

C H A P

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*Reaching Men
Who Have Sex
with Men*

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INTRODUCTION

Few challenges in responding to HIV/ AIDS have proven to be as difficult as reaching and providing effective prevention and care services to men who have sex with men (MSM). Although homosexual and bisexual behaviors have been documented in all countries and cultures, widespread stigma and discrimination are associated with such practices. This has often made it difficult even to begin discussing the risk of HIV infection and the impact of AIDS among populations of MSM. One of the negative consequences of stigma and discrimination in many settings has been the relatively limited development of sexuality-based communities and community support structures. Many government agencies and international donors have almost completely failed to prioritize MSM in developing programmatic responses to the HIV/AIDS epidemic.

Fortunately, at least some local-level community and advocacy organizations have gradually emerged to respond to the epidemic in a range of resource-constrained settings, offering a growing understanding of the ways it is possible to reach MSM through prevention and care programs, and the key components that such programs ideally should include to be effective. This chapter briefly reviews programs designed for MSM in a range of resource-constrained settings to outline some of the ways these key components have been identified and the extent to which they are essential to effective program development.

STATE-OF-THE-ART APPROACHES, STRATEGIES AND EXPERIENCE

DEFINING THE MSM POPULATION

There is significant and growing evidence that MSM are an important population vulnerable to HIV infection everywhere in the world. In spite of growing levels of heterosexual transmission in Latin America, for example, HIV prevalence levels among populations of MSM have ranged from 20 percent to 35 percent in the major cities of a number of larger countries. HIV prevalence and incidence data for homosexually and bisexually active men are less readily available for countries in Asia and Africa. This is due in part to the fact that terms such as “homosexuality” and “gay” fail to adequately describe the diverse forms of traditional male-male sex that can be found in many African and Asian societies.

CONFRONTING A HISTORY OF DENIAL AND NEGLECT

The history of the HIV/AIDS pandemic has been marked by continued denial and neglect of the importance of prevention and care services for MSM, particularly on the part of official HIV/AIDS programs. This denial and neglect has unfortunately been widespread almost everywhere, but it has been most explicit in relation to the HIV/AIDS epidemics found in resource-constrained settings.

HIV/AIDS PREVENTION EFFORTS AMONG MSM IN AFRICA

Only a small number of AIDS prevention programs or behavioral interventions directed at MSM have been developed in the sub-Saharan African region; the situation is only marginally better in northern Africa. Even on the basis of relatively unsystematic information, however, it is clear that in Africa, as in other parts of the world, nongovernmental AIDS-service organizations and gay and lesbian rights organizations have been largely responsible for the initiatives that do exist.

PREVENTION EFFORTS AMONG MSM IN ASIA

The situation in Asia is also marked by relative neglect of MSM as an important population for HIV/AIDS prevention programs. Fortunately, it is not characterized by the kind of almost absolute denial that still seems widespread throughout much of sub-Saharan Africa. In a number of South and Southeast Asian countries, important programs directed at MSM, and at the newly emerging gay communities found in many countries, have been initiated.

PREVENTION EFFORTS AMONG MSM IN LATIN AMERICA

As in Asia, small, nongovernmental, gay and AIDS activist organizations in Latin America typically have taken the lead in developing HIV prevention programs. For the most part these initiatives have been relatively small-scale, carried out without significant financial support and even, in some cases, in the face of official resistance. Nonetheless, by focusing on strategies such as street outreach, cultural activism and community-building and mobilization, important steps are being taken to redress the previous lack of attention to one of the most vulnerable population groups in virtually all of the countries in the region.

PREVENTION EFFORTS AMONG MSM IN THE CARIBBEAN

The Caribbean region has HIV prevalence rates second only to sub-Saharan Africa. It is important to examine the role of MSM in transmission as regionally there is widespread denial of MSM activity to the point that it is often disregarded or ignored as a mode of HIV transmission. Although the levels of HIV among MSM in the Caribbean are not completely known, there are strong indications that it is high.

LESSONS LEARNED AND RECOMMENDATIONS

It is clearly possible to provide a strong theoretical framework for the development of programs that should make it possible for policy makers and other stakeholders to design and implement meaningful programs even in the absence—or while awaiting the results—of more experimentally valid scientific research findings. If implemented urgently enough, these programs will surely save lives and reduce HIV/AIDS-related human suffering. A number of key principles emerge that can be defined as absolutely essential for the development of effective HIV/AIDS prevention and care programs for MSM.

FUTURE CHALLENGES

It is essential that programs for MSM remain deeply rooted in community structures and organizations precisely because these contexts provide the necessary vehicle for reaching isolated individuals and segments of the larger population group out of which they have grown. The task that remains for the future—everywhere in the world—is to recognize this fact and provide these communities and community-based organizations with the resources, structural and policy support and creative freedom necessary to do their work.

CASE STUDY

PREVENTIVE INTERVENTION AT PUBLIC SEX SITES IN SANTIAGO

The Chilean experience of an HIV/AIDS prevention program in public sex sites (PSS) will be of particular interest to countries where public sex, particularly sex between men, is more difficult to acknowledge or where homosexuality is more stigmatized.

