HIV Prevention with MSM

Balancing Evidence with Rights-based Principles of Practice

A Policy Brief

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The problem of HIV must be understood in its interpersonal, social and cultural contexts if our responses are to have any chance of succeeding. HIV prevention requires varied, multi-level, and well-resourced approaches sustained over many years.

INTRODUCTION

For years, there has been silence at the global level about the disproportionate impact that HIV and AIDS have on men who have sex with men (MSM). This silence has led to unabated epidemics and especially weak HIV prevention programming at national levels for MSM across the globe. Perpetuating this silence is a dearth of ethically implemented and methodologically sound surveillance, epidemiologic and social science research that could sensitively inform HIV prevention and advocacy responses around the world.

Complicating this situation is the fact that HIV-related services tend to be poorly resourced. This is particularly true for HIV prevention programs targeting MSM. Many authorities have commented on the global prevention funding gaps, indicating that prevention services reach only 1 in 10 MSM.[1] A significant crunch in the availability of resources has led to flat-funded prevention programs, ineffective use of limited resources, and therefore a general failure to curb new infections.[2,3] Moreover, draconian public health policies and/or neglect of the health-related needs of MSM are permitted to flourish, justified by claims about the absence of data. Sensitively conducted, reliable research is necessary to substantiate funding and political investment in comprehensive HIV prevention and sexual health programs for MSM. However, HIV prevention approaches and guidance issued for their broad-based adoption are only as good as the principles underlying their implementation. Research and public health guidance must be balanced by rights-based principles of practice if they are to have their intended impact on the fight against AIDS among MSM.

KEY CHALLENGES TO HIV PREVENTION WITH MSM

MSM continue to shoulder a disproportionate disease burden when it comes to the HIV epidemic in all regions of the world. Prevalence among MSM is higher than that of the general population in nearly every country that reliably collects and truthfully reports HIV and AIDS surveillance data.[4] The availability of reliable HIV surveillance data and a dearth of sensitively implemented social science research focused on MSM are huge challenges, especially in repressive countries that either criminalize homosexuality or outright deny the existence of gay, lesbian, bisexual, transgender (LGBT) and other same gender loving people within their national borders.

Widespread and ongoing human rights abuses and discrimination are also huge challenges globally.[5] The link between HIV and social oppression of MSM is well established in the literature and difficult to overlook.[6,7,8,9] Social oppression can be particularly harmful for MSM who are young or who also belong to indigenous, migrant, or ethnic minority groups and who experience serious financial hardship in low, middle, and high income countries. In addition, MSM living with HIV often experience a double stigma associated with their sexuality and their HIV status.

As of March 2010, 78 countries had criminal penalties for same-sex acts between consenting adults.[5] Currently, two-thirds of African countries ban male-to-male sex. Punishments range from imprisonment – for instance five years in Cameroon, Senegal, and Ghana; life in Uganda – to death in Mauritania, Sudan, and parts of Nigeria. In Central American and Caribbean countries, there is widespread harassment by police and violence directed at MSM. Criminalization of and violence directed towards sexual minorities cause social dislocation, influence transnational migration, and fuel human rights abuses. This heightens the risk for HIV transmission and drives those most at need away from prevention, care, treatment, and support services.

Poor penetration of key HIV prevention and related services, potentially as a result of such criminalization, discrimination and violence is evidenced by a recent UNAIDS-commissioned study from developing countries reporting that fewer than 31% of MSM tested for HIV in the past 12 months and knew their status. Only 33% participants in the study had access to information about HIV, less than half (44%) had accurate knowledge about HIV and only 54% used condoms the last time they had anal sex with another man.[10] This is the socio-cultural context in which HIV prevention must continue to innovate and act with resolve.

Prevention services reach only 1 in 10 MSM.

CONTEMPORARY APPROACHES TO HIV PREVENTION WITH MSM

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, should be adopted to effectively address HIV prevalence and incidence among MSM. Combination approaches are ones that combine and integrate biomedical and behavioral strategies with community-level and structural approaches.[11,12,13,14] Examples of coordinated approaches 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). Table 1 below summarizes these interrelated approaches to HIV prevention.

