The AIDS Accountability Scorecard on LGBT 2011

Project Framework

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.

In Loving Memory

To the memory of our colleague Irene Guevara Harris and her impassioned commitment to human values and rights for all people.

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Phillipa Tucker, AAI Senior Researcher, is the project manager for the AIDS Accountability LGBT Scorecard. Per Strand, AAI Research Director, has contributed research and writing to this report.

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.

List of Acronyms

AAI
AIDS Accountability International

AIDS
Acquired Immunodeficiency Syndrome

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

HCT
HIV counseling and testing

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

Glossary

Gender and sex
The term 'sex' refers to biologically determined differences, whereas 'gender' refers to differences in social roles and relations. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity, and religion, as well as by geographical, economic, and political environments.

Bisexual
A bisexual is defined as a person who is attracted to and/or has sex with both men and women and who identifies with this as a cultural identity.

Cisgender/Cismen/Ciswomen
People whose gender identity matches their sex at birth. This has a more positive connotation than 'normal' or 'non-transgender'.

Gay
The term 'gay' can refer to same-sex sexual attraction, same-sex sexual behaviour, and same-sex cultural identity.

Heterosexual/heterosexuality
The term 'heterosexual' is used to refer to people who have sex with and/or are attracted to people of the opposite sex.[i]

Homosexual/homosexuality
The word homosexual refers to people who have sex with and/or sexual attraction to or desires for people of the same sex.[ii]

Lesbian
The term lesbian refers to women who have sex with and/or sexual attraction to or desire women.

Men who have sex with men (MSM)
MSM is an abbreviation referring to 'men who have sex with men' or 'males who have sex with males', regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. It also includes men who self-identify as heterosexual but have sex with other men.

Sex worker
The term 'sex worker' is non-judgmental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally.[iii]

Transgender
Transgender people have a gender identity that is different to their sex assigned at birth by default of genitals.

Transman /FTM
A transman, or female-to-male, starts his life with a female body, but his gender identity is male. Male pronouns should always be used in reference.

Transwoman/ MTF
A transwoman, or male-to-female, starts her life with a male body, but her gender identity is female. Female pronouns should always be used in reference.

Transsexual
A transgender person in the process of seeking or undergoing some form of medical treatment to bring their body and gender identity into closer alignment. Not all transgender people undergo reassignment surgery.[iv]

Women who have sex with women (WSW)
The term 'women who have sex with women' includes women who self-identify as lesbian or homosexual and have sex only with other women, bisexual women and women who self-identify as heterosexual but have sex with other women.[v]

Stigma and discrimination
LGBTIQ individuals frequently experience stigma and discrimination; however there is a difference between the two concepts. Stigma is the feeling experienced by a sexually diverse person based on what others think and affects the way they view themselves. It is the "holding of derogatory social attitudes or cognitive beliefs, a powerful and discrediting social label that radically changes the way individuals view themselves or the way they are viewed by others."[vi]

Discrimination is "an action based on a pre-existing stigma; a display of hostile or discriminatory behavior towards members of a group, on account of their membership to that group"[vii] Name-calling or refusing to hire a person based on their sexual orientation or gender identity are examples of discrimination.

Transphobia, lesphobia and homophobia
These terms refer to the fear of, rejection of, or aversion to, transsexuals, transgender people, transvestites, lesbians and women who have sex with women and/or gay men or other men who have sex with men. These phobias are often expressed as stigmatizing attitudes or discriminatory behavior.

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 April to November 2011, each covering a key element of the AIDS response. The LGBT Scorecard Framework Paper is launched simultaneously with the first element to provide more information on methodological and analytical issues. A concluding synthesis report will be launched in December 2011.

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. Our research is intended to be a tool for activists, government officials, civil society including community based organizations, health care workers and many others who work in the HIV arena, to use to reduce the transmission of HIV.

Language

Many civil organizations currently use 'sexual orientation and gender identity' (SOGI) as the term to collectively identify the following people:

- Bisexuals
- Gays
- Lesbians
- Intersex people
- Men who have sex with men
- Transgender people
- Queer (a previously derogatory term, now being re-defined by self-identifying individuals as a means to counter heteronormativity)
- Women who have sex with women

The International Planned Parent 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."[viii]

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.

Similarly the following are seldom considered when SOGI is used.