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I N T R O D U C T I O N

Over the last two decades few challenges in responding to HIV/ AIDS have proven to be as difficult as reaching and providing effective prevention and care programs to men who have sex with men (MSM). There are multiple, complex reasons for this difficulty. Although homosexual and bisexual behaviors have been documented in all countries and cultures, widespread stigma and discrimination are often associated with such practices. This has made it difficult in many places even to begin to discuss the risk of HIV infection and the impact of AIDS among populations of MSM.¹

One of the negative consequences of stigma and discrimination in many settings has been the relatively limited development of sexuality-based communities and community support structures. Perhaps most worrisome, many government agencies and international donors have almost completely failed to prioritize MSM in developing programmatic responses to the HIV/AIDS epidemic. This has limited what might have been one of the most effective ways of overcoming the negative impact of widespread discrimination: the development of more effective health and welfare services, such as STD clinics specifically serving homosexually or bisexually active men, and human rights protection with an emphasis on sexual rights and the protection of sexual minorities.^{1,2}

Fortunately, at least some local-level community and advocacy organizations have gradually emerged to respond to the epidemic in a range of resource-constrained settings. They offer a growing understanding of the ways it is possible to reach MSM through prevention and care programs and the key components that such programs ideally should include to be

effective.¹ Unfortunately, these truly heroic efforts on the part of community-based organizations and frontline prevention workers have rarely been given adequate research attention in ways that might make possible a more systematic evaluation of their impact. A good deal of descriptive information is available, however, outlining the components of many programs. On the basis of such observational and descriptive case studies, it is possible to develop a strong theoretical model that synthesizes what would appear to be the key ingredients necessary for the design of meaningful HIV/AIDS prevention programs for MSM. Based on these accounts, it is apparent that at least five different elements must be present to reduce the risk of infection and guarantee responsible care and treatment for those who are already infected with HIV:

1. What might be described as “the democratization of information” is essential. While information alone is clearly not enough to ensure effective risk reduction,³ ensuring access to correct and current information about HIV and AIDS is nonetheless a necessary condition for the development of effective programs—especially for highly marginalized populations who are often excluded from the normal flow of information in mainstream social life.

2. To guarantee that information reaches the widest possible population of MSM—including those segments that are most hidden and marginalized—systematic outreach efforts aimed at connecting with these men, on their own terms and in their own social and sexual settings, consistently have been shown to be a key component of effective prevention and care.

3. To give consistency and long-term support to the democratization of information and the development of systematic outreach efforts, community mobilization and building must be a primary focus of AIDS-related programming. Effective responses to the epidemic can be sustained over time only within the context of increasingly strong and coherent community support structures.

4. Building stronger communities in turn must be linked to an ongoing process of collective and individual empowerment aimed at overcoming the discrimination, oppression and even violence that have consistently been associated with heightened vulnerability in the face of HIV and AIDS.

5. The defense of human rights has been identified as absolutely essential to developing a broader social climate capable of reinforcing risk reduction and guaranteeing access to care and treatment services. Defending human rights, particularly for highly stigmatized populations such as MSM, is necessary not only because it is ethically correct, but also because it is pragmatically necessary to bring individuals and communities into broader support structures capable of providing them with appropriate social, psychological and clinical services.

Taken together, these key components offer a framework within which to develop prevention and care programs capable of effectively reaching MSM. They combine to produce what has been identified as the single most important element in *all* HIV/AIDS prevention programs for *all* population groups: a supportive social environment in which it is possible to reach MSM and provide them with the information, skills, tools and

social mobilization necessary to respond effectively to the risk of HIV infection. While such programs to now have been relatively limited, the existence of this framework offers real hope that even with a reasonably small investment of human and financial resources, their scope and impact can be significantly extended in the future.

This chapter briefly reviews programs designed for MSM in a range of resource-constrained settings to outline some of the ways these key components have been identified and the extent to which they are essential for effective program development. It emphasizes the ways these components have emerged in relatively small-scale, community-based program development, and offers suggestions about the implications for scaling-up programs that will be able to reach a broader public in a range of different resource-constrained settings.

STATE-OF-THE-ART APPROACHES, STRATEGIES AND EXPERIENCE

DEFINING THE MSM POPULATION

There is significant and growing evidence that MSM are an important population vulnerable to HIV infection everywhere in the world.²⁴ This has been true since the beginning of the epidemic among the populations of gay and bisexual men in the United States, Canada, Australia and in many of the countries of Western Europe, where HIV prevalence rates ranging from 20 percent to 50 percent were often reported during the 1980s.⁵ Much the same can be said of Latin American countries where, in spite of growing levels of heterosexual transmission in some countries, HIV prevalence levels among populations of MSM have ranged from 20 percent to 35 percent in the major cities of a number of larger countries such as Argentina, Brazil and Mexico, and from 5 percent to 10 percent in provincial areas and smaller countries such as Costa Rica.⁶

HIV prevalence and incidence data for homosexually and bisexually active men are less readily available for countries in Asia and Africa, where a clearly defined “gay” identity seems to be considerably less common than in the United States, Europe or even Latin America—and where the widespread denial of significant levels of sexual activity between men may also have resulted in a lack of research attention to these otherwise “hidden” populations.⁴ Throughout Asia, behavioral surveys of men have often reported high levels of bisexual behavior, and male-male sex has been responsible for an important percentage of the HIV infections reported among men. In a study of military conscripts in Thailand, for example, male-male sex was reported by only 7 percent of the sample, yet it was associated with 13 percent of the HIV infections in this population in 1995. While there has been strong denial of male homosexual behavior in sub-Saharan Africa over the years, social and behavioral studies by African researchers are increasingly calling this denial into question. They suggest that in many countries largely hidden homosexual practices may in fact be far more common than previously reported—and that levels of male-male HIV transmission may themselves be hidden in the HIV prevalence estimates for supposedly uniformly heterosexual men.⁷

