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# HUMAN RIGHTS CONSIDERATIONS IN ADDRESSING HIV AMONG MEN WHO HAVE SEX WITH MEN

TECHNICAL BRIEF

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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## INTRODUCTION

Men who have sex with men (MSM) face a disproportionate share of the HIV epidemic throughout the world (Baral et al. 2007; Cáceres et al. 2008), and in low- and middle-income countries bear a greater burden of the epidemic relative to the general population. In many countries, the HIV risk to MSM is exacerbated by social, cultural, and political factors. These include cultural biases against MSM, limited access to information and services, low national investments in health, and legal, institutional, or social barriers, including negative bias among providers, that make it difficult for MSM to negotiate safe sex or obtain adequate services for preventing and treating HIV and other sexually transmitted infections (STIs). This situation is compounded by adverse human rights environments—for example, in settings where same-gender sexual relationships are illegal—where MSM may fail to seek treatment because doing so may lead to harassment, refusal of services, arrest, or violence.

Yet international consensus and recommendations—including the 2011 United Nations (UN) Political Declaration on HIV/AIDS, to which the United States was a signatory—recognize the vulnerability of MSM to HIV and endorse national and international efforts to include MSM in HIV programming and address discriminatory laws and practices that keep this group from obtaining services. In keeping with this consensus,

***Just as I was very proud to say the obvious more than 15 years ago in Beijing—that human rights are women’s rights and women’s rights are human rights—let me say today that human rights are gay rights and gay rights are human rights.***

**—Hillary Clinton, U.S. Secretary of State (U.S. Department of State 2010)**

the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) has issued guidance on developing comprehensive programming to reduce HIV among MSM.

This AIDSTAR-One technical brief provides a systematic global review and synthesis of practical approaches, program examples, and resources to support human rights as a core element of HIV programming for MSM. The brief complements and is aligned with other global and regional publications that have relevance to human rights, health programming, HIV, and MSM.<sup>1</sup> This document gives an overview of U.S. policies on and commitments to MSM and human rights, and outlines recommended approaches, including program examples in various countries, for linking health and human rights to address HIV among MSM. It also offers a synthesis of questions for developing and monitoring HIV programs for MSM, and a list of program resources.

## U.S. GOVERNMENT POLICY ON HIV AND MSM

The United States, like all governments, has an obligation to respect, protect, and fulfill its commitment to universal human rights. The United States takes this obligation particularly seriously, having ratified key international human rights covenants and made human rights, including the right to HIV services, a central part of its foreign policy. This implies a commitment by the U.S. Government to promote all people’s rights to speak, criticize, debate, seek and impart information, and associate in the way that they choose. As part of this commitment, the United States strongly supports international commitments to help all people avoid HIV infection and obtain needed HIV treatment and care in agreement with internationally accepted human rights.

<sup>1</sup> Other related AIDSTAR-One documents produced in 2010 and 2011 include case studies about MSM-focused programming in Ghana, India, and Nicaragua; a technical brief about MSM programming in the Anglophone Caribbean; and a January 2011 technical brief about balancing MSM-related research with rights-based principles. All of these publications are listed in the AIDSTAR-One Resources section at [www.aidstar-one.com/resources](http://www.aidstar-one.com/resources).

## PEPFAR Technical Guidance on Combination HIV Prevention for MSM

In May 2011, PEPFAR issued new guidance, Technical Guidance on Combination HIV Prevention for MSM, to help country teams design and implement country-specific, evidence-based programming, using a combined approach (see Definitions) to address HIV among MSM. The guidance—which is consistent with public statements by the U.S. Global AIDS Coordinator, Ambassador Eric Goosby, and other PEPFAR staff—specifically directs programs to conform to the U.S. mandate to eliminate violence and discrimination based on sexual orientation and gender identity. In addition to calling for a comprehensive range of services for MSM, the guidance recommends that programs:

- Address laws and environments that discriminate against MSM, and advocate for these issues at the national level
- Support the capacity of MSM communities in the countries where PEPFAR works
- Support national-level dialogue about how HIV programs engage and retain clients in health interventions.

### Other U.S. Commitments to Human Rights

The 2011 PEPFAR Technical Guidance on Combination HIV Prevention for MSM is consistent with other commitments by the U.S. Government to address the health and rights of MSM:

- On June 10, 2011, the United States was a signatory to the 2011 UN Political Declaration on HIV and AIDS which, for the first time ever, explicitly recognized the vulnerability of MSM to HIV and urged governments to develop tailored responses that take into account national epidemiological

## DEFINITIONS

**“Men who have sex with men”** and **“MSM”** are behavioral terms that refer to all men who engage in same-gender sexual behavior, in multiple contexts and for multiple reasons.

