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MSM, HIV and the Law: The Case of Gay, Bisexual and other Men who have Sex with Men (MSM)

Chris Beyrer, Stefan D Baral[1]

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Key themes

- Criminalisation of same-sex behaviour has profound implications across the spectrum of policies, issues, and programmes relating to men who have sex with men (MSM): criminalisation matters.
- Responses to HIV epidemics among MSM in highly disparate legal, political and human rights environments have to be context specific: one size will not fit all.
- Laws and policies that promote universal access and gender equality in principle may fail for MSM in practice where homophobic cultural, religious, or political forces are active: good policies for HIV do not guarantee good outcomes for MSM and other sexual minorities.
- Although quantification of the impact of structural interventions is important, action is mandated to decrease human rights abuses against MSM on social justice and human dignity grounds alone. We have enough evidence to act now.

Introduction

The international community is at a critical period in the HIV response. HIV infections continue to rise in a number of subpopulations, resources for continuing the response are threatened, and the legal, human rights and social and political standing of MSM are the subject of intense public, media, political, and public health debate.[2] Major advances in the legal standing of sexual minorities, most notably the judicial striking down of India's sodomy law and the recognition

1 Chris Beyrer is Professor in the Departments of Epidemiology, International Health, and Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health. He serves as Director of the Johns Hopkins Fogarty AIDS International Training and Research Program and as founder and Director of the Center for Public Health and Human Rights at Johns Hopkins. He also serves as Senior Scientific Liaison and Chair of the Injecting Drug Use Working Group of the HIV Vaccine Trials Network (HVTN). Stefan D Baral is a physician epidemiologist who is a member of the faculty in the Department of Epidemiology at the Johns Hopkins School of Public Health.

2 Men who have sex with men (MSM) is the preferred term for this population in the HIV literature. MSM includes such sexual orientation categories as homosexual, bisexual and heterosexual, gay and straight, and the like but attempts to categorise men by behavior rather than orientation. Most legal frameworks do not use this terminology, and refer to homosexuality, or to sodomy or other terms from the past. We will use MSM here.

of same-sex relations and diverse gender identities in Nepal, have been tempered by sharp rises in homophobic attacks and discriminatory legislative efforts in a number of countries, including Kenya, Malawi, and Uganda in Africa and the Russian Federation and Uzbekistan in Europe and Asia. Yet, there is evidence from multiple reports that HIV epidemics among MSM in many low-, middle-, and high-income countries are a severe, expanding, and underappreciated component of global HIV.[3] For more than 80 countries, we still do not have any HIV prevalence data among MSM (Table 1). Essential services for these men remain grossly limited in resources, challenging to access, and insufficient in scale and scope to address these expanding epidemics and to provide services for the growing number of MSM in need.[4]

Since the evidence base on HIV among MSM is so sparse in many of the most repressive and legally constrained environments for these men, there is something of a data paradox at work: we know the least about HIV among MSM and the impact the law may have on the epidemic in those countries where MSM are the most hidden and stigmatised. Nevertheless, in the third decade of Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS), where surveillance for populations and access to testing for individuals are accepted components of basic responses to HIV, the lack of even a single data point for MSM is evidence itself of a failure to protect and to fulfill the right to health.

The results of a recent pre-exposure prophylaxis study of oral daily Truvada to reduce acquisition risk for HIV infection among MSM and transgender women, which demonstrated a 44% reduction in risk, bring these resource and access issues for MSM to the fore.[5] Although the pre-exposure prophylaxis result was encouraging, and upcoming trials may confirm the utility of this approach for other at risk populations, MSM who might benefit from this new approach still lack access to much more basic components of services, such as health information, condoms and safe clinical contexts, access to quality HIV testing with counselling relevant to risks for MSM, and basic care for other sexually transmitted infections (STIs). New advances in AIDS science will still face the human rights barriers confronting MSM and will only heighten the importance of rights-based responses, including those relating to laws and legal practices.

The recent report by Cohen, et al, that early HIV treatment with effective antiretroviral therapy (ARVs) not only improved clinical outcomes but had a powerful (92% efficacy) effect on reduction of HIV transmission from HIV-positive partners to their uninfected partners has been a truly revolutionary advance in the HIV field.[6] This study demonstrates that enhanced access to AIDS therapy has a potent impact on HIV transmission. It also means that exclusion from access to HIV treatment, while a violation of an individual's right to treatment, is also a critical factor in HIV spread in couples, networks, and almost certainly populations. The reality that HIV rates are so much higher in networks of MSM may at least now be partially understood to be a function of the lower levels of access to HIV testing, treatment, and care among these men. High levels of stigma within healthcare systems can lead to limited numbers of MSM receiving HIV testing, and some HIV-positive MSM lack access to ARV therapy. While empirical data are currently being collected, it seems that these factors are contributing to the high rates of HIV seen among MSM.

The struggle to expand services for MSM in repressive environments is now clearly under way, and the United Nations (UN) family of agencies has emerged as a leader in calling for human rights for sexual and gender minorities as part of the HIV response. On World AIDS Day, December 1, 2009, UN Secretary-General Ban Ki-moon said the world must

> *"… shine the full light of human rights on HIV. I urge all countries to remove punitive laws, policies, and practices that hamper the AIDS response. In many countries, legal frameworks institutionalise discrimination against groups most at risk. Yet discrimination against sex workers, drug users, and men who have sex with men only fuels the epidemic and prevents cost-effective interventions. We must ensure that AIDS responses are based on evidence, not ideology, and reach those most in need and most affected."* [7]

More recently, in September 2010, Secretary-General Ban stressed the importance of decriminalisation of lesbian, gay, bisexual, and transgender (LGBT) populations globally in saying:

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3 Beyrer C, Baral SD, Walker D, Wirtz AL, Johns B, Sifakis F. *The expanding epidemics of HIV type 1 among men who have sex with men in low- and middle-income countries: diversity and consistency*. Epidemiol Rev. 2010; 32(1): 137-51.

4 Beyrer C, Wirtz, A., Walker, D., Johns, B., Sifakis, F., Baral, S. *The Global HIV Epidemics among Men Who Have Sex with Men: Epidemiology, Prevention, Access to Care and Human Rights*. Washington, D.C.: World Bank Publications; 2011.

5 Grant RM, Lama JR, Anderson PL, McMahan V, Liu AY, Vargas L, et al. *Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men*. N Engl J Med. 2010.

6 Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, et al. *Prevention of HIV-1 infection with early antiretroviral therapy*. The New England journal of medicine. 2011; 365(6): 493-505

7 Nations U. The Secretary-General Message on World Aids Day. Geneva; 2009.

> *"I therefore repeat the appeal I made in May: for all countries that criminalise people on the basis of their sexual orientation or gender identity to take the steps necessary to remove such offences from the statue books and to encourage greater respect for all people, irrespective of their sexuality or gender identity."* [8]

In June, 2011, The UN Human Rights Council narrowly (23 for, 19 against) passed a declaration put forward by South Africa in support of LGBT rights and protections. The resolution stated that the Council shared *"grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity."* The resolution also established a formal mechanism within the UN system to document human rights abuses against LGBT persons.