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Table 1: Contemporary Approaches to HIV Prevention Among MSM

	Examples
Biomedical	Early identification and treatment of HIV; pre-exposure prophylaxis (PrEP); post exposure prophylaxis (PEP)
Behavioral	
• **Individual**	Risk reduction, substance abuse, mental health counseling
• **Group**	Skills building (e.g., condom use, communications) workshops; support groups
• **Partner and Couple**	Couples counseling; disclosure; sero-sorting
• **Family**	Family counseling
• **Networks**	Peer education; diffusion of innovation; network-based strategies
Institutional	Work place training; sensitization of service providers; comprehensive sex education
Community	Mass media; social marketing; community mobilization
Structural	Anti-discrimination laws and legal protections; increased availability of condoms and water-based lubricants

Combining prevention approaches is important because a singular focus on individual, group, community, or structural factors that contribute to heightened risk for HIV transmission will not suffice if the goal is to address HIV incidence at the population level. Similarly, although there is renewed attention and excitement placed on biomedical strategies like pre-exposure prophylaxis[15], overly medicalized approaches alone are unlikely to result in significant, long term HIV prevention gains because serious inequities in access to basic health care persist. For example, MSM cannot benefit from bio-medical interventions if their access to these resources is undermined by their cost or by social isolation resulting from stigma, discrimination, or criminalization. Table 2 presents emerging approaches to HIV prevention that have both promising potential and considerable limitations.

Table 2: New HIV Prevention Strategies and Key Issues

Strategies	Description	Key Issues and Challenges
Circumcision	Surgical removal of foreskin from the penis.	• Three studies have examined the association between circumcision status and HIV infection among MSM: two in the U.S. found a protective effect associated with circumcision. • A more recent study found no statistically significant evidence of a protective effect associated with circumcision status among ethnic minority MSM. • It is unlikely that the results of the circumcision trials in Africa apply to MSM.
Vaccines	Vaccine successes that prevent illness from pathogens such as poliovirus, smallpox, measles, and yellow fever have led to the opinion that an AIDS vaccine that prevents infection would be the single most powerful tool for ending the epidemic.	• AIDS vaccine candidates have aimed to contain or reduce viral load after infection in the hope of delaying the time to treatment of HIV-related disease. • Altering the course of disease as a goal in vaccine research is based on research that identifies elements of the immune profile that are associated with virologic control: focusing on these may yield specific targets for vaccine design. • It is not known whether the virologic control mechanisms are the same as those underlying prevention.
Microbicides	Antiretroviral (ARV) drugs used in gels, films, or other products that would be inserted in the rectum to reduce the likelihood that the user becomes HIV infected during sex.	• Additional research is needed on intermittent vs. daily use, rectal use, long-term toxicity and drug resistance, adherence, and use by adolescents. • Careful planning for targeted rollout will be required. • When successful, there will be a need for expanded and frequent HIV testing including the need to optimize rectal delivery methods to maximize acceptability among MSM.
PrEP	Strategy in which HIV-negative people take prescribed ARV drugs (tenofovir [TDF] or a combo of TDF and emtricitabine [FTC]) orally on a regular basis to reduce their risk for acquiring HIV.	• Additional research is needed on intermittent vs. daily use, long-term toxicity and drug resistance, adherence, and use by adolescents. • Planning for targeted rollout is necessary. • Rollout is unlikely in settings lacking basic HIV prevention capacity, and/or limited access to HIV treatment and care. • Expanded and frequent HIV testing will be required. • Only partial effectiveness is likely if at all. • Risk compensation or behavioral disinhibition is a concern. • Availability will likely be targeted to those at highest risk. • Cost and financing are additional factors to consider.

WHAT GLOBAL INSTITUTIONS ARE RECOMMENDING

UNAIDS has recommended combination approaches to HIV prevention in recent years, 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 UNAIDS recommendations for a minimum standard package of prevention services for governments planning and developing HIV prevention programs for MSM begin by asserting the importance of human rights and the removal of legal barriers that undermine access to HIV-related services such as laws that criminalize consensual sex between men.[16,17,18] UNAIDS guidance for HIV prevention goes on to recommend promotion of condom and water-based lubricant use; empowerment of LGBT communities to participate equally in social and political life; availability of safe physical and/or virtual spaces for MSM to seek information and referrals for care and support; and access to medical and legal assistance for boys and men who experience sexual coercion and/or violence. The complete list of UNAIDS recommendations is provided below:

UNAIDS Recommended Components for Comprehensive HIV Prevention Programs with MSM

1. Promotion and guarantee of human rights; removal of legal barriers that undermine access to HIV-related services such as laws that criminalize consensual sex between men;
2. Access to and promotion of consistent condom and water-based lubricant use;
3. Detection and management of sexually transmitted diseases;
4. Confidential, voluntary HIV screening, care, treatment and support services;
5. Safer drug-use commodities and treatment services;
6. Empowerment of gay, lesbian, bisexual and transgender communities to participate equally in social and political life;
7. Safe virtual and/or physical spaces for MSM to seek information and referrals for care and support;
8. Training and sensitization of health-care providers to avoid discriminating against MSM;
9. Medical and legal assistance for boys and men who experience sexual coercion and/or violence;
10. Specific and targeted information on prevention and risk reduction strategies designed to appeal to and meet the needs of MSM;
11. Information, prevention and care services for the female and transgender partners of MSM;
12. Prevention and treatment of hepatitis; and
13. Availability of HIV-related prevention information, care and support services for transgender people who may not identify as MSM.

A similar 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.[19] A striking feature of the consensus statement is that it explicitly suggests framing HIV within the broader sexual health needs of MSM and transgender people and 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 and problematic silence in the AIDS sector on issues of sex and sexuality. Such silence is 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 and run by and for MSM living with and affected by HIV are important strategies for maximizing service utilization and coverage, access to sexually transmitted infections (STI) management, and HIV counseling and testing.

Similar recommendations and guidelines focused on MSM and transgender populations are being developed by the World Bank in collaboration with Johns Hopkins Center for Public Health and Human Rights and the World Health Organization (WHO). These efforts aim to answer several key questions critical to a strengthened global response to the HIV epidemic among MSM in low and middle income countries. These documents are scheduled to be released later in 2010.

MSM FRONT AND CENTER

As we witness the proliferation of important and well-researched HIV prevention guidance from global institutions and researchers, it is vital that HIV and MSM advocates become deeply engaged in creating a common voice to ensure that guidance be enacted at the country level. MSM, including MSM living with HIV, should be leading research, programmatic and policy responses to HIV in their communities. Moreover, MSM should not become subordinate to repressive government policies or political agendas that result in a deviation from the evidence-informed guidance being issued by global international health authorities. Recent events involving the unprovoked intimidation, torture, arrests, and murder of MSM signal that we are currently experiencing a disturbing pattern of backsliding taking place in the area of human rights. These incidents must not stand unchallenged. They are plainly wrong and counter to sound public health.

Nor should researchers, public health officials, or policy makers succumb to Draconian, overly medicalized or individualistic disease control paradigms since such paradigms typically lead to diminished or substandard programs and services. Research has shown no public health advantage to adopting more prescriptive STI or HIV program and policy approaches. Public health strategies have their biggest impact when: a) they are co-authored and implemented by members of the community for which they are intended; and b) individuals and communities are self-motivated and given the freedom and resources to participate in health promoting behaviors they have worked to develop.

Evidence-informed HIV prevention responses and guidelines are essential given the disproportionate impact the AIDS epidemic is having on MSM. Equally important is the manner in which guidance and subsequent services are rolled out. Research-based evidence must be balanced by *client-centered and human rights-based principles of practice*. This means that MSM advocates, including MSM living with HIV, must be front and center in identifying their specific needs in their respective political, social, economic and epidemiological contexts. MSM should lead efforts in determining research, policy, and program priorities. This also means that researchers, policy makers, and practitioners alike must work to challenge stigma, social discrimination and criminalization directed at MSM as an extension of their HIV prevention efforts.

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MOVING FORWARD: CORE PRINCIPLES OF PRACTICE

Principles of practice have long been deliberated, published and advocated by AIDS 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.[20,21] The following are some important core principles of practice that can serve as broad guidelines in the design, implementation, and evaluation of targeted HIV prevention programs and paradigms within MSM communities worldwide:

- The imperative of reducing STD 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;
- All people, including MSM and MSM living with HIV, have the right to be self-determining;
- 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—participatory processes should be utilized throughout;
- HIV prevention programs and services should not be risk or deficit oriented—instead successful HIV prevention efforts should leverage, and be rooted, in the strengths, resources, competencies, social connections, capacities, and resiliency that are already present in MSM individuals and communities;
- Pleasure, gender, satisfaction, intimacy, love, and desire are key concepts in a fuller understanding of sex and sexuality among MSM and therefore in formulating more meaningful research, programmatic, and policy responses; and
- Researchers, prevention practitioners, and policy makers should consider structural, situational, and contextual factors in understanding HIV risk and in developing sexual health interventions tailored to the specific needs of MSM.

Broader adoption of these principles will provide a common foundation for the ongoing development and promotion of effective, evidence-based 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.

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The Global Forum on MSM and HIV (MSMGF) is an expanding network of AIDS organizations, MSM networks, and advocates committed to ensuring robust coverage of and equitable access to effective HIV prevention, care, treatment, and support services tailored to the needs of gay men and other MSM. Guided by a Steering Committee of 20 members from 17 countries situated mainly in the Global South, and with administrative and fiscal support from AIDS Project Los Angeles (APLA), the MSMGF works to promote MSM health and human rights worldwide through advocacy, information exchange, knowledge production, networking, and capacity building.

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