1. Situational sexual behavior, when individuals only engage in particular sexual activities in particular circumstances or places, for example:

- Individuals who can only engage in same-sex relationships outside of their country because it is illegal or dangerous to do soin their own country due to the criminalization of homosexuality.
- Gender-segregated communities such as in prison or the military.
- Sexual tourism, where people travel to countries to more easily access same-sex sex workers.

2. Pomosexuality, when individuals either refuse to take on or be given an identity or behavior.

3. Third sex individuals (for example the Hijras in South Asia and the Fa'afafine in Samoa).

4. Pre-transition transgender individuals who have a sexual preference based on their gender identity and not on their physiological sex. This means

Sexual diversity is a term that refers to a full range of sexuality.

transgender women who might still possess male genitals who partner with women and identity as WSW are completely invisibilized by current understanding of SOGI. The same applies to pre-op transgender women who have sex with men who are currently invisibilized by MSM statistics.

Marc Epprecht, in Heterosexual Africa? The History of an Idea from the Age of Exploration to the Age of AIDS, discusses how Western terms do not necessarily apply, or are not necessarily useful, in the context of Africa where "The language Africans have used to describe such relationships is in fact commonly euphemistic or coy almost to the point of incomprehensibility beyond those in the know." "The language by which same sex relationships are described […] is often Eurocentric – the word homosexuality, notably, suggests a clarity arising from a specific history of scientific enquiry, social relations, and political struggle that did not historically exist in Africa and still does not very accurately describe the majority of men who have sex with men or woman who have sex with women in Africa.[ix]

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. We therefore use LGBT, sexually diverse and same-sex inter-changeably.

This report uses the terms LGBT, sexually diverse and same-sex inter-changeably.

The Marginalization of LGBT

The marginalization and discrimination that sexually diverse people experience in most countries around the world are in many ways mirrored in the AIDS response. In many research projects sexual orientation and gender identity have been pushed aside or lost under the ambit of gender and/or most at risk populations (MARPs) and combined with injecting drug users (IDUs), and sex workers (SW). Irrespective of the level of exposure to HIV, LGBT people across the world face stigma and discrimination that deny them universal access. The AAI LGBT Scorecard will make it very clear that most of these groups are 'invisible' to national and global M&E efforts. This means that we have little systematic data with which to assess the burden they carry in terms of HIV prevalence or what level of access they have to treatment and other essential services.

For the same reason we will fail to implement targeted interventions that would reduce HIV incidence in concentrated epidemics that are likely to lead to HIV infections also in the general heterosexual population. In this context, MSM represent the exception. Many countries monitor HIV and AIDS among MSM effectively and, in some countries, the necessary services appear to be provided at scale. A central argument that underpins this scorecard analysis is that the political struggle that won these victories for MSM in some countries needs to be broadened to include sexually diverse groups in general in all countries. There are, in other words, epidemiological reasons for focusing a scorecard analysis on government performance in relation to sexually diverse populations. If these groups remain invisible to the AIDS response, many people will become infected, fall ill and die unnecessarily.

The second rationale is even more simple and direct. Beyond the science of epidemiology, and beyond the notion of group or identity, remain diverse ways of showing love and sharing the joys of sex. As these are essential to what it means to be human, they are essential human rights. The AIDS Accountability LGBT Scorecard is therefore also an argument for making sure that sexually diverse populations have full part in advocacy for securing human rights in general

Good public health = epidemiology + human rights.

and rights to health in particular. If sexually diverse populations are invisible also in the discourse on human rights we undermine the very principle of Universal Human Rights, an omission from which all stand to lose.

The following sections will sketch out how this general reasoning applies to different sexually diverse people.

Women who have sex with women, bisexual and lesbian women

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.

The belief that sex between women carries a low possibility of HIV transmission has led to the almost universal exclusion of WSW in HIV prevention efforts and research. The lack of indicators and focus on these women reflects the current state of mainstream knowledge about HIV epidemiology which does not see these groups of sexually diverse women as being affected to a degree that warrants inclusion in a global M&E framework.