Part of the problem here undoubtedly is due to the fact that terms such as “homosexuality” and “gay” fail to adequately describe the diverse forms of traditional male-male sex that can be found in many African and Asian societies.^{8,9} Closer study of the contexts within which male-male sex occurs—among adolescents or adults, as part of clan solidarity, in connection with spiritual and initiation activities—will in time reveal what many local people already know. Male-male sex does occur throughout the world, although only some forms are understood as being homosexual or “gay.”

CONFRONTING A HISTORY OF DENIAL AND NEGLECT

Even though there is significant evidence that MSM are an important population vulnerable to HIV infection, the history of the HIV/AIDS pandemic has nonetheless been marked by continued denial and neglect of the importance of prevention and care services for this population group—particularly on the part of official HIV/AIDS programs. This has unfortunately been widespread almost everywhere, though it has been most explicit in relation to the HIV/AIDS epidemics in resource-constrained settings. In fact, the lack of available data in some regions, particularly in Asia and Africa, is likely the result of official denial feeding into the limitation of HIV/AIDS research agendas.

The persistent denial of the importance of MSM has been clearly documented in a study by the Panos Institute in association with the Norwegian Red Cross.² The study included a targeted survey of national AIDS programs, AIDS service organizations and nongovernmental organizations involved in AIDS-related work and gay groups and individuals in countries around the world. The survey’s goal was to document both the extent of same-sex behavior but also, even more importantly, the kinds of programmatic and prevention responses that had been generated in

response to HIV vulnerability among MSM in the developing world. Data were collected from more than 40 national AIDS programs, more than 100 AIDS service organizations (ASOs) and NGOs, and more than 50 gay organizations in countries throughout Africa, Asia and Latin America. Unfortunately, only 25 percent of national AIDS programs list MSM as a target group for AIDS prevention campaigns. Only 9 percent report the development of programs for male sex workers—in contrast to 84 percent targeting heterosexual adults, 78 percent targeting adolescents or teenagers and 69 percent targeting female sex workers.²

These results were confirmed when national AIDS programs were asked not whether they specifically targeted prevention programs to MSM, but whether any AIDS-related services were available to MSM in their countries. Once again, a large majority, 74 percent, stated that no such services were available, while only 24 percent reported that some services were available. When asked what kinds of services were available, 23 percent said advice and counseling services; 18 percent said information and education programs; 16 percent said condom distribution; 12 percent said outreach work; and 9 percent said there were HIV testing and treatment services targeted to MSM.² These extremely limited AIDS-related services for MSM clearly reflect the almost complete lack of official attention to these populations in the international response to the HIV/AIDS pandemic, particularly in resource-constrained countries.

Given this history of denial and neglect on the part of most official governmental programs, the fact that at least some efforts have been developed and demonstrated important signs of success is a testament to the creativity of community-based organizations and activists in countries around the world. While these programs are often poorly documented and only rarely evaluated in any systematic way, they offer real hope concerning what is possible in terms of AIDS prevention programs for MSM in resource-constrained settings—particularly if more adequate sources of funding and political commitment can be generated on the part of governments and donors.³

HIV/AIDS PREVENTION EFFORTS AMONG MSM IN AFRICA

Only a small number of AIDS prevention programs or behavioral interventions directed at MSM have been developed in the sub-Saharan African region.^{2,3,10} The situation is only marginally better in northern Africa. The Association Marocaine de Lutte contre Le Sida, for example, has conducted outreach work with male sex workers in Casablanca and Marrakesh, aimed at raising HIV and AIDS awareness and promoting condom use.¹¹ While limited information has been collected on the sexual practices and self-perceptions of the men concerned, as well as on the number of contacts made and condoms distributed, information concerning the impact of this outreach work is not available.

But even on the basis of relatively unsystematic information, it appears that in Africa, as in other parts of the world, nongovernmental AIDS-service organizations (ASOs) and gay and lesbian rights organizations have been largely responsible for the initiatives that do exist. In the Panos Institute survey of prevention programs for MSM, only one national AIDS program (Mozambique) of the 20 surveyed reported any targeted prevention programs for MSM, though the extent of such programming is unclear. Likewise five percent of the 53 ASOs surveyed indicated they are developing at least some kind of service. But the few gay and lesbian organizations that exist in sub-Saharan Africa are the only ones that have explicitly prioritized work for MSM.² The Panos report also suggests that a number of gay organizations in Africa have taken leading roles in providing AIDS services to sex workers and prisoners.² In spite of these efforts, it is clear that much more must be done, and that there is still a pressing need in this context.

PREVENTION EFFORTS AMONG MSM IN ASIA

The situation in Asia is marked by relative neglect of MSM as an important population for HIV/AIDS prevention programs. Fortunately there is not the kind of almost absolute denial that still seems widespread throughout much of sub-Saharan Africa.³ In a number of South and Southeast Asian countries, important programs have been initiated which target MSM and the newly emerging gay communities in many countries. In India, for example, as in most other parts of Asia, small, emerging gay community and gay rights organizations have served as the point of departure for outreach activities aimed at reaching non gay-identified men and building a stronger sense of gay community among this population.

In spite of the possible difficulties and contradictions implicit in such a strategy, a number of organizations have initiated important efforts. In the early 1990s, for example, a nongovernmental group in Mumbai began to publish *Bombay Dost* (an Indian word meaning “friend”), a magazine targeting gay men and lesbians printed quarterly in English with a Hindi section. The group also started marketing condoms with Hindi- and English-language instructions on proper usage, and actively networked with other organizations throughout the country.¹² Since then the Humsafar Trust, also in Mumbai, has provided a wide range of AIDS-related information and services through printed materials, a library of resources, support groups and “street counselors” who can be accessed by leaving messages on a publicized voice mail system. They have also worked further among non-gay-identified MSM, including the “massage boys” of one of Mumbai’s beaches, in certain public sex environments and within several other sexual networks.

A range of other programs to promote the sexual health of MSM can also be found elsewhere in India. In Calcutta, for example, the Counsel Club has launched a gay magazine called *Pravartak* to reach substantial numbers of gay-identified middle-class men in Calcutta and surrounding areas, and there are plans to extend this work to meet the needs of non gay-identified MSM. In Lucknow, Friends India publishes a quarterly magazine called *Sacred Love*, whose articles promote HIV-related risk reduction.

Despite a number of preliminary studies documenting the complex and clandestine character of most same-sex relations in India, there have been relatively few other broad-based programs. A widespread denial of homosexual behavior as a key element in HIV transmission in India still seems to be a major problem, even among AIDS prevention workers.¹³ There are some notable exceptions to this trend in the work of the Community Action Network in Chennai (Madras) which has conducted a number of interventions among transgender and non-gay-identified sex workers in the city.¹⁴ Elsewhere in Tamil Nadu, the Praktiti sexual health project has worked with truck drivers to promote sexual risk reduction in relations with other men. In Cochin, in the state of Kerala, the Indian Council for the Prevention of AIDS has undertaken some limited sexual health promotion among local male-male sexual networks. But again, these interventions and activities have not been rigorously evaluated for their effectiveness in promoting risk reduction and reducing the number of new HIV infections.

Throughout much of Asia, as in India, there continue to be debates about how best to address the sexual health needs of MSM. In Bangladesh, for example, three contrasting frameworks of motivation and identity have been documented in relation to MSM: (1) Those among a few English-literate middle-class men for whom the term “gay” is an adequate self description; (2) Those for whom sexual identity is linked more closely to who is giving and who receiving in acts of penetration; and (3) Those for whom sexual access to other men is perceived as a matter of “discharge,” urgency and relief rather than a question of desire or longing.¹⁵ Also in Bangladesh, the Association

for Health and Social Development has been undertaking prevention work among students and members of the professional and middle classes in the manner of an activist gay-oriented group. The Bandhu (which means “friend”) Social Welfare Society has been offering education about HIV and AIDS, distributing condoms and facilitating access to STD treatment services among men who do not identify themselves as gay, but for whom the role taken in penetration is more salient.³

In Sri Lanka there have also been a small number of prevention projects and activities among MSM. “Companions on a Journey” is a gay group founded in 1994 to develop gay support networks, decriminalize homosexual behaviors, provide AIDS awareness and promote sexual health among gay men and those with emerging gay identities. The organization runs a drop-in center and has begun outreach work among male sexual networks, promoting community building and safer sex. While a number of other agencies have been involved in HIV prevention activities among male sex workers and their clients, much of this work has focused on relations with “foreign” tourists, leaving well-developed sexual-exchange networks among local men largely unexamined—and almost completely ignored in local service provision.³

Given Singapore’s strict legal regulations condemning homosexual behavior, the problem of reaching clandestine populations of MSM in the country has been especially difficult. As a result, at least one documented prevention program relied on outreach work as the key strategy for reaching men in settings associated with same-sex contacts. Wallet-sized invitations were distributed for events organized by the intervention team, where games and quizzes were conducted focusing on AIDS-related issues such as HIV testing, safer cruising and safer sex practices. A four-session risk reduction workshop was also organized. Over a two-year period, from 1990 through 1992, attendance at these events jumped from five to more than 200 participants, though evaluation of this work has been limited, as most participants have failed to respond to knowledge, attitudes and beliefs (KAB) surveys conducted by program staff.¹⁶

In the Philippines, the Library Foundation, a gay community organization, has sought to promote greater HIV/AIDS awareness among MSM. Beginning in the early 1990s, the foundation developed a series of eight weekend-long workshops on Healthy Interactions and Values in which 15 to 30 participants discuss HIV/AIDS, safer sex and the organization of homosexuality and gay life in the Philippines. The foundation conducted pre- and post-workshop surveys of participants, finding a 90 percent increase in AIDS awareness and a “high level” of behavior change among them.^{17,18} As this program was extended from 1992 to 1993, the Library Foundation reported an increasing sense of gay community developed through interpersonal networking and periodic social activities. The program focused increasingly on moving beyond HIV/AIDS information to address issues of empowerment and community mobilization.¹⁹ There has also been work among male sex workers in the Philippines to promote risk reduction, raise self-esteem and encourage greater awareness of HIV-related risks.²⁰ Targeted outreach work also has been carried out in the Philippines by the ReachOut AIDS Education Foundation in the only acknowledged gay bathhouse in Manila. Patrons of the bathhouse were given a KAB survey, and the results were used to develop a safer sex brochure, which was distributed together with condoms and lubricants. Safer sex seminars have also been organized for patrons, and initial results suggest an increased level of knowledge, improved personal risk assessment and increased condom use inside the bathhouse.²¹

