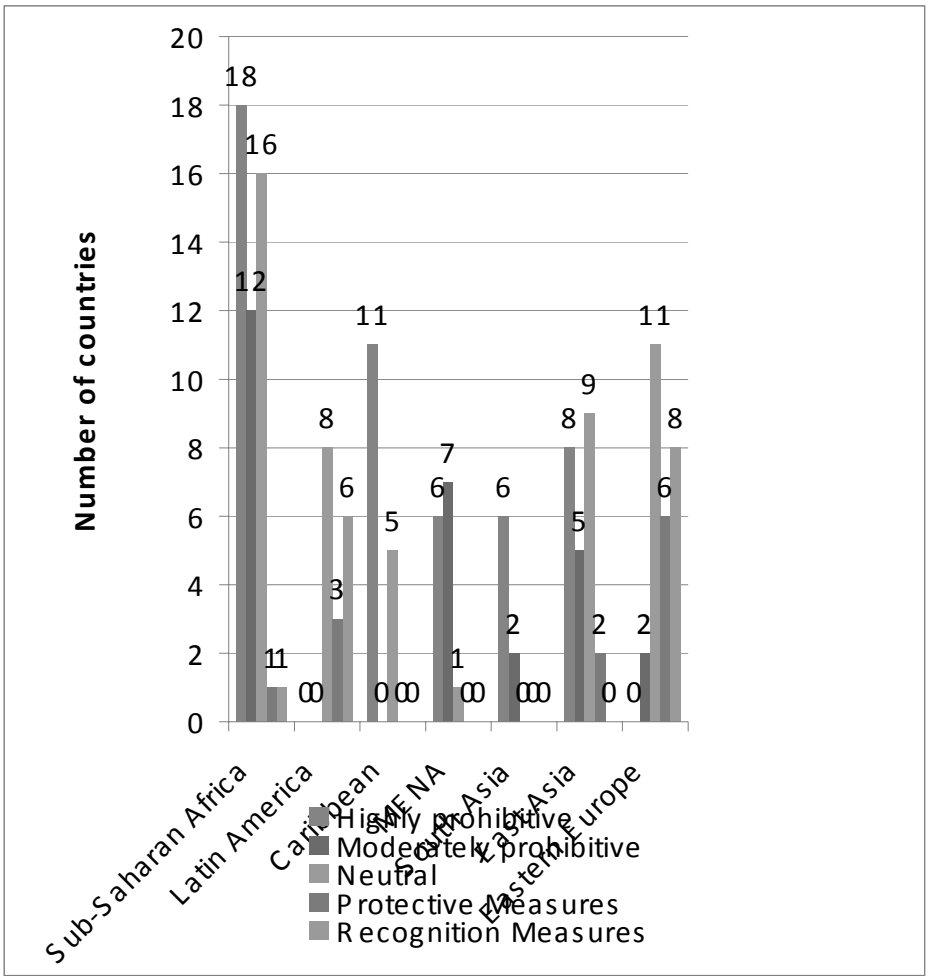
The extent to which MSM including transgender persons are affected by the HIV epidemic reflects their higher vulnerability in the region. HIV vulnerability is considered to depend on three groups of influences [48]: (a) Membership in groups or subcultures, that is sexual networks, with higher HIV prevalence (i.e. a more individual factor), and a higher frequency of practices associated with transmission probability (i.e. anal sex); (b) higher-level social/environmental influences (such as laws, policies, norms, culture) which configure a hostile environment; and (c) lower quality and coverage (in total numbers and in terms of population groups covered) of services and programs. The last two are distal and proximal social drivers of HIV vulnerability among MSM and will be discussed below.

Legal Aspects, Human Rights, Stigma and Discrimination

Beyond the individual level, the most encompassing dimension of social drivers of the HIV epidemic is related to the legal and human rights environment. There we can speak of three interrelated but distinct elements: legal frameworks, state practices regarding human rights, and societal practices that may or not configure discrimination. While in some countries protective and affirmative legal measures regarding sexual diversity are being adopted, in many others systems are neutral, despite the fact that rampant homophobia prevails, and discrimination hampers access to prevention and care [49].

A study conducted with UNAIDS in 2008, to be published soon [50], assessed the legal standing of sexual diversity in lower and middle income countries. Frameworks were classified in 5 categories, that is, as highly or moderately prohibitive, neutral, or with protective or recognition measures in place. Figure 1 shows the numbers of countries in each region with legal frameworks in each of those 5 categories. The red column indicates highly prohibitive, usually meaning death or long-term imprisonment, that is, the worst version of sodomy laws.

Figure 1: Legal frameworks regarding sexual diversity in lower-middle income countries



Source: UNAIDS (2009). Legal Frameworks, Human Rights and Stigma and Discrimination in relation to Sexual Diversity in Lower and Middle Income Countries. Geneva: UNAIDS.

As we see, 11 countries in the Caribbean out of 16, together with 18 in Sub-Saharan, 6 in the MENA region, 6 in South Asia and 8 in East Asia still have highly prohibitive legal frameworks in place. Not surprisingly, information is accompanied by disturbing reports about the impossibility of starting HIV prevention work among MSM in some countries, in correlation with a strong discrimination against sexual diversity, leading to legal invisibility of sexual minority status. The question is, then, what kind of HIV prevention among MSM can be offered if to be an MSM is illegal in the first place. A remaining 5 countries in the Caribbean have legal frameworks that are neutral towards sexual diversity.

By contrast, in all countries of Latin America homosexuality is legal. Out of 17 countries, 8 have legal systems that are neutral to sexual diversity (i.e. they do not mention it); 3 have some protective measures and 6 have already adopted recognition measures such as equality of rights of same-gender couples. As the same report points out, however, these positive frameworks usually cannot avoid the persistence of discrimination and abuse of human rights. In most countries there is recognition of the need to direct actions to MSM communities, but achievements are uneven. In Latin America, despite lack of sodomy laws and even some protective measures, heteronormativity prevails, linked to fear of being the

target of homophobic practices, including violence and direct discrimination. Moreover, the non-existence of options for legally and socially recognized stable partnerships between men in most of the region is likely an additional driver of more frequent casual sex. And the clandestine nature of many sexual practices also generates obstacles for prevention. In fact, the HIV epidemic has played a role in recognition of rights, but it is only a starting point for work that should link with other perspectives, including human rights.

A clear response to improve the legal/human rights environment affecting sexual diversity is needed in Latin America and, especially, in the Caribbean, not only on grounds of progress of the international agenda on human rights, but also based on a public health and development perspective. Multisectoral efforts should be made to show the social harm of homophobic laws and practices, and to generate initiatives leading to positive changes. For example, given the association between prohibitive legal frameworks and the common law tradition in the Caribbean and other parts of the world, efforts within the Commonwealth to foster changes in legal frameworks that mirror the strategies leading to those changes in the United Kingdom, Canada and South Africa would be particularly useful.

Access to Prevention and Care Services

Accurate indicators of access to prevention and care among MSM and other key populations remain a glaring need in the health sector. Only a few countries provide estimates for MSM-related indicators in the UNGASS reports [51], and those countries tend to be those most responsive to MSM epidemics, so that the UNGASS figures are not very useful.

In general, resources allocated by countries to offer prevention and care services to MSM do not match the level of need, particularly as compared to other population groups [52]. Examples of health projects targeting men who have sex with men have been documented in some countries in Latin America. However, very few such programmes have been monitored and evaluated. In Peru, the HIV prevention strategy of the Ministry of Health involves “peer health promoters” to encourage men who have sex with men to seek periodic screening for sexually transmitted infections and HIV. Preliminary results from a study in MSM attending clinics for the management of sexually transmitted infections in 5 cities in 2007 revealed that 55% of those who regularly received medical check-ups had been referred to a clinic by peer health promoters [52]. However, data on the effectiveness of such program are non-existent, and complaints remain among MSM about the fact that the only MSM health concern addressed by the health system is HIV and STI, in a response that is still heavily medicalized [53]. Efforts should be made to respond to the diverse health needs of equally diverse MSM, which go beyond HIV/STI concerns [51; 54; 60]. Service provision should not be limited to public health services, and should utilize the capacities of community health organizations, in an effort to strengthen communities and reduce vulnerability [54].

Some Hope on the Horizon

Before focusing on challenges, a perspective of hope in light of steps made forward will help us better understand that progress is possible. As already mentioned, prohibitive legal frameworks in Latin America have already been eliminated in the whole region. Increasingly, human rights organizations, as well as national Ombudperson offices are considering the protection of the human rights of sexual minorities as part of their mission, and LGBT communities are becoming increasingly visible and vocal. In the context of HIV work, the Horizontal Technical Cooperation Group (HTCG), a cooperation mechanism of national AIDS programs and community networks, has assumed an open anti-homophobic stance and, together with PAHO and UNAIDS, developed Guidelines for Strategic Action Against Discrimination based on Sexual Orientation and Gender Identity [55]; a Strategic Plan against homophobia [UNAIDS, PAHO & HTCG, Draft Document]; and Guidelines for MSM-oriented services [PAHO, UNAIDS & HTCG, Draft Report). Networks of organizations of MSM and Transgenders are part of the Steering Committee of the HTCG; and government-sponsored Anti-homophobic campaigns

have taken place in 4 countries (i.e. Argentina, Brazil, Colombia and Mexico [see 56]). In Brazil the 1st National LGBT Conference, called by President Lula da Silva took place last year [57]; and during the Mexico City Conference a Regional Ministerial Declaration to enforce diversity-sensitive sex education was signed and the first march against homophobia in an AIDS conference ever took place [58]. Progress is possible in this region in magnitudes that are not thinkable in most of lower-middle income countries, but there is still a long way to go.

Challenges and Recommendations

In conclusion, there is an urgent need to improve surveillance and research data concerning MSM, since those presently available reflect a number of problems such as: insufficient studies, lack of a replicable sampling scheme; insufficient work on definitions (e.g. asking about "sex with men" regardless of the interpretation subjects may make of their sexual activity with travesties); sexual acts (e.g. any sexual activity vs. high-risk activities); or timeframes (e.g. ever vs. recently sexually active with other men). Nevertheless, a prevalence range for lifetime sexual activity with other men among adult men in Latin America was estimated from various studies to be between 6 and 20%, while the prevalence range for recent homosexual activity was approximately half of the lifetime experience (e.g. 3-10%).

Importantly, far from showing MSM as participants of an isolated sexual network, data demonstrate that MSM often have sex with women and/or are united to women, so that prevention among MSM is not only important because of the severe HIV burden affecting this population, but because such population is often indistinguishable from the 'general population' and its own sexual networks. This means, however, that prevention and care programs should not assume a uniform population, but understand its diversity and address needs that are likely to be diverse as well. This is not only important to consider the situation of non-gay identified bisexual men, but also to emphasize the very specific needs of transgender persons, who should not be considered part of the 'MSM' collective any longer.

About 40 to 60% of such recent homosexual activity seems to involve unprotected penetrative sex, although less frequently with casual partners. Prevention programs should remain vigilant of changes in sexual cultures, including those derived from the increased survival to HIV infection associated with antiretroviral treatment, and work with the community to find new preventive messages and responses that counteract potential trends towards increased unprotected sex. The role of new patterns of recreational drug use and new technologies, particularly the internet, should be better understood. The scant data about effectiveness of preventive programs for MSM is another difficulty to be overcome with an established practice of evidence-based programming and program evaluation.

As a recent global consultation on the role of the health sector regarding MSM pointed out, access to sensitive, comprehensive health care among sexually diverse populations is also a glaring need, beyond the limited, medicalized model of HIV testing and STI control. A strengthened response should not only consider other health needs of these populations, but include their strengthened community organizations in the needs assessment as well as in care delivery, as appropriate.

Finally, an honest response to the HIV epidemic among sexually diverse populations cannot ignore any longer that the legal/human rights environment is crucial for adequate prevention and care. Concerted action is needed, locally, regionally and globally, to end prohibitive legal frameworks and human rights abuses, and to promote social inclusion through developing a culture of respect for difference. This is all the more important as it is both a public health and a human rights cause, and progress in this arena is likely to have important effects not only on HIV; but on the quality of life and dignity of a significant number of human beings.

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