Contrary to this mainstream argument, data and analyses are increasingly coming to the fore that shows the extra vulnerability of WSW. For example, a study found that the majority (85%) of British women, who had had sex with other women, had also had sex with men. However, "compared with women who reported sex exclusively with men, women who reported sex with women and men reported significantly greater male partner numbers, unsafe sex, [...] and sexually transmitted infection diagnoses."[x] There is an urgent need for additional attention to be paid to this group of highly marginalized individuals globally.

These findings are important not only as the basis for new and better M&E indicators, but also to affect policy development and programming. Further, it is important also to inform WSW themselves of their increased vulnerability to HIV infection and thus affect behavior change. Moreover, these women and transgender men are at heightened 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.

Homophobic, or more correctly lesphobic rape, often leads to genital trauma, lesions on the body, unprotected sex and increased risk of HIV infection. The apparent "rationale" for raping lesbian women is that the perpetrator can "cure" the women of their sexual orientation and it has become an epidemic of its own in South Africa. So much so in fact, that research indicates that 86 per cent of black lesbian women in the Western Cape Province live in fear of sexual assault.[xi]

Indeed, human rights groups estimate that no less than 30 lesbian women have been murdered in South Africa in recent years. Triangle, a gay rights organization, based in Cape Town, says it works with as many as ten new cases of 'corrective' rape every week.[xii] This places lesbian women at a substantially high risk of contracting HIV, yet still no acknowledgement of the need for inclusion in HIV M&E statistics exists.

Transgender men and women

Transgender refers to the gender identity of an individual and their self-identification as either a woman, man, both or neither one of these. Transgender people consider that their gender identity does not match their sex assigned at birth. For some people they may identify themselves as transgender, bi-gender, as having no gender or even as moving effortlessly along a gender continuum, traditional or not. Transsexual people usually have had some medical or surgical assistance in achieving their ideal gender identity.

Transgender gender identity has no connection to sexual orientation as transgender people may identify as lesbian, gay, bisexual, heterosexual, pansexual or asexual or queer the distinction is not related to their genitals but to their gender identity.

All transgender people, but most especially transwomen are highly vulnerable to HIV. Marginalisation, limited access to employment, the resulting poverty, and related higher rates of sex work all place transgender men and women in an especially vulnerable position. "Unresolved sexual identity often results in high risk sexual experimentation. Female gender roles are often associated with abuse by a partner. Transwomen, due to

Homophobic rape places WSW at increased risk of HIV infection.

stigma are highly vulnerable to sexual assault and punitive rape."[xiii] Similarly for transmen in Africa transphobic "corrective" rape is an ongoing human rights issue.

Transgender individuals face barriers in accessing healthcare, and due to the fact that the very nature of those health needs are specific even more so. Very seldom do any sexual and reproductive health and rights programmes address the needs of transgender individuals. "Transgender people have very specific needs for e.g. (among others) cross gendered hormone treatment and possible interaction with ARVs and other medicine are not known. Prostate cancer in post operative transwomen and cervical cancer with transmen are often ignored because of pre-conceived notions of transgender bodies."[xiv]

All too often reports on transgender people do not specify whether the information refers to transgender men (female bodied people with a male gender identity) or transgender women (male bodied people with a female gender identity). However, their health care needs are significantly different, with transgender men requiring medical care for issues such as cervical cancer screening when applicable. Healthcare workers are not trained on providing these services as they often operate on traditional male/female gender identities and cisgender people.

Men who have sex with men, bisexual men and gay men.

Unsafe sex between men was the main driver as the global epidemic began in the early 1980s, and it remains a central feature of the epidemic in several low-prevalence and concentrated epidemics across the world. The response to the needs of MSM in the context of HIV/AIDS has been relatively effective when compared to other groups among LGBT people. This is due in parts to the centrality of MSM in the early epidemic and successful political advocacy from MSM stakeholders. But those gains apply unequally across the world. MSM still face criminalization, discrimination and violence in many countries, with little hope for adequate access to prevention, treatment and care and support. Several elements of the LGBT Scorecard will reflect the fact that MSM remain marginalized in, if not completely absent from, the response to AIDS in many countries, even though data show high HIV prevalence and that human rights abuses against MSM are rife. 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.

Men who have sex with men are at an increased vulnerability for a variety of reasons, not least of which are:

- HIV is more easily transmitted through unprotected anal sex than through unprotected vaginal sex.
- In countries and cultures where MSM are stigmatized they are reluctant to seek healthcