The AIDS Accountability Scorecard on LGBT 2011

Element 2: An analysis of global data on HIV Prevention

for Lesbian, Gay, Bisexual and Transgender people

Holding leaders accountable

AIDS Accountability International

About AIDS Accountability International

AAI is an independent non-profit organization established to increase accountability and inspire bolder leadership in the response to the AIDS epidemic. It does so by rating and comparing the degree to which state and non-state actors are fulfilling the commitments they have made to respond to the epidemic. AAI aims to build bridges between actors and institutions that collect and analyze primary data in the field of HIV/AIDS and those who make use of this data in different contexts, such as policy makers and advocates. AAI provides these actors with a compass that points to new policy and programmatic directions and helps stimulate debate on the need for greater accountability and leadership.

AAI's efforts are made possible through the support of Ford Foundation, Swedish International Development Cooperation Agency (Sida), Norwegian Ministry of Foreign Affairs and Open Society Foundation for South Africa as well as leading experts and civil society organizations in the field of HIV/AIDS.

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AAI would appreciate your feedback. Please send comments and/or corrections to:phillipa@aidsaccountability.org or phone Phillipa on +27 (0)21 466-8074, and these will be included in future revised editions of the report.

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List of Acronyms

AAI	AIDS Accountability International
AIDS	Acquired Immunodeficiency Syndrome
AMFAR	The American Foundation for AIDS Research
CBO	Community based organization
CSO	Civil Society Organization
DHS	Demographic and Health Survey
FHI	Family Health International
FSW	Female sex worker
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
ICPD	International Conference on Population and Development
IDU	Injecting drug user
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
IPPF	International Planned Parenthood Federation
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and queer
M&E	Monitoring and Evaluation
MARP	Most at risk population
MDGs	Millennium Development Goals
MSM	Men who have sex with men
MSW	Male sex workers
NCPI	National Composite Policy Index
ND	No data
NGO	Non-Governmental Organization
SOGI	Sexual Orientation and Gender Identity
STD	Sexually transmitted disease
SW	Sex worker
TB	Tuberculosis
TG	Transgender
UA	Universal Access (to HIV prevention, treatment, care and support)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WSW	Women who have sex with women

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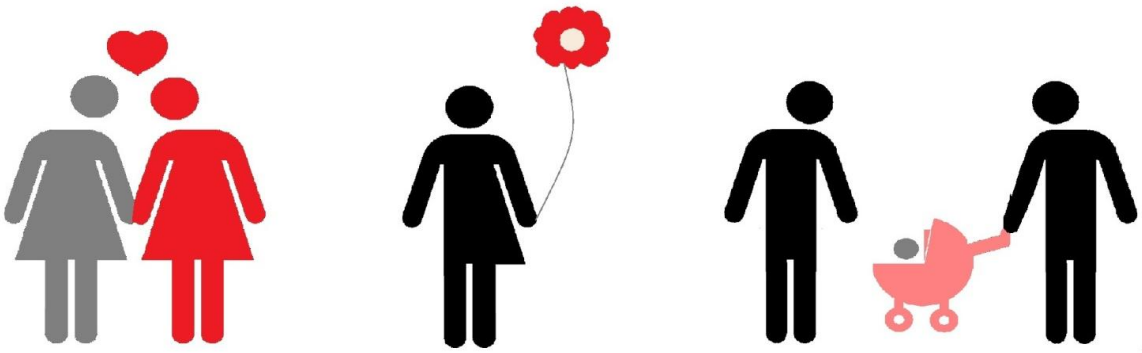
Introduction

In 2010 AIDS Accountability initiated research to analyze the degree to which countries are fulfilling commitments to lesbian, gay, bisexual and transgender (LGBT) people in the response to HIV and AIDS: the *AIDS Accountability LGBT Scorecard*. This scorecard analysis follows on the *AIDS Accountability Country Scorecard* (2008) and the *AIDS Accountability Women Scorecard* (2009). The *LGBT Scorecard* will be launched in a sequence of ten brief reports from March to November 2011, each covering a key element of the AIDS response.

This second element assesses country performance in terms of the reported coverage of HIV prevention, policies in place that support prevention programs and budget allocation on prevention for LGBT.

The *LGBT Scorecard Framework Report* discusses some methodological and other concerns with the data used in this report. It is important to state here that AAI makes no independent claims for the veracity of the data. For the purposes of this scorecard analysis, AAI relies on the screening UNAIDS conducts of the data. The fact that, of all sexually diverse LGBT people, only MSM are covered in the UNGASS set of core indicators is a shortcoming that will be discussed further in the concluding synthesis report.

A concluding synthesis report will be launched in December 2011.



Why a focus on sexual diversity?

Lesbian women, gay men, bisexual people, transgender men and women, intersex and queer people face discrimination and marginalization in many social and economic areas. This is reflected in the response to HIV and AIDS. For instance, the exclusion of LGBT people, with the exception of men who have sex with men (MSM), from the global monitoring and evaluation (M&E) framework can in part explain why their role and behavior in the HIV epidemic is not fully understood. This report will show the lack of monitoring and research even on an issue as basic as HIV prevntion. The focus on LGBT people in this project is thus motivated and shaped by concerns relating to both epidemiology and human rights.

All women are vulnerable due to gender inequalities resulting in reduced employment opportunities (and the related financial constraints), freedom of movement, and exposure to domestic and other violence, among various other societal factors. This situation is exacerbated for lesbian and transgender women, as stigma and discrimination worsen barriers to accessing quality health care. Moreover, these women and transgender men are at increased risk of homophobic rape and other forms of physical violence that put them at increased risk of HIV infection. Discrimination and violence represent violations of human rights that must stop. Irrespective of the level

of exposure to HIV, LGBT people across the world face stigma and discrimination that deny them universal access.

Unsafe sex between men is a key driver in many low- or concentrated HIV epidemics. In some of these countries, effective political advocacy by stakeholders has secured universal access to prevention, treatment, and care and support services. Such levels of coverage must be extended to all who need it. In addition there is a need to better understand the role, the needs and the vulnerabilities of MSM in countries with generalized epidemics and hyper-endemic HIV.

The overall aim of the *AIDS Accountability LGBT Scorecard* is to motivate greater emphasis in the AIDS response on the particular needs of all sexually diverse people. The full scorecard that will be available at the end of 2011 will highlight a lack of data from many countries and poor performance from some, but also point to strong performances and a progressive approach in others. The scorecard analysis is designed to provide an evidence-base for a constructive dialogue between government and stakeholders on the strengths and weaknesses in countries' responses to AIDS. The scorecard is not intended as a final statement that apportions blame, but rather as a catalyst for an inclusive dialogue that will result in constructive change. It is our hope that the *AIDS Accountability LGBT Scorecard* will empower stakeholders with new information and analysis that will increase the leverage of their advocacy for stronger responses to AIDS from their respective governments.