In Vietnam, the Nguyen Friendship Society is reported to have carried out a range of educational, outreach and other activities—including condom distribution—to MSM in Ho Chi Minh City.²² Fashion events have been organized to promote AIDS awareness and enhance self-esteem among MSM. There are

reports of similarly innovative, but as yet unevaluated, outreach work among different groups of MSM in a range of locations in Indonesia, including Surabaya.²³

There seem to be a number of patterns in reviewing these reports from Asia. As in other parts of the world, the projects targeting MSM have almost always been conducted by small, nongovernmental, gay or gay-emergent organizations with limited staff and resources. Much of this work has focused on outreach activities that seek to reach MSM in settings where they congregate, socialize or meet sexual partners. A number of groups also have begun to initiate meetings and workshops aimed at involving men with AIDS prevention programs and organizations. As in the case of the Library Foundation in the Philippines, they are increasingly emphasizing notions of collective empowerment and building a stronger sense of gay community as a way of providing social support for risk reduction.³

PREVENTION EFFORTS AMONG MSM IN LATIN AMERICA

Many of the same approaches for AIDS prevention and intervention directed at MSM are being used in Latin America. As in Asia, small, nongovernmental, gay and AIDS activist organizations have tended to take the lead role in developing prevention programs. In Mexico, for example, gay rights organizations such as Colectivo Sol have undertaken a range of HIV prevention activities. A Todo Vapor, Colectivo Sol's project in the public steam baths of Mexico City, aims to inform patrons and bathhouse managers about STD and HIV transmission, safer sex practices and condom use. Condoms and water-based lubricants have been distributed as part of this work.¹

In Costa Rica, a well-developed gay subculture coexists with more traditional forms of homosexual and bisexual behavior—independent of a distinct “gay” identity. The Instituto Latinoamericano de Prevención y Educación (ILPES) has undertaken a wide range of prevention activities, including a telephone information line, holistic workshops in which sexual health concerns are addressed within the broader framework of self-understanding and self-esteem, work in prisons and outreach work in a

variety of locations, including male brothels. A recent evaluation of ILPES' workshops for gay men showed them to be effective in reducing the incidence of reported unprotected insertive and receptive sex.²⁴

A number of important programs have been developed in Peru.²⁵⁻²⁷ In collaboration with the Homosexual and Lesbian Movement in Lima, an educational intervention was initiated in 1988 for a cohort of 50 middle-class homosexual and bisexual men in Lima. The men in the cohort attended a program of three workshops that used group dynamics and audiovisual materials to provide information about HIV/AIDS and eroticizing safer sex practices. Evaluation documented a relatively high initial level of information about HIV/AIDS, as well as significant willingness to change risk behavior as a result of participation in the workshops.²⁴ This work was extended in the early 1990s through the work of the Via Libre Association in Lima. Following a survey on AIDS-related knowledge, attitudes, beliefs and practices, a three-and-a-half hour workshop was developed to improve HIV/STD risk perception, increase motivation and skills related to prevention and develop solidarity with people living with HIV/AIDS (PLHA). Pre- and post-workshop questionnaires were used to evaluate knowledge, attitudes and perceived skills. A follow-up survey was used to compare recent behavior with that of a non-interview control group, as well as to assess the accuracy of risk perception. The program was reported to have raised knowledge and decreased discrimination against PLHA, with a high percentage of the participants approving of the workshop methodology.²⁷

Brazil probably has the largest number and most varied range of projects. A number of important early activities, such as an AIDS hotline and free condoms, were developed in the mid- to late-1980s by a range of gay rights organizations, including Atobá in Rio de Janeiro and the Grupo Gay de Bahía (GGB) in

Salvador.²⁸ Like the projects in other parts of the developing world, these early initiatives for the most part were both poorly funded and relatively unsystematic due to their lack of resources.

One important exception to the relatively few small-scale intervention programs that have characterized the response to HIV/AIDS in most other developing countries has been the “Homosexualities Project” developed for MSM in Rio de Janeiro and São Paulo. The project sought to develop a range of activities and strategies designed to clarify the relationship between homosexuality and HIV/AIDS, and create a supportive social environment for risk-reducing behavioral change on the part of the emerging gay community. It aimed to address the stigma and discrimination related to homosexuality in Brazilian society, seeking to demystify homosexual behavior and develop a more realistic assessment among the population as a whole of the relationship between AIDS and homosexuality. Intervention methods included a range of outreach activities aimed at reaching MSM in the diverse sites in which work was carried out, and developing a range of cultural activities such as theater workshops, video and theater production and related cultural events.²⁹⁻³²