**Community** refers to any group of people who share a perspective or identity. In many settings, communities of MSM may not be visible, unified, or well defined, and may also be identified with other labels and affiliations, including cultural or national identity, age, or religious belief. Men may also self-identify by their HIV status, their identity within the spectrum of “alternative” sexual styles, or other identities that are seen as key populations in the HIV epidemic, such as people who inject drugs, sex workers, at-risk youth, or prisoners.

**Human rights** are those rights and freedoms to which all humans are entitled. Though the concept of rights originated in ancient philosophical and legal traditions (Afshari 2007; Churchland 2011; Lauren 2003), in the last century human rights have been codified in international declarations and treaties such as the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Civil and Political Rights, the 1966 International Covenant on Economic, Social and Cultural Rights, the 1969 Convention on the Elimination of All Forms of Racial Discrimination, and the 1987 Convention Against Torture.

**Combined approach for health** is a holistic approach to improving health outcomes, which entails a broad spectrum of strategies (clinical care, services and treatment for mental health and substance abuse, legal and human rights support, and case management). This is the approach that the World Health Organization and the Joint UN Programme on HIV/AIDS advocate for addressing HIV among MSM, and the recommended approach for PEPFAR-supported programs.

and social contexts that may affect that vulnerability.

- On June 17, 2011, the United States voted as a member of the UN Human Rights Council to call on the UN High Commissioner for Human Rights to document discriminatory laws and practices and acts of violence against people based on their sexual orientation and gender identity.

These U.S. commitments align with other international documents, including the 2009 Joint UN Programme on HIV/AIDS (UNAIDS) Action Framework for MSM and transgender people; Amnesty International's 2009 declaration on sexual orientation and gender identity; the Sexual Orientation and Gender Identities Strategy of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the June 2011 World Health Organization (WHO) guidance on preventing and treating HIV and other STIs among MSM and transgender people; and the June 2011 World Bank report on HIV among MSM (Beyrer et al. 2011).

## **The Link between Human Rights and HIV among MSM**

The confluence of human rights and health has been well described by leading HIV advocates since the 1990s (Mann et al. 1999). In 2006, UNAIDS and the Office of the UN High Commissioner for Human Rights published the International Guidelines on HIV/AIDS and Human Rights. In June 2011, in the UN Political Declaration on HIV/AIDS, the United States and other UN member states reaffirmed the essential role of human rights in the fight against AIDS, stating that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV epidemic. Some of the many ways in which a human rights approach provides a necessary framework for effective HIV programming include:

- Providing an obligation to act within, beyond, and outside of justifications and arguments related to health and public health
- Clarifying structural and non-medical approaches to addressing HIV and improving health
- Furnishing a holistic framework for action, focused on health as defined by WHO (i.e., health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity [WHO 1946])
- Converting needs into state obligations and ideals into laws and accountability
- Showing how HIV programming contributes to broader societal goals, including social and economic development and efforts to reduce poverty
- Empowering communities to demand access to services and to seek redress for abuses that increase their vulnerability to HIV and magnify HIV's spread and impact.

## ***HIV and MSM***

Globally, MSM experience a much higher share of the HIV epidemic relative to the general population. In low- and middle-income countries where reliable data have been collected, HIV prevalence among MSM has surpassed 20 percent—for example, in countries as diverse as Bolivia, Ghana, Jamaica, Mexico, Myanmar, Thailand, Trinidad, and Zambia (Baral et al. 2007; Cáceres et al. 2008).

In part, high rates of infection stem from biology and epidemiology (i.e., the efficiency of HIV transmission through unprotected rectal sex and the likelihood of exposure in high-prevalence sexual networks). However, another important determinant of high HIV infection rates is the absence of an enabling environment for MSM, who often do not

have sufficient information, abilities, or opportunities to negotiate safer sex, safer drug use, or access to HIV treatment and care. Beyond limited health systems and inadequate overall national investments in health, governments are failing to address the specific health needs of socially marginalized groups, including MSM.