Language

The International Planned Parenthood Federation (IPPF) describes sexual diversity as a 'term (that) refers to the full range of sexuality which includes all aspects of sexual attraction, behavior, identity, expression, orientation, relationships and response. It refers to all aspects of humans as sexual beings."[i]

The concept of sexual diversity does not position some groups as 'normal' and others as 'abnormal' or 'other', but rather reflects the reality that people have a variety of different kinds of sex, thus challenging the idea of heteronormativity.

For this reason this report, whilst acknowledging that the research cannot statistically always speak to all sexually diverse individuals due to lack of data, prefers to use the term sexual diversity as an all encompassing term. As an international evaluation of government responses to HIV and AIDS this more global term seems fitting. This report therefore refers to LGBT, sexually diverse and same-sex inter-changeably. This discussion is continued in the Framework report.

Government Commitment

In the *Millennium Declaration* (2000) and the *Declaration of Commitment on HIV/AIDS* (2001) all United Nations (UN) Member States made far-reaching political commitments for an effective response to HIV and AIDS. The 2001 declaration set targets for the AIDS response against which governments should be held accountable. To measure progress, the Joint United Nations Programme on HIV/AIDS (UNAIDS) developed a monitoring and evaluation framework that, by 2010, had collected four rounds of data on 25 indicators of the response. The provision of HIV prevention is included in the commitment to Universal Access to prevention, treatment and care and support services that was central to the subsequent *Political Declaration on HIV/AIDS* (2006). This discussion is continued in the Framework report.

Indicator 9: HIV prevention

The basis for this report is the data countries submitted to UNAIDS in the 2010 round of the United Nations General Assembly Special Session (UNGASS) reporting on indicator 9. The Guidelines on Construction of Core Indicators (United Nations General Assembly Special Session on HIV/AIDS) stipulates the following with regard to this indicator:

Purpose: To assess progress in implementing basic elements of HIV prevention programmes for most-at-risk populations.
Applicability: Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemic within a generalized epidemic
Data Collection Frequency: Every two years
Measurement Tool: Behavioural surveillance or other special surveys

Method of measurement:

Respondents are asked the following questions:
1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

Numerator: Number of most-at-risk population respondents who replied "yes" to both (all three for injecting drug users) questions.
Denominator: Total number of respondents surveyed.

Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator. Data collected for this indicator should be reported separately for each most-at-risk population and disaggregated by sex and age (<25/25+). Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.[ii]

The purpose of the indicator is to measure progress amongst most-at-risk populations in terms of HIV prevention. UNAIDS requires that all countries with low-prevalence epidemics or concentrated epidemics report on the indicator and collect data on men who have sex with men, sex workers and injecting drug users. However, UNAIDS points out that also countries with generalised epidemics should collect this data in case of concentrated sub-epidemics in these groups. However, the large majority of countries with generalized epidemics fail to conduct such monitoring and/or report whatever data they may have collected. A subsequent LGBT Scorecard element will highlight data that suggest that concentrated sub-epidemics are in fact present among MSM and other sexually diverse populations in many of these countries. While general resource constraints may be the reason for this lack of monitoring it may also, arguably, reflect prevailing discrimination against MSM in those countries.

In addition to data on indicator 9 this report will highlight any relevant information on prevention for same-sex people that countries included in the narrative reports.

HIV Prevention

Various methods of preventing HIV and STI transmission exist and the following section discusses a few of these that are applicable to the LGBT group. Whichever way a person chooses to protect themselves and their sexual partners (if they do choose to do so), it is usually understood that a combination of some the following methods is used and necessarily so. A MSM who is forced to live a stealth lifestyle due to the criminalization of same sex activity in his country may choose to use condoms with male partners but have unprotected sex with his wife for example.

Treatment as Prevention

HIV is more easily transmitted when there a high viral load present in the blood.[iii] Antiretroviral (ARV) drugs significantly decrease the amount of virus, so the viral load, and consequently – infectiousness – of a person on ARVs, is much lower than someone who is not on treatment.[iv] Therefore, treatment is prevention.[v] However, there is cautionary evidence to suggest that as access to treatment improves, prevention efforts may suffer. Results from an anonymous survey in Atlanta, Georgia showed that men who have sex with men (MSM) who practiced unprotected anal intercourse, as the receptive partner, were younger, less educated and more likely to believe that it is safe to have unprotected anal intercourse with an HIV-positive partner who has an undetectable viral load and that new treatments for HIV relieve their worries about unsafe sex.[vi]

Other research also corroborates this concern that AIDS treatment advances may lead to behavioural prevention setbacks, lowering thresholds of perceived acceptable risks among some men's willingness to practice unprotected anal intercourse.[vii] This suggests treatment as prevention is not that straightforward, behaviourally speaking, although it may seem so from an epidemiological perspective. Efforts to promote treatment as prevention therefore need to be coupled with emphasis on other forms of behavioural prevention.

Medical male circumcision

Medical male circumcision has recently been found to be a highly effective preventative measure for HIV transmission. The procedure removes mucosal tissue in the foreskin of the penis that contains Langerhans cells, which have unique receptors for HIV.[viii] Circumcision also toughens the skin on a man's penis, so lesions become less common.[ix]

Medical male circumcision as an HIV prevention method has been shown to cut a man's risk of contracting the virus by approximately 50 per cent.[x,xi] Other studies show efficacy rates of up to 60 per cent.[xii,xiii] This prevention method also works to

protect women. There are research findings that show female partners of HIV-positive men to be 30 per cent less likely to contract the virus if their partners are circumcised.[xiv] As for above, prevention experts need to be aware that MMC needs to be rolled out with other BCC as it is not a sure-fire method of prevention and can be associated with increased risk-taking behaviour if the public do not understand this caveat.

Condoms, Microbicides and IEC Materials

Consistent male condom use has been shown to be, on average, 87 per cent effective at preventing HIV transmission, but it may be as low as 60 per cent or as high as 96 per cent.[xv] Some worry that condom distribution may increase teen sexual activity, but this has been disproven.[xvi] Despite comparable efficacy rates between male and female condoms[xvii] and high acceptability levels[xviii], female condoms are significantly more difficult to access and come at a substantially higher cost.[xix] These factors are thought to have narrowed the uptake and use of female condoms, limiting an opportunity to reduce HIV infection through a female-led initiative.

It is important to note, however, that usage of female condoms is not entirely limited to women. In a study, conducted across six American cities, it was found that 13 per cent of MSM surveyed used a female condom for anal sex in the last 6 months.[xx] In fact, MSM who have HIV-positive partners were twice as likely to have used female condoms as men whose partners were HIV negative or of unknown HIV status.[xxi] The study highlights significant problems with this practice, showing that 49 per cent of users cited problems such pain and bleeding.[xxii] However, there is a lack of scientific consensus, as another study suggests that 54 per cent of participants rated the female condom *more* pleasurable than male condoms.[xxiii] While there is evidence of local efforts to promote the female condom to MSMs in San Francisco,[xxiv] there is clearly a need to increase the information, awareness and endorsement of this HIV prevention method to the wider at-risk LGBT community.

Furthermore, male condoms are not strictly used by men, either. Pinto et al. show that 55 per cent of the women who have sex with women (WSW) in their study used and changed male condoms when they shared sex toys, as an HIV prevention method.[xxv] There is some evidence of this practice being promoted in the UK, with The United Kingdom National guideline on safer sex advice recommending male condom use for WSW.[xxvi] However, in the same vein as female condoms, it is evident that male condoms are not adequately marketed to certain LGBT populations who could be further protecting themselves from potential HIV infection.

In addition to condoms, microbicides are seen to be increasingly successful in clinical trials as an effective method of HIV prevention. The recently published Caprisa 004 trial tenofovir microbicide gel used intra-vaginally to prevent HIV was an impressive success, showing 50 per cent efficacy levels after one year, and 39 per cent over two and a half years (likely due to declining adherence over time).[xxvii] Results are promising, as this is just one outcome of more than 50 candidate microbicide products in preclinical development, 11 of which are being tested in 21 ongoing trials.[xxviii]

Despite efficacy of both condoms (male and female) and, increasingly, microbicides, compliance is often poor with intercourse-related interventions, which is why these methods have higher failure rates than long-acting methods, such as education and behaviour change.[xxix] However, research on the efficacy of Information Education Communication (IEC) and Behaviour Change Communication (BCC) is limited. There have been consistent observations from a number of studies to suggest that many of those at risk for HIV do not recognize the danger they face, and even if they do, knowledge alone is not enough to effect behaviour change to reduce their risks.[xxx] However, some studies on HIV/AIDS education programs of adolescents indicate that school-based prevention programs are the most effective in delaying first sexual activity and in causing people to use a condom.[xxxi]

Sero-sorting

Sero-sorting is most commonly understood in the context of men who have sex with men (MSM) as the limiting of unprotected anal sexual partners to those who are of the same HIV status, as a risk reduction strategy.[xxxii] However, there is also evidence that the sexual behaviour patterns of heterosexual couples show signs of sero-sorting.[xxxiii] By contrast, women who have sex with women tend not to discriminate between positive and negative partners.[xxxiv] Sero-sorting has been identified as a relatively recent phenomenon in HIV prevention that is becoming an increasingly adopted behaviour.[xxxv,xxxvi] Hopkins and Rietmeijer suggest that the increasing popularity of the internet may have something to do with the rise in sero-sorting.[xxxvii] There is also evidence to suggest a rise in the practice of sero-positioning, the strategic placement among discordant MSM to have the positive partner as the receptive participant to reduce HIV transmission.[xxxviii] This prevention method is not as common as sero-sorting[xxxix], but, unlike sero-sorting, has not been shown to significantly contribute to HIV sero-conversion.[xl]

There are some studies that have shown that sero-sorting can decrease levels of HIV transmission[xli], while there is other evidence that suggests the practice can actually lead to an increase in HIV incidence and increase the probability of re-infection among people living with HIV.[xlii] In particular, Butler and Smith argue that sero-sorting is a flawed strategy for prevention since it does not properly account for the prevalence of recent HIV infections.[xliii] In this vein, men may overestimate the degree to which their partners may be able to correctly infer their own sero-status, creating a situation of 'sero-guessing'.[xliv] To that end, most agree that sero-sorting works better in theory than it does in practice.[xlv]

Another issue associated with sero-sorting is the creation of an environment for actively seeking a positive HIV status, or 'bug chasing'. There is disagreement around this as well, with some saying that there is not a significant degree of 'bug chasing' occurring[xlvi] and others claiming that bug chasing has been increasing in frequency as the virus has progressed.[xlvii] Some contend that 'bug chasing' is occurring within sero-sorting in connection to the formation and maintenance of certain personal identities.[xlviii,xlix] However, there is evidence that while AIDS has united many MSMs and lesbians, it has certainly divided others, fracturing notions of uniform gay identity in doing so.[l] There is also disagreement with respect to the degree to which dishonesty occurs within sero-sorting, and bug chasing in particular. Halperin feels that if someone claims to be sero-positive, he is probably not lying[li], whereas Dean as well as Parsons highlight that there are those who may misrepresent their HIV status in tacit efforts of seeking infection.[lii,liii]

In addition to bug chasing, the issue of re-infection is another significant element of sero-sorting that needs to be considered. Not to mention the risk of other sexually transmitted infections, unprotected encounters through sero-sorting can expose positive men to different, more virulent strains of HIV that could potentially result in co-infection or recombination.[liv] There is significant scientific research to support the reality of this risk, especially in relation to treatment resistance ramifications.[lv,lvi,lvii]

Outside of scientific journals and books, there has been startlingly little discussion around sero-sorting and its related risk factors. Whether in relation to its relatively recent emergence, or the scientific disagreement around it, the international community has yet to meaningfully engage with sero-sorting. Both The Global Fund and the Global Health Council have no mention on their web pages, or in any hosted documents, about sero-sorting. UNAIDS only discusses it in their online segment called "HIV This Week – what scientific journals said" which is a list of links to external articles. To the same effect, the only mention of sero-sorting on the web pages of the International AIDS Society and the World AIDS Campaign is in the capacity of links to journal articles. The only international organization that presents any online discussion around sero-sorting is the World Health Organization. In a 2008 meeting report, they identify "[t]he role that "sero-sorting" (selection of partners according to their stated HIV sero-status) can and should play in risk reduction strategies" as an area that needs further research.[lviii]

Men who have sex with men, including male sex workers

Indicator 9 captures data for MSM and MSW only. It does not cover WSW or transgender people.

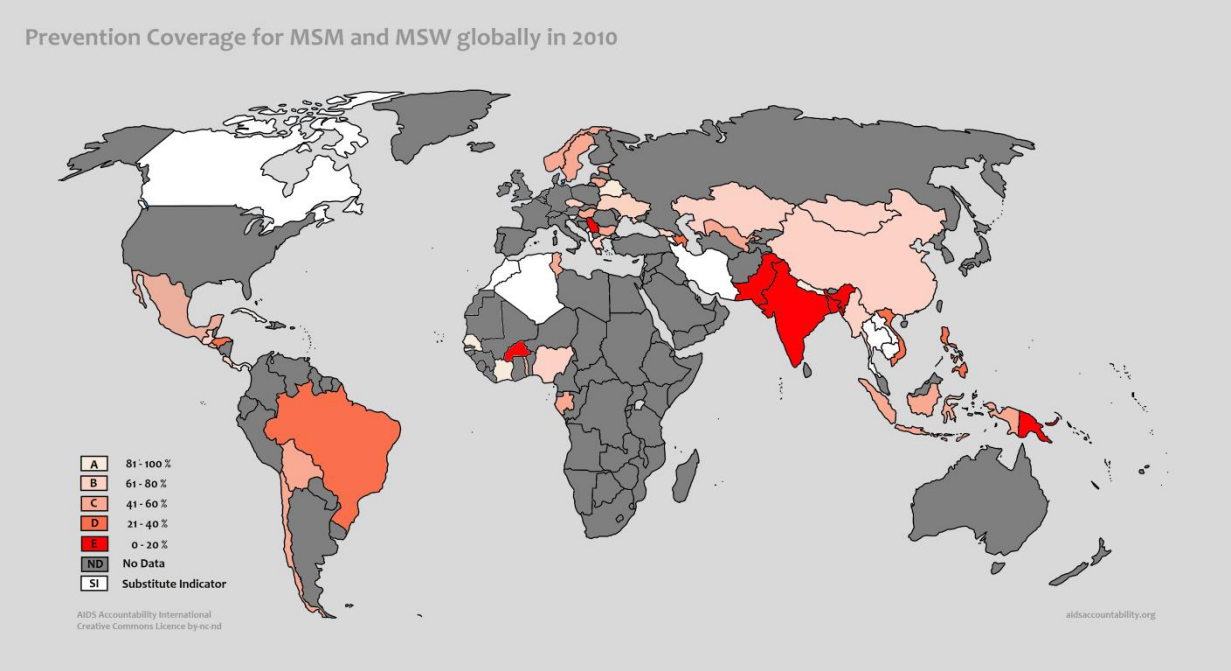
In an attempt to capture country responses this analysis combines the data reported on both MSM and MSW in order to gain a broader insight into government response.

Scorecard grading on reported prevention coverage

The following section seeks to analyze country performance in terms of prevention coverage for MSM and MSW in 2010.

The AAI Scorecard methodology captures the countries performances in five broad 'grades', from A to E based on the data submitted by governments to the UNAIDs system. The grades are allocated according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%). More information on the AAI grading and scorecard methodology is available in the framework report.

Thus the following map captures the grades achieved by governments with regards to HIV prevention for MSM and MSW as per their own reported statistics in 2010.



Map 1: Grades of the countries that reported data on Indicator 9 for MSM and MSW in 2010.

It is important to note that only 57 of the 192 countries reported data on prevention for MSM in 2010. This figure is considerably lower at 16 for MSW. This lack of collecting and reporting data is in itself a significant example of the lack of focus on same-sex groups and their experiences of the HIV response. AAI firmly believes that "know your epidemic, manage your epidemic" is a necessary part of government obligation from both a human rights and epidemiological perspective. Governments that do not prioritize this data can be said to be failing their citizens and people within their borders.

These 57 countries and their leaders should be recognized for the role they are playing on both a national and global stage in setting a good example by reporting, even

if their performance is low. Perhaps especially if their performance is low. It is a well known fact that governments do not like to report statistics that indicate their failures however that these countries have begun a process that will hopefully lead them to improvements is commendable and their transparency laudable.

Some of these countries reported substitute data (14 on MSM and 1 on MSW) on prevention. This suggests that although their data did not meet the specific criteria set by UNAIDS for the indicator leadership still considers the reporting of the data important. Often countries with limited budgets fail to collect data on numerically smaller groups, albeit the more vulnerable groups, and justify this with demands for financing in other areas. This is acceptable practice in some cases and needs to be considered and weighed on a country by country basis. However, oftentimes this substitute data is above the standard of UNAIDS demands and is not comparable with UNAIDS systems. Perhaps the data is available at municipal level for example, and so may reflect a country that has made significant strides in understanding their local challenges.

An overview of all country grades for MSM and MSW separately can be found at the end of this paper.

Scorecard grading on reported prevention policy

As part of the UNGASS reporting process all countries are required to submit a National Composite Policy Index. See Framework Report for more information on this document.

As a complementary or alternative method of rating country responses on prevention for same sex people we are able to evaluate these NCPIs on various issues.

Under the heading of prevention in the NCPI countries are asked the following questions:

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

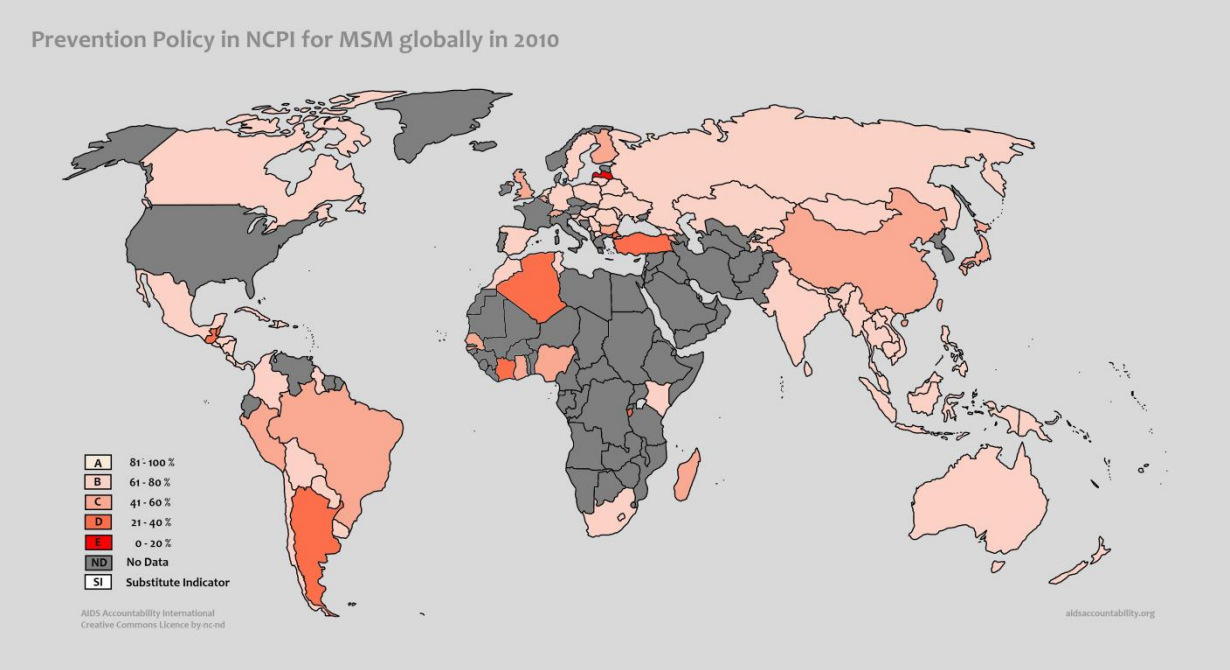
3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?
Check which specific populations and elements are included in the policy/strategy

1. Targeted information on risk reduction and HIV education
2. Stigma and discrimination reduction
3. Condom promotion
4. HIV testing and counseling
5. Reproductive health, including sexually transmitted infections prevention and treatment

Countries complete this section with the names of groups of people that have been the target of the above preventive health interventions.

The following section attempts to rate countries on a similar basis as before (Grades A-E) on these responses. For each constructive or ppositive response (that is to say when MSM formed part of the target population) the country was given a point for each of the health interventions. A total maximum score of 5 was thus possible. Countries were then rated as 2/5 or 4/5 and placed into the corresponding grade. A score of 4/5 equals Grade B for example.

The following map demonstrates the results of the analysis and countries performances on their own reporting around policy for prevention for MSM.



Map 2: Grades of the countries that reported data on policy for prevention targeted at MSM in 2010.

Scorecard grading on reported spending on prevention for MSM

An additional method of rating country responses to prevention for MSM is to look at budget expenditure as reported in the CRIS to UNAIDS.

The following elements of budget expenditure are all possible measures of government commitment:

- Total expenditure on prevention
- Total expenditure on prevention for MARPS
- Total expenditure on MARPS prevention as % of all expenditure
- Total expenditure on MARPS prevention as % of prevention expenditure
- Total expenditure on MARPS Prevention as % of domestic expenditure

Budget expenditure is a useful way to measure government commitment to particular issues. However this data is limited in its usefulness for M&E analysis for LGBT advocacy work. The principal restriction is that the reporting is for MARPS, and not MSM alone. Indeed the data includes budget expenditure for "Programs for sex workers and their clients, for MSM, and programme for harm reduction for IDUs".

Using budget expenditure alone as a measure for prevention in this case is problematic in some ways. The UNGASS reporting process does not demand that the budget reporting specifically draw out any same sex spending. Because it is joined with other MARPs its limitations are obvious. Thus although we may be able to say that Australia, Macedonia and Poland all have excellent budget allocations, we are unable to know whether it is for sex workers, injecting drug users or for MSM. In future we hope to see this differentiation for vulnerable groups, with the caveat of course that often these individuals belong to more than one of these groups.

However, if commitments to marginalized groups that are often seen as the outsiders and most ignored by government are any indication of a government's political will then the following table has some value, albeit limited.

A		B		C		D		E	
Above 50%		Btn 20%-50%		Btn 5%-20%		Less than 5%		Less than 1%	
Australia	71	Ukraine	43	Panama	17	Rep Moldova	5	Kazakstan	0.9
FYRO Macedonia	70	Georgia	40	Mongolia	16	Uruguay	4	Indonesia	0.6
Poland	66	Nepal	36	Croatia	14	Thailand	4	El Salvador	0.6
		Latvia	34	Mexico	13	Turkey	4	Ecuador	0.5
		Mauritius	33	Armenia	12	Cambodia	3	Mozambique	0.4
		Philippines	31	Sri Lanka	12	Mali	3	Zambia	0.2
		Peru	21	Trinidad & Tobago	12	Bolivia	2	Ghana	0.2
		Bulgaria	21	Tajikistan	11	Argentina	2	Uganda	0.2
		Lebanon	21	Paraguay	11	Burkina Faso	2	Congo	0.2
				Kyrgyzstan	9	Togo	1	DR Congo	0.2
				Honduras	8	Saint Lucia	1	Gabon	0.1
				Haiti	7	Brazil1	1	Tanzania	0.1
				Algeria	6	Chile	1	Cote d'Ivoire	0.0

Table 1: Total expenditure on MARPS prevention as % of prevention expenditure

Some of the methodological constraints are discussed further in the Framework Report linked to this scorecard. Suffice it to say here that various concerns make it clear why the reported data on prevention is not a clear cut measure of government response but that all three measures should be taken together and then national experts consulted to devise strategic advocacy plans.

Combined analysis

When analyzing the countries based on the above three methods, Cuba receives the highest grading, with 3 out of a possible maximum 4 being A Grades.

	RPC MSM	RPC MSW	PP MSM	RS MSM	TOTAL As/4
Cuba	A	A	A	B	3
Saint Lucia	A	A	ND	B	2
Belarus	A	A	ND	B	2
Panama	A	A	B	B	2
Nepal	A	B	A	B	2
Côte d'Ivoire	A	A	ND	D	2
Senegal	A	A	ND	C	2
Slovenia	A	A	ND	B	2

Table 2: Top-performing countries on MSM (and MSW) Prevention in combined grading. Key: RPC: Reported Prevention coverage; PP: Prevention Policy; RS: Reported Spending

A combined analysis points to countries that are reporting positive changes in policy, programming and implementation in their countries. As always local experts should be consulted as all too often critical aspects such as human rights are not able to be incorporated in this kind of rating. However, it is a useful guide to best and worst practices globally.

CASE STUDY: CUBA

According to the UNAIDS Global Report on HIV and AIDS (2010), the Caribbean has a higher HIV prevalence, after Sub-Saharan Africa, than any other geographical region in the world, with 1 percent of the adult population infected.