One of the most important elements of the Homosexualities Project in Brazil was the fact that it was developed in partnership among local AIDS-service organizations, gay activist groups and university research centers. Largely because of this partnership, it was possible to develop a set of ongoing research activities to monitor intervention activities through ethnographic observation and to monitor community impact through repeated surveys of sexual behavior and behavior change.^{12,32} These studies showed that between 1990 and 1995 there was a dramatic increase

in the perception of risk on the part of the men interviewed concerning their potential risk of HIV infection as well as in their belief that they could take positive action to avoid infection. Although the number of men reporting anal sex in the six months prior to the interview rose from 67.4 percent in 1990 to 76.3 percent in 1995, the proportion of unprotected anal sex fell from 54.1 percent in 1990 to 22.0 percent in 1995. The proportion of anal sex protected by condoms rose even more dramatically, more than doubling from 34.0 percent in 1990 to 68.7 percent in 1995.³²

An expanding number of interventions throughout Brazil in recent years have sought to address the needs of MSM, as well as men involved in sex work or in prison. AIDS-service organizations and gay groups—such as GAPA-Minas Gerais in Belo Horizonte, GAPA-Ceará in Fortaleza, GAPA-RS and Nuances in Porto Alegre, Grupo Dignidade in Curitiba, Atobá and the Grupo Arco-Íris in Rio de Janeiro, as well as GGB and GAPA-Bahía in Salvador—have all developed programs largely funded by the National AIDS Program of the Brazilian Ministry of Health.³¹ In a number of cases, special programs have been designed for behaviorally bisexual men, sex workers and men in prisons.³²⁻³⁴

Throughout the Latin American region, a growing number of HIV/AIDS and gay organizations have become increasingly involved in similar prevention activities. The Corporación Chilena de Prevención del Sida³⁵ and the Centro Lambda³⁶ in Santiago, Chile, for example, have developed a range of research and prevention activities directed at gay and bisexual men (see the case study below). As in Asia, these initiatives for the most part have been relatively small-scale—most frequently carried out without significant financial support, and in some cases, unfortunately, even in the face of official resistance. By focusing on strategies such as street outreach, cultural activism and community-building and mobilization, important steps are being taken to redress the previous lack of attention to one of the most vulnerable population groups in virtually all of the countries in the region.

PREVENTION EFFORTS AMONG MSM IN THE CARIBBEAN

The Caribbean region* has HIV prevalence rates second only to sub-Saharan Africa. By year-end 2000, UNAIDS estimates that an average of 2.3 percent of adults in the Caribbean were infected, 35 percent of them women.³⁷ Heterosexual contact was the primary mode of transmission and male-male sex a distant second. Up to five percent of the adult population in Haiti is HIV positive. The rates varied in countries such as Trinidad and Tobago (1.05 percent adult), Barbados (1.17 percent adult), Guyana (3.01 percent adult) and the Bahamas (4.13 percent adult).³⁸ The number of new AIDS cases in this region doubles every four to five years. Many cultural, social and behavioral factors and practices contribute to such high rates in the Caribbean, including early sexual initiation; acceptance and even encouragement of multiple sexual partners for males; low levels of condom use; substance abuse; denial that sexual activity occurs in prisons; and social norms that prevent open dialogue about sex with youth in schools.

While heterosexual contact is the primary mode of HIV transmission in the Caribbean, it is important to examine the role of male-male contact in transmission. There is widespread denial in the region of MSM activity, so it is often disregarded or ignored as a mode of HIV transmission. Homosexual behavior is illegal in most Caribbean countries (i.e., Barbados, Jamaica, and Trinidad and Tobago).³⁹ There are high levels of homophobia in the region and homosexuality is highly stigmatized by the general population as well as influential sources such as religious groups and politicians. Because of the stigma and fear of persecution and even prosecution, MSM are often not open about their sexual orientation. In fact, many MSM do not self-identify as homosexual or even bisexual. Research has shown that there are a significant number of men in the Caribbean region who have sex with men, and are not only openly involved in sexual relationships with women, but self-identify as being heterosexual.⁴⁰ This obviously has serious implications for prevention programs and makes it extremely diffi-

cult to target this group with effective communication interventions. These complex factors result in a lack of interventions targeting MSM.

An analysis of HIV data from this region reveals a high percentage of “other” listed as the mode of transmission. In conjunction with research this lends credence to the supposition that there are relatively high levels of MSM transmission in the Caribbean. The “probable exposure” category of the Pan American Health Organization (PAHO)/ World Health Organization (WHO) 1997 estimates of HIV cases in the English-speaking Caribbean suggests that 14.5 percent of all new exposures were attributable to male-male contact. More recent statistics report an average of 18 percent of cases listed as “unknown” across the region and as high as 35 percent in some countries.³⁹ Although the levels of HIV among MSM in the Caribbean are not completely known, there are strong indications that it is high. This comes mainly from the high percentage of those who claim “other” as their transmission mode and from health care practitioners who report a large number of young gay men dying from AIDS.⁴¹

Commercial sex in this region is complex and deserves mention and examination in the context of HIV/AIDS and MSM programming. There are various forms of heterosexual and homosexual prostitution in the Caribbean—street workers, bar workers and independent workers—as well as many types of sex tourism, such as casino girls, “sanky panky” (MSM), beach boys/“rent a dread” and female tourism workers. Among these are men and women who cater to both men and women in heterosexual and homosexual settings. Sentinel surveillance in the Dominican Republic for 1999 shows an HIV prevalence rate of 10 percent among commercial sex workers.^{42,43}

* This section refers mainly to the English-speaking Caribbean region, with some focus on the Spanish-speaking Dominican Republic.

HIV/AIDS interventions with MSM are further complicated by the existence of often complex sub-groups within the broad category of MSM. In the Dominican Republic, for example, there are four main sexual identity groups that may include MSM behavior: cross dressers, homosexuals, gigolos and bisexuals. These sub-groups need to be more fully understood and considered when creating prevention messages. It is extremely important to consider the role of MSM in society—their behavioral patterns and individual and group needs when planning prevention, care and support programs in the Caribbean. Programs need to foster openness, promote understanding and work towards eliminating stigma.⁴⁴ The most successful programs will understand and address the social and psychological factors behind MSM behaviors. Programs also will work to help men protect themselves in their sexual relations with other men, as well as with their female partners and future children. MSM interventions will be strengthened by working with the men on skills-building and self-esteem issues. Successful MSM programs have decreased vulnerability in this group. They become successful by having the backing of political leaders and other key stakeholders. Acceptance of MSM and successful interventions with MSM in the Caribbean region still have a long way to go, but MSM are an important constituency of HIV prevention planning and implementation, and can no longer be ignored by policy makers and program implementers.

LESSONS LEARNED AND RECOMMENDATIONS

In countries and cultures around the world, the types of small-scale, community-based programs described above have emerged to respond to the vulnerability of MSM in the face of HIV and AIDS. Given their limited scale, it is not surprising that such programs have not been enough to turn back the tide of the epidemic. Because they have almost never been systematically evaluated through the use of experimental or quasi-experimental research designs, the programs have not provided the kind of empirical information base that would ideally be available to programmers and policy makers in developing countries seeking replicable models of HIV/AIDS prevention programs for MSM. One of the most obvious conclusions from this review is that rigorous intervention and evaluation research on the structure, process and outcomes of prevention programs for MSM in developing countries are urgently needed.

In spite of these limitations, however, the descriptions we have reviewed above—they are largely based upon observational reports and case studies rather than experimental evaluation designs—nonetheless provide a clear sense of the issues that must be addressed. On the basis of such reports, it is clearly possible to provide a strong theoretical framework that will enable policy makers and other stakeholders to design and implement meaningful programs even in the absence—or while waiting for the results—of more experimentally valid scientific research findings. If they are implemented urgently enough, these programs will surely save lives and reduce HIV/AIDS-related human suffering.

First and foremost, the programs have demonstrated the fact that correct, up-to-date information about HIV/AIDS is necessary to prevention and care, which must be guaranteed to all population groups—especially those that have traditionally been marginalized and stigmatized in society. But the programs also have confirmed the fact that although access to information is necessary for responding effectively to the epidemic, it alone is not enough to ensure a successful response.

Beyond knowledge and information, or behavior change models based on notions of rational decision making, there are more intangible social, cultural, eco-

conomic and political issues of central importance. Above all else, perhaps, these programs demonstrate the importance of reaching out, building communities capable of providing community support structures, empowering MSM to take action on their own behalf, and ensuring their basic human rights and dignity—even in the face of persistent stigma and discrimination on the part of the wider society. In fact, a number of key principles emerge from this experience that can be considered as absolutely essential to the development of effective prevention and care programs. To be successful, such programs must recognize:

- The diversity of both identity and behavior among MSM, and their HIV prevention and sexual health needs.
- In many cultures concepts such as homosexuality, bisexuality or being “gay” may have little meaning, and even in societies that use such categories many MSM may not consider them to be relevant to their own identities or experiences.
- The value of gay community attachment for men who do identify as gay, and show confidence in their emerging sexual identity.
- The value of community outreach work in public sex environments, bars and other sites where men meet other men to have sex.
- The importance of mobilizing communities and developing community support structures to reach MSM and provide them with social and psychological support for adopting and sustaining safer sexual practices.
- The importance of collective and individual empowerment in the face of widespread stigma and discrimination as a key element of all intervention programs for MSM.
- The importance of defending basic human rights for MSM as part of broader efforts to develop a social climate capable of supporting the reduction of vulnerability to HIV/AIDS and other health risks.

Each of these principles is centrally important to creating a social context capable of reaching MSM. Ultimately it will only be possible to reduce the vulnerability of MSM to HIV and AIDS by linking all such principles together as part of a coherent program of mobilization and support.

FUTURE CHALLENGES

Recognizing the applicability and interdependence of such principles is the key challenge to the development of HIV/AIDS programs for MSM in resource-constrained settings—whether in the countries and cultures of the developing world or among the many poor and marginalized populations in the so-called developed countries. Such recognition will be possible only by building on the experience of highly localized community-based programs to scale-up existing activities with the goal of reaching larger and more isolated segments of the MSM population. Scaling-up, in turn, will require a serious investment in formative and evaluation research to ensure that programs meet the needs of communities and help reduce vulnerability and behavioral risk. It will also require ongoing commitment to providing the necessary resources for ensuring successful prevention. It helps very little to promote condom use, for example, if condoms are unavailable or inaccessible. (See Chapter 12 for information on condom social marketing strategies.)

