

Men who have sex with men, HIV prevention and care

Report of a UNAIDS stakeholder consultation

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Background

In mid-2005, the UNAIDS policy position paper on *Intensifying HIV Prevention* was endorsed by the Programme Coordinating Board. It offers a comprehensive response to undertaking HIV prevention in the context of treatment scale-up. The paper addresses the needs of minority populations and especially vulnerable groups as well as the population more generally. However, it does not specify in detail the policy and programmatic actions that need to be undertaken when working with different groups.

This UNAIDS stakeholder meeting aimed to add detail to the actions necessary with respect to the situation, circumstances and needs of men who have sex with men. The overall goal was to identify successful and promising practices in HIV prevention with different groups of men who have sex with men based on work to date. A related goal lay in identifying work that still needs to be undertaken to strengthen international, national and local responses.

More specific aims for the current meeting include identifying:

- key needs and priorities in work with men who have sex with men with respect to HIV prevention, treatment, care and impact mitigation;
- ways of strengthening programmatic and policy actions at country level for men who have sex with men and HIV prevention, treatment, care and impact mitigation; and
- the roles of key stakeholders in the above process, including national governments, international and national nongovernmental organizations and the UN system.

The meeting brought together a wide range of experts—including programme managers, representatives of international and national nongovernmental organizations, researchers, policy-makers and practitioners—with successful experience in HIV prevention, care and impact mitigation among men who have sex with men. Appendix 1 provides a full list of participants.

Opening comments

Dr Purnima Mane and Dr Anindya Chatterjee opened the meeting. Dr Mane indicated that at the July 2005 Gleneagles G8 Summit, leaders had called upon UNAIDS and WHO to move towards achieving universal access to HIV treatment by 2010. The more recent September 2005 World Summit had called for a scaling up of responses to HIV and AIDS, through prevention, care, treatment and support, and the mobilization of additional resources from national, bilateral, multilateral and private sources. Countries are to be encouraged to set their own targets, so that they *own* the strategies and have a real commitment to meeting them.

Current indicators suggest that less than 10% of men who have sex with men globally have access to the HIV prevention and AIDS care services they need. Many factors contribute to this situation including societal and community denial, stigma and discrimination, and human rights abuse. Scaling up interventions for men who have sex with men is sensitive and difficult because doing so often raises the visibility of the men themselves, with concomitant consequences for interpersonal and community relationships (especially in contexts where sex between men is taboo, criminalized or denied) and personal safety.

Globally, there exists a profound lack of understanding of the needs and circumstances of men who have sex with men. There is a paucity of relevant epidemiological information and male-to-male HIV transmission may be obscured within apparently heterosexual patterns of viral transmission. There is also deep seated confusion concerning who men who have sex with men are. It is a fact that in many parts of the world men who have sex with men are married, and also a fact that they are less a group set apart than a key constituent of the general population. Crucially, in many parts of the world sex between men is not associated with a particular individual or social identity and may not be openly talked about.

Despite early evidence of success in preventing male-to-male HIV transmission, there is evidence in some countries of a resurgence of risk behaviours, most notably in the ‘North’ but also elsewhere. There are many possible reasons for this, but central among them must be the lack of focused HIV prevention measures built upon best practice and appropriately brought to scale. It is within this context that the present meeting took place.

Male same-sex behaviour in low- and middle-income countries—what do we know and what do we need to do?

A short presentation was given by Carlos Cáceres from Cayetano Heredia University, Lima, Peru based on recently completed work for UNAIDS. This sought to address the continuing problem whereby, through lack of evidence, national authorities deny that men who have sex with men are a part of their reality.

The aim of the research was to gather together information on a global scale as a means of countering denial by presenting empirical, largely quantitative, information. The aim has to be qualified, however, because there is at present insufficient information of high quality to come up with reliable epidemiological indicators. Sample sizes are often small, respondents have been chosen adventitiously and the focus is usually on the most easily identifiable groups and populations. The majority of available studies come from Latin America from South Asia. Very little work has been undertaken in Sub-Saharan Africa.

