

Different preventions methods lead to different choices? Questions on HIV/AIDS prevention for men who have sex with men and other vulnerable populations

Diferentes prevenções geram diferentes escolhas? Reflexões para a prevenção de HIV/AIDS em homens que fazem sexo com homens e outras populações vulneráveis

Veriano Terto Jr.¹

ABSTRACT: On the basis of an ethnographic narrative on sexual interactions observed in urban parks in large Brazilian cities, the article discusses the adoption of new strategies and methods for AIDS prevention in vulnerable populations, especially in men who have sex with men (MSM). By following some guiding questions, the text debates when, why, with whom, and in which context the new prevention methods should be adopted. It emphasizes, in agreement to the initial narrative, the importance of taking into account the prevention strategies created by the population itself to manage HIV risk infection. It also addresses how prevention practices and messages are adapted and recreated by individuals and groups in an attempt to suit them to their sexual desires, practices, and choices. In this perspective, the article recommends the inclusion of the experiences and voices of individuals and groups considered vulnerable in the new AIDS prevention methods and programs targeted to them.

Keywords: Homosexuality. Disease prevention. Vulnerable populations. Social participation. Safe sex. Access to information. Risk management.

¹Associação Brasileira Interdisciplinar de AIDS (ABIA). Instituto de Estudos em Saúde Coletiva, Universidade Federal do Rio de Janeiro – Rio de Janeiro (RJ), Brasil.

Corresponding author: Veriano Terto Jr. Av. Pres. Vargas, 446, 13o andar, CEP: 20071-907, Rio de Janeiro, RJ, Brazil. E-mail: verterto@gmail.com

Conflict of interests: nothing to declare – **Financial support:** none.

RESUMO: A partir de um relato etnográfico sobre transas sexuais em parques de grandes cidades brasileiras, o artigo buscou discutir a aplicação de novas estratégias e métodos de prevenção de vírus da imunodeficiência humana / síndrome da imunodeficiência adquirida (HIV/AIDS) em populações vulneráveis, em especial na população de homens que fazem sexo com homens (HSH). O texto aborda quando, o porquê, para quem e em quais momentos adotar novos métodos de prevenção. Argumenta e enfatiza, conforme o relato inicial indica, a importância de se levar em conta as formas criadas e adaptadas pela própria população para manejar os riscos de infecção pelo HIV. Aborda ainda como as práticas e mensagens de prevenção são adaptadas e moldadas por indivíduos e comunidades, como forma de adequá-las aos seus desejos, escolhas e práticas sexuais. Nesse sentido, o artigo recomenda a inclusão da voz e das experiências das próprias pessoas consideradas vulneráveis nos programas que promovem a adoção de novos métodos de prevenção.

Palavras-chave: Homossexualidade. Prevenção de doenças. Populações vulneráveis. Participação social. Sexo protegido. Acesso à informação. Gestão de risco.

It's 11:00 p.m. on a Saturday, when Carlos walks in the park in this pleasant summer evening. As he leaves behind the most well-lit alleys and approaches the darkest corners of the northwest part of the park, he feels that his senses are sharpened; his vision penetrates the gloom, trying to guess what those shadows, walking past each other over there, are doing under those big trees; his nose breathes in the smell of mud, still fresh from the rain of the previous days, and of the urine of those who have sought refuge in those shadows for a quiet pee and something else; his ears, similar to a radar, try to detect tones of voices and laughter in the distance, from another group of queens*

*The use of emic terms in this report is intended to strengthen the aspects and features of the reported experience. Not all apply to all the regions in Brazil. It is important to consider them in the prevention and education activities in order to bring these activities closer to the experience and language of the target population. The following is an explanation of the gay slang used, in the order of appearance in this text, used in some regions of the country.

^Translator's note: This article was translated into American English from Brazilian Portuguese and was culturally adapted for better understanding.