What are the legal and human rights issues of most relevance to MSM and the HIV response? First and most important, those laws, policies, and practices that lead to reduced access to health care services are limitations of the right to health care.

Methods

This paper is the result of mixed methods approach to reviewing the available literature on MSM, HIV, and the Law. The available medical literature on HIV among MSM globally was systematically searched, using key words including "MSM', "gay", "bisexual men", "homosexual men", "HIV", "HIV/AIDS", and "AIDS", in the PUBMED and EMBASE databases for the years 2007-2011. These papers were reviewed and data extracted for the tables on HIV burdens presented here. The legal and human rights literature was then searched, data extracted, and a qualitative synthesis of the legal and medical literature undertaken. Finally, the reports of the Regional Dialogues of the Global Commission on HIV and the Law and submissions for the same were searched for the term "MSM" and relevant findings extracted from those documents. Generally, these documents underscored findings from the legal and human rights reports.

Discriminatory Laws and Practices in Access to Health Care for MSM

Discrimination based on sexual orientation or gender identity is a violation of Article 26 of the International Covenant on Civil and Political Rights (ICCPR), which prohibits "discrimination ... on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." In the 1994 UN Human Rights Committee decision of *Toonen v. Australia*, the committee ruled that "sex" includes sexual orientation. This decision was the first recognition of gay and lesbian rights within the UN human rights system. *Toonen* was also argued on privacy rights, because Article 17 of the ICCPR bars "arbitrary or unlawful interference" with privacy.

Kirby has recently reviewed the British colonial legacy of sodomy laws within Commonwealth states. While laws criminalising same sex sexual behaviour between consenting adults have long been repealed in the UK itself, these laws remain in force in 41 of the 54 Commonwealth States in 2011.[9] Kirby also points out that of the approximately 80 countries worldwide which maintain some form of legal sanction for adult consensual and private same sex behaviour, more than half were from British Colonial holdings, making this both a widespread and lasting legacy.

On a positive note, Kirby highlights the striking down of India's British era sodomy law in 2009 as an example of a Commonwealth state eventually overcoming this legacy. This was a particularly relevant case for HIV, since the respondents included the National AIDS Control Organisation (NACO) of India. NACO argued against the sodomy law, arguing that while it was uncommonly applied, the law nevertheless allowed police and other security forces to harass and beat MSM and transgender outreach workers with impunity.[10] This harassment emerged as a very real barrier to provision of services, such as street outreach and condom distribution, and particularly for low income, street-based, and other marginalised MSM who could not be reached except through peer networks. Police assaults on MSM and transgender outreach workers took place with impunity, since the peer staff could always be threatened with sodomy laws. This is the kind of direct (and brutal) impact sodomy statutes can have on HIV prevention workers, on their clients at risk, and on the overall community-level HIV response. They are also deeply paradoxical. Why should the Indian Ministry of Health's funds aimed at HIV prevention be wasted by police forces' harassment of MSM outreach workers? Who is served by worsening HIV spread and climates of fear, abuse, and state sanctioned violence? Kirby notes that this law devised by the British with essentially the same language and punishments as India's remain in force in Kenya, Tanzania, Uganda, and Nigeria.[11]

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8 Nations U. The Secretary-General Message to Event on Ending Violence and Criminal Sanctions Based on Sexual Orientation and Gender Identify. Geneva; 2010.

9 Kirby M. *The Sodomy Offence: England's Least Lovely Criminal Law Export?* Journal of Commonwealth Criminal Law. 2011.

10 Brahme RG, Sahay S, Malhotra-Kohli R, Divekar AD, Gangakhedkar RR, Parkhe AP, et al. *High-risk behaviour in young men attending sexually transmitted disease clinics in Pune, India.* AIDS Care. 2005; 17(3): 377-85.

11 Kirby M. *The Sodomy Offence: England's Least Lovely Criminal Law Export?* Journal of Commonwealth Criminal Law. 2011.

The Yogyakarta Principles

The Yogyakarta Principles, formally known as the "Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity," were released in 2007, and have been widely cited since.[12] The principles lay out and affirm those fundamental rights and dignities inherent to all human beings, which should never be abrogated on the basis of real or perceived sexual orientation or gender identity and which have status in existing conventions. The principles draw on existing human rights law to lay out a series of fundamental rights already extant in international human rights conventions and treaties. They were invoked in both the Indian and Nepali decisions to strike down anti-homosexual/anti-sodomy laws. In the Indian case it was stated that:

> *"The [Yogyakarta] principles are intended as a coherent and comprehensive identification of the obligation of States to respect, protect and fulfill the human rights of all persons regardless of their sexual orientation or gender identity…. [T] he Constitution of India recognises, protects and celebrates diversity. To stigmatise or to criminalise homosexuals only on account of their sexual orientation would be against the constitutional morality."*[13]

The principles have had significant traction within the UN family, having been cited by UNAIDS, the UN Office on Drugs and Crime, and the Office of the High Commissioner for Human Rights.[14] In Latin America legal briefs invoking the principles have been filed in Argentina and Colombia, and national legislatures have invoked them in several countries including Argentina, Brazil, Mexico and Uruguay.[15]

Amnesty International

The international human rights organisation Amnesty International has embraced a sexual orientation and gender identity framework based on human rights principles and on the need to change discriminatory laws, policies, and practices. It states:

"Everyone has a sexual orientation and a gender identity. When someone's sexual orientation or gender identity does not conform to the majority, they are often seen as a legitimate target for discrimination or abuse. All people should be able to enjoy all the human rights described in the Universal Declaration of Human Rights. Yet millions of people across the globe face execution, imprisonment, torture, violence and discrimination because of their sexual orientation or gender identity. The range of abuses is limitless:

- *women raped to "cure" their lesbianism, sometimes at the behest of their parents;*
- *individuals prosecuted because their private and consensual relationship is deemed to be a social danger;*
- *loss of custody of their children;*
- *individuals beaten by police;*
- *attacked, sometimes killed, on the street – a victim of a "hate crime";*
- *regular subjection to verbal abuse;*
- *bullying at school;*
- *denial of employment, housing or health services;*
- *denial of asylum when they do manage to flee abuse;*
- *raped and otherwise tortured in detention;*
- *threatened for campaigning for their human rights;*
- *driven to suicide;*
- *executed by the State*

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12 The website of the Yogyakarta Principles introduces them as follows: "In 2006, in response to well-documented patterns of abuse, a distinguished group of international human rights experts met in Yogyakarta, Indonesia to outline a set of international principles relating to sexual orientation and gender identity. The result was the Yogyakarta Principles: a universal guide to human rights which affirm binding international legal standards with which all States must comply. They promise a different future where all people born free and equal in dignity and rights can fulfill that precious birthright." Available at: http://www.yogyakartaprinciples.org/index.html

13 *Naz Foundation (India) Trust v. Govt. of NCT of Delhi* 160 Delhi Law Times 277

14 Dittrich BO. *Yogyakarta Principles: applying existing human rights norms to sexual orientation and gender identity*. HIV AIDS Policy Law Rev. 2008; 13(2-3): 92-3.

