

AIDSTAR-One | SPOTLIGHT ON PREVENTION

Balancing Research With Rights-Based Principles of Practice for Programming for Men Who Have Sex With Men

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For decades, there has been silence at the global level about the disproportionate impact of HIV on men who have sex with men (MSM).¹ That silence has led to unabated epidemics and extremely weak HIV prevention programming at the national level for MSM around the world. Today, prevention services reach only 1 in 10 MSM globally (The American Foundation for AIDS Research 2008).

Perpetuating this is a dearth of ethically implemented and methodologically sound surveillance, epidemiologic studies, and social science research that sensitively reflect the HIV-related needs and advocacy priorities of MSM. Without valid and reliable data, service providers and advocates struggle to mount effective prevention responses for MSM in their countries and communities.

Concern is growing worldwide about the lack of targeted programming efforts to reach high-risk populations, while ineffective, broad-scale awareness campaigns proliferate (Joint U.N. Programme on HIV/AIDS [UNAIDS] 2009). A significant crunch in the availability of resources has led to flat-funded prevention programs, ineffective use of limited resources, and therefore failure to curb new infections (Centers for Disease Control and Prevention 2004; U.N.

Development Programme [UNDP] 2004). The crisis is exacerbated in many places by draconian public health policies and neglect of the health-related needs of MSM, justified by claims about the absence of data necessary to substantiate funding and political investment in HIV prevention and sexual health programs for this community.

Sensitively conducted, reliable research is critical to inform the development of comprehensive and effective HIV prevention strategies. Those strategies and the guidance issued for their broad-based adoption must be balanced by rights-based principles of practice if they are to have their intended impact on HIV among MSM.

High Prevalence, Widespread Oppression

MSM continue to shoulder a disproportionate burden of HIV infection in all regions of the world. Prevalence among MSM is higher than that of the general population in nearly every country reliably collecting and truthfully reporting HIV surveillance data (Baral et al. 2007). Elsewhere, the availability of reliable HIV surveillance data and a dearth of sensitively implemented social science research focused on MSM is a huge challenge, especially in repressive countries that either

¹ The acronym MSM refers to men who have sex with men, including men who self-identify as gay or bisexual. It is not a reference to transgender people. It is important to note that the term MSM has been used as an epidemiological term of convenience, but may not adequately reflect the diversity of this population in relation to individual sexual behavior or individual and community self-identification. A broad range of homosexual and homosocial acts, identities, and communities form a continuum of sexual and gender self-expression. The term MSM used in this document is not intended to diminish the rich diversity of sexuality, sexual partnerships, sexual expression, or gender expressions of this population. Common experiences of exclusion, sexual otherness, and verbal or physical discrimination form a basis for potentially useful alliances among MSM and other stigmatized groups.

criminalize homosexuality or deny the existence of gay, lesbian, bisexual, transgender, and other same-gender-loving people within their borders.

MSM also face widespread and ongoing human rights abuses and discrimination globally (Ottosson 2009). The link between HIV and social oppression of MSM is well established in the literature and difficult to overlook (Díaz, Alaya, and Bein 2004; Kreiger 1999; Meyer 1995; Williams, Neighbors, and Jackson 2003). Social oppression can be particularly harmful for MSM who are young; who also belong to indigenous, migrant, or ethnic minority groups; and who experience serious financial hardship. In addition, MSM living with HIV often experience stigma associated with both their sexuality and their HIV status.

As of March 2010, 78 countries impose criminal penalties for same-sex acts between consenting adults (Ottosson 2009). Two-thirds of African countries ban male-to-male sex. Punishments range from imprisonment—for instance, five years in Cameroon, Senegal, and Ghana, and life in Uganda—to death in Mauritania, Sudan, and parts of Nigeria. In Central American and Caribbean countries, there is widespread violence and police harassment directed at MSM. Criminalization of and violence directed toward sexual minorities causes social dislocation, influences transnational migration, and fuels human rights abuses, heightening the risk for HIV transmission and driving those most at need away from prevention, care, treatment, and support services.