Cuba has had remarkable success in controlling HIV, though it has taken a very heavy-handed approach, paying little attention to human rights in the early years. In 1986 people in Cuba were routinely screened for HIV and by 1993 an estimated 12 million tests had been performed. (The population of Cuba was estimated at10,620,099 in July 1990.)[lix]

Involuntary quarantine in sanatoriums followed, where patients would receive medical care and education, whilst authorities sought their previous sexual partners and submitted them to this forced health care as well. In 1993, a less forceful approach began with this programme becoming voluntary and if peole diagnosed with HIV rejected being entered into the programme they were left without healthcare. Voluntary submission figures have shown to be high. [lx] The government maintains a database of HIV positive people and their sexual partners.[lxi]

Previously a homophobic state, in October 2010, the MSM Cuba programme celebrated its ten year success story. The programme was based on a framework of social inclusion of MSM as a means to addressing HIV prevention. As of 2010, 1700 MSM volunteers work in 14 of the 15 provinces (and an additional municipality not included in any province.) [lxii]

"By using peer education as a tool, men who have sex with men (MSM) themselves urged each other to practice safe sex," says Razl Regueiro a co-founder of the project.[lxiii]

In Cuba, eight out of 10 HIV-positive people are men, according to official sources that have recorded about 13,000 cases in this country of 11.2 million people.

Out of the total male HIV-positive group, over 80 percent have sex with other men, equivalent to 7.6 percent of all Cuban males in the 12-49 age range, according to a 2009 study by the National Statistics Office (ONE). [lxiv]

The article continues:
"Yoire Ferrer, who helped launched the program in Santiago de Cuba in the southeast of the country, said the initiative has been "extremely useful" for the national health service and is unique in terms of its "coverage level and the links established with sexual minorities."

"We have capacity-building and management programs at all levels, and we promote recognition of sexual diversity and encourage respect for and acceptance of gay, bisexual and heterosexual men," Ferrer told IPS in an e-mail from Santiago de Cuba.
Health interventions among populations suffering from discrimination encompass "the whole range of sexuality-related elements, and help improve quality of life by addressing issues like self-esteem and empowerment, focusing on the individual as a social and sexual being," Omar Parada, a co-founder of the project, told IPS.

Over time, MSM-Cuba "has become a voice, a representative, an open door to generate relationships, including friendships, while fomenting personal growth," Regueiro said.

"The HIV/AIDS epidemic has shown how important community participation is for any effective response," he said. [lxv]

Cuba represents an example of how inclusiveness, education and leadership involvement can be fundamental to HIV prevention among MSM. Albeit initially based on an approach that was lacking in a human rights lens, it would appear to most that Cuba has turned the tables not only on state-sponsored homophobia, and social discrimination but has done so to effectively programme IV prevention for MSM.

Male sex workers

Only 14 of the 192 countries reported on prevention coverage for male sex workers (MSW).

This figure alone is startlingly indicative of the lack of commitment from all leaders, civil society, funders, bi and multi-laterals as well as government to this group of highly vulnerable men.

The few countries that did report achieve on average very high figures with only 4 scoring less than a C. However, we can also understand it to mean that 7 (or half) of the countries achieved more than 50% coverage.

Male sex workers have traditionally been one of the more complex groups of MARPs to access in order to complete accurate and useful research. What is interesting is that similar countries[1] that reported on HIV counseling and testing (Scorecard on LGBT Element 1, available on the AAI website) are seen reporting on prevention coverage. This indicates a commitment to knowing and managing sub-epidemics and thus their effect on the general epidemic where applicable.

It is interesting to note, in conjunction with the case study on MSM prevention above that Cuba reports the highest coverage for prevention reaching MSWs.

A		B		C		D		E	
Cuba	96	Panama	73	Indonesia	55	None		Serbia	19
Nepal	93	Bulgaria	72	Gabon	48			Bangladesh	18
		Togo	63	Montenegro	43			Burkina Faso	15
		Mexico	61	Sweden	40			Pakistan	13

Table 3: Grades of the 14 countries that reported percentage data on Indicator 9 for MSW in 2010.

[1] Bangladesh, Bulgaria, Cuba, Gabon, Indonesia, Nepal, Pakistan, Panama, Serbia, Sweden, and Togo also reported on HIV Counseling and testing, Indicator 8.

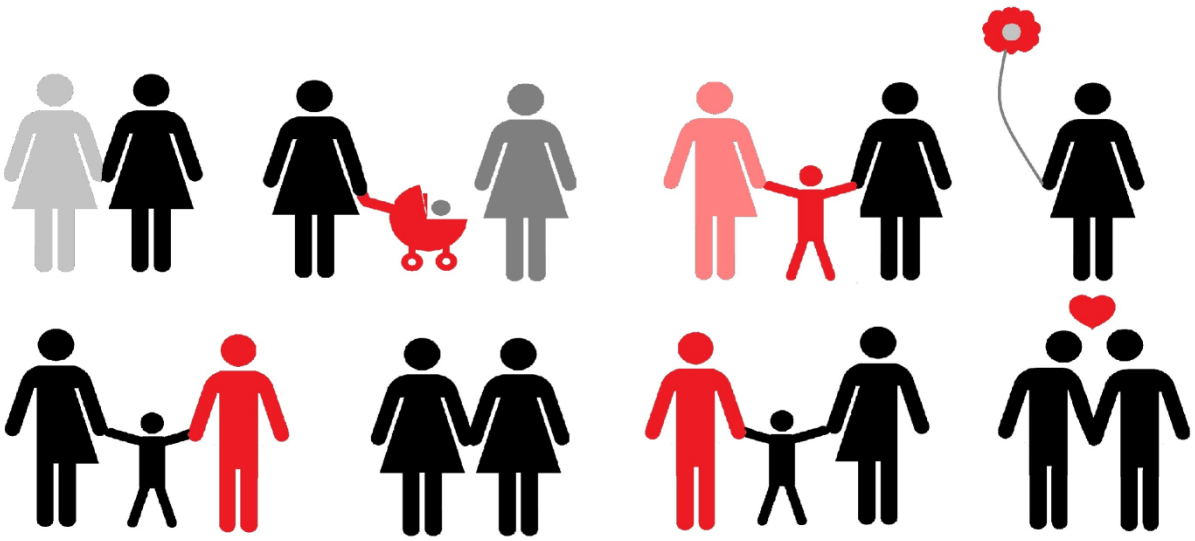
Women who have sex with women, bisexual and lesbian women

The UNGASS reporting process does not demand reporting on any indicators for women who have sex with women, lesbian, bisexual or transgender women. For this reason it is difficult to determine which countries are performing best based on the UNAIDS data with regard to rolling our prevention campaigns for WSW as a group. Few countries do have any targeted campaigns as sex between women is thought by many in the field, and many WSW themselves, to carry very low risk, if any at all.

Indeed Cochran and Mays indicate that younger bisexual and lesbian women may be at a higher risk of exposure to HIV and other sexually transmitted infections (STIs) due to sexual experimentation with both men and women, including 26% reporting having had sex with a man in the previous year, and 19% with a gay man in the prior 3 months[lxvi]. Increasingly we are seeing evidence of a variety of sexual behaviors but continue to categorize individuals into unhelpful boxes, which neglects their needs based on assumptions of their behavior.