1. "Queen": an effeminate male homosexual;
2. "Camp": be obviously and obnoxiously homosexual, mimic or exaggerate female mannerisms;
3. "Trade": a homosexual looking for action, a person regarded only as a sex partner;
4. "Gay basher": someone who are violent toward and/or attacks LGBT// people;
5. "To bang": to have intercourse;
6. "Trick": any quick sexual encounter with someone, short-term sex partner;
7. "Twinkie": a young and fresh-looking homosexual;
8. "Boner": an erection;
9. "Blowjob": oral intercourse;
10. "Wanking": masturbation;
11. "To make out": to kiss and touch sexually;
12. "Well-endowed": to have a large penis;
13. "Hung": to have a large penis;
14. "Top": dominant person in a sexual relationship;
15. "Bottom": submissive person in a sexual relationship;
16. "Mugger": thief;
17. "Tranny": transvestite or transsexual female.

nearby that insist to gather to chat and be camp, a cry of “Thief!” echoing among the trees, or police sirens; his taste buds bring to his mouth the memories of some pleasures of the flesh he had enjoyed there in the previous weekend. His whole body prepares itself for, somehow, mapping the whole scenario and chasing after, efficiently and effectively, some interesting and available trade. However, he must be alert! He cannot be careless! There are many risks that compete with the possibilities of pleasure in the park, risks that can often turn the night into a nightmare. Thieves, repressive and corrupt police, gay bashers, and psychopaths of all kinds require the utmost care and attention. He still needs to be careful enough to use protection and not catch a disease. Still, Carlos prefers to go to the park rather than getting himself into a noisy, claustrophobic, and often tedious environment, such as the gay bars and clubs in the city. He thought about not going to the park anymore, but more often than not, when he realizes, he is there again.... There were many times that he did well, but he also has gone through some hard stuff! Once, he was going down on a motorcycle courier and, at one point, the guy flipped, turned violent, and almost hit his head with the helmet. He has also seen some robberies and was almost caught by the police, who now and then decide to show up. He also remembers last year’s incident, when he decided to have sex with a guy in the park, and when they finished banging, he realized that the condom had broken. Good thing the Emergency Hospital of the Unified Health System (SUS) is right nearby, only a few feet away, and he knew that postexposure prophylaxis (PEP) was available and affordable at that time of night. He took the prophylaxis and, 6 months later, he did a test: the result was still negative. But anyway, this is not the time to remember these unpleasant things! There, in that bamboo grove just ahead, seems to be several potential tricks almost hidden in the darkness. It’s time to find them and get to “work”! After going twice through with a twinkie, who was leaning there against that tree displaying his boner, Carlos decides to engage him. The act repeats what he and so many others do there most of the time: a little foreplay involving a kind of rushed blowjob, some wanking, some making out — which is always good! — but it can also be different, and that is what happened with the second trick of the night: a very “well-endowed” guy, super hung, super naughty, and who he met by chance near the pond! Without exchanging many words, they began with the fun and games, lots of making out and hugs, and when Carlos realized, was already being penetrated. Despite being mind-blowingly horny, he managed to put a condom on the trick and use the lubricant in his shorts’ pocket. It is rare to find such a hot guy with whom he had so much chemistry to the point that they had actual intercourse, whether he was acting as a top or as a bottom. Doing it in the park is uncomfortable! And despite being horny, there is still the risk of being bothered by the police or by muggers. This time, however, it all worked out! The police seemed busy monitoring the public’s exit from a rock concert that had just ended in the park auditorium. All the other gays nearby, in the bamboo grove, seemed to be still “working” but were still alert and ready to sound the alarm if any muggers showed up. And the condom worked. Carlos decided to go home and crossed the park toward the bus stop, not before seeing, in the distance, near the avenue, that some prostitutes and trannies were still on duty, and a regular and always excited little group that stayed in the east side of the park, sharing their joys and thrills with some drugs. “That’s enough for today,” he thought. He concluded he was very lucky and successful that night and was able to relax and think of everything he wanted to do on Sunday: going to the market, walking the dog, eating lunch with his parents, going to the movies....

This article aimed to bring some reflections on the new ways for prevention of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), especially the prevention aimed at vulnerable populations, and, in the case of this text, men who have sex with men (MSM)**. The idea of beginning the study using this scene is precisely to bring the discussion closer to the experience, with the adoption of prevention methods and in the places attended by a significant part of this population. Incidentally, this scene was assembled from informal ethnographic observations performed sporadically over the last 10 years by the author in different parks in big Brazilian cities, where homosexual practices occur on some nights. This approach was used by the author to learn about the sexual scenarios frequented by MSM in Brazil¹. To compose this narrative, some fragments of informal conversations with colleagues who participated in these sex scenes and those experienced by the author were used. It should be emphasized that this story is only inspired by the reality and does not correspond to a specific situation, being just a recreation of some observed situations. In this sense, the character described here is fictional but reflects experiences that took place in sexual encounter scenes. Some elements and events in that scene will be resumed in the discussions opened by this article.