These systemic weaknesses are compounded by adverse human rights environments. More than 75 countries criminalize consensual same-gender sexual activity as of 2011 (International Lesbian, Gay, Bisexual, Trans and Intersex Association 2011). In these countries, fear of legal consequences may deter MSM from seeking HIV information or services—hence the continuing high HIV infection rates among MSM. Punitive laws also facilitate harassment of MSM and the organizations that provide services to them, promote violence against MSM, and enable providers to limit the services available to this population. Criminalizing same-gender sexual relationships encourages a vicious cycle: adverse legal conditions reinforce social stigma and discrimination based on both sexual choices and HIV status. This in turn diminishes the social and economic autonomy of MSM and increases the risks of depression and substance use, which are documented factors in HIV incidence and HIV outcomes (WHO 2011).

Research from several countries correlates high rates of HIV infection with reported human rights violations (Baral et al. 2009). HIV programs and advocates routinely report that supporting human rights is a necessary precondition for helping people access services and negotiate health care (African Men for Sexual Health and Rights 2011; WHO 2011). Indeed, it is common sense that the success of HIV programming depends on people's freedom to seek services and support without encountering discrimination, blackmail, violence, and criminalization. This freedom must be extended to MSM.

## LINKING HEALTH AND HUMAN RIGHTS IN HIV PROGRAMMING FOR MSM

Evidence suggests that limiting HIV transmission among MSM can have a significant impact on the global epidemic. Modeling by the World Bank, focused on four scenarios based on the epidemics in Kenya, Peru, Thailand, and Ukraine, indicates that in many countries, effectively preventing and treating HIV among MSM is an essential factor in reducing HIV among *all* people at risk for infection (Beyrer et al. 2011). Addressing the human rights environment is thus fundamental to ensuring universal access to services for prevention and treatment.

To effectively reach MSM and other key populations, HIV programs need to understand local human rights dynamics and pursue approaches that promote universal human rights while also supporting development, reform, and reinforcement of constitutional and legal commitments to human rights, the rule of law, and the recognition that MSM should be treated equally under the law.

The following are three practical measurable strategies that, if implemented in combination, can help to promote improved health and human rights environments for MSM:

1. Engage with those who would benefit
2. Remove barriers that limit access to HIV programming
3. Integrate rights approaches within health programming and support universal rights to health.

Each strategy includes a justification, program examples, and ways of measuring success.

## Strategy I. Engage with Those Who Would Benefit

A first and frequently neglected step in rights-based programming for HIV is to meaningfully engage with the populations who are intended to benefit from new investments and programming.

There are several reasons to engage with the target community, as follows:

- *Engagement mobilizes existing creativity and resources:* A primary reason for engagement is practical—people are resourceful and resilient, and where MSM face an HIV epidemic, they have already invariably developed their own concepts and strategies for negotiating to protect their health (Ayala 2011; Guzman et al. 2005). No health program for MSM should proceed without some understanding of these local strategies.
- *Data support engagement:* Research shows that health outcomes improve when communities take part in efforts to improve their own health (Latkin et al. 2010). This participation yields a series of benefits: establishing locally appropriate health norms, improving social connectedness and enhancing peer-to-peer information and support, increasing the input of community-relevant components into program design, and increasing the visibility and perceived legitimacy of the community's health goals. Data from long-term cohorts of MSM have also shown since the 1980s that the availability of supportive peer norms is consistently, significantly, and positively related to multiple measures of HIV-related outcomes (Joseph et al. 1987).
- *Engaging MSM supports human rights:* Effective HIV programming for MSM requires that those

men have the right to and opportunity for free speech, open association, public assembly, expression of their health needs, and negotiation of solutions to those needs.

- *Engaging MSM aligns with international agreements:* Over the past 20 years, international agencies have repeatedly emphasized the need for community partnership, empowerment, and community-centered HIV programming for MSM. In a June 2011 article from *The Lancet* proposing an updated global HIV investment framework, a global panel of experts recommended building solidarity and social support networks through community organizations, peer groups, and coalitions for access to justice, health care, and human rights (Schwartländer et al. 2011). The June 2011 WHO program guidelines regarding HIV and MSM call on governments to include MSM and transgender people in health plans, in accordance with medical ethics and the right to health. These recommendations are consistent with previous literature about the importance of rights-affirming health programming to ensure access for MSM (Peacock et al. 2009).

Numerous existing regional and subregional community networks can help HIV programs engage with the MSM populations targeted for new programming. These networks can link national and local community organizations, share intervention and advocacy strategies, and facilitate linkages between community groups and national and international health programs and researchers. For more information, see the “Key Resources and Contacts” section.

### Recommended Program Approaches

The following two major approaches can help health program planners and implementers engage with their target communities:

*Encourage peer-to-peer support, dialogue, and leadership among MSM.* A first step for health programs seeking to engage with MSM is to invest in communities of men so that they can create and reinforce their own networks of exchange and support. Support may target existing social networks and events, community coalitions, and community organizations.

*Encourage and support the involvement of MSM in health and rights programming.* Health programs should employ or otherwise engage individuals from MSM networks and organizations in program planning, design, implementation, and monitoring and evaluation. To be meaningfully engaged, those individuals and their networks must be able to inform themselves and to be honest and vocal in their participation.

### **Practical Examples**

- In India, one government report estimates a population of over 2.3 million MSM and transgender people, with an average HIV prevalence among MSM of 7.41 percent as of 2007 (Robertson 2010a). The Indian Government included MSM as a prevention priority in the country's second National AIDS Strategy (1999), but implementation has not always been easy. For example, in 2000, personnel from Naz Foundation International in Lucknow were arrested and charged under obscenity and sodomy laws for conducting HIV prevention outreach and education for MSM. Since October 2010 and with support from GFATM, a new program called Pehchan, led by the India HIV/AIDS Alliance and including Naz Foundation International (now known in India as Maan AIDS Foundation), Hum-safar Trust, Solidarity and Action Against the HIV Infection in India, Sangama, and South India AIDS Action Program, is building the capacity of 200 community-based organizations in 17 states to reach more than 453,000 MSM and transgender people with HIV prevention and related services. Working closely with national and state govern-

ments, the Pehchan program places strengthening community systems for MSM, transgender, and *hijra* populations at the heart of efforts to make government prevention interventions for these groups more effective and sustainable.

- In Indonesia, the national network of MSM and transgender people, GWL-INA, is a rapidly expanding network created in 2007 to build comprehensive HIV prevention programming for MSM and transgender people, and to build community knowledge about health and rights. GWL-INA members represent the network in national consultations and meetings with the National AIDS Commission, the national GFATM Technical Working Group, and other entities. The organization, a member of the Indonesian National AIDS Commission (NAC), oversaw the roll-out of the NAC's national MSM program and co-led a successful proposal for a U.S.\$12 million multicountry GFATM grant.

Also in Indonesia, HIV programs in six cities work with rights organizations to organize events to coincide with the Q! Film Festival, a large-scale, annual cultural event for lesbians, MSM, bisexuals, and transgender people (UN Development Programme [UNDP] 2011). The Q! Film Festival includes film screenings, panel discussions, interviews, art exhibitions, performances, and public debates. HIV programs are discussing how to integrate health promotion campaigns within this event.

- In Honduras, the Asociación Jóvenes en Movimiento (AJEM, or Youth in Movement Association) is an organization that promotes health and human rights among young people, including young MSM, in Tegucigalpa, Honduras. With a volunteer network of over 80 young men and women, AJEM reaches approximately 1,000 young people with education about their right to health and practical information about sexual health and HIV prevention. A central focus for

AJEM is to promote youth engagement and leadership in health, and the organization has increased young people's capacity to be informed and vocal about sexual health policies and programs in Honduras.

- In Belize, the United Advocacy Movement is setting up a shelter for young MSM who have been kicked out of their homes, often because of their sexual orientation or gender identity. The project seeks to provide emergency housing to such young people and to work with their families on reintegration as part of broader programming for health and rights.
- In sub-Saharan Africa, although there is limited governmental support for MSM programming, HIV programs have engaged with MSM networks and organizations in many ways. In Ghana, the Centre for Popular Education and Human Rights is supported through small GFATM and PEPFAR subgrants and through several HIV and rights programs (Robertson 2010b). In Mozambique, Lambda, a sexual minority rights group, is recognized by the Ministry of Health as a key player in the national HIV effort and is engaged with the National Human Rights Commission in an upcoming review of the Constitution and the penal code.

### Measuring Success

The purpose of engaging communities of MSM is to 1) advance their collective needs and priorities for health and rights, and 2) support effective measures to prevent HIV and improve health in the community. Programmers can use the following questions and related indicators to measure engagement with the MSM community.

*Guidance from the target population of MSM:* Do the design, implementation, and evaluation of government-funded health programs and health research incorporate input from the communities meant

to benefit from those efforts, through advisory or planning groups and involvement of MSM as full partners and providers?

Indicators of success:

- MSM leaders involved as partners or advisors will report that they are informed and trained, have structures and processes to ensure that they represent the community's views, and are held accountable to the communities for whom they speak.
- MSM in the target community will report that they are aware of and have access to government-funded health programs, and that those programs are safe, accessible, and relevant to their needs.

*Community-generated advocacy:* Are community-generated advocacy efforts on HIV evident and under way?

Indicators of success:

- National policymakers will report that this advocacy is helping to increase awareness of and legitimize broader community health and rights issues, which in turn contribute to political and social commitments and action on health and rights.
- MSM in the target community will report that this advocacy is reinforcing their engagement in their own health, including decisions about reducing exposure to HIV, testing for HIV, and sustaining HIV treatment.

### Strategy 2. Remove Barriers That Limit Access to HIV Programming

In many settings, MSM want to seek health services but cannot access them without fear of stigma, discrimination, or violence related to their sexual ori-

entation or gender identity. These fears present real barriers to health services, public health, human rights, and the response to HIV.

International organizations recognize the importance of antidiscrimination laws and enforcement to the protection of both human rights and human health. The new WHO program guidelines for HIV and MSM describe broad-based, routinely enforced protection from discrimination—through reform of both laws and social norms—as a first good practice recommendation about human rights and inclusive environments for MSM and transgender people. The guidelines call for policymakers to work with civil society organizations to confront the realities of discrimination and transform punitive legal and social norms into protective statutes (WHO 2011). A recent report from the World Bank likewise calls for action to end the criminalization and social censure of same-gender relationships. The report warns that laws promoting universal access and gender equality may fail if cultural, religious, or political factions that stigmatize MSM remain in place (Beyrer et al. 2011).

UNAIDS recommends that every national HIV response includes a package of seven key human rights programs that:

1. Reduce stigma and discrimination
2. Sensitize police and judges
3. Provide legal services
4. Train health care workers on nondiscrimination, confidentiality, and informed consent
5. Monitor and improve the impact of the legal environment surrounding HIV
6. Implement campaigns to promote understanding of rights and laws and advance legal literacy

7. Counter harmful gender norms.

### **Recommended Program Approaches**

Health program planners and implementers might consider the following approaches to champion removal of barriers to HIV programming and support protections against human rights violations.

*Document policies and practices that present barriers to the HIV response.* Program managers can commission studies to understand and document how existing legal and human rights frameworks impede access to HIV interventions, and how adoption of international standards and models for laws, judicial practice, and law enforcement might improve this access.

*Promote literacy about human rights and supportive policies and practices.* Health programs should integrate locally appropriate “know your rights” programs to inform key populations about national laws and human rights, build literacy about human rights, and help MSM obtain counseling, protection, and redress for human rights violations. Education should also include police, lawyers, and judges, who may not understand the impact of punitive laws and enforcement on public health and access to health services. Program implementers should work with judiciary and law enforcement agencies to promote policies and practices that support effective health programs for MSM, including education on sexual health, HIV counseling, testing and treatment, distribution of condoms and lubricants, sterile injection equipment, and other health promotion and harm reduction measures.

*Support reporting of and response to rights violations.* As of 2011, approximately 110 countries had national human rights institutions, including legal aid clinics and networks, hotlines, and human rights networks, that have a mandate to monitor the human rights environment, take individual complaints,

and carry out rights education programs. Health programs should link with these organizations to facilitate confidential reporting about human rights violations and advocate for appropriate responses from relevant administrative and judicial authorities. Some health programs can train peers from MSM communities in paralegal work and hire them to link community members with legal and social services, and to compile evidence for broader human rights action (American Foundation for AIDS Research 2011; Csete and Cohen 2010).

*Facilitate dialogue between MSM and policymakers.* As HIV service providers, program managers and implementers occupy a unique bridging role that includes both direct interaction with clients (including MSM) and direct interaction with ministries of health and other governmental stakeholders. This gives them the vantage to identify gaps between clients' needs and health policies, including policies that undermine access to HIV services for MSM (i.e., HIV monitoring and surveillance systems that do not collect data on MSM, or policies that allow police to arrest MSM peer educators). When strategic opportunities arise, implementers should use their bridging role to bring clients together with policymakers to discuss problems, find workable solutions, and build the community's informed participation in health policy development. On the global stage, the Inter-Parliamentary Union has established an advisory group on HIV, and has published a handbook for parliamentarians working on HIV (UNAIDS and Inter-Parliamentary Union 1999).

### **Practical Examples**

UNDP has recently developed important resources for HIV program managers who want to understand human rights considerations in relation to MSM (UNDP 2007). One UNDP initiative to support health and human rights is the Global Commission on HIV and the Law. This international

commission, composed of 15 members recognized for their expertise and public service, provides leadership by compiling evidence on emerging issues, building awareness, and promoting public dialogue and civil society engagement in human rights and legal issues related to HIV. Beginning in 2009, UNDP also sponsored reviews of legal barriers to HIV interventions for MSM in Asia and the Pacific, Eastern Europe, and the Middle East and North Africa. UNDP has also published reviews showing examples of how HIV service programs have supported law reviews, human rights literacy campaigns, legal services, and linkages with human rights organizations (Godwin 2010a, b, c; International HIV/AIDS Alliance and Commonwealth HIV and AIDS Action Group 2010).

Examples of initiatives to link HIV services and human rights at local and national levels can be found in many countries, including the following:

- In Bangladesh, a nongovernmental organization, Bandhu Social Welfare Society (BSWS), has worked since 1996 to promote the sexual health and human rights of MSM and transgender populations. Beginning with two paid staff in 1997, the organization now employs more than 600 staff and provides services in 21 districts in Bangladesh. BSWS supports education and outreach among MSM and transgender networks, social and community-building activities, and HIV prevention and sexual health programming. The group is also a strong advocate for human rights; since 2006, BSWS has had dedicated policy staff to document problems in law enforcement and human rights and to promote human rights with community leaders, police, lawyers, journalists, and government policymakers. UNAIDS has cited the BSWS service model as a best practice example, and the 2010 national UN General Assembly Special Session report names one of the BSWS advocacy programs, the District Level Lawyers Group, as an example of a best practice

by the Bangladesh government (Ahmed 2011; Bandhu Social Welfare Society 2011).

- In Jamaica, where MSM face harassment and violence due to social stigma and discrimination, the Jamaica Forum for Lesbians, All-Sexuals and Gays (J-FLAG) provides financial, psychosocial, and other support to dozens of people each year who have been expelled from all other sources of support, including their families and local communities. J-FLAG provides links to a range of services, including peer-based support and case management, legal services, emergency housing and stipends, life skills training, HIV testing and counseling, and assistance with medical bills and medication. Of particular importance is that J-FLAG works from an advocacy framework that ultimately aims at widespread understanding, respect, and promotion of universal principles of human rights. J-FLAG also works with other community organizations, human rights organizations, and UN agencies to build understanding about barriers to HIV programming and the need to protect human rights.
- In Senegal, a 2008 media-fueled controversy and subsequent arrests of MSM temporarily closed down GFATM-supported HIV programming. Subsequent investigation by Senegalese researchers, supported by Johns Hopkins University and UNDP, showed a correlation between these events and a negative impact on access to HIV interventions by MSM. Senegalese health authorities and nongovernmental organizations have used this research to argue for new national investment to address human rights as a part of public health, and to evaluate policies and practices that might overcome barriers to the HIV response.

### Measuring Success

The intended outcome of removing rights-related barriers to HIV programming for MSM is to in-

crease the number of MSM who access HIV services, thus increasing the proportion of MSM who receive HIV counseling, testing, and treatment in the context of combination HIV interventions, and ultimately reducing rates of HIV infections and improving the overall health of MSM. Programs can use the following questions and related indicators to measure success.

*Measuring the status quo:* What are the current barriers for MSM seeking to prevent, test for, or treat HIV?

Indicators of success:

- Judicial and law enforcement authorities will report specific policies and practices, such as professional or social stigma; lack of awareness and knowledge, appropriate guidance, standards, or training; or lack of political, institutional, or peer support. These factors can be targeted for change during interventions.
- MSM in the target community will similarly report specific policies, practices, discrimination, violence, or other human rights violations that they experience from health care providers or law enforcement, based on actual or perceived sexual orientation or gender identity. These will change with successful intervention.

*Assessing change:* What are current actions to overcome structural barriers for MSM seeking to prevent, test for, or treat HIV?

Indicators of success:

- As a result of rights literacy efforts and rights-focused dialogue, judicial and law enforcement authorities will understand the existing legal framework and human rights environment, alternatives for improving policies and practices, and efforts to improve policies and practices (through activities such as training, education, and professional

standards and management) to eliminate human rights violations.

- As a result of rights literacy efforts and rights-focused dialogue, MSM in the target community will understand the existing legal and human rights environment, present options for alternatives or improvements to policies and practices, and participate in dialogue on judicial, law enforcement, and policy barriers to HIV services.

### **Strategy 3. Integrate Rights Approaches within Health Programming and Support Universal Rights to Health**

Recently completed research showing that earlier initiation of HIV treatment can prevent HIV transmission to sexual partners (Cohen et al. 2011) emphasizes the importance of ensuring that MSM understand their right to health care and, specifically, know their HIV status and where to obtain HIV care and treatment. Public health efforts should be implemented in ways that respect, protect, and fulfill human rights. Indeed, many governments already formally endorse universal access to care and the right to health services. According to a 2010 WHO study, a total of 135 countries include the right or commitment to health in their national constitutions. Of these, 95 mention the right to access health facilities, goods, and services; 62 refer to equity and nondiscrimination; and 111 mandate the right to equal treatment or freedom from discrimination (Perehudoff, Laing, and Hogerzeil 2010). However, MSM in many of these countries report discrimination and other barriers to obtaining health care (Global Forum on MSM & HIV 2011).

Yet many examples of programs, practices, and guidance exist. Several international studies review various models of HIV programs for MSM, describe good practices, and identify measures of HIV service relevance, attractiveness, safety, and accessibility (AIDS Projects Management Group 2009). A range

of international, regional, and national guidelines and training materials have been developed to support these practices both in institutional policy and by providers (Desmond Tutu HIV Foundation and Kenya Medical Research Institute 2011; Fenway Institute 2007; International Union Against Sexually Transmitted Infections 2006).

At a minimum, providers who work with MSM should be required to adhere to protocols for ensuring safe and confidential health services, as well as clinically competent, supportive, and nonstigmatizing provider-initiated sexual health counseling. Health service institutions can be encouraged and funded to adopt a range of measures, including appropriate service locations and hours; appropriate signage; confidentiality and cultural competency in intake, record keeping, and follow-up; referral to social and legal services; and ombudsman services and internal quality monitoring to meet standards for safety, confidentiality, nondiscrimination, and accessibility.

### **Recommended Program Approaches**

Programs should consider the following approaches to apply human rights considerations to improve the quality, effectiveness, accessibility, and scale of combination HIV interventions for MSM.

*Promote professional and institutional standards in health care settings.* Maintaining standards is important to the advancement of human rights in health care settings. Funders and providers should work with national health care accreditation and training agencies to improve professional and institutional standards, including related training, certification, and recertification requirements, to ensure quality health care in relation to HIV and MSM.

*Support peer-based health services in both community and clinical settings.* Clinicians and other health providers with direct experience in MSM communities,

including those who are MSM themselves, can be essential partners, not only providing nondiscriminatory health care but also serving as links to communities of MSM, to ensure that HIV program designs match community needs. In its 2011 guidance, WHO states that using trained individuals who have direct experience with the target community can enhance the delivery of combination services (WHO 2011).

*Fund health programming for MSM at sufficient scale.* To change the course of the HIV epidemic in any country, high-quality HIV programs must be implemented in key populations at scale. Several international publications show that in most regions, national health programs focused on MSM are not yet funded at a level matching their relative HIV burden and are not carried out at a scale sufficient to have a major impact on HIV infection rates, HIV treatment rates, and health outcomes. National resource allocations should be strategically allotted to achieve national public health goals, maximize the benefit and fairness of health resource distributions, and allow MSM to fully exercise their right to health.

### **Practical Examples**

- In Kenya, a Nairobi-based organization, Liverpool VCT, Care & Treatment, began offering space and a facilitator to provide MSM with a peer support group and access to HIV testing and clinical services. The organization launched the program in 2004, responding to the requests of MSM (mostly male sex workers). Over the next five years, Liverpool VCT established well-defined professional and institutional standards for safe, confidential, and nondiscriminatory care; trained 75 staff on these standards; and recruited MSM clients as providers of peer outreach and health services, ultimately reaching over 3,000 MSM in Nairobi. As one of the organizations to pioneer HIV programming for MSM, Liverpool VCT helped to create an environment that was conducive to others publicly announcing services. By 2009, the number of community organizations and research institutions openly working with the government to document HIV prevalence and health care access of MSM had increased. Starting in 2005, MSM were listed as a target population in the National AIDS Strategic Plan for Kenya. PEPFAR funding now supports an MSM clinic at the offices of the Gay and Lesbian Coalition of Kenya and its coalition partner Ishtar. The government has initiated national purchasing of condoms and water-based lubricants for MSM outreach programs and has established a national target of reaching 71,000 MSM with HIV services by 2013.
- In Mumbai, India, the Humsafar Trust has worked for almost two decades with MSM and transgender communities, linking advocacy and support activities to HIV prevention and health services. Humsafar Trust collaborates with a number of government clinics, providing training on the needs of MSM, transgender patients, and people living with HIV, and supporting clinic hours for these clients.
- In the Dominican Republic, the organizations Amigos Siempre Amigos (ASA, or Friends, Always Friends) and Centro de Orientación e Investigación Integral (COIN, or the Center for Integrated Training and Research) have provided health services to MSM for nearly 20 years. Their success is based on their policy of engaging MSM as outreach workers and advisors; encouraging clients to see health as a right guaranteed by national law, protect their own health, and help

their peers do the same; and continually training and sensitizing staff and patients at government-run hospitals and clinics. ASA and COIN have documented 10 years of success in involving thousands of MSM in health promotion, increasing men's willingness to test for HIV and STIs, and increasing service uptake and retention of MSM in HIV treatment and care.

- In Indonesia, the Jakarta Planned Parenthood Association has connected MSM to health care and built a foundation for universal access by helping individuals from MSM and transgender organizations sensitize staff in government clinics and hospitals, and to encourage others from their communities to attend those sites for services.
- In Ukraine, the Penitentiary Initiative has worked in Ukrainian prisons since 2001, providing HIV prevention information to prison staff and inmates. The organization also provides HIV treatment, care, and support to inmates living with HIV, including those who inject drugs, who constitute the majority of persons living with HIV in Ukraine. To engage MSM, the Penitentiary Initiative formed a partnership in 2008 with the Nikolaev Association for Gays, Lesbians and Bisexuals (LiGA), which contributed funding for an initial pilot project and trained Penitentiary Initiative staff in the specific needs of MSM. The Penitentiary Initiative staff then developed an outreach model for HIV prevention and psychosocial support and implemented the model in four prisons in the Nikolaev, Lugansk, and Cherkassy regions. The Penitentiary Initiative has employed multiple strategies, among them training prison staff, supplying HIV prevention kits to MSM, organizing support groups, and providing access to social and mental health counseling. The project also assists inmates on release from prison by linking them to LiGA's social support and outreach programming and referring them to MSM-friendly health services.

- In Zimbabwe, a community organization, Gays and Lesbians of Zimbabwe (GALZ), has provided a wide range of services for over two decades. GALZ provides medical insurance, health care, and access to antiretroviral therapy for members living with HIV; promotes safer sex; and advocates for social tolerance of sexual minorities and the repeal of homophobic legislation. GALZ has protocols for orienting new members and staff and for training health care providers, and maintains a database of MSM-friendly doctors, health care workers, and clinics throughout Zimbabwe. The organization, which is supported by international donors, sustains direct contact with the Zimbabwe Ministry of Health.

### **Measuring Success**

The goal of integrating rights approaches within health programming and supporting the right to health is to increase access to and use of appropriate, nondiscriminatory, and easily available HIV services, with the ultimate aim of reducing the incidence of STIs, HIV, and AIDS-related illness.

To assess progress toward this goal, program managers can use the following question and related indicators.

*Integration of rights within HIV services:* How are HIV-related health services being implemented in ways that respect, protect, and fulfill human rights?

Indicators of success:

- Health service providers will report specific policies and protocols, including professional certification, recertification, and training requirements, that ensure that health services are welcoming, safe, responsive, and free of discrimination based on sexual orientation or gender identity, loss of

confidentiality, or inappropriate refusal of health services.

- MSM who use HIV-related health services, such as HIV testing, treatment, and care, will experience improved health outcomes. These clients will report that health services are welcoming, safe, and responsive to their needs, and that they experience no human rights violations, including instances of discrimination, loss of confidentiality, or refusal to provide health services.
- MSM in the target community who are not engaged in care will be measurably less likely to report reduced rights-related barriers such as discrimination, loss of confidentiality, or refusal of services as reasons for not obtaining care.

## KEY RESOURCES AND CONTACTS

**Global:** Global Forum on MSM & HIV,  
[www.msmsgf.org](http://www.msmsgf.org)

**Africa:** African Men for Sexual Health and Rights,  
[www.amsher.net](http://www.amsher.net)

**Asia and the Pacific:** Asia Pacific Coalition on Male Sexual Health, [www.msmasia.org](http://www.msmasia.org)

**Latin America and the Caribbean:** Asociación para la Salud Integral y la Ciudadanía de América Latina y el Caribe, [www.asical.org](http://www.asical.org)

**Eastern Europe and Central Asia:** Eurasian Coalition on Male Health, [msmeurasia@gmail.com](mailto:msmeurasia@gmail.com)

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