> "What is it about the issue of lesbians and HIV that makes it so difficult to amass a useful body of scientific and psychosocial information? Why is it that after more than ten years of a pandemic that has left no one untouched by its reach, we are still unsure when faced with questions about WSW, lesbians and HIV risk? […] The invisibility of lesbians and other WSW in the surveillance data […] as well as the invisibility of these women in the prevention and service arenas continues to frustrate those who work closely with these populations. "[lxvii]. (1996)

Fifteen years later, increasingly knowledge around how women have sex with women, the quantity and nature of sexual fluids involved, including female ejaculate, and the complacency around their risk is pointing us to place more emphasis on knowing the risks these women face in order to protect them from exposure. Global M&E needs to play a role as a leader in this process and demand greater meaningful inclusion and develop indicators for WSW, lesbian and bisexual women for inclusion into the UNGASS reporting process.



Transgender men and women

Similarly to WSW, lesbian and bisexual women, the UNGASS reporting process does not have any indicators that apply to transgender men and women. However, it is a well-established fact that transgender people experience elevated levels of HIV exposure and infection.[lxviii] Transgender male-to-female and female-to-male health care needs are substantially unique from other individuals, and differ from each other too. Grouping the two together is often counter-productive. In terms of prevention campaigns, this rings especially true. In Pakistan research on male-to-female transgender people shows that "female gender identity and their unique social organizational structure differentiate them from other MSWs or MSM with whom they are usually grouped by prevention programmes".[lxix]

Simple issues, such as over-stretching terms such as using hijra for both male-to-female and female-to-male is a misnomer. "Transgender males who identify themselves as female are zenanas. However, in practice both society and health/prevention workers conflate the terms, calling all zenanas Hijras. [lxx]

In Los Angeles, research indicates that additional factors such as race/ethnicity (African-American versus Hispanic), higher household incomes, cohabitation/ marriage, and not seeking recent health care played a role as a predictor of lower HIV prevention utilisation. The authors' findings include the need for "prevention efforts should increase outreach to these subgroups, tailor programs for those who are African American or partnered, and increase the proportion of FSWs and TGW who periodically engage in active HIV prevention services such as client-centred counselling and small-group interventions to build skills related to safer sex." [lxxi]

All too often transgender people are grouped with other vulnerable groups, and although there may exist some crossovers there needs to be specifically taregetd prevention efforts globally to both MTF and FTM transgenders. And these efforts should be considered a matter of urgency.

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Conclusions and Recommendations

Conclusions

This element report can conclude that the following issues remain problematic:

- **Low-level response on Indicator 9 for MSM and MSW:** To date there has been an insufficient response to indicator 9 globally. Far too many countries have failed to report data on the existing MSM and MSW indicator for prevention.
- **Inadequate attention to creation of indicators for WSW and TG:** The global lack of M&E on WSW and TG on prevention is a reflection of the widespread neglect of these individuals. Calls need to be made for both human rights and epidemiological reasons for this to be rectified as a matter of urgency.
- **Various prevention approaches have been effective yet the need to maintain and prioritize a human rights approach is fundamental:** Although Cuba's prevention programme may have been effective in its early years, this heavy-handed approach is not acceptable. The new inclusive, non-discriminatory human rights approach however is to be congratulated and emulated.
- **Additional research is necessary to both convince leaders to further incorporate these vulnerable groups into their decision-making and to guide informed prevention programming:** Without sufficient empirical evidence many leaders will not find sufficient reason to include LGBTs in budget allocation, policy and programming decision and prioritization in other aspects of sexual and reproductive health care. More funding is required in this area. Additionally more research is required to cater prevention programmes to these audiences to ensure efficiency and impact.

Recommendations

- There needs to be an increased demand from civil society, multi and bi-lateral agencies, funders and government representatives for LGBT inclusion in all aspects of sexual and reproductive health and rights work. This needs to extend to M&E, policy, programming, research, implementation and legal review.

- LGBT people need to be given representation in government AIDS committee, as well as with funding committees, such as the Global Fund's Country Co-coordinating mechanisms (CCMs). This will create meaningful inclusion as well as capacity building and awareness among all stakeholders of the needs experienced by LGBTs.

- Human rights and epidemiology both need to be used as a lens when working on this field of work. It is not sufficient to say that in a generalized epidemic these individuals are statistically not significant. Total equality for all people should be realized so that access to quality sexual and reproductive health care is a reality for all.

Country	Prevention data from Country Reports and CRIS Combined MSM and MSW	Prevention data from Country Reports and CRIS MSM	Prevention data from Country Reports and CRIS MSW	Prevention data from NCPI MSM
Caribbean				
Antigua & Barbuda	ND	ND	ND	B
Bahamas	B	B	ND	C
Barbados	ND	ND	ND	ND
Cuba	A	A	A	B
Dominica	ND	ND	ND	B
Dominican Republic	ND	ND	ND	B
Grenada	ND	ND	ND	C
Haiti	ND	ND	ND	B
Jamaica	SI	SI	ND	B
Saint Kitts and Newis	ND	ND	ND	B
Saint Lucia	A	A	ND	B
Saint Vincent and the Grenadines	SI	SI	ND	ND
San Marino	ND	ND	ND	ND
Trinidad and Tobago	ND	ND	ND	E
East Asia				
China	B	B	ND	C
Japan	ND	ND	ND	C
Mongolia	B	B	ND	B
Republic of Korea	ND	ND	ND	ND
Eastern Europe and Central Asia				
Armenia	SI	SI	ND	C
Azerbaijan	D	D	ND	ND
Belarus	A	A	ND	B
Bosnia and Herzegovina	ND	ND	ND	ND
Bulgaria	C	D	B	C
Croatia	ND	ND	ND	B
Estonia	C	C	ND	ND
Georgia	B	B	ND	B
Kazakhstan	B	B	ND	B
Kyrgyzstan	ND	ND	ND	B
Latvia	ND	ND	ND	E
Lithuania	C	C	ND	B
Moldova, Republic of	ND	ND	ND	B
Romania	ND	ND	ND	B
Russian Federation	ND	ND	ND	B

Tajikistan	ND	ND	ND	B
Turkmenistan	ND	ND	ND	ND
Ukraine	B	B	ND	B
Uzbekistan	C	C	ND	ND
Latin America				
Argentina	ND	ND	ND	D
Belize	ND	ND	ND	D
Bolivia	C	C	ND	B
Brazil	D	D	ND	C
Chile	C	C	ND	B
Colombia	ND	ND	ND	B
Costa Rica	B	B	ND	B
Ecuador	ND	ND	ND	ND
El Salvador	C	C	ND	B
Guatemala	B	B	ND	D
Guyana	ND	ND	ND	B
Honduras	D	D	ND	B
Mexico	C	D	B	B
Nicaragua	ND	ND	ND	B
Panama	A	A	B	B
Paraguay	ND	ND	ND	B
Peru	ND	ND	ND	C
Suriname	ND	ND	ND	ND
Uruguay	ND	ND	ND	B
Venezuela	ND	ND	ND	ND
North Africa and Middle East				
Algeria	SI	SI	ND	D
Bahrain	ND	ND	ND	ND
Cyprus	ND	ND	ND	ND
Egypt	ND	ND	ND	ND
Iraq	ND	ND	ND	ND
Jordan	ND	ND	ND	ND
Kuwait	ND	ND	ND	ND
Lebanon	SI	SI	ND	ND
Libyan Arab Jamahiriya	ND	ND	ND	ND
Morocco	SI	SI	ND	B
Oman	ND	ND	ND	ND
Qatar	ND	ND	ND	ND
Saudi Arabia	ND	ND	ND	ND
Syrian Arab Republic	ND	ND	ND	ND
Tunisia	C	C	ND	B
Turkey	ND	ND	ND	D
United Arab Emirates	ND	ND	ND	ND
Yemen	ND	ND	ND	ND

North America				
Canada	SI	SI	ND	B
United States of America	ND	ND	ND	ND
Oceania				
Australia	ND	ND	ND	B
Fiji	ND	ND	ND	B
Kiribati	ND	ND	ND	ND
Marshall Islands	ND	ND	ND	ND
Micronesia, Federated States of	ND	ND	ND	ND
Nauru	ND	ND	ND	ND
New Zealand	ND	ND	ND	B
Palau	ND	ND	ND	ND
Papua New Guinea	E	E	ND	B
Samoa	ND	ND	ND	ND
Solomon Islands	ND	ND	ND	ND
Tonga	ND	ND	ND	ND
Tuvalu	ND	ND	ND	ND
Vanuatu	ND	ND	ND	ND
South and South East Asia				
Afghanistan	ND	ND	ND	ND
Bangladesh	E	E	E	B
Bhutan	ND	ND	ND	ND
Brunei Darussalam	ND	ND	ND	ND
Cambodia	SI	SI	ND	B
Democratic People's Republic of Korea	ND	ND	ND	ND
India	E	E	ND	B
Indonesia	C	C	C	B
Iran	SI	SI	ND	ND
Lao People's Democratic Republic	SI	SI	ND	B
Malaysia	ND	ND	ND	B
Maldives	ND	ND	ND	ND
Myanmar	B	B	ND	B
Nepal	A	B	A	B
Pakistan	E	ND	E	ND
Philippines	D	D	ND	B
Singapore	ND	ND	ND	C
Sri Lanka	ND	ND	ND	B
Thailand	SI	SI	ND	B
TimorLeste	ND	ND	ND	ND
Viet Nam	D	D	ND	B

Sub Saharan Africa				
Angola	ND	ND	ND	ND
Benin	ND	ND	ND	ND
Botswana	ND	ND	ND	ND
Burkina Faso	E	ND	E	ND
Burundi	ND	ND	ND	D
Cameroon	ND	ND	ND	ND
Cape Verde	ND	ND	ND	E
Central African Republic	ND	ND	ND	ND
Chad	ND	ND	ND	ND
Comoros	E	ND	ND	ND
Congo	ND	ND	ND	ND
Côte d'Ivoire	A	A	ND	D
Democratic Republic of Congo	ND	ND	ND	ND
Djibouti	ND	ND	ND	ND
Equatorial Guinea	ND	ND	ND	ND
Eritrea	ND	ND	ND	ND
Ethiopia	ND	ND	ND	ND
Gabon	C	ND	C	ND
Gambia	ND	ND	ND	ND
Ghana	ND	ND	ND	C
Guinea	ND	ND	ND	ND
Guinea Bissau	ND	ND	ND	ND
Kenya	ND	ND	ND	B
Lesotho	ND	ND	ND	B
Liberia	ND	ND	ND	ND
Madagascar	ND	ND	ND	C
Malawi	ND	ND	ND	ND
Mali	ND	ND	ND	ND
Mauritania	ND	ND	ND	ND
Mauritius	ND	ND	ND	B
Mozambique	ND	ND	ND	ND
Namibia	ND	ND	ND	ND
Niger	ND	ND	ND	ND
Nigeria	B	B	ND	C
Rwanda	ND	ND	ND	ND
Sao Tome and Principe	ND	ND	ND	ND
Senegal	A	A	ND	C
Seychelles	ND	ND	ND	ND
Sierra Leone	ND	ND	ND	ND
Somalia	ND	ND	ND	ND
South Africa	ND	ND	ND	B
Sudan	ND	ND	ND	ND
Swaziland	ND	ND	ND	ND
Togo	C	C	ND	ND
Uganda	ND	ND	B	ND
United Republic of Tanzania	ND	ND	ND	ND
Zambia	ND	ND	ND	ND
Zimbabwe	ND	ND	ND	ND

Western and Central Europe				
Albania	SI	SI	ND	ND
Andorra	ND	ND	ND	ND
Austria	ND	ND	ND	ND
Belgium	ND	ND	ND	C
Czech Republic	B	B	ND	ND
Denmark	ND	ND	ND	ND
Finland	ND	ND	ND	C
France	ND	ND	ND	ND
Germany	ND	ND	ND	B
Greece	B	B	ND	ND
Hungary	C	C	ND	B
Iceland	ND	ND	ND	ND
Ireland	ND	ND	ND	ND
Israel	ND	ND	ND	ND
Italy	ND	ND	ND	ND
Liechtenstein	ND	ND	ND	ND
Luxembourg	ND	ND	ND	ND
Malta	ND	ND	ND	ND
Monaco	ND	ND	ND	ND
Montenegro	B	SI	ND	B
Netherlands	ND	ND	C	B
Norway	C	C	ND	ND
Poland	ND	ND	ND	B
Portugal	ND	ND	ND	ND
Serbia	E	E	ND	B
Slovakia	ND	ND	E	ND
Slovenia	A	A	ND	B
Spain	ND	ND	ND	B
Sweden	C	C	ND	B
Switzerland	ND	ND	C	C
The former Yugoslav Republic of Macedonia	SI	SI	ND	B
United Kingdom of Great Britain & Northern Ireland	ND	ND	ND	C

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