Since the mid-1990s, and especially since the 2000s, a number of studies, accompanied by discussions and positions taken by people and civil society organizations, coordinated from various countries, have put into question the dominant discourse that focuses on the consistent and correct use of the condom as the most efficient and effective way to prevent HIV. This debate has pointed to a growing number of individuals and groups who express a fatigue regarding the use of condoms and poses the urgency of new, more appropriate prevention alternatives, suitable to their sexual practices and their lifestyles². Fatigue regarding to condom use would simply be a result of disinhibition caused by the availability of antiretroviral (ARV) drugs or the neglect regarding condom use, but may be it expresses the limits of current prevention strategies***.

On the other hand, in the last decade, a lot of research has proven the effectiveness of new technologies and biomedical strategies for prevention. These are studies that demonstrate the effectiveness of prophylaxis, pre- and postexposure to HIV (with the use of ARV drugs), circumcision³ in heterosexual men, topical vaginal and rectal microbicides, and the

**The term “men who have sex with men” is deliberately used here to highlight the (homo)sexual experiences had by these men, without ignoring that, in their social and political lives, they can identify as homosexual, gay, bisexual, or even heterosexual, among other possible sexual identities.

***One of the first signs of the “fatigue” in relation to condom use and the of public health discourse on the prevention originated from segments of the US gay community that, in the second half of the 1990s, gave visibility to consensual and deliberately unprotected sexual practices for HIV and other sexually transmitted diseases (STDs) and released manifestos in the media claiming the reasons for this resignation to condom use and the adoption of practices that they called barebacking. The term spread to several countries, including Brazil, to the point that, currently, any unprotected sexual practices among MSM are classified as barebacking, despite these current practices being often noncompliant to the original rituals, meanings, and political reasons expressed in the writings of those early individuals that adopted barebacking in the 1990s¹⁷.

impact that treatment with ARV drugs in HIV-positive people has showed in HIV transmission. In the latter case, it happens when the treatment can reduce viral load measured in the blood to undetectable levels, and the person maintains a high rate of cluster of differentiation 4 (CD4) immune cells⁴.

The results of these studies, coupled with the demands and positions defended by the population itself, indicate that a single prevention strategy, be it based on the use of condoms or some other method, is not enough to respond to the epidemic. Different technologies, methods, and strategies are needed to ensure the increasing adherence of individuals and vulnerable groups, thus decreasing the spread or perhaps eliminating new HIV infections. This is not to demonstrate that the condom is outdated and should no longer be used but to present other prevention possibilities, also including constant and correct condom use.

On one hand, studies with biomedical methods, broadening the range of possibilities for prevention, point out the challenges for its implementation and present the reasons why they should not be used alone. Some methods, such as PEP, preexposure prophylaxis (PrEP), voluntary male circumcision, and the strategy to immediately treat all those with a positive test for HIV, are already available in a growing number of countries and are approved and recommended by the World Health Organization (WHO) for the so-called key populations, including MSM⁵. On the other hand, studies on vaginal and rectal microbicides have advanced considerably but not enough to be included in the prevention programs of these countries⁶.

To be most effective, these methods should be used in combination, according to the needs and circumstances of individuals and populations. For example, circumcision in heterosexual men can show a protection rate between 50 and 60% in the prevention in heterosexual relationships⁷. To improve their effectiveness, they could be used in combination with condoms or with the use of microbicides that are potentially protective against HIV infection. On the other hand, it is a method whose effectiveness in gay men was not observed; therefore, it should not be recommended for this population, owing to the characteristics of their (homo)sexual practices****. This example shows that a combination of methods may be more effective, also according to populations, needs, scenarios, times, practices, and values and social representations involved in the lives of people and social groups.

The choices and decisions that people make not always happen rationally. In an adverse context, in the absence of external and internal resources, people may be led to choices and decisions that do not necessarily match their wants and needs but that were determined as possible by the time and the place. As the individual in the scene at the beginning of this article, people create and choose ways of protecting themselves according to the situations and conditions in which sexual experiences and encounters happen. For example, some

****Many MSM alternately practice penetrative (“actively,” performing the penetration) and receptive (“passively,” being penetrated) anal intercourse. For those who are penetrated, being circumcised would not provide any protection. In this sense, circumcision would be recommended for countries with generalized epidemics with heterosexual pattern.

people in a situation of anonymous sex (as in the scene described), with limited comfort conditions, can avoid practices involving penetration, may perform oral sex without a condom, but avoiding ejaculation in the mouth, or may only choose masturbation alone and/or with others, that is, they adapt information, methods, and inputs according to the situation and the conditions under which sexual relations take place.

The choices, the adjustments, and the adoption of preventive methods and behaviors can also be linked to a person's care with the quality of their sexual experiences, here considering performance in sex, degree of satisfaction, fulfillment of sexual fantasies, among others. In this sense, the advent of new technologies and their influence on people's sexual lives can provide an opportunity to reflect on the quality of sexual life of individuals and groups in relation to current HIV prevention schemes.

In this sense, the choices of which methods and combinations to adopt are likely to become even more complex, because they imply a number of and social and psychological issues and dynamics we should consider. In this article, we address some of these issues, especially those that may involve individual decisions, in addition to the relationship between health professionals and users when choosing forms of prevention.

WHICH PREVENTION STRATEGIES AND METHODS AND COMBINATIONS ARE WE TALKING ABOUT?

Prevention strategies and methods currently available can be categorized as behavioral, educational, and biomedical⁸. The first two do not depend on doctors and other health-care professionals but can be created and adopted by groups and individuals from their own communities, as discussed further. Among the educational methods, we can mention condom promotion, dissemination of information on prevention, and individual or collective counseling, which can be recommended and practiced alone or in combination and can rely on guidance of professionals from other disciplines [educators, teachers, professionals from non-governmental organizations (NGOs), and activists] and volunteer educators (peer education).

Biomedical strategies and methods (PEP, PrEP, microbicides, and circumcision) usually rely on health-care professionals, usually a physician, for its recommendation, adoption, and monitoring⁹. The effectiveness of these new methods is known only in some specific populations and regions, where they were studied; however, the results are encouraging and suggest that such instruments can be used in combination with other techniques. Thus, new methods compose prevention packages that are suitable for different moments and situations faced by individuals throughout their lives.

In parallel with the advent of new prevention technologies, some groups of MSM are adopting sexual behaviors that are more appropriate to their sexual practices and desires. In recent years, for example, in some gay communities in western Europe and the United States, a behavior called serosorting was identified. It involves sexual transactions between people with concordant serology, that is, HIV-negative people would have sex with

seronegative people and people living with HIV would have sex with seropositive people, thus renouncing the use of condoms in a mutual agreement⁹. This behavior, usually adopted by individuals who are highly educated and knowledgeable about HIV, involves risks that are taken by the people who manage well their levels and forms of exposure to the virus.

One can think of the availability of a home HIV self-test in the future that will increase if the serosorting behavior increases, as it is a quick test done in situ (home, motel, etc.) by the supposedly HIV-negative partners themselves immediately before a sexual relationship, to, thus, negotiate and/or give up on condom use. Studies on the acceptability of a home testing in some populations, such as American homosexuals, are already underway, and according to some results, they are encouraging regarding its adoption in future. The idea is that its proposal and adoption are accompanied by an increase in education and the level of user information, so that they can inform and advise potential partners about the test and, in the case of a positive result, support and reference the newly known seropositive to health services for supplementary tests for confirmation of the diagnosis and early treatment¹⁰. Of course, even with the home test, the serosorting strategy still implies risks for other STDs, and even for HIV, if we consider issues such as the window period in recent infections. The window period is the initial infection period in which the available tests, including quick tests, do not detect the presence of antibodies to HIV, although the infection is already installed and active. In this period, the possibility of HIV transmission is greater owing to the higher viral load at this early stage of infection.

The examples cited here, such as barebacking and serosorting, demonstrate how people and sexual communities react, adapt, or create their own strategies for the prevention and management of the risk of becoming infected with HIV. In the case of barebacking, some of its practitioners end up creating almost a counter-discourse to the dominant discourse of prevention in public health from the late 1990s, whose emphasis is on using a condom always, in all sexual relations, in order to avoid any exchange of bodily fluids. Instead, in the barebacking discourse and practices, there is an erotic reinvestment in the exchange of bodily fluids such as semen, and the revaluation of collective sexual experiences, such as orgies and sex parties, as a structuring factor of community ties between certain sexual groups and communities. In the case of serosorting, there is a repositioning in relation to the methods available or being tested, not rejecting them totally but integrating some new features, such as the use of the home test (and the exchange of test results between two partners) and perhaps PrEP. In addition, they seem to incorporate information on the risks associated with sexual practices, such as the chances of becoming infected while practicing insertive or receptive anal sex, oral sex with or without ejaculation, among others.

It is noteworthy that, in both the positions cited here, we are dealing with communities that are well-informed about HIV/AIDS and its prevention methods, which make them able to respond, accept, reject, or adapt this information to their practices, their styles, and

their sexual preferences. The protagonist of the scene described earlier, without resorting to barebacking and serosorting, also makes adaptations and choices, creating some forms of prevention that are appropriate to the environment, the timing, and the type of sex that can be experienced in a park setting. Certainly, the level of information on the forms of transmission, having a condom at hand and having the knowledge that there is a health-care service nearby where PEP is offered are fundamental for the character to be able to adapt and create his own forms of prevention.

The latest international literature on prevention identifies at least three main behaviors adopted by individuals and groups of MSM, which also represent the ways found by people to manage their risks, desires, and needs in prevention, similar to the subject of the scene described in this text. They are¹¹:

Seroadaptive behaviors: any attempt to reduce the risk of HIV transmission by changing sexual behavior, according to the partner's serology. Most commonly, it means restricting unprotected anal sex to anal sex partners with the same HIV status.

Negotiated security: when unprotected sex among HIV-negative men is confined to a stable primary relationship. In any eventual sexual encounters with other partners, condoms would be used.

Seropositioning: having unprotected receptive anal intercourse (i.e., passively) only with HIV-negative sexual partners and only having insertive anal intercourse (actively) with partners with unknown or positive serology to HIV.

Reflection on these adaptive behaviors can be very fruitful to understand how the discourse of prevention can approach or distance itself from the concrete sexual experience lived by individuals. This combination between what is studied and recommended by scientists and health and education professionals and what is rejected, recreated, and adapted by people may occupy an important place in the debates in the field of prevention in the coming years.

HOW TO DISCLOSE THE MESSAGES ON NEW PREVENTION TECHNOLOGIES AND HOW TO RECOMMEND THEM?

The disclosure on new forms and new methods of prevention, and the results of corresponding research, has been the subject of discussions in different scientific events and debates in communities and activist groups. On one hand, according to some health professionals and managers, dissemination of research findings and information to the public about these new methods could lead to disinhibition effects in some individuals and encourage them to relax in relation to condom use. On the other hand, the information is already in the media, in NGOs, and in the conversations between people, and we need to know and monitor how such information is reaching the public. However, access to information is a right that must be respected and guaranteed and is also an important step toward the results of research and new technologies becoming available and becoming a real resource in choices involving prevention.

The disclosure of these new methods should also be accompanied by education strategies involving the dissemination of correct, current, and appropriate information to the public to which they are addressed. The public disclosure and debate are important to promote acceptance and adherence by individuals and groups to the chosen technology combinations, and being spaces for them to express their needs and their own ways of dealing with the prevention discourses and practices. For example, the correct adherence to the ARV drug regimen is critical to the success of PEP and PrEP, leading to the need to discuss people's interest and chances of adhering, and for how long, to a prevention method that involves the use of drugs. On the other hand, more debates between community managers and scientists are also needed to encourage social mobilization and promote activism to ensure access to new methods and social control of current prevention policies and future prevention actions.

From an educational perspective, counseling deserves special attention because it will be crucial to update and train the counselors within the health system about these new methods and on how to guide and support the choices of users. This update may even be an opportunity for health-care professionals involved in counseling to take ownership and understand the diversity of sexual practices and desires of those advised and, thus, develop a more appropriate and focused advice on the person's needs. Likewise, in the community-based organizations and NGOs, among the peer educator, an opportunity arises to recycle their knowledge and integrate the new methods of prevention to the promotion of condoms. In some workshops on new prevention technologies, in which peer educators participated, the fear of incorporating these new methods and strategies would be brought up more than once, because, according to some reports, incorporating them now could undermine the authority and legitimacy of the educator with their peers, achievements that came after a big long effort to make condoms accepted****. This could pose a dilemma for educators: adhering to the official prevention discourse, still very focused on the slogan "always use a condom,, or reflecting to what extent they could include the needs and the recreated and adapted forms of prevention expressed by communities and, from there, incorporating new methods and their possible combinations in their work as instructors. Similarly, in other workshops on the subject, some health managers and professionals have questioned about the extent to which current health services of the Unified Health System (SUS) could be adapted to employ the new methods or whether it would be necessary to create services more prepared to administer the prevention packages (set of methods and strategies), because of the shortage in human resources and lack of logistic conditions of services to meet the current demands¹².

****Since 2010, from invitations by managers and NGOs, the author coordinates, alone or in partnership with Jorge Beloqui (GIV), workshops for health professionals and NGO activists about work with HIV. These workshops last for about 4 hours and involve presentations on new prevention technologies and exercise group participation, where cases, vulnerability, and risk situations are discussed.

The disclosure, dissemination, and appropriation of information by communities and health professionals still needs to be debated, as we saw in the preceding paragraphs, and this debate should not ignore questions such as knowing what these new methods are recommended to: the prevention of HIV/AIDS? Viral hepatitis? Other STDs? All these diseases together? As we will see in the next sections, these are fundamental questions for the choices and the decisions on which prevention method people will adopt.

WHEN TO ADOPT? WHEN TO RECOMMEND?

In a time when prevention methods tend to diversify, the choices about which methods to use, at what times, situations, and circumstances also tend to get more complex. For example, in the case of male circumcision, we can discuss at what point it should be performed: at birth, by decision of the parents; later, when the individual may have an understanding of the reasons for the procedure and may participate in the decision with his parents; or only in adulthood, when he may decide autonomously about the procedure.

The adoption or recommendation by health professionals regarding what combination of prevention methods and strategies to use must also take into account the history and life plans of individuals, the moments and milestones in handling situations of risk and prevention, and projects and plans, for example, wanting to get married, remaining or returning to being single, having children, keeping monogamous or not, among others. Similarly, thinking about what sexual practices are more common at a certain time of life can help deciding which methods to combine. There are times when people can be almost or completely abstinent from sex, or, for some groups of MSM, phases in which sexual practices focus on masturbation with other men in cinema halls and bathrooms, in which there may be little penetrative sex. There are other situations in which there may be more emphasis on oral sex and penetration during the same act, for example, in a steady relationship situation. In these different stages and situations, a higher or lower adherence condoms can happen, and, in some situations, until the fatigue in their use happens. This, however, does not necessarily mean abandonment or disinterest in prevention but different forms of risk management and prevention concepts.

IN WHICH CIRCUMSTANCES?

The choices involving prevention methods and combinations thereof are also determined by the context, social and institutional situations and logics in which people meet, such as being deprived of freedom (prisons and psychiatric hospitals), the fact of being in a marital relationship or not, and the adhesion or not to belief systems and values related to sexuality, health, among others. To be able to understand the context, it is necessary to know where people are coming from for prevention and to know the

destination of the messages. For example, in the case of communities where married women have a hard time trying to, or even where it is impossible to, propose and negotiate condom use with their husbands. Possibly, in these situations, combined methods can be put together to allow for greater adherence to prevention by the couple, not necessarily going through condom use. The use of effective microbicides (when available) allied with circumcision would be a combination that could reduce the risk of HIV infection in these and other similar situations.

The structural context also plays an important role, for example, in countries that decide to adopt the use of ARVs as a prevention method. In addition to PrEP and PEP, there is the strategy called “test and treat,” in which the treatment should start as early as possible in the course of HIV infection, as soon as the seropositive diagnosis is confirmed, even with acceptable or high rates of CD4 T cells (above 500 per mm³ of blood), in order to lower the viral load to undetectable levels in the blood and other body fluids¹³. Thus, the risk of HIV transmission would be substantially reduced. In this case, a wide and an effective program including testing, availability, and universal access to ARVs and quick and easy access to health services, along with mechanisms to increase adherence of HIV-positive individuals to treatment, are fundamental to the success of the strategy. In Brazil, universal access to ARVs could be a facilitator for the implementation of this strategy; however, the lack of more effective testing policies and actions, the stigma that still affects HIV-positive individuals, and the delay in access to health services in the public system would be considerable obstacles to access and adherence to this approach by people living with HIV. In this sense, investment for increased HIV testing and the incorporation of new diagnoses must be accompanied by investment in more staffs and more resources in order to ensure the acceptance and adherence of HIV-positive people to health services.

Just as it is important to know the cultural, political, and economic contexts, it is equally important to know the epidemic in each community and in each of the groups to which prevention programs are designed. After more than 30 years into the epidemic, it is known that different groups and individuals experience different “epidemics” of HIV/AIDS, in very specific contexts, with their own stories of impact, changes, with important moments and events, and the coexistence of the past and present health needs. The story of community groups and people with the epidemic may also be important in the processes of choice and both individual and collective decisions.

FINAL CONSIDERATIONS

According to the issues raised in this study, risk management and individual choices about combinations of new prevention methods depend not only on biomedical technologies but also on structural and programmatic factors (e.g., the way the public health system is organized, access to inputs, the political and legal environment, and costs), and

social (values, social representations and degree of stigma related to gender, race, and sexual orientation and HIV status, injection drug use, prostitution, etc.) and individual factors (frequency of sexual behavior and practices, level of information, individual path to prevention, to name a few)¹⁴. These factors should be considered, especially when it comes to vulnerable populations, such as gay men and MSM, group in which there was an increase in new cases of HIV/AIDS, according to the Joint United Nations Program on HIV/AIDS (UNAIDS)¹⁵.

Access to the results of studies on new methods of prevention and the limits and possibilities of those currently in existence are a matter of human rights. This is about the right to information and right to health, to the extent that these results can turn into ways to manage higher quality of individual and collective health. The appropriation of this knowledge by the most vulnerable people and communities (not forgetting those living with HIV/AIDS) requires a greater participation by them in current political and scientific debates on the subject¹⁶. In fact, sexual and affective experiences and the needs of people and groups regarding prevention — expressed through their own voice — should be heard both by those who advocate a more educational or social approach to prevention and by those who advocate a more biomedical approach to prevention. This could be critical to the development and implementation of any policy and prevention action, especially those aimed at more vulnerable populations such as MSM, sex workers, and injecting drug users, in their different stages of life and their socioeconomic backgrounds.

In this sense, the new prevention scenarios should be developed in an interdisciplinary (involving biomedicine, social sciences, community knowledge, and people's experiences) and intersectoral way (organized civil society groups, professionals and managers, lawyers, and scientists) in a collective and united effort. This is the only way to make prevention meant not only for the prevention of HIV/AIDS and other diseases but also for it to go further, meaning more rational choices and more individual and collective emancipation.

ACKNOWLEDGMENTS

This text is dedicated to the memory of Gabriela Leite, Brazilian tireless activist for Human Rights of Brazil's prostitutes, who died on October 10, 2013. Although already gravely ill, Gabriela was one of the reviewers in this article with Luis Vasconcelos. My thanks to both, and, especially Gabriela, for her efforts and generosity in such a difficult time of her life. Her participation in this text culminates from a common history of more than 20 years, in which we shared a countless number of discussions, panels, meetings, debates in national and international events, in which I got to have the pleasure of her company and of learning from her ideas and positions. She will be missed, and my admiration will be eternal.

REFERENCES

1. Terto Jr. V, Seffner F. Sex in Motion – Notes on urban Brazilian sexual scenes. In Aggleton P, Parker R. *Routledge Handbook of Sexuality, Health and Rights*. New York: Routledge Ed.; 2010.
2. Brasil. Ministério da Saúde. Gays e outros HSH são mais escolarizados, têm maior poder aquisitivo e acessam mais o serviço público de saúde que os homens em geral, junho 17, 2010. Disponível em: <http://www.aids.gov.br/noticia/gays-e-outros-hsh-sao-mais-escolarizados-tem-maior-poder-aquisitivo-e-acessam-mais-o-servico> (Acessado em 18 de outubro de 2014).
3. Camargo R. Novas tecnologias de prevenção: circuncisão médica masculina. Apresentação no II Seminário Nacional sobre Vacinas e Novas Tecnologias de Prevenção. São Paulo, setembro de 2014. Disponível em: <http://www.giv.org.br/Semin%C3%A1rios/II-Semin%C3%A1rio-Nacional-Vacinas-e-Tecnologias-de-Preven%C3%A7%C3%A3o-HIV-Aids/index.html> (Acessado em 19 de outubro de 2014).
4. Brasil. Ministério da Saúde. Recomendações para terapia antirretroviral em adultos infectados pelo HIV-2008. Suplemento III Tratamento e Prevenção. Brasília: Ministério da Saúde; out. 2010.
5. Calazans G. Diretrizes consolidadas sobre diagnóstico, prevenção, tratamentos e cuidados para populações-chave. Apresentação no II Seminário Nacional sobre Vacinas e novas Tecnologias de Prevenção. São Paulo, setembro de 2014. Disponível em: <http://www.giv.org.br/Semin%C3%A1rios/II-Semin%C3%A1rio-Nacional-Vacinas-e-Tecnologias-de-Preven%C3%A7%C3%A3o-HIV-Aids/Apresenta%C3%A7%C3%A3o-GabrielaCalazans-Popula%C3%A7%C3%B5es-Chave-II-Semin%C3%A1rio-Vacinas-e-Novas-Tecnologias-GIV.pdf> (Acessado em 19 de outubro de 2014).
6. Microbicide Trials Network (MTN). Rectal Microbicides Fact Sheet, 25 March, 2014. Disponível em: <http://www.mtnstopshiv.org/node/2864> (Acessado em 25 de dezembro de 2014).
7. Roehr B. Male circumcision helps to prevent HIV acquisition, says Cochrane review. *BMJ* 2009;338:b1545.
8. De Wit J, Aggleton P, Myers T, Crewe M. The rapidly changing paradigm of HIV prevention: time to strengthen social and behavioural approaches. *Health Educational Research (Oxford Journals)* 2011;26(3):381-92. Disponível em: her.oxfordjournals.org/content/26/3/381 (Acessado em 23 de dezembro de 2014).
9. Pietranelo A. Living with HIV: is serosorting safe. *Healthline*. Published on 24th July, 2013. Disponível em: <http://www.healthline.com/health/hiv-aids/serosorting-safe#Serosorting1> (Acessado em 22 de maio de 2013).
10. Carballo-Diéguez A, Frasca T, Balan I, Ibitoye M, Dolezal C. Use of a rapid HIV home test prevents HIV Exposure in a High Risk Sample of Men who have sex with men. *AIDS Behav* 2012;16:1753-60.
11. Cairns G. A sorodiscordância ajuda a prevenir o HIV – até certo ponto. *Boletim Vacinas Anti-HIV/AIDS*, n. 27, set. 2012. p. 5-6.
12. Belouqui J, Seffner F, Terto Jr. V. Pontos de Tensão e Tesão: limites e possibilidades para a inovação da prevenção na quarta década da epidemia de HIV/AIDS. In: Paiva V, França Jr. I, Kalichman A (orgs.). *Vulnerabilidade e Direitos Humanos: prevenção e promoção da saúde*. Curitiba: Ed. Juruá; 2013. p. 105-36.
13. Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, et al. HPTN 052 Study Team. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365(6):493-505
14. Ayres JR, Paiva V, França Jr. I, Conceitos e Práticas de Prevenção: da história natural da doença ao quadro da vulnerabilidade e direitos humanos. In: Paiva V, Ayres JR, Buchalla C. *Vulnerabilidade e Direitos Humanos: prevenção e promoção da saúde*. Curitiba: Juruá Ed.; 2012. p. 71-94.
15. GLOBAL REPORT UNAIDS report on the global AIDS epidemic 2013. Disponível em: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf (Acessado em 25 de dezembro de 2014).
16. ONUSIDA & GNP+. *Salud, Dignidad y Prevención Positivas*; Genebra, 2009.
17. Terto Jr. V. Questões para um sexo mais seguro. *Boletim Pela Vidda*, Rio de Janeiro, v. 33, p. 10-1, 1999.

Received on: 03/15/2014

Final version presented on: 10/21/2014

Accepted on: 02/12/2015