15 *Ibid.*

Human rights abuses based on sexual orientation or gender identity include the violation of the rights of the child; the infliction of torture and cruel, inhuman and degrading treatment; arbitrary detention on grounds of identity or beliefs; the restriction of freedom of association and basic rights of due process."[16]

The Convention on the Rights of the Child is a critical treaty to note here.[17] This is because it remains the most widely ratified of all UN human rights conventions, but also because the protection of children has often been seen as justification for anti-gay laws and policies. And in many settings it is LGBT adolescents who face the most severe forms of abuse, including violence, family rejection and school expulsion, and various forms of religious or secular "reparative therapy" to attempt to change their orientation or identity. A recent review of these putative therapies showed they had no evidence of success in changing orientation, but did increase adolescent levels of depression, low self-esteem, suicidal ideation, and social isolation.[18] Depression, low self-esteem, and resultant substance abuse have all been clearly linked in the HIV literature with increased risk among adolescent boys for HIV infection.[19]

Finally Amnesty International asserts one additional key point: it considers people detained or imprisoned solely because of their homosexuality – including those individuals prosecuted for having sex in circumstances which would not be criminal for heterosexuals, or for their gender identity – to be *prisoners of conscience* and calls for their immediate and unconditional release.

What is Amnesty International calling for?

> *"The decriminalisation of homosexuality where such legislation remains. This entails reviewing all legislation, which could result in the discrimination, prosecution and punishment of people solely for their sexual orientation or gender identity.*
>
> *This includes "sodomy" laws or similar provisions outlawing sexual conduct between people of same-sex or transgender individuals; discriminatory age-of-consent legislation; public order legislation used as a pretext for prosecuting and punishing people solely for their sexual orientation or gender identity; and laws banning the "promotion" of homosexuality which can be used to imprison lesbian, gay, bisexual, same-sex practicing and transgender individuals and human rights defenders. All such laws should be repealed or amended.*
>
> *A review of all legislation under which a person may be killed by the state, with the immediate aim of progressively restricting the scope of the death penalty so that it is not applied on the basis of sexual orientation or gender identity, and with a view to the eventual abolition of the death penalty, and flogging, all other corporal punishments and all other cruel, inhuman and degrading punishments should be abolished in law.*
>
> *The immediate and unconditional release of all prisoners of conscience held solely on the basis of their actual or imputed sexual orientation or gender identity."*[20]

In addition, Amnesty International calls on states to:

> *"ensure that all allegations and reports of human rights violations based on sexual orientation or gender identity are promptly and impartially investigated and perpetrators held accountable and brought to justice;*
>
> *take all necessary legislative, administrative and other measures to prohibit and eliminate prejudicial treatment on the basis of sexual orientation or gender identity at every stage of the administration of justice;*
>
> *end discrimination in civil marriage laws on the basis of sexual orientation or gender identity and recognise families of choice, across borders where necessary;*
>
> *ensure adequate protection of human rights defenders at risk because of their work on human rights and sexual orientation and gender identity."*[21]

Amnesty International's positions on this issue make a clear-cut human rights-based argument for the repeal of all anti-gay laws.

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16 International A. Sexual Orientation and Gender Identity London, UK; 2011.

17 Convention on the Rights of the Child 1989.

18 Beyrer C, Wirtz, A., Walker, D., Johns, B., Sifakis, F., Baral, S. *The Global HIV Epidemics among Men Who Have Sex with Men: Epidemiology, Prevention, Access to Care and Human Rights. Washington, D.C.*: World Bank Publications; 2011.

19 Herrick AL, Lim SH, Wei C, Smith H, Guadamuz T, Friedman MS, et al. *Resilience as an untapped resource in behavioral intervention design for gay men*. AIDS and Behavior. 2011; 15 Suppl 1: S25-9.

20 International A. Sexual Orientation and Gender Identity London, UK; 2011.

21 *Ibid.*

Repressive Laws and HIV

Because denial of HIV care to this high-prevalence population is life-threatening, laws, policies, and practices that limit access to prevention, treatment, and care of MSM may also be violations of the most fundamental right of all – that to life itself.

Stigma and discrimination in markedly homophobic contexts may go beyond those rights protected in international human rights law to affect MSM in intensely personal ways. In a recent study by Baral, Beyrer and colleagues three African states that had never reported on MSM or HIV were selected.[22] These were Botswana, Malawi, and Namibia. All three have very high rates of HIV infection in general population samples. All three also have legal frameworks criminalising homosexuality. While Namibia and Botswana's laws are only occasionally used, Malawi has been arresting, charging and imprisoning citizens for consensual sex between consenting adult men. Malawi's laws were recently expanded to criminalise sex between women, not previously clearly criminalised in Malawi's British era sodomy law. Whether or not laws like Namibia's or Botswana's are seldom actually used for prosecutions does not diminish their power to threaten, impede, and limit LGBT citizens from enjoying their full rights and freedoms. A report from three African countries found the fear of discrimination in health care settings among MSM in these countries to be much more common than the actual experience of discrimination.[23] The ever-present threat of arrest and exposure also exposes these men to blackmail, which Fay, et al, found to be common among men who had chosen to disclose their sexual practices with other men to health care providers.[24]

Table 2, presented here, is from the Fay, et al, analysis of the associations between fear of discrimination, actual discrimination events, and self-reported uptake and use of health care services relevant for HIV and other STIs. Overall some 560 men from these countries participated in anonymous and unlinked assessments of demography, identity, risks for HIV infection, and experience of stigma, discrimination, and abuse in health care settings. Fay, et al, used univariate logistic regression modelling, a classic epidemiologic approach for understanding associations across variables, to assess, as an example, if men who reported having had an STIwere more or less likely to have felt discriminated against in a health care setting, or been too afraid to even present for health care.

Positive associations which reached statistical significance (at the 95% confidence interval) are shown in **bold** in the table. The results were striking (see Table 2). MSM who reported having had an STI were about 2.4 times as likely to report fear of seeking health care, but about 6 times as likely to actually have been denied services due to their orientation. And here we should remember that some STI, such as anal or oro-pharyngeal infections, can be taken as evidence of homosexual sex in men, and often are highly stigmatised by providers. The highest rates of perceived and experienced discrimination were among those who reported they were on ARVs for treatment of HIV infection. These men were 3.7 times as likely to report fear, 46 times more likely to report actual discrimination, and more than five times as likely to report having been blackmailed than were MSM without HIV infection.[25] These are remarkably high rates for countries, which have all adopted multiple UN, World Health Organisation (WHO) and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) guidelines and commitments to non-discrimination in health care. Fear of blackmail due to one's sexuality is a potent inhibitor of health seeking behaviour, and is hard evidence of the ways in which discrimination in health care can be life-threatening for MSM[26].

How else do such restrictive legal environments affect MSM uptake and use of health services? In the Baral, et al, study MSM reported a range of rights-related abuses outside of health care settings. They included being afraid to walk in their own communities (19%), and having been blackmailed because of their sexuality (21%) (Table 2, Fay et al. 2010). Overall, some 42% of MSM reported at least one abuse.[13]

More detailed analysis of these same men showed that MSM who reported having been blackmailed were also more likely to have disclosed sexual orientation to a family member, were less likely to have had an HIV test in the last six months, and were more likely to be afraid to seek health care. Having disclosed sexual orientation to a health care worker was highly associated with being denied health care and with being much less likely to have had an HIV test in the last six months. These findings demonstrate the very direct impact stigma and discrimination can have on important

22 Baral S, Trapence G, Motimedi F, Umar E, Iipinge S, Dausab F, et al. *HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana.* PLoS One. 2009; 4(3): e4997.

23 Fay H, Baral SD, Trapence G, Motimedi F, Umar E, Iipinge S, et al. *Stigma, Health Care Access, and HIV Knowledge Among Men Who Have Sex With Men in Malawi, Namibia, and Botswana.* AIDS and Behavior. 2010.

24 *Ibid.*

25 Baral S, Trapence G, Motimedi F, Umar E, Iipinge S, Dausab F, et al. *HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana.* PLoS One. 2009; 4(3): e4997.

26 Fay H, Baral SD, Trapence G, Motimedi F, Umar E, Iipinge S, et al. *Stigma, Health Care Access, and HIV Knowledge Among Men Who Have Sex With Men in Malawi, Namibia, and Botswana.* AIDS and Behavior. 2010.

prevention and treatment-related activities such as HIV testing, disclosure of actual risks to health care providers, and seeking health care in general.

Table 2. Analysis of the associations between fear and experienced discrimination with sexual health and use of services among MSM in Malawi, Botswana, and Namibia.

Variable	Fear of Seeking Health Care OR (95% CI) P=	Denied Health Care Services OR (95% CI) P=	Blackmailed OR (95% CI) P=
Diagnosed with an STI	**2.4 (1.4-4.3)** <.05	**6.9 (3.0-15.6)** <.001	1.5 (0.8-2.7)
Treated for an STI	**2.8 (1.7-4.9)** <.001	**7.3 (3.3-16.2)** <.001	1.5 (0.8-2.6)
Received recommendation for an HIV test	1.9 (1.2-3.0) <.05	2.2 (0.98-4.8)	**1.8 (1.1-2.8)** <.05
Ever tested for HIV	1.1 (0.7-1.7)	1.6 (0.7-3.7)	1.0 (0.7-1.6)
Self-Reported Diagnosis of HIV or AIDS	2.6 (1.1-6.5) <.05	3.3 (0.9-12.1)	**2.7 (1.1-6.6)** <.05
Self-Reported Treatment for HIV	**3.7 (1.6-8.6)** <.05	**46.1 (17.3-122.8)** <.001	**5.4 (2.2-13.2)** <.001
HIV positive	1.7 (0.9-3.2)	1.2 (0.4-3.6)	0.9 (0.5-1.6)
Any interaction with health care	**2.6 (1.6-3.9)** <.001	**6.4 (2.5-16.1)** <.001	**2.1 (1.4-3.2)** <.05

data from three countries are pooled

Fay H, Baral S, Trapence G, Motimedi F, Umar E, Beyrer C. Stigma, Health Care Access, and HIV Knowledge Among Men Who Have Sex With Men in Malawi, Namibia, and Botswana. AIDS and Behavior, Dec 2010: 1-10.

The Evidence Base

While many countries with repressive laws have no data on HIV among MSM, and most have little or no data on MSM generally, there are a number (50 in 2010) of low- and middle-income countries for which both HIV data and information on the legal status of MSM are available. Table 3 (Appendix) shows HIV prevalence rates of MSM and the general population for the 50 low- and middle-income countries (LMICs) where data were available for MSM.[27] The legal status of male homosexuality is then characterised in Table 3 for these same countries.

Overall, the legal environment for MSM in LMICs is best in Latin America, which, after the European Union (EU), is the first region to have ended criminalisation for same-sex behaviour. Guyana continues to have legal sanctions against homosexuality, but is generally considered with the English-speaking Caribbean nations and not Latin America. The English-speaking Caribbean states remain among the most hostile and punitive legal environments for sexual minorities, but many have little or no published or publicly available data on HIV among MSM. Jamaica is an exception, and has recently conducted a large study of HIV among MSM, which found a very high rate of HIV infection: 31.8% of MSM.[28], [29] Jamaica punishes homosexuality with up to ten years imprisonment.

Eastern Europe and Central Asia present a mixed picture, with criminal sanction remaining in a few states, predominately in Central Asia (Azerbaijan and Turkmenistan.) Most of the Eastern European states have repealed anti-homosexual legislation, many to join the EU.

Arguably the most problematic region for which there is HIV data is Sub-Saharan Africa, where, with the exception of South Africa, all of the States for which HIV has been measured in MSM have harsh anti-homosexuality laws and several

27 These data were collected as part of a systematic review of HIV among MSM for the World Bank-Johns Hopkins project on MSM. The data were published in Epidemiology Reviews, in 2010 by Beyrer C, et al.

28 Figueroa C, Weir SS, Jones-Cooper C, Byfield L, Hobbs M, McKnight I, et al. *High HIV prevalence among hard to reach gay men in Jamaica is associated with high social vulnerability* (MOPE0400). 17th International AIDS Conference 2008/01/08/; Mexico City: IAS.

29 Figueroa JP, Duncan J, Byfield L, Harvey K, Gebre Y, Hylton-Kong T, et al. *A comprehensive response to the HIV/AIDS epidemic in Jamaica: a review of the past 20 years*. West Indian Med J. 2008; 57(6): 562-76.

have the death penalty. African states with data on MSM and punitive laws include Namibia, Botswana, Zambia, Tanzania, Kenya, Malawi, Nigeria, Sudan, Ghana, and Senegal. North Africa and the Middle East have generally highly repressive legal environments for sexual minorities and little or no reliable data on HIV among MSM. Egypt is an exception here, where there have been some studies on MSM, but where the recently deposed Mubarak regime was an aggressive enforcer of anti-homosexuality laws and argued for their use and expansion in international fora.

Asia is large, diverse, and has a very mixed picture both in regard to HIV rates and to legal status. Three Asian states for which we have HIV data continue to have laws criminalising same sex behaviour: Indonesia has some regions with imprisonment for homosexuality; Pakistan also has imprisonment up to ten years, and some areas under Sharia law where the death penalty may be invoked; Myanmar maintains British era sodomy laws with fines, imprisonment, and hard labor for homosexuality, and also has a high rate of HIV infection among MSM.[30]

The Malaysian law Section 377 of its *Penal Code*:

> *"377A. Carnal intercourse against the order of nature. Any person who has sexual connection with another person by the introduction of the penis into the anus or mouth of the other person is said to commit carnal intercourse against the order of nature.*
>
> *377B. Committing carnal intercourse against the order of nature. Whoever voluntarily commits carnal intercourse against the order of nature shall be punished with imprisonment for a term which may extend to twenty years, and shall also be liable to whipping."*

In a Malaysian submission to the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, Raymond Tai of the PT Foundation noted that this harsh law was an active impediment to HIV prevention and outreach activities for MSM in Malaysia. He noted, as an example, that because of this law and current government policy, there was no prevention messaging in local media for MSM.