The impact of criminalization, discrimination, and violence is evidenced by a UNAIDS-commissioned study from developing countries reporting that fewer than 31 percent of MSM had been tested for HIV in the past 12 months and knew their status. Only 33 percent of participants in the study had access to information about HIV, less than half (44 percent) had accurate knowledge about HIV, and only 54 percent used condoms the last time they had anal sex with another man (Adam et al. 2009).

Combining Prevention Approaches

There is now consensus among HIV behavioral researchers and practitioners that combination approaches to prevention, sustained over time and tailored to the specific local needs of MSM, can effectively lower HIV prevalence and incidence among MSM. Combination approaches combine and integrate biomedical and behavioral strategies with community-level and structural approaches (Bingenheimer and Geronimus 2009; Coates, Richter, and Caceres 2008; Gupta et al. 2008; Johnson et al. 2008). These include, for example, delivering behavioral interventions (e.g., skills building focused on proper condom use and safer sex negotiation) with HIV treatment (e.g., ensuring that all people living with HIV have access to treatment, care, and support services), while addressing barriers to access (e.g., sensitization programs targeting health care providers).

The argument for combination HIV-prevention approaches is supported by the fact that a singular focus on individual, group, community, or structural factors associated with heightened risk for HIV transmission will not suffice if the goal is to reduce or eliminate HIV incidence at the population level. Similarly, although there is renewed attention to such biomedical strategies as pre-exposure prophylaxis (AIDS Vaccine Advocacy Coalition 2009), overly “medicalized” approaches are unlikely on their own to result in significant, long-term gains because serious inequities in access to basic health care persist across the planet. For example, MSM cannot benefit from biomedical interventions if their access to them is undermined by cost or by social isolation resulting from stigma, discrimination, or criminalization. It is important to note that biomedical interventions are not completely protective on their own, and many clinical trials that have shown these interventions to be effective have included strong behavior change and social support components in the study protocols. The problem of HIV must be understood in its interpersonal, social,

and cultural contexts if our solutions are to have any chance of succeeding. Successful HIV prevention programming requires targeted, varied, multilevel, and well-resourced approaches sustained over many years.

Since 2007, UNAIDS has recommended combination approaches to HIV prevention, acknowledging the importance of sensitively delivering HIV prevention interventions tailored to the specific needs of MSM, while addressing more broadly their human rights. In fact, the agency's recommendations for a minimum standard package of prevention services for governments developing HIV prevention programs for MSM assert the importance of human rights and removal of legal barriers that undermine access to HIV-related services (UNAIDS 2007). UNAIDS guidance for HIV prevention goes on to recommend promotion of condom and water-based lubricant use; empowerment of gay, lesbian, bisexual, and transgender communities to participate equally in social and political life; availability of safe virtual and physical spaces where MSM can seek information and referrals for care and support; and access to medical and legal assistance for boys and men who experience sexual coercion or violence.

A similarly comprehensive package of HIV prevention services for MSM and transgender people was recently endorsed during a regional consensus-building consultation with researchers, providers, and advocates in Asia (UNDP et al. 2009). What is striking about the consensus statement is that it explicitly suggests framing HIV within the broader sexual health needs of MSM and transgender people as well as integrating mass and targeted media, including the internet, as a component in the delivery of prevention messages, health promotion, and social support services. This is important given the relative silence in the HIV sector on issues of sex and sexuality; it is also problematic given that the primary mode of HIV transmission is sexual. The consensus statement goes on to emphasize targeted peer-led outreach, support groups, drop-in centers, referral mechanisms, and other community programs designed, run by, and for MSM as

important strategies for maximizing service utilization and coverage, access to sexually transmitted infection (STI) services, and HIV testing and counseling.