Treating STDs as an important way of reducing HIV infection will be doomed to failure if health care services are unable to guarantee a nondiscriminatory environment for attending patients who are homosexually or bisexually active. (Chapter 15 discusses STD control among special populations.) Increasing the scale of program activities must never be confused with substituting their fundamental community base—or taking control of program activities out of the hands of community members in favor of professional staff or bureaucratic administrators from outside the community. It is essential that programs for MSM remain deeply rooted in community structures and community organizations precisely because these contexts provide the necessary vehicle for reaching isolated individuals and segments of the larger population. The task that remains everywhere in the world is to recognize this fact, and provide these communities and community-based organizations with the resources, structural and policy support and creative freedom they need to do their work.

CASE STUDY

PREVENTIVE INTERVENTION AT PUBLIC SEX SITES IN SANTIAGO

Sites where there is public sex between men have traditionally been the focus of AIDS prevention programs in Western gay communities. Such interventions have been less common in other countries where there is public sex, particularly between men, because it is more difficult to acknowledge or because homosexuality is more stigmatized. This makes the Chilean experience of an HIV/AIDS prevention program in public sex sites (PSS) of particular interest in this chapter.*

This program was implemented by the Corporación Chilena de Prevención de SIDA (Chilean AIDS Prevention Council [CChPS]). In the first phase, carried out in 1993 and 1994, CChPS assessed homosexual activity in public places to characterize the context and identify the intervention needs in these venues. This assessment was aimed at determining patterns of sexual behavior among homosexual and bisexual men who have sex in public places; their level of information about STD/HIV/AIDS; risk perception; attitudes and beliefs about their sexual activity; and the role of public sex in their affective and emotional life. Two types of spaces, namely open venues such as parks (“type 1”) and saunas (“type 2”) were targeted.

Of the 35 persons who were approached, 22 mostly middle- and upper-middle-class men agreed to have verbal contact in the locations studied, while another six participated in in-depth interviews. They ranged in age from 17 to 50, with an average between 21 and 30. Sixteen defined themselves as homosexual, three as heterosexual, two as bisexual and one did not specify. Twenty expressed their fear of contracting STD/HIV/AIDS. Ten reported practices posing high- or medium-risk for HIV/AIDS, and another 10 had less than basic information about the transmission and prevention of STD/HIV/AIDS. Twenty believed that preventive interventions were important in those places.

Information gathered in this first phase led to the conclusion that riskier situations occur in open spaces because the brevity of the encounter impedes the negotiation of safer practices. In contrast, saunas offer better conditions in which to negotiate safer practices. The men had a range of motives for seeking sex in these spaces. A few individuals who seem to seek anonymous sex to escape emotional abandonment are highly vulnerable and require the design of specific preventive interventions. A second group of individuals, who look for anonymous sex—sometimes under the influence of alcohol—are also highly vulnerable and have special intervention needs. A third group appear to seek casual sex for personal convenience. They seem to be less vulnerable and more receptive to prevention messages. It became clear that most individuals understood prevention to mean not doing things that they did not find exciting or amusing.

The second phase sought to implement and evaluate an intervention aimed at:

- Providing adequate sexual health information to the MSM population who use PSS, so it is possible to do realistic assessments of personal behavioral risks.
- Facilitating access to condoms and safer sex information.
- Generating common ground between the prevention program monitors and the users of public sex spaces so as to present prevention as a lifestyle applicable everywhere and in any situation, without giving up pleasure.

Both open spaces and saunas were targeted. CChPS devised a schedule of visits to the sites and reprinted educational materials. Intervention records, which would serve in monthly process evaluations and to measure the intervention impact, were revised and improved. A training workshop for new monitors was designed and applied in January 1996. Visits to PSS were made three times a week on the busiest days between May and July 1996, and the team held weekly meetings to evaluate program implementation and prepare evaluation reports.

* In preparing this case study, we would like to acknowledge information provided by Tim Frasca from the Corporación Chilena de Prevención de SIDA; Victor Parra, originator and chief investigator on the project; and Juan Carlos Silva and Juan Carlos Rios, the principal collaborators during the execution phase of the project.

Process information collected in the first semester of 1996 reveals that a total of 8,100 PSS users were observed, 64.5 percent of whom were reached and given educational materials and condoms. First-level contact—asking the monitor for information about STD/HIV/AIDS or CChPS—was made with 780 (9.6 percent) individuals. Second-level contacts—the individual talking about his sexuality, emotions and doubts about STD/HIV/AIDS—were made with 225 individuals (3.2 percent). Of the total population observed and interviewed at the PSS, 68 (0.31 percent) individuals phoned CChPS with more specific questions, and 79 (0.97 percent) visited CChPS to use its services.

Monthly qualitative and quantitative reports on the visits to the PSS were prepared so the impact of the intervention could be analyzed. Of the 225 contacted at a second level, 96.8 percent felt the intervention was very adequate, positive or very positive, and declared that the distribution of condoms at PSS was very important, since having them at hand might increase their use. On the downside, three percent were indifferent or reacted negatively to the intervention without stating their reasons.

This research experience is of particular value in the region because it has an adequate framework of development (i.e., a formal needs assessment), a focus on a usually neglected sex scene which should be a priority for prevention efforts and a well-documented process and impact evaluation. Another of the study's merits was its success in gaining access to subjects who are looking for the anonymity of the PSS in Chile, where homosexuality is illegal.

RELEVANT CHAPTERS

Chapter 12 *Social Marketing for HIV/AIDS Prevention*

Chapter 15 *Issues in STD Control for Special Populations*

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