

Advancing the Sexual and Reproductive Health and Human Rights of **Men who have Sex with Men Living With HIV**

***A POLICY BRIEFING**



Bhumesh Racherralai (left), and G. Komaraiah (right), a same sex couple at their house in Mancheril, in the Indian State of Andhra Pradesh. Credits: Amit Bhargava/Corbis

*Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV: A Guidance Package*¹ is a detailed and comprehensive report that describes the key areas of policy and practice change needed to advance the sexual and reproductive health and human rights of people living with HIV.

In order to examine issues that affect specific populations key-population specific Policy Briefings to compliment the Guidance Package have been created. Five key populations affected by HIV have been selected: men who have sex with men; sex workers; injecting drug users; prisoners and migrant populations. This Policy Briefing focuses on men who have sex with men (MSM) living with HIV and aims to provide advice and support to those advocating for the sexual and reproductive health (SRH) and human rights of MSM at a national and international level.

WHY FOCUS ON MSM

MSM living with HIV face double stigma due to:

- 1) fear and ignorance surrounding HIV transmission; and
- 2) negative social attitudes and perceptions that exist towards MSM. This double stigma can cause MSM – both HIV-positive and HIV-negative – to avoid or fear accessing health services, including counselling and testing, treatment, prevention and support.

The detrimental effects of such stigma and discrimination on sexual health has been well documented in the global north, where HIV infection rates among MSM in large urban centres are unacceptably high and in some places steadily increasing. There are also rapidly escalating epidemics among MSM even in countries where the HIV epidemic is typically characterised as generalised. For example, HIV prevalence among MSM is as high as 25% in Ghana, 26% in Mexico, 32% in Jamaica, 43% in coastal Kenya, and 25% in Thailand. In fact, MSM are 19 times more likely to be living with HIV than the general population in low- and middle-income countries.² HIV disproportionately affects gay men and other men who have sex with men (MSM) in all parts of the world.

As policy makers, programme managers, sexual health advocates, HIV care workers, and other community stakeholders work to refine responses to the sexual and reproductive health needs of MSM living with HIV, it is important that there be a shared understanding of the complexity inherited in the use of the terms “gay and MSM.” Around the world, the term MSM has been used as an epidemiological term of convenience, but may not adequately reflect the diversity of this population in relation to individual sexual behaviour or individual and community self identification. In fact, the terms gay and MSM are culturally bounded terms, which may not be useful or appropriate in some contexts, given the range of masculinities and genders, sexual behaviours, partner choices, perceived sexual needs and desires among men.³ A broad range of homosexual and homosocial acts, identities, and communities form a continuum of sexual and gender self-expression. For example, for some men penetrated versus penetrative sex differentiates one’s sexual identity as male or not male. For political and social reasons, it may be more appropriate to use

alternative terminology for MSM, for example terms that refer to men in the context of their sexual behaviours.⁴ MSM living with HIV may identify as bisexual, chava, gay, heterosexual, hijra, kothi, masti, queer, same gender loving, or zenana. Thus, who we mean, when we refer to gay or MSM must remain an open and continuously, critically examined question.

The term gay men and other MSM used in this document is not intended to diminish the rich diversity of sexuality, sexual partnerships, sexual expression, or gender expressions of this population. Common experiences of exclusion, sexual otherness, and verbal or physical discrimination form a basis for potentially useful alliances among gay men and other MSM.

YOUNG PEOPLE AND HIV

As of 2007, 16% of the 33.2 million people living with HIV were youth between the ages of 15-24.⁵ The primary mode of transmission among young people in that age category varies by region of the world in official reports. However, collecting data on exposure category is riddled with challenges that are linked to stigma about homosexuality, making HIV prevalence among young MSM difficult to estimate. The effects of stigma and discrimination combined with legal barriers affecting young people in particular, also undermine their access to HIV testing and health care services. For example, laws that prohibit young people under the age of 18 from accessing HIV-related services without parental consent make it difficult to reach this group with programs they may need. As a result, the vast majority of young people living with HIV do not know that they are infected or not linked to treatment, care, and support they need. Likewise, confidentiality breaches by health care providers are common when it comes to youth and therefore a critical issue for young MSM living with HIV.

It is important that young MSM living with HIV are permitted to safely and confidentially access sexual and reproductive health services, even if they are below the age of consent for sex. This includes access to comprehensive sexuality education.⁶ This is especially important given the high rates of sexually transmitted diseases other than HIV among young MSM.⁷ It is equally vital that health care providers receive adequate sensitivity training to understand the particular needs of young MSM as well as their obligation to protect young people from stigma, discrimination, and breaches in confidentiality.

HOW THIS POLICY BRIEFING WAS DEVELOPED

The Policy Briefing begins with a review of important rights-based principles, continues with an examination of issues linked to the sexual and reproductive health of MSM, and concludes with a set of recommendations adapted from the original recommendations proposed in the Guidance Package¹, offered here with the specific needs and priorities of MSM living with HIV as foreground.

This policy briefing was produced in close consultation with MSM living with HIV, including staff and steering committee members from the Global Forum on MSM and HIV (MSMGF). In addition, the authors of this Policy Briefing consulted with staff from AIDS Project Los Angeles and MSM sexual health advocates around the world about priority issues and themes. The authors and their consultants strongly believe that the needs of MSM living with HIV cannot be met without understanding and addressing first their issues and priorities as men who love and have/enjoy sex with other men. In this regard, the MSM Policy Briefing should be seen as an accompanying resource, designed to complement the Guidance Package.

SEXUAL & REPRODUCTIVE HEALTH RIGHTS & NEEDS OF MSM LIVING WITH HIV

HUMAN RIGHTS

Although epidemiologic and behavioural research indisputably supports prioritising MSM living with HIV at both the national and global levels, MSM needs are often neglected in discussions about programmes and services that is expressed through silence, denial, or explicit exclusion. At the global level, only 1.2% of funding for HIV-related services is directed at MSM. Moreover, only one in twenty MSM has access to the prevention, care, and treatment services they need worldwide.⁸

Inadequate representation of gay men and other MSM living with HIV in planning processes at all levels fuels the widening disparity in resources devoted to programmes and services.⁹ At present, less than one in four countries around the world report full participation of MSM in HIV national planning.¹⁰ It is difficult to know more specifically whether countries reporting participation of MSM actively engage MSM living with HIV.

Exacerbating an already dire situation are wide-spread and ongoing human rights abuses and discrimination faced by MSM globally.¹¹ The link between HIV and social oppression of MSM is well established in research literatures and difficult to overlook.^{12 13 14 15} Criminalisation and economic disenfranchisement of sexual minorities cause social dislocation, influence transnational migration, and fuel human rights abuses, heightening the risk for HIV transmission and driving those most at need away from prevention, care, treatment, and support services.

In 2009, no less than 80 countries had criminal penalties for same-sex acts between consenting adults.¹¹ In Central American and Caribbean countries, there is widespread harassment by police and violence directed at MSM. Two-thirds of African countries ban male-to-male sex. Punishments range from imprisonment (five years in Cameroon, Senegal, and Ghana; life in Uganda) to death (Mauritania, Sudan, and parts of Nigeria). 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 both developing and developed countries. Even in countries without explicit legal prohibitions against same-sex behaviour, widespread stigma often prevents individuals belonging to sexual minority communities from seeking or receiving essential HIV programmes. As a result, HIV infection rates may remain disproportionately high among sexual minorities in both developed and developing countries and access to sexual health services for MSM living with HIV unacceptably low for years to come.

Given the high proportion of MSM living with HIV, expanding access to effective MSM-sensitive HIV prevention, care, treatment, and support programs must be a high priority in the global response to HIV. This priority was articulated and reiterated by key global HIV leaders at the 2008 International AIDS Conference in Mexico City and again at consultations held in 2009 by UNAIDS, UNDP, and the Global Fund on AIDS Tuberculosis, and Malaria.

Contemporary public health practices and HIV criminalisation trends continue to underscore the importance rights-based principles to guide our work in promoting the sexual and reproductive health and rights of MSM living with HIV. Those practices include but are not limited to:

- State mandated HIV testing
- Emphasis on HIV testing and case finding absent adequate or quality health care
- Emphasis on partner notification without adequate community-based resources or support
- Criminalisation of consensual same sex practice
- Criminalisation of drug addicts
- Criminalisation of sex workers
- Criminalisation of HIV transmission
- Restricting condom and sterile injection equipment
- Abstinence only programmes.

MSM living with HIV are not able to access their full rights in many places around the world and rights violations are not consistently reported due to fear of reprisals, and in rare cases that reports are made, they are not taken seriously. The Yogyakarta Principles

unequivocally asserts that the application of rights be universal and that MSM living with HIV should have universal human rights, including the right to:

- Equality and non-discrimination
- Recognition before the law
- Life
- The security of the person
- Privacy
- Freedom from arbitrary deprivation of liberty
- Health¹⁶

Now, more than ever, it is vital that sexual and reproductive health advocates and other stakeholders become deeply engaged in creating a common voice to ensure that all MSM, especially MSM living with HIV do not become subordinate to conservative policies or political agendas that result in substandard programs and services, which render MSM living with HIV invisible. This is especially important as people with HIV live longer, stigma and discrimination are allowed to thrive, and as traditional public health institutions and policy makers continue to succumb to draconian disease control paradigms. Research has shown no public health advantage to adopting more prescriptive STI or HIV programme and policy approaches over other more libertarian strategies. Effective public health advances the public good while preserving personal liberties, because people are more likely to follow through with health promoting behaviours when they are self-motivated and given the freedom and resources to do so on their own. In that regard, we offer the following four additional rights-based principles to help inform sexual and reproductive health programs and policies targeting gay men and other MSM living with HIV:

- The imperative of reducing STI and HIV infection rates should not impinge on personal freedoms
- All people living with HIV, including MSM, deserve the same level of support, health care, support services and political rights as anyone else
- All people living with HIV, including MSM, are entitled to a fulfilling and satisfying sex life
- Barring harm to others, all people living with HIV, including MSM, have the right to be self-determining

Broader adoption of these principles will provide a common foundation for the development and promotion of effective sexual and reproductive health services that address the specific needs of MSM living with HIV.

SOCIAL DISCRIMINATION AND STIGMA

For the purposes of this Policy Briefing, social discrimination is defined as mean, unfair, or unequal treatment (including acts of verbal or physical violence) intended to marginalise or subordinate individuals or communities based on their real or perceived affiliation with socially constructed stigmatized attributes. Dominant forms of discrimination are based on race/ethnicity, gender, sexual orientation, disability, age, class financial status, or HIV serostatus. Discrimination serves to maintain inequities between different groups. At the cultural level, discrimination is justified in ideology and expressed in discourse or interactions among and between individuals and institutions.¹⁷ The consequences of discrimination can be characterised by differences in proximity to social and economic resources often resulting in differences in health – both physical and mental well-being.¹⁸

The psychosocial correlates of HIV risk behaviour for gay men and other MSM, which are often interrelated, may have a common basis in the considerable stigma and discrimination that many MSM, including MSM living with HIV experience and must navigate in their day to day lives.^{12 19} For example, poverty, racism, and homophobia tend to produce heightened risk for HIV and STI infection and re-infection by increasing social isolation, alienation, and personal shame.¹³ For some MSM living with HIV, financial hardship, family rejection, stigma, and disparities in access to health care and prevention education, create barriers to health promoting behaviours – preventing their fair and full participation in community life.

Although much of our knowledge about HIV-related stigma comes from studies conducted with the general population,²⁰ stigma is as much a problem among gay men as for anyone else. For example, in a probability sample of Latino gay men (n=912) in three U.S. cities (New York, Miami, and Los Angeles), the prevalence of HIV-related stigma among HIV-negative men was

disquieting. More than half of the sample (57%) believed that HIV-positive individuals are responsible for getting infected, and close to half (46%) of the sample believed that HIV-positive persons are to be blamed for the spread of HIV. In addition, 52% of the sample saw HIV-positive men as more sexually promiscuous, and 18% believed that they are people who cannot be trusted. In the realm of sexual interactions and relationships, the findings were also alarming. The overwhelming majority (82%) of HIV-negative men felt that sex with HIV-positive men was dangerous, with 57% saying that they were not willing to have sex with an HIV-positive person, even if condoms were available. Close to two-thirds (57%) of HIV-negative men reported that they were not willing to have an HIV-positive person as a boyfriend or girlfriend.

A substantially large proportion of HIV-positive men in the same sample reported that being HIV-positive had impacted negatively their social and sexual lives, beyond the physical/medical challenges posed by their HIV infection. For example, about half of the sample felt that HIV has made it more difficult for them to find sex (46%) and an even larger proportion (58%) felt that HIV made it more difficult to find lover relationships. Two-thirds (66%) of the sample reported that HIV has made it harder for them to enjoy sex. The overwhelming majority (82%) of HIV-positive men thought sexual partners might reject them if they knew their HIV serostatus. Nearly half (46%) of all HIV-positive participants reported having been treated unfairly because of their serostatus and 45% believed that they had to hide their status to find acceptance from their families and friends. Further analysis demonstrated that for HIV-positive men, experiences of racism, homophobia, and poverty, when combined with HIV-related stigma predicted loneliness, low self-esteem and psychological symptoms of emotional distress more strongly than experiences of racism, homophobia and poverty alone.²¹

MENTAL HEALTH & DRUG USE

The sexual and reproductive health of MSM living with HIV must be understood in the context of contemporary interpersonal, sexual, and social realities that gay men in general must navigate on a day-to-day basis. These realities involve substance use, violence, sexual assault, homelessness, social isolation, and other social factors that are constantly at play in the sexual exchanges between men. In fact, the co-occurrence of sexually transmitted diseases (i.e., syphilis and HIV) with depression, anxiety, anger, low self-worth, and substance abuse among gay men, including MSM living with HIV, has been documented repeatedly by researchers for nearly two decades.^{22 23 24}

The role of childhood sexual abuse has also emerged as an important factor to consider in understanding gay men's sexual and reproductive health. For example, Lenderking et al. found that men who were abused reported more lifetime male sex partners and were more likely to have had unprotected receptive anal intercourse in the past 6 months.²⁵ Other researchers reported similar findings.^{26 27 28} For gay men and other MSM living with HIV, an important correlate to their sexual health is depression.²⁹ Reducing symptoms of depression and other mental health issues are associated with reductions in HIV-related risk behaviours and improvements in overall sexual satisfaction.³⁰ Research overwhelmingly point to the importance of interventions that emphasize reductions in depression and anxiety and that consider contextual aspects of substance use.²⁹

Substance abuse including abuse of alcohol and crystal methamphetamine among MSM is associated with the risk for HIV transmission and continues to complicate HIV prevention and care efforts.^{31 32} It is important to note that research and prevention efforts have not systematically focused on MSM-Injecting drug use (IDU) populations; instead, MSM-IDUs are consistently treated as a subpopulation.³³ Studies of gay/bisexual men tend to lack sufficient numbers of MSM-IDUs to make any generalisations about the subpopulation; in addition, they tend to lack rigorously designed questions regarding injection-related risk. Similarly, studies of IDUs tend to be lacking in numbers of MSM-IDU and to lack questions designed to focus on the dynamics of sexual behaviour among MSM.

Sex work is more common among MSM-IDU than other MSM.^{34 35} Prevalence of sex work activity ranges from 26% among HIV-positive MSM-IDU to 72% among young MSM-IDU.^{36 37} MSM-IDU involved in sex work are more likely to be HIV positive,³⁵ and more likely to report unprotected sex with non-commercial and casual partners, both male and female.³⁸

RELATIONSHIPS

Multiple HIV prevention studies indicate that gay men and other MSM are less likely to practice safe sex with close, regular relationship partners compared with sexual partners perceived as casual.³⁹ This poses a sexual health challenge for serodiscordant couples and couples that are unaware of their respective serostatus. Even for seroconcordant couples – HIV-positive or negative – monogamy without consistent and close communication, social support or negotiated safety agreements, represents a fragile STI and HIV prevention strategy.

Misinformation, lack of social support (partner, relational, friendship), experiences of social discrimination (i.e., HIV-related stigma, heterosexism) and behavioural skills deficits (communication and negotiation skills) specific to relationships, can create unique barriers to safer sexual practices for same sex male couples.^{40 41 42} For example, when communication is impaired due to unexpressed fears about HIV transmission, potential illness, relationship instability, loss, future uncertainty and the desire to protect each other against these concerns, many aspects of the relationship important for sustaining sexual health-promoting behaviours can be negatively affected. In addition, key emotional issues between gay couples can compromise the couple's capacity to guard against sexually transmitted diseases, when left unaddressed.⁴³ Addressing these issues and legitimizing the emotional and intimacy needs of both members of a same sex relationship, are be critical to ensuring the sexual and reproductive health of all gay men, regardless of HIV serostatus.⁴⁴

Serosorting has been commonly reported among MSM living with HIV.⁴⁵ Serosorting is a HIV risk minimalisation strategy in which individuals select and limit sex partners to persons of a particular HIV serostatus. MSM living with HIV are more likely to engage in safer sex practices if their partners are HIV-negative.

Factual knowledge about one's HIV serostatus and that of their sexual partners is necessary, making routine HIV screening and disclosure important components to serosorting as a risk reduction practice.⁴⁶

THE INTERNET

It has always been the case that gay men and other MSM find new and novel ways to socialise and create sexual spaces, partly as a strategy for avoiding, challenging, or coping with stigma and discrimination. The internet is one important, contemporary example.

The internet permits MSM important opportunities to socialise and anonymously access informational resources and support. In research about MSM and the internet, MSM report enjoying the anonymity and convenience of internet sex seeking and many prefer the internet to bars or clubs because: sexual negotiation is direct and completed before the first meeting; emotions can be easily separated from sex; it is easier to manage the risk for rejection (especially as it relates to disclosure about HIV status); particular brands of body politics that exists inside of gay bars and clubs can be avoided; seekers can embody multiple roles, personas, or characters (subjectivities) via different online profiles; it is less expensive than going out; and it is sexually explicit and unapologetically sexual.

Internet sex seeking resulting in sexual liaisons or “hook ups” made via online chat rooms or personal ads is associated with high-risk sexual behaviour among some gay men.^{47 48 49} For example, behavioural studies indicate that MSM who seek sex on the internet were significantly more likely to report using methamphetamine, having received money or drugs for sex, and meeting partners in bathhouses, bars, parks and circuit parties than those who seek sex elsewhere.^{50 51 52} In addition, MSM surfing the net for sex are more likely to be younger and to have a sexually transmitted infection (STI), more sex partners and unprotected anal sex.^{53 54} However, more recent data attributes, in part, declines in new HIV infections among gay men in San Francisco to gay men’s use of the internet to serosort.⁵⁵ The internet as social and sexual space is an important site for innovation in sexual and reproductive health education and interventions.

VISIBILITY OF SEXUAL AND REPRODUCTIVE HEALTH MESSAGING FOR MSM LIVING WITH HIV

As troubling as the HIV epidemiologic data concerning gay men may be, rather than witnessing a proliferation in sexual and reproductive health programmes and prevention messages tailored to MSM, including MSM living with HIV, there has been a decrease in public representations of gay men in HIV prevention campaigns in some communities. Sustained social marketing campaigns aimed at MSM have been substituted for pre-packaged, prescriptive, individual and group-level behaviour modification programs and generic public health messages, which often assumes the principle target audience for prevention services to be HIV-negative gay men.

When gay men and other MSM appear in public ads about HIV and AIDS, they are often white or Western European in appearance and depicted with lean, muscled and smooth bodies. Moreover, MSM living with HIV are at times depicted within ads that utilise “shame and blame” or fear tactics as a strategy for persuading HIV-negative MSM to avoid “risky” sex. The resulting disconnect MSM living with HIV often feel, seriously reduces the salience of sexual and reproductive health messages.⁵⁶

In addition, the relative absence of affirming, realistic depictions of HIV-positive MSM in HIV prevention social marketing campaigns colludes with silence about HIV-related stigma and discrimination in both the gay and mainstream heterosexual communities. This may leave MSM living with HIV feeling isolated and without proper support. And because gay men and other MSM, especially MSM living with HIV, are kept largely outside of public discourse about HIV and AIDS via media messaging and social marketing, our ability to imagine inclusive, and more relevant approaches to sexual and reproductive health is seriously hampered. In fact, outdated and over-simplistic prevention messages for gay men and other MSM, may be behind what is often referred to as “HIV prevention fatigue,” “complacency,” or “AIDS burnout.”^{57 58}

PROTECTIVE FACTORS: RESILIENCE

Around the world, MSM, including MSM living with HIV have responded to the devastating consequences of HIV and AIDS with resourcefulness, creativity, and personal agency. Intervention approaches employed by the HIV prevention sector are often deficit oriented and rarely leverage the knowledge, skills and resources gay men and other MSM have and can employ in maximising their sexual and reproductive health. This is especially true for interventions involving MSM living with HIV. Sexual and reproductive health programmes must find ways to address the hardships faced by MSM living with HIV while bolstering their strengths and resiliencies. Moreover, the complex nature of STI and HIV risk for gay men and other MSM requires sexual health approaches that: 1) address the consequences of oppressive forces in the lives of MSM; and 2) work at the community level to mobilise and validate men's successful risk reduction strategies, friendship networks, families, spiritual beliefs, artistic talents, organising skills, community involvement, and social connectedness, that are each likely to have protective effects against HIV transmission.^{59 60 61}

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RECOMMENDATIONS FOR ADVANCING THE SEXUAL AND REPRODUCTIVE HEALTH AND HUMAN RIGHTS OF MSM LIVING WITH HIV

Despite growing awareness of how sexual and reproductive health and wellness for MSM living with HIV is essential to ensuring both human rights and public health, programmatic and policy responses have been disappointing. Improving this situation will require challenging criminalisation, discrimination, and stigma directed at all gay men and other MSM, especially those living with HIV. And it will necessitate open, effective, and sensitive delivery of information and services tailored to the specific needs and priorities of MSM living with HIV, even within political and cultural environments that are unwelcoming or hostile to gay men and other MSM.

Understanding factors that may undermine the sexual and reproductive health of all gay men and other MSM, including MSM living with HIV – forms the basis for designing robust programmatic and policy responses that are respectful, appropriate, relevant, salient, and sensitive. Co-factors that undermine sexual and reproductive health for MSM living with HIV may vary from person to person, family to family, and from group to group. From a public health perspective, decision makers and service providers must recognise that people living with HIV enter into relationships, have sex, and bear children. Careful assessment should therefore precede programme and policy development. And at a minimum, the rights-based principles referenced above regarding the meaningful engagement of MSM living with HIV must be followed.

This Policy Briefing brings needed focus to gay men and other MSM living with HIV. The following recommendations are adapted from the Guidance Package and from guidelines published by UNAIDS aimed at intensifying HIV prevention and building universal access.⁶²

FOR PROGRAMME MANAGERS AND POLICY MAKERS

1. Voluntary and affordable STI and HIV prevention, care, treatment and support services must be expanded and tailored to meet the specific needs and priorities of MSM living with HIV – based on confidentiality, informed consent, and counselling.
2. Systems for HIV prevention, care, treatment and support must be strengthened to deal with disproportionately high numbers of MSM living with HIV at the same time that HIV testing is scaled up – case finding without appropriate services constitutes substandard and unethical public health practice.
3. National laws criminalising homosexuality and HIV transmission should be overturned in favour of laws that guarantee the rights of gay men and other MSM, including MSM living with HIV.
4. All MSM living with HIV, including young MSM and their sex partners (male, female, or transgender) should have access to a full and comprehensive range of sexual and reproductive health services including STI screening and treatment, hepatitis immunisation, mental health and other psychosocial support services.
5. Health service providers and advocates should receive sensitivity training related to the specific needs and priorities of MSM living with HIV, including stigma reduction, confidentiality, and the specific challenges facing young MSM.

FOR SEXUAL HEALTH ADVOCATES AND HIV CARE WORKERS

- 6. Health service providers and advocates should strive for closer linkages between STI and HIV prevention, care, treatment; sexual and reproductive health, substance abuse, and mental health services; and anti-discrimination and anti-violence initiatives.
- 7. Access to affordable legal assistance should be made available to MSM (youth and adult) who experience sexual coercion or violence.
- 8. Specific and targeted information on sexual and reproductive health designed to appeal to MSM living with HIV should be made available, including social marketing efforts that reflect the subjective experiences of MSM.
- 9. Availability of safe virtual or physical social spaces for MSM living with HIV should be expanded and promoted.

FOR COMMUNITY AND CIVIL SOCIETY ORGANISATIONS

- 10. Empowerment of MSM living with HIV should be integral to all sexual and reproductive health programmes and policies – including the establishment of self-help groups and networks of MSM living with HIV.
- 11. Campaigns to decrease stigma, discrimination, and the acceptability of homophobia should be supported and promoted.
- 12. Initiatives that encourage the greater involvement of MSM living with HIV must be supported.

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RESOURCES

Global Youth Coalition on HIV/AIDS (GYCA)

www.youthaidscoalition.org

HIV Law Project

www.hivlawproject.org/StayInformed/resources.html

The Global Forum on MSM and HIV (MSMGF)

www.msmsgf.org

The Global Network of People living with HIV (GNP+)

www.gnpplus.net

UNAIDS. (2008). Report on the Global AIDS Epidemic. Geneva: UNAIDS.

www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

World AIDS Campaign

www.worldaidscampaign.org/en/Constituencies/People-Living-with-HIV-and-AIDS/Resources



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About the Global Forum on MSM and HIV (MSMGF):

The Global Forum on MSM and HIV (MSMGF).

The MSMGF advocates for equitable access to HIV prevention, care, treatment, and support services tailored to the needs of gay men and other men who have sex with men, including MSM living with HIV, while promoting their health and human rights worldwide.

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About the Global Network of People living with HIV (GNP+):

GNP+ is the global network for and by people living with HIV. GNP+ advocates to improve the quality of life of people living with HIV (PLHIV). As a network of networks, GNP+ is driven by the needs of PLHIV worldwide and its work is guided by the Global Advocacy Agenda, determined by and for PLHIV, through the implementation of the GNP+ platforms of action: Positive Health, Dignity and Prevention; Human Rights; Sexual and Reproductive Health and Rights of people living with HIV; and Empowerment.

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Two participants at a sexual health meeting in Senegal.
Credits: UNAIDS/P. Viot