Repressive legal contexts which limit HIV services are also common in the English-speaking Caribbean, where British colonial era "buggery" laws contribute to climates which restrict MSM access to services, information, and HIV prevention. In a submission to the Caribbean Regional Dialogue of the Global Commission on HIV and the Law, Maurice Tomlinson from AIDS Free World summarised this situation succinctly:

> *"Jamaica's anti-buggery/gross-indecency law contributes to violence and abuse by police and private citizens of LGBTI citizens. The laws also marginalize LGTI and inhibit them from seeking treatment for HIV and other sexually transmitted diseases that increase the risk of HIV transmission. The prevailing association of HIV and AIDS with homosexuality compounds the marginalization of many people living with HIV and AIDS, who face additional stigmatization through the presumption that they have engaged in illegal sex. It also keeps those at highest risk of the disease—including people who do not engage in homosexual sex—from seeking HIV-related information and health services."*

Instances described in submissions for the Africa Regional Dialogue of the Global Commission on HIV and the Law from Burundi[31], Cameroon[32], Cote d'Ivoire[33], Malawi[34], Mozambique[35], Nigeria[36], Namibia[37], Senegal[38], Uganda[39], and Zimbabwe[40] consistently demonstrate that similar anti-homosexual laws, policies, and attitudes limit MSM access to HIV services in these African states.

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30 Beyrer C, Baral SD, Walker D, Wirtz AL, Johns B, Sifakis F. *The expanding epidemics of HIV type 1 among men who have sex with men in low- and middle-income countries: diversity and consistency*. Epidemiol Rev. 2010; 32(1): 137-51.

31 See for example: Submission made by Réseau Burundais des Personnes vivant avec le VIH/sida (RBP+), Burundi for the Africa dialogue of the Global Commission on HIV and the Law.

32 See for example: Submission made by ADEFO, Cameroon, for the Africa dialogue of the Global Commission on HIV and the Law.

33 See for example: Submission made by Anonymous Individual through the Alternative Cote D'Ivoire, Ivory Coast, for the Africa dialogue of the Global Commission on HIV and the Law.

34 See for example: Submission made by Catholic University of Malawi, Malawi, for the Africa dialogue of the Global Commission on HIV and the Law. See also submission made by Center for Rights and Development, Nigeria for the Africa dialogue of the Global Commission on HIV and the Law.

35 See for example: Submission made by LAMBDA, Mozambique, for the Africa dialogue of the Global Commission on HIV and the Law.

36 See for example: Submission made by Queer Alliance Nigeria, Nigeria for the Africa dialogue of the Global Commission on HIV and the Law.

37 See for example: Submission made by Out-Right Namibia, Namibia for the Africa dialogue of the Global Commission on HIV and the Law.

38 See for example: Submission made by Xam Xamle du Senegal, Senegal, for the Africa dialogue of the Global Commission on HIV and the Law.

39 See for example: Submission made by Concerned Children and Youth association, Uganda, for the Africa dialogue of the Global Commission on HIV and the Law. See also submission made by Eddoboozi Human Rights Defenders' Network, Uganda, for the Africa dialogue of the Global Commission on HIV and the Law.

40 See for example: Submission made by Sexual Rights Center, Zimbabwe, for the Africa dialogue of the Global Commission on HIV and the Law.

Harsher Sanctions

A number of countries continue to have the death penalty for same sex relations between consenting adults. These include Iran, Yemen, Saudi Arabia, Sudan, Somalia, Mauritania, and Nigeria.[41] Of these, Iran appears to be among the most aggressive in actual use of the death penalty for homosexual relations.[42]

Because HIV infection rates are related to multiple factors, and epidemics among MSM are also highly multi-factorial, it is not possible to draw simple conclusions between the legal status of MSM and HIV infection rates among MSM populations. HIV vulnerability may be more telling, but again, may be subject to great complexity with any attempt at attribution. Access to services measures and other measures such as prevention resources may be more indirect ways of assessing these relationships. And though legal status does not ensure rights protections or enabling environments, it is a key parameter for understanding social tolerance and the space for rights advocacy at country levels.

Distinctions must also be made between laws, and actual policies and practices in many settings. As a negative example, Russia repealed its strong anti-homosexuality laws at the end of the Soviet Union. Yet police harassment and unofficial, but tolerated, brutality by police and other forces remains commonplace.[43] Because ARVs are available in Russia largely through the Federal system, which is heavily Soviet in its staffing, thinking, and orientation, people with HIV are forced to enroll by name, have no confidentiality protections, and are, as in Soviet times, are required to register their "risk group". Since so many MSM refuse to do this, or lie, the largest risk category for HIV Infection after people who use drugs is "unknown" at over 28% of all cases.[44]

While anti-gay laws, sodomy laws, or other restrictive legal structures may not exist or may not be in use, MSM can still face considerable hostility and abuse from law enforcement through the use of an array of "public safety", "vagrancy" or "solicitation" statues which give enforcement authorities wide leeway to harass and control MSM groups, gathering places, and outreach and programme staff. In Uzbekistan, a prominent gay rights and HIV advocate and psychologist, Dr. Maxim Popov, was arrested on return from a UNAIDS meeting carrying UN educational materials for MSM which were deemed to be "pornographic" by airport authorities. He is now serving a seven-year sentence for this "crime".[45] And again, the withholding of HIV preventive materials through this action is a direct inhibition on Uzbekistan's HIV response.

Because of the great diversity of HIV epidemics among MSM, and the challenges of understanding the impacts of legal and human rights contexts on these epidemics, we have chosen to focus on four case studies of countries with available data on MSM and diverse policy and legal contexts.

Country Case Studies: Peru, Thailand, Kenya, Ukraine

The four countries selected for in-depth analysis here represent a range of legal human rights contexts for MSM. Peru has removed punitive laws and policies and implemented policies of access to care for sexual minorities and active outreach to communities of MSM. Nevertheless, cultural attitudes continue to stigmatise behaviour of MSM, effeminacy in men, and being the receptive partner in sex between men. Peru's high HIV prevalence in MSM and low prevalence in virtually every other risk group ensure that MSM predominate among HIV patients and make the potential for HIV stigma significant among open MSM.

Thailand has never had laws penalising same-sex behaviour, largely because of its unique history in having avoided European colonisation. A long-standing cultural tradition of tolerance of traditional transgendered persons (*Katoey*, biological males who take on the cultural role and appearance of women) has led to a relatively tolerant, if not accepting, society. MSM are not formally discriminated against in health care settings. During the 2003 law-and-order campaign of the former Thaksin regime, gay-identified venues including bars, saunas, and other clubs were targeted for harassment by the police. During these crackdowns, condoms were seen as evidence of the "promotion" of homosexual behaviour, and venues were forced to remove all visible condom displays – a reversal of Thailand's previously successful 100% condom campaign targeting heterosexual sex venues. [46], [47]

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41 Ilga. *State-Sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults*. Brussels, Belgium; 2007.

42 *Ibid.*

43 Strathdee SA, Hallett TB, Bobrova N, Rhodes T, Booth R, Abdool R, et al. *HIV and risk environment for injecting drug users: the past, present, and future.* Lancet. 2010; 376(9737): 268-84.

44 Russian Ministry of H. *Country Report of the Russian Federation on the implementation of the Declaration of Committment on HIV/AIDS*. Moscow; 2005.

45 Rights HRCbG. *The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in Uzbekistan*. Boston, MA: Harvard Law School; 2010.

46 van Griensven F. *Non-condom use risk-reduction behaviours: can they help to contain the spread of HIV infection among men who have sex with men?* AIDS (London, England). 2009; 23(2): 253-5.

47 van Griensven F, Varangrat A, Wimonsate W, Tanpradech S, Kladsawad K, Chemnasiri T, et al. *Trends in HIV Prevalence, Estimated HIV Incidence, and Risk Behavior Among Men Who Have Sex With Men in Bangkok, Thailand*, 2003-2007. J Acquir Immune Defic Syndr. 2009.

Ukraine decriminalised homosexuality after independence from the former Soviet Union. Social stigma and fear of disclosure of sexual orientation and MSM status, however, remain prevalent in society, and services from MSM are extremely limited. Ukraine is an example of how removing criminal statutes against homosexuality without enacting positive social policies can have little effect on MSM and HIV.

Kenya has colonial-era sodomy laws that remain in force, making same-sex behaviour between consenting adults a crime punishable by up to 14 years' imprisonment. Behaviour of MSM is highly stigmatised and therefore hidden, although an open community is emerging. Clinical services for MSM were beginning to emerge in 2010, and data from several studies suggested Kenyan MSM were at substantial risk for infection. In February 2010, in Mtwapa town in the coastal Kilifi District (near Mombasa), rumors of a purported gay wedding sparked attacks against individuals suspected of being gay and soon led to organised vigilante attacks on the Kenya Medical Research Institute (KEMRI). KEMRI had been providing services to MSM and had a policy of inclusion in services on its website. These attacks on KEMRI appear to have been organised by religious leaders in Kenya, including leaders of the Council of Imams and Preachers of Kenya and of the National Council of Churches of Kenya.[48] They held a press conference on 11 February 2010, in which they called for investigation of KEMRI and criticised the government of Kenya for "providing counselling services for criminals".[49] The mob attached KEMRI on 13 February 2010, immediately affecting the clinic's activities and LGBT persons in the community and in Kenya more broadly; mob attacks lasted for some days and eventually spread to Mombasa. A climate of fear and the very real threat of violence have driven many MSM underground and interrupted services provision.

What these case studies highlight is that laws are important, but that policies and practices which continue to limit the HIV response can continue even where legal frameworks are supportive or neutral. Implementation matters.

The UN Family, PEPFAR, and The GFATM: Rights And Policies Affecting MSM and HIV

The GFATM put forward a Sexual Orientation and Gender Identities Strategy in May 2009 that encourages all partners, concentrating on governments, to strengthen their focus on those marginalised because of sexual orientation, gender identity, or consensual sexual behaviours.[50] The GFATM includes in this strategy MSM; men, women, and transgendered persons who sell sex; and transgendered persons more broadly. The GFATM also asserts that "[t]hese groups exist in all countries".[51] Although this point seems basic, it has been contentious for a number of states that deny or minimise the existence of their sexual minorities for cultural or political reasons and to use laws to restrict their rights and freedoms.

The GFATM is one of the largest funders of HIV programmes globally, with a considerably wider number of country programmes than the US President's Emergency Plan for AIDS Relief (PEPFAR), which targets US strategic priorities. Hence, the funding policies of the GFATM can play key roles in incentivising rights-based approaches to sexual minorities, including MSM, in country funding proposals. The GFATM mandates the participation of affected and infected communities in its Country Coordinating Mechanisms (CCMs) and makes funding available to build such participation and outreach. This goal is explicit in the 2010 Funding Policy of the GFATM and should serve as a further incentive for the inclusion of MSM in country-level programmes.

The GFATM also funds non-CCM proposals when the evidence is clear that governments are unwilling or unable to address a key activity area. For example, the GFATM funded a USD 18.6 million award through a non-CCM mechanism for South Asian MSM (Afghanistan, Bangladesh, Bhutan, Pakistan, India, Nepal, and Sri Lanka) in Round 9 with Naz Foundation International, a long-standing community-based organisation for MSM. This programme includes a substantial human rights component with a plan to adapt rights advocacy and efforts to local contexts with in-country nongovernmental organisation partners.

In 2009, UNAIDS also put forward a policy guidance on MSM that includes a central human rights and nondiscrimination component. The *UNAIDS Action Framework: Universal Access for Men Who Have Sex with Men and Transgender People* urges that a conducive legal, policy, and social environment to support programming address HIV-related issues among MSM and transgendered people and that this can be strengthened though the promotion and guarantee of human rights.[52]

The US Office of the Global AIDS Coordinator and its PEPFAR programme have also developed a guidance on HIV prevention, treatment, and care for MSM.[53] The guidance strongly endorses human rights and nondiscrimination in

48 Watch HR. *Kenya: Halt Anti-Gay Campaign*. New York City, NYC; 2010.

49 *Ibid.*

50 Csete J. *Human Rights and the Global Fund to Fight AIDS, Tuberculosis and Malaria*. New York City: OSI; 2011.

51 GFATM. *Global Fund Information Note: Sexual Orientation and Gender Identities*. Geneva; 2010.

52 UNAIDS. *Action Framework on Universal Access for Men who have Sex with Men and for Transgender People*. Geneva; 2009.

53 PEPFAR. *Technical Guidance on combination HIV prevention among MSM*. Washington, D.C.: USAID; 2011.

access to health care for MSM in PEPFAR programmes. This is important, as many PEPFAR programmes are active in countries with strongly discriminatory policies toward MSM, including Kenya, Tanzania, Uganda, Nigeria, and Ethiopia. The guidance reflects the recent policy shift of the US government in supporting the UN call for decriminalisation worldwide and the recent statement of US Secretary of State on the occasion of National LGBT Pride Day in June 2010: *"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"*.[54] On the US domestic front, the new National AIDS Strategy and the implementation plan for that strategy are the first documents of their kind to recognise the primacy of gay, bisexual, and other MSM in the US HIV epidemic, where they comprise some two-thirds of all HIV infections, and to focus resources on these men.[55], [56]

Legal and Policy Contexts and HIV Programmes for MSM

Brazil and Peru are relatively tolerant societies with a strong LGBT civil society; a long history of decriminalisation of homosexuality; and a national commitment to inclusion of MSM in HIV prevention, treatment, and care. Brazil has engaged in interventions to address social exclusion and homophobia – such as the "Brazil without Homophobia" campaign – *as an HIV preventive intervention*. A marked policy parallel exists here to India's recent striking down of its colonial-era sodomy law, which was overturned by a court ruling based on, amongst other things, the argument put forward by NACO that the law impedes the right to health of MSM. These are examples of structural interventions at national levels aimed at enhancing the environment for MSM to come forward for HIV and other health services.

In marked contrast are the policy environments and legal restrictions in Kenya and Senegal. The national Senegalese AIDS strategy for 2007–11 identified MSM as a key target population for prevention, and the Senegalese Ministry of Health has implemented some outreach programmes from MSM. Senegalese LGBT organisations have been partners in prevention programmes run by the ministry.[57] In December 2008, the International Conference on AIDS and STIs in Africa was held in Dakar. There, Senegalese government officials publicly pledged their support to reducing HIV among sexual minorities.

The willingness of the Ministry of Health in Senegal to address HIV among MSM appears to have led to a political backlash. Within weeks of the conference, police arrested nine male HIV prevention workers in Dakar on suspicion of engaging in homosexual conduct. Article 319.3 of the Senegalese *penal code* states that "whoever commits an improper or unnatural act with a person of the same sex" will be punished by imprisonment of between one and five years and a fine of CFA francs 100,000 to 1,500,000 (USD 200 to 3,000).[58] In January 2009, these men were sentenced to eight years in prison and a fine of CFA francs 500,000. The arrest and sentencing were widely publicised locally and garnered international attention. All of the men were subsequently released on appeal, because no evidence existed of actual homosexual acts – the men were at a meeting in a private apartment at the time of their arrest – but the social and religious (in this case Islamic leadership) pressure has been intense, and these men remain in hiding or have left the country. With the support of UNDP, the Center for Public Health and Human Rights at Johns Hopkins University in partnership with Enda-Santé in Senegal has recently conducted a qualitative investigation into health-seeking behaviour among MSM in Senegal in the wake of these events, and preliminary data suggest that use of services has dramatically declined among MSM in Senegal.[59]

The Senegal situation starkly portrays a reality for MSM in many settings and in much of Africa: policy reform may be difficult or impossible in some political contexts, and enabling environments may simply not exist. For these settings stand-alone LGBT-friendly health services or MSM clinic services may be both unfeasible and unwise if they generate the kinds of backlash that have marked the Senegal experience. In these settings, quiet work with sympathetic providers and reform efforts within HIV services may be more realistic policy goals. Engagement and support with community partners will be even more essential in these settings than in environments less hostile to MSM.

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54 State USDo. Remarks by Secretary of State Hillary Rodham Clinton at an Event Celebrating Lesbian, Gay, Bisexual and Transgender (LGBT) Month. Washington, DC; 2010.

55 House W. National HIV/AIDS Strategy for the United States. Washington, DC; 2010. 30.

56 House W. *Implementation of the National HIV/AIDS Strategy for the United States*. Washington, DC: White House Office of National AIDS Policy; 2011.

57 Moreau A, Tapsoba P, Niang C, Diop AK. *Implementing STI/HIV Prevention and Care Interventions for Men who Have Sex with Men in Dakar, Senegal.* Washington, D.C.: Population Council; 2007.

58 Senegal: *nine gay men arrested, convicted and given harsh sentences*. HIV AIDS Policy Law Rev. 2009; 14(1): 49-50.

59 Baral SS, P.; Diouf, D.; Trapence, G.; Poteat, T.; Ndaw, M.; Drame, F.; Dhaliwal, M.; Traore, C.; Diop, N.; Bhattacharya, S.; Sellers, T.; Wirtz, A.; Beyrer, C. *Criminalization of same sex practices as a structural driver of HIV risk among men who have sex with men (MSM): the cases of Senegal, Malawi, and Uganda* (MOPE0951). In: IAS, editor. International AIDS Conference 2010; Vienna; 2010.

Conclusions

Homosexuality remains criminalised in more than 80 UN member states, with punishments ranging from jail time to the death penalty. Where not criminalised, policy environments can still leave MSM unprotected and vulnerable to harassment and intimidation. Repressive legal contexts and pervasive social stigma can limit access for these men to appropriate services for STIs and HIV, including prevention, treatment, and can even be life-threatening – as is the case for ongoing executions of gay men in the Iran and Iraq or the current Ugandan legislative process to sharply increase legal punishments for homosexuality, including the death penalty for "aggravated homosexuality." In these environments, even if funding were available for state-of-the-art comprehensive HIV prevention and care packages for MSM, such assistance would likely be of limited value because men in such settings are quite justified in not seeking care. Therefore, growing HIV epidemics among MSM in many settings are in part attributable to inappropriate governance responses on multiple levels. Moreover, criminalisation of same-sex practices could be posited as an extreme case of misguided governance in the development of a comprehensive HIV/AIDS response.

The role of governance in the AIDS response is relevant because for HIV the social drivers of risk are much more predictive of disease burden than endogenous susceptibility, which is the case in very few other diseases. To effectively respond to social drivers of risk, governments should adopt evidence-based interventions mitigating the effects of the risk environment. In the context of MSM, many governments have done the opposite and have potentiated the risk environment by limiting the availability of service provision and preventing the uptake of whatever services are available. Although the majority of the laws criminalising same-sex practices in these settings are national, they are implemented and enforced by municipal and regional tiers of government. This fact is relevant to the international community because all of the countries that criminalise same-sex practices are UN member states and signatories to a number of conventions that include legislated protections for sexual minorities. Separate from the issue of governance decisions related to politicians is the concept of public health governance. Whereas public health is global in that infectious diseases know no boundaries, and global institutions, including UN agencies, provide technical support and guidance to all UN member states, the public health prevention activities are still implemented at a local or regional level. It is the mandate of the public health practitioner to develop comprehensive health protection and promotion programming for all populations at risk of a disease. For HIV, that population includes MSM in the vast majority of the settings where the disease has been studied. The criminalisation of same-sex practices limits the development of a comprehensive HIV/AIDS response including prevention, treatment, and care.

Several fundamental policy recommendations are drawn from these reviews:

- Criminalisation of same-sex practices has profound implications across the spectrum of policies, issues, and programmes relating to MSM: criminalisation matters.
- Sodomy laws and other anti-gay laws should be repealed.
- All persons currently incarcerated for same sex behaviour between consenting adults should be considered as prisoners of conscience.
- Responses to HIV epidemics among MSM in these highly disparate political and human rights environments have to be context specific: one size will not fit all.
- Community participation in every step of programme development and implementation for MSM is crucial: the community is *the* key partner for this population.
- Laws and policies that promote universal access and gender equality in principle may fail for MSM in practice where homophobic cultural, religious, or political forces are active: good policies for HIV do not guarantee good outcomes for MSM and other sexual minorities.
- Although quantification of the impact of structural interventions is important, action is mandated to decrease human rights abuses against MSM on social justice and human dignity grounds alone.
- While the available evidence base does not allow for the direct measurement of laws against homosexuality on HIV rates among MSM, there is compelling and consistent data to demonstrate that legal sanctions and stigma and discrimnation limit MSM access to HIV prevention, treatment, and care, and are a barrier to universal access.
- Because HIV infection remains incurable, limits on the right to access to prevention and treatment services are limits on the right to life itself, making the repeal of anti-homosexual legislation a life-saving intervention.

- The evidence from public health demonstrates that MSM remain at high risk for HIV infection in low, middle, and high income country settings, so HIV prevention for MSM is an urgent global public health priority, and one for which every effort, including legal and policy reform, should be made with urgency.
- Law enforcement programmes and policies should move from harrassment to protection, and to being valued partners in the HIV response, rather than obstacles to outreach, services provision, and public health.

Table 1. Countries with insufficient* or no epidemiologic data on MSM and HIV in 2011

Afghanistan	Kazakhstan
Albania	Korea, Dem Rep.
Algeria	Kiribati
American Samoa	Kosovo
Angola	Kyrgyzstan
Antigua and Barbuda	Lebanon
Azerbaijan	Lesotho
Bangladesh	Libya
Belarus	Lithuania
Belize	Macedonia, FYR
Benin	Madagascar
Bhutan	Malaysia
Bosnia and Herzegovina	Maldives
Bulgaria	Mali
Burkina Faso	Marshall Islands
Burundi	Mauritania
Cameroon	Mauritius
Cape Verde	Mayotte
Central African Republic	Micronesia, Fed. Sts.
Chad	Mongolia
Chile	Montenegro
Comoros	Morocco
Congo, Dem. Rep	Mozambique
Congo, Rep.	Myanmar (Burma)
Costa Rica	Niger
Côte d'Ivoire	Palau
Cuba	Papua New Guinea
Djibouti	Philippines
Dominica	Romania
Eritrea	Russian Federation
Ethiopia	Rwanda
Haiti	Samoa
Liberia	São Tomé and Principe
Dominican Republic	Seychelles
Fiji	Sierra Leone
Gabon	Solomon Islands
Gambia, The	Somalia
Grenada	Sri Lanka
Guinea-Bisau	St. Kitts and Nevis
Guyana	St. Lucia
Iran, Islamic Rep.	St. Vincent and the Grenadines

Table 1. Countries with insufficient* or no epidemiologic data on MSM and HIV in 2011	
Iraq	Suriname
Jordan	Swaziland
Syrian Arab Republic	Uganda
Tajikistan	Uzbekistan
Tonga	Vanuatu
Tunisia	Venezuela, RB
Turkmenistan	West Bank and Gaza
Tuvalu	Yemen, Rep.
Togo	Zimbabwe
Turkey	

**Insufficient data' also includes country studies in which data have been collected and reported but were not peer or scientifically reviewed or reported insufficient sample sizes*

HIV infection rates among MSM and Legal status in Low and Middle Income Countries Reporting HIV rates, 2010.

The Americas

Country	Aggregate HIV Prevalence among MSM (Range)		Law Against Male to Male Relationship and Punishments
Ecuador	15.10%	(12.8-17.4)	No Law
Peru	13.80%	(13.4-14.3)	No Law
Bolivia	21.20%	(17.6-24.7)	No Law
Uruguay	18.90%	(16.1-21.7)	No Law
Argentina	12.10%	(10.8-13.4)	No Law
Colombia	19.40%	(17.2-21.6)	No Law
Paraguay	13%	(6.2-19.9)	No Law
Brazil	8.20%	(6.9-9.4)	No Law
Honduras	9.80%	(8.1-11.5)	No Law
Panama	10.60%	(6.7-14.6)	No Law
Guatemala	11.50%	(6.7-16.4)	No Law
El Salvador	7.90%	(4.8-10.9)	No Law
Nicaragua	9.30%	(4.8-13.7)	No Law
Mexico	25.60%	(24.8-26.5)	No Law
Jamaica	31.80%	(25.4-38.3)	Imprisonment <10 yrs

Eastern Europe

Country	Aggregate HIV Prevalence among MSM (Range)		Law Against Male to Male Relationship and Punishments
Poland	5.40%	(3.3-7.6)	No Law
Serbia	8.70%	(5.4-12.0)	No Law
Armenia	0.90%	(0.0-2.7)	No Law
Georgia	5.30%	(1.2-9.4)	No Law
Moldova	1.70%	(0.0-4.0)	No Law
Russia	3.40%	(2.6-4.2)	No Law
Ukraine*	10.6%	(7.8-14.2)	No Law

Africa

Country	Aggregate HIV Prevalence among MSM (Range)		Law Against Male to Male Relationship and Punishments
Namibia	12.40%	(8.1-16.8)	Not legal; no data punishment
Botswana	19.70%	(12.5-26.9)	Imprisonment < 10yrs
South Africa	15.30%	(12.4-18.3)	No law
Zambia	32.90%	(29.3-36.6)	Imprisonment >10yrs
Kenya*	15.20%	(13.3-17.2)	Imprisonment >10yrs
Tanzania	12.40%	(9.5-15.2)	Imprisonment >10yrs
Malawi	21.40%	(15.7-27.1)	Imprisonment >10yrs
Nigeria	13.50%	(12.0-15.)	Death
Sudan	8.80%	(7.1-10.4)	Death
Ghana	25%	(20.5-29.5)	Imprisonment >= 10 yrs
Senegal	24.30%	(21.9-26.7)	Imprisonment <10yrs
Egypt	5.3%	(2.9-7.7)	Imprisonment< 10 yrs

Asia

Country	Aggregate HIV Prevalence among MSM (Range)		Law Against Male to Male Relationship and Punishments
Thailand*	23%	(20.1-25.4)	No law
Vietnam	6.20%	(5.1-7.3)	No law
Laos	5.40%	(3.5-7.2)	No law
Cambodia	7.80%	(5.9-9.7)	No law
China	4.30%	(4.0-4.7)	No law
Indonesia	9%	(6.9-11.0)	Legal in some areas; imprisonment <10yrs
India	14.50%	(13.3-15.6)	No law
Burma/Myanmar	29.3%	(CI 24.4-33.5)	Imprisonment < 10yrs
Nepal	4.80%	(2.6-7.0)	No law
Pakistan	1.80%	(1.1-2.6)	Imprisonment < 10yrs
Timor-leste	1%	(0.0-2.6)	No law

Unavailable Data

Country	Aggregate HIV Prevalence among MSM (Range)		Law Against Male to Male Relationship and Punishments
Belarus	0%	(0.0-0.0)	No law
Kazakhstan	0%	(0.0-0.0)	No law
Kyrgyzstan	0%	(0.0-0.0)	No law
Azerbaijan	42.90%	(6.2-79.5)	No law
Turkmenistan	ND	ND	Imprisonment < 10yrs
Lebanon	ND	ND	Imprisonment < 10yrs
Iran	ND	ND	Death
Yemen	ND	ND	Death
Angola	ND	ND	Fines or restrictions
Zimbabwe	ND	ND	Imprisonment < 10yrs

Source for Laws: International Lesbian, Gay, Bisexual, Trans and Intersex Association (IGLA) 2010. http://ilga.org/
Source for HIV data: Beyrer C, et al, Epidemiology Reviews, 2010.