An extraordinarily wide range of lifetime prevalence rates of male-to-male sex (6-20%) are indicated in the studies, highlighting problems of both the paucity of good quality information and of the difficulties of comparison across contexts in which male-to-male sex may be heavily or not so heavily stigmatized. Cáceres and colleagues’ investigation also attempted to come up with a set of relevant HIV prevalence ranges, after factoring in the differing quality and scope of data. These vary from 2% or less to 20% or more, depending on the region. Statistical data of the kind presented are, however, useful because they offer a ‘hard’ case which can be persuasive to national authorities and those with a responsibility for future HIV programming. It must be recognized, however, that behavioural measures such as those obtained do not engage with the more nuanced aspects of male-to-male sexuality.

In discussion, a range of issues was explored. They included limitations of the method of analysis outlined and its failure to take into account different identities and ‘subject positions’; the importance

of taking action now and not delaying until perfect information is available; the dangers of using language such as the term ‘prevalence of MSM’ which carries associations of surveillance and stigmatization; and the importance of using civil society estimates alongside official statistics in developing country-level estimates.

National situations and contexts

A series of linked presentations were given by members of the meeting, highlighting country level issues and concerns.

Africa

Describing issues of relevance to **Senegal**, Cheikh Niang drew attention to the importance of ethnographic work to identify the multiplicity of relevant identities/non-identities pertaining to male-to-male sexuality. It is important also to consider why some people do not adopt specific identities in respect of male-to-male sexual behaviours. Under the impact of modernisation and globalization, new groupings of men who have sex with men are forming in Senegal; there are also many informal networks. These groupings and networks need to be included and integrated into an effective response.

Glenn de Swardt talked of issues of relevance to **South Africa**. The country has a liberal constitution with respect to homosexuality, but a President who has had some problems engaging with HIV. This presents unique challenges for male-to-male HIV prevention. Qualitative data is needed to capture the dynamics of the epidemic and make it alive in people’s minds. ‘Sex-positive’ approaches are needed because gay and other men who have sex with men have been told so often that their sex is bad. There is a critical need to promote access to and use of water-based lubricants. It is important to understand how people of non-heterosexualities find safety in groups and create alternative family structures (kinship of choice). These need to be integrated into community-based prevention strategies.

Othman Mellouk described the work of ALCS (Moroccan AIDS Service Organization) in **Morocco**. ALCS has been working since 1995. It is very much a gay-friendly organization, and identity politics are intrinsic to its agenda. A strong position is taken on human rights as well as the health issues. Working in a predominantly traditional Muslim context has its challenges. Initially, ALCS did not work closely with government, but this has changed over time. Big issues to be addressed include HIV treatment access, discrimination, condom distribution (especially in prisons), and the challenge of working in a legally ambiguous environment.

Asia

Don Baxter described some of the challenges and opportunities in **Australia**. Among gay and other homosexually active men, there have been reported increases in sexual risk behaviour since the introduction of antiretroviral treatment. In recent times, there has also been a rise in levels of HIV infection as well as the incidence of other sexually transmitted infections. As yet there are no effective programmatic solutions. Recent ongoing changes in the gay community mean that HIV and being gay mean different things to younger gay men than they did in the past. This presents major challenges for community development work.

Kim Mulji and Ruben del Prado reported that in **India** capacity building for the scaling-up of successful programmes is a key issue, as well as matters of finance. The situation is made more complex by the fact that policy towards HIV prevention and men who have sex with men can be variable—both between ministries and between AIDS Societies at state level. To date, men who have sex with men have not been a priority group for antiretroviral therapy roll out. While there are networks for HIV-positive people in India, these might be better linked into men who have sex with men work. There is some evidence, however the National AIDS Control Organization will give greater emphasis to men who have sex with men in its next five-year plan. It is to be hoped that this will result in a more programmatic approach to work than has sometimes been evident in the past. Additional issues that need to be tackled include stigma and discrimination, condom availability for men who have sex with men, and the training of health care workers in relevant issues and a non-judgemental approach.

Wan Yanhai and Chung To spoke about issues of relevance to **China**. Throughout the country, there is a large diversity of needs and constituencies to address. The experience of larger cities is not the same as that in smaller cities or non-urban areas, where male-to-male sexual networks may be harder to work with. The Government has made significant progress in recognizing the issue of male-to-male sexual health and HIV in the last year. However, despite the fact that gay communities are now more active in China, the political environment is not open or transparent. Some nongovernmental organizations do not have legal status and so it is difficult for them to have long-term development plans. There are currently between 30 to 40 gay groups in China and hundreds of web sites. This has created competition for funds. Overcoming ‘in-fighting’ is a major challenge.

Latin America

Fernando Seffner spoke about issues of special relevance in **Brazil**. Against the backcloth of a generally positive national response, challenges remain. They include the importance of ensuring good linkage between HIV prevention and AIDS care; respect for the rights of those who are most vulnerable; and ensuring access to the full range of prevention measures known to be successful. A range of different ‘publics’ need to be involved in, and spoken to, through HIV prevention activities. It is crucial that the politics of HIV and concern for men who have sex with men remain high on the agenda and that HIV prevention is not likened to a technical response.

Mario Pecheny described the situation in **Argentina**. Key priorities include how best to bring about an integration between primary and secondary care, and how to ensure that the needs of lesbians, gay men, bisexuals and transgendered (LGBT) people are equitably met in HIV programming. Legal status remains a big issue, especially for transgendered people, and LGBT issues need to be more fully integrated into the work of public and private health systems. The predominant discourse is one of there being a heterosexual epidemic—this needs to change especially in a context where there are large numbers of infections acquired through male-to-male sex. Outreach to rural areas is also a priority.

In **Jamaica**, homosexual behaviour between men remains illegal. In this context, Boris Bloomfield talked about the need for a stronger and more programmatic response. Key to success must be the decriminalization of homosexuality as well as efforts to reduce stigma especially among health care providers. Parties offer a significant environment in which HIV prevention can take place and services can be taken to people. A key challenge exists concerning the lack of anonymity faced by men who have sex with men in the context of community-based interventions. This can be a major difficulty in smaller Caribbean communities.

With respect to **Peru**, Carlos Cáceres talked of the need for better evidence on the extent of sex between men, and its differences in different contexts. There is an urgent necessity to address stigma and discrimination associated with ‘non-heterosexual sexualities’. It is vital too to de-naturalize the perception that high HIV prevalence is the norm among men who have sex with men. More work needs to take place with doctors and health care workers to redress stigma and discrimination. Special issues are relevant to the circumstances of transgendered individuals whose needs may not be understood by health care providers. Efforts are needed to counter the negative responses of some church groups and to ensure that health care workers come to understand HIV prevention among men who have sex with men as being a priority.

Europe and North America

Anne-Lise Middelthon describes aspects of the current situation in **Norway**. Since 1985, the Norwegian Gay Men’s Health Committee has been funded by Government to undertake HIV/AIDS programmes. Recent data indicated increasing prevalence of untreated sexually transmitted infections among men who have sex with men. Within the gay community, there is a need both to sustain safer-sex and to ‘keep condom culture alive.’ The goal must be that of securing and sustaining ‘real ownership’ so that targeted groups can have the last say in project work. This presents unique challenges. To date, much work has been communication-based. However, HIV prevention work is not only about knowledge but also about skills and context. It is also important to remember that gay men and other men who have sex with men are a part of the general population and need to be addressed as such, as well as via more specialized forms of activity.

Ted Myers described how **Canada** had been fortunate in being able to learn from the best of its southern neighbour’s approach to HIV prevention whilst learning from its mistakes. Early initiatives had been led not led by central government, provincial governments or local governments but by communities and activists. Prevention models have generally been both sex positive and explicit. Despite Canada’s reputation for being liberal and progressive, HIV-related stigma still persists and prevention efforts does not seem to have brought down the rise in infection amongst men who have sex with men. Currently, there is a dearth of good prevention research. The sense of gay community has changed and both activists and programme developers need to know how to respond to this. There remains too little dialogue between people living with HIV and HIV-negative communities.

Eric Fleutelot described how in **France** there is currently a distinct lack of good data concerning HIV transmission among men who have sex with men. In the context of what may be a very dynamic epidemic, there is little reliable data on incidence. It is important to recognize that while the French epidemic as a whole is heterosexual, ‘nationally acquired HIV’ occurs predominantly among men who have sex with men. Ongoing debate persists in relation to risk reduction versus risk elimination, the risks of oral sex, and when to encourage HIV testing. There has been some move towards the promotion of gay health as a more encompassing approach to health promotion among men who have sex with men. The sexual transmission of hepatitis C is also of growing concern.

Michael Hauserman reported on the current situation in Switzerland. Recent Federal Government statistics indicate that 33% of all new HIV infections are amongst men who have sex with men. Key issues to be addressed include changes in gay men’s behaviour subsequent to the availability of antiretroviral therapy. More gay men are reporting having unprotected anal sex, but importantly these changes are not inscribed with a ‘barebacking’ culture *per se*. Few HIV positive people currently

attend gay-oriented services for treatment—they go to mainstream medical services instead. As for the future, it is important not to reduce male-to-male sexual health issues to HIV alone. Depression and anxiety are also major concerns.

Zoran Jordanov reported that in **Macedonia**, HIV prevention among men who have sex with men is relatively new. Treatment and care remain largely absent. Limited research has been carried out to date but the little information that exists suggests that stigma and denial are widespread. Many men who have sex with men do not identify as gay but see themselves simply as ‘men’. Confidentiality is not well observed in medical contexts. As a result, people are not willing to take an HIV antibody test for fear of being recognized. Nevertheless, with the support of outside agencies innovative work is beginning to take place.

Finally, David Winters described the current context in the **USA**. Here, there is strong evidence of men who have sex with men has been marginalized from the start within the epidemic. In the USA, the incidence and prevalence of HIV cannot be understood without reference to race, class and other fundamental disparities. There remains an urgent need to create an enabling environment such that the state is obliged to provide basic services, regardless of people’s sexual orientation. Sexuality education needs to be recognized as a fundamental human right. There is a need for better data on gay and other men who have sex with men, to ensure that their interests are taken account of in budget allocation. ‘Sero-selection’ is becoming a key issue affecting partner choice and transmission. This and related concerns need to be explored further.

In discussion, a variety of points were raised. They included the following.

- 1) The continuing lack of good quality epidemiological, behavioural and social data so that we can better understand the issues to be addressed.
- 2) The need for a stronger evidence base and the importance of balancing qualitative and quantitative work in understanding men who have sex with men’s circumstances, situations and needs.
- 3) Issues of legality and human rights—and the respective roles of governments and different government departments in responding to these concerns (including the decriminalisation of homosexuality where relevant).
- 4) The importance of promoting condoms—how best to keep condom culture alive.
- 5) How best to scale up—too often small and often piecemeal projects are taking the place of a coherent and enduring national response.
- 6) The need to recognize the place and needs of transgendered people within the epidemic.
- 7) The need to keep pace with both changing and emerging nature of gay and other communities of men who have sex with men.
- 8) The need to recognize that there are increased numbers of infections through male-to-male sex throughout the developing world.
- 9) The need to recognize the existence of different forms of unprotected sex among gay and other men who have sex with men—for example positive-positive sex, and not all of which can be encompassed by the rubrics of ‘barebacking’.
- 10) The importance of sero-sorting and partner selection based on HIV status as new issues.

There followed some discussion of the role of UNAIDS in future work with men who have sex with men. Among the priority issues highlighted were the importance of the following points.

- 1) Using internationally agreed human rights instruments and global guidelines as leveraging points for a more comprehensive and equitable response.
- 2) Acting as an advocate for those who might otherwise be marginalized in the face of the epidemic.
- 3) Promoting recognition of the role of culture, religion and gender stereotypes as determinants of negative responses towards men who have sex with men in the face of the epidemic.
- 4) Undertaking advocacy for rights-based, scaled-up and inclusive responses in HIV prevention, treatment and care.
- 5) Being proactive in relation to meeting the needs of men who have sex with men with respect to HIV prevention, treatment and care, including encouraging recognition of their diversity and changes over time.

Regional issues

Discussion then focused on the identification of regional issues and concerns relevant to the advancement of HIV prevention, treatment and care. Participants divided into four affinity groups based on place of residence or work. Each group was then invited to identify a range of priorities for action at regional level.

Africa

- 1) In general, there are legal and religious issues pertaining to the influence of Islamic and Christian belief systems that need to be tackled if progress is to be made. Even in contexts where discrimination on grounds of sexuality is outlawed and rights are protected (e.g. in South Africa with respect to constitutional rights), this does not necessarily ameliorate prejudice.
- 2) Because of the illegality of male-to-male sex in many contexts and resultant stigma, it is difficult to get good data of relevance to HIV prevention, treatment and care among men who have sex with men.
- 3) There are huge differences between and within countries in the way people identify themselves sexually, so 'hard' comparative data is often difficult to come by.
- 4) There may be important generational differences with respect to openness about and willingness to discuss sexuality (including male-to-male sex).
- 5) There is an urgent need for better training on research among men who have sex with men. To date, it has been difficult or sometimes impossible to involve communities in research and policy formation.
- 6) The view still exists in many African communities that homosexuality and male-to-male sex is not indigenous and has been imported from outside.
- 7) New technologies, including the internet, present new opportunities for information sharing and community building.
- 8) There has to date been a greater emphasis on primary prevention but at the expense of support for people living with HIV.

- 9) Country-level policies towards groups such as men who have sex with men are often influenced by donor priorities and discourse. These raise questions about who controls the HIV prevention agenda and what kinds of sexualities can be addressed.

Latin America and Caribbean

- 1) There is enormous diversity across the region. Data indicate that there are concentrated HIV epidemics among men who have sex with men in some countries. In other places, more generalized epidemics prevail.
- 2) Some Latin American countries do not have laws prohibiting sex between men. In others, male-to-male sex is illegal.
- 3) Some countries have universal access to antiretroviral therapy. In others, access is uneven or is in the process of being developed.
- 4) A few countries have undertaken campaigns against homophobia and hate crimes based on sexuality. In others, a more negative discourse prevails.
- 5) There are important ‘horizontal’ linkages between Latin American countries that can be built upon in advancing HIV prevention treatment and care agendas, including work with men who have sex with men. The Brazilian AIDS programme has been regionally very influential.
- 6) Nongovernmental and civil society organizations can sometimes feel like ‘prisoners’ to treatment-centred and epidemiological approaches. There is a need to retain their vitality and closeness to the grass roots, not to have them reduced to being to epidemiological targets. It is critical to maintain the intactness of different agendas and stances.
- 7) Efforts need to be directed towards the public health sector to make practice in HIV prevention treatment and care for men who have sex with men stronger and better.
- 8) There may be profound differences of need and response between urban and rural areas—for example, in relation to attitudes towards men who have sex with men, responses to HIV, local epidemiology and so on.
- 9) In perhaps the majority of countries, ‘bisexuals’ remain invisible.
- 10) General approaches to male sexual health are still lacking.

Asia

- 1) There is a lack of leadership amongst governments across the region, combined with a lack of money earmarked for HIV prevention, treatment and care for men who have sex with men, and lack of education concerning male-to-male sexuality.
- 2) Stigma concerning male-to-male sex remains common—but its legal status varies across the region (partly corresponding to legacies of colonialism).
- 3) Generally health departments find it difficult to challenge the authority of interior or home affairs ministries with respect to homophobic policies or practice.
- 4) Across all countries there is a social divide between the urban rich and rural poor.
- 5) In some countries, through advocacy, activism and education men who have sex with men have been able to influence the development of national HIV strategies and plans.

Europe and North America

- 1) There is enormous diversity of situation and experience within and across the countries of Europe and North America.
- 2) In perhaps the majority of countries, access to HIV treatment is now a top priority.
- 3) Concomitantly, however, increasing rates of HIV infection can be found among men who have sex with men in many (but not all) of these countries.
- 4) The advent of new prevention technologies and strategies raise new issues (e.g. in relation to ‘negotiated safety’, positive-positive sex, sero-sorting, etc).
- 5) HIV prevention to be renewed and sustained over time.
- 6) Sustained effort is needed to promote public concern for the HIV-related needs of gay men and other men who have sex with men at all policy levels.

A recurrent theme

Across all regions, a core problem was identified as hampering the development of HIV prevention, treatment and care with men who have sex with men. Put quite simply, there is lack of funding because there is a lack of evidence; and there is a lack of evidence because there is a lack of funding.

From understanding to action

Dr Purnima Mane and Dr Anindya Chatterjee drew the meeting’s attention to two documents on which views were welcomed: these were the (i) UNAIDS policy position paper on *Intensifying HIV Prevention* and (ii) the UNAIDS Position Paper on *HIV and Men who have Sex with Men*.

Dr Purnima Mane introduced the first of these papers by explaining that the intention was to energise the emphasis placed on HIV prevention in the context of treatment. Of key concern is the fact that the number of people living with HIV is rising, while prevention coverage remains poor. There needs to be greater emphasis on the real synergy between treatment and prevention. What though does this mean for future work with men who have sex with men?

Key aspects of the general way forward are described in the UNAIDS Position Paper on *HIV and Men who have Sex with Men* on which comments were welcomed, but publication of which predates the policy position paper described above. Detailed feedback on this latter document should be provided to the UNAIDS Secretariat.

In the interim, the meeting was convened to focus on two key questions: namely, (i) the essential policy and programmatic actions that need to be taken to scale and intensify HIV prevention; and (ii) the key elements of a successful national-level response. A wide range of options were identified as listed below.

Essential policy and programmatic actions

Policy actions

1. Repeal laws prohibiting male-to-male sex (e.g. existing sodomy laws).
2. Ensure the existence of anti-discrimination legislation on the grounds of sexual orientation, gender identity and HIV status.
3. Ensure specific reference is made to sexuality/sexual orientation in human rights frameworks and antidiscrimination legislation.
4. Promote the effective enforcement of anti-discrimination laws as above.
5. Take action to eliminate: stigma in healthcare settings; homophobic violence.
6. Ensure specific mention of men who have sex with men as a key affected group in plans for HIV prevention and care.
7. Promote sexuality education, which includes respect for sexual diversity, gender equality, and gender identity.
8. Actively monitor human rights violations against men who have sex with men and other sexual minorities.
9. Encourage a strengthened relationship between members of the UNAIDS family with respect to work to meet the prevention, treatment and care needs of men who have sex with men.
10. Promote wider understanding and action to ensure the protection of health as a fundamental human right regardless of sexual orientation or sexual identity.
11. Promote best practices in stigma reduction relevant to men who have sex with men especially with respect to HIV.
12. Ensure access to HIV prevention (including condoms) by men who have sex with men in all-male settings and institutions.
13. Ensure the active recruitment and involvement of sexual minorities including men who have sex with men in policy and decision making relating to HIV.
14. Address gender issues through a broader approach which recognizes the rights and circumstances of transgendered people and men who have sex with men.
15. Generalize concern for HIV and men who have sex with men throughout health education and health promotion.
16. Promote research on rectal microbicides.
17. Ensure sufficient resources for the conduct of good quality epidemiological and social research on men who have sex with men.

Programmatic Actions

1. Undertake heightened advocacy among UNAIDS Cosponsors to ensure that concern for HIV prevention, treatment and care among men who have sex with men remains high on the agenda.
2. Give support to and provide technical assistance to countries to build and/or improve a comprehensive programmatic response to men who have sex with men (focusing on prevention and care needs) in all national HIV plans.

3. Help countries identify and define “comprehensive” programmes of relevance to men who have sex with men.
4. Encourage multilateral and bilateral agencies to support men who have sex with men-related HIV prevention and AIDS care programmes.
5. Promote initial training and continuing professional development on issues of relevance to HIV and men who have sex with men for national authorities and UN system agencies active in the response to AIDS
6. Harness new opportunities to promote HIV prevention for men who have sex with men within expanded treatment access programmes.
7. Review epidemiological surveillance protocols to insure that men who have sex with men are appropriately addressed within these, even in contexts where the epidemic is not directly driven by male-to-male sex.
8. Ensure the production, dissemination and utilization of voluntary confidential counselling and testing guidelines that are more friendly to men who have sex with men.
9. Provide/produce guidelines and technical assistance to reduce homophobia and ignorance among healthcare workers.
10. Increase access to HIV treatment for men who have sex with men.
11. Encourage good quality social and behavioural research on men who have sex with men even in countries that deny it exists.
12. Promote greater recognition that male-to-male sex is a fact in all societies that should always be considered in all HIV prevention and care programming.
13. Support civil society organizations at local, national and regional level in their work on HIV and sexual rights.
14. Strengthen leadership by UNAIDS on men-who-have-sex-with-men issues.
15. Create an Inter-Agency Task Team on HIV and men who have sex with men.

Key elements of a national level response

A number of elements were identified as central to coherent and potentially successful national-level responses to HIV prevention, treatment and care for men who have sex with men.

- 1) **National commitment to protect the rights of men who have sex with men.** There should be clear and unequivocal national government commitment to protect the rights of men who have sex with men. This requires commitment from all parts of the government including National AIDS Councils and ministries of health, as well as others, including ministries of interior/home affairs and education, the police and the judiciary.
- 2) **Genuine community participation and representation in planning and implementation.** Tokenism and lack of transparency should be avoided and appropriate selection of community representatives should be ensured.
- 3) **Prioritize the special needs of men who have sex with men in the national strategic plans.** There should be a specific HIV prevention and AIDS treatment and care plan for men who have sex with men as part of the one agreed national AIDS action framework. Planning and programme implementation of this plan should proceed from a sound epidemiological, behavioural and contextual evidence base. A comprehensive set of programmes should include peer-

led education, outreach work, availability and access to HIV counselling and testing, sexually transmitted infection treatment, condoms and lubricants, AIDS treatment and care. Such a plan should ensure that an environment is created that enables programmes for men who have sex with men to operate effectively.

- 4) **Increase coverage and fully fund programmes for men who have sex with men.** Coverage and resource allocation for programmes aimed at men who have sex with men in most countries is inadequate. Implementing scaled up programmes requires on-going and sustained financial commitments. This is necessary to allow programmatic expansion, long-term planning, institutional strengthening and capacity building. As scaling up takes place, quality assurance procedures should also be put in place to monitor programmes developed and services provided.
- 5) **Create a vocal constituency for men who have sex with men.** Advocacy for HIV prevention, treatment and care for men who have sex with men is a key element of scaling up response and appropriate resource allocation should be made. Alliances should be built between epidemiologists, social scientists, politicians, human rights groups, lawyers, clinicians, journalists, groups of men who have sex with men and civil society organizations.

Apportioning responsibility

By way of conclusion, discussion moved to the responsibilities of national governments, international and national nongovernmental organizations and UNAIDS in supporting a comprehensive response to HIV prevention among men who have sex with men.

The meeting agreed that **national government** responsibilities included ensuring the development of comprehensive HIV prevention, treatment and care programmes in which work with men who have sex with men is integral. These programmes should ensure that men who have sex with men have access to the full range of HIV prevention options as well as HIV treatment and care, on an equitable basis with other populations and groups. National governments also have a responsibility to educate and inform people about HIV, tackle stigma and discrimination on grounds of sexuality and HIV, and defend the programmes that have been put in place. National authorities need to be active at times but also need to know when not to react, especially to forms of opposition that might undermine their success in protecting the rights and meeting the needs of diverse constituencies of men who have sex with men.

International and national nongovernmental organizations, on the other hand, have a key role to play in advocacy for government action, in working with national authorities, but also in holding governments to account. They have a special role to play in stimulating and supporting positive community responses to the epidemic; in promoting good practice; and in ensuring strategic alliances with other groups. The latter include organizations that may not yet be active in meeting the needs of men who have sex with men, but which are in a position to make a positive contribution to HIV prevention, treatment and care, respectful of the circumstances and rights of men who have sex with men. International and national nongovernmental organizations have a responsibility to be clear about their commitments, goals and roles as well as the partnerships they enter into. They may be able to reach parts of society not easily accessible to national (and local) authorities and have a special role to play in work with vulnerable and 'hard to reach' groups. Their work, however, should not absolve national governments of their responsibility for HIV prevention, treatment and care including among men who have sex with men.

Both the **Secretariat and Cosponsors of UNAIDS** have responsibility for developing better understanding of issues relevant to HIV prevention and men who have sex with men throughout the UN system. To this effect, they may wish to consider the creation of a reference group on HIV and men who have sex with men to help guide them in their work. Work should also take place towards the development of a position paper on men who have sex with men and HIV for consideration first by the Committee of Cosponsoring Organizations and then endorsement by the UNAIDS Programme Coordinating Board. Beyond this, UNAIDS has a responsibility for developing guidance to theme groups issues of relevance to HIV and men who have sex with men, and how to take forward programming with their national counterparts. Additional actions to be considered include closer work with the Special Rapporteur on the Right to Health of the United Nations Commission on Human Rights (to ensure that the rights of men who have sex with men are duly considered), with the United Nations Development Programme (to promote relevant legal reform), and to ensure that the UNAIDS Action Plan for Intensifying Prevention is specific in its recommendations concerning future work with men who have sex with men.

Concluding comments

Dr Purnima Mane closed the meeting by thanking participants for their time and contributions. She indicated that UNAIDS took very seriously the comments and recommendations that had been made. Key priorities for the future included ensuring greater ‘presence’ for work on HIV prevention and men who have sex with men. She was heartened by the strong emphasis given throughout the meeting to issues of gender and human rights, as well as the need to promote a strong evidence base. She looked forward to future occasions upon which a stakeholder consultation might take place and undertook to ensure that the UNAIDS Position Paper on *HIV and Men who have Sex with Men* was further developed prior to dissemination.

Appendix I: List of Participants

UNAIDS Stakeholders Consultation on HIV Prevention and Care among Men who have Sex with Men

Geneva, 10-11 November 2005

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