Similar recommendations and guidelines focused on MSM and transgender populations are being developed by the World Bank in collaboration with the Johns Hopkins Center for Public Health and Human Rights and the World Health Organization. These efforts aim to address key issues critical to a strengthened global response to the HIV epidemic among MSM in low- and middle-income countries.

Principles of Practice in HIV Prevention

As well-researched HIV prevention guidance emerges from global institutions and researchers, it is vital that advocates for MSM create a common voice to ensure that the guidance is provided at the country level. Self-motivated MSM, including those living with HIV, should be leading research, programmatic, and policy responses to HIV in their communities to ensure that public health strategies have their biggest impact. Moreover, MSM should not become subjected to repressive government policies or political agendas that deviate from the evidence-informed guidance being issued by global international health authorities. Nor should researchers, public health officials, or policymakers succumb to individualistic, overly medicalized disease control paradigms, which typically lead to diminished or substandard programs and services. Research has shown no public health advantage to adopting more top-down, directive STI or HIV program and policy approaches (Annas, Mariner, and Parmet 2008).

But strong guidance and implementation of evidence-informed prevention interventions are not enough to ensure the effectiveness of HIV prevention with MSM, even if combination approaches are adopted. The best guidance and most robust research must be balanced by *client-centered and human rights-based principles of practice*. This means that MSM advocates, including MSM living with HIV, are front and center

in identifying their specific needs within their respective political, social, economic, and epidemiological contexts. MSM should lead efforts in determining research, policy, and program priorities. All actors in the HIV sector—researchers, policymakers, and practitioners—must challenge stigma, social discrimination, and criminalization directed at MSM. They must also be unwavering in reversing silence and denial about the disparities in HIV-related health outcomes and financing among MSM communities worldwide.

Principles of practice have long been deliberated and published by HIV service providers and advocates but are often overlooked in policy discussions because of a narrow focus on evidence or science in substantiating HIV-related interventions and program strategies (Ayala, Husted, and Spieldenner 2004; Yogyakarta Principles 2004). Among community-based providers in the HIV sector, *principles of practice* refers to a set of accepted or professed values, actions, and codes of conduct that informs the development, implementation, and evaluation of interventions and services. The principles are used to balance the use of evidence in the decision-making process. Principles of practice are also employed as a strategy for ensuring that the rights of marginalized groups, like MSM, including MSM living with HIV, are not overlooked. The following are some important core principles of practice when working with MSM:

- Barring harm to others, all people, including MSM and MSM living with HIV, have the right to self-determination—to decide for themselves if, when, and how best to achieve health and wellness.
- The imperative of reducing STI and HIV infection rates should not impinge on personal freedoms.
- All people, including MSM and MSM living with HIV, deserve the same level of support, health care, support services, and political rights as anyone else.
- All people, including MSM and MSM living with HIV, are entitled to a fulfilling and satisfying sex life.
- MSM, including MSM living with HIV, should be actively and meaningfully engaged at all stages and levels in research, program and policy development, implementation, and evaluation, using participatory processes throughout.
- HIV prevention programs and services should not focus solely on risks but rather leverage the strengths, resources, competencies, social connections, capacities, and resiliency that are already present in MSM and their communities.
- Pleasure, gender, satisfaction, intimacy, love, and desire are key concepts in a fuller understanding of sex and sexuality among MSM and should be included when formulating more meaningful research, programmatic, and policy responses.
- Researchers, prevention practitioners, and policymakers should consider structural, situational, and contextual factors in understanding HIV risk and in developing sexual health interventions tailored to the specific needs of MSM.

Although these principles of practice are focused on MSM, they can easily be adapted and applied when working with other socially marginalized groups. Broader adoption of these principles will provide a common foundation for effective HIV prevention and sexual health services that address the specific needs of MSM. Principles of practice can also bring balance to discussions about HIV prevention with and for MSM, discussions that too often take place without us.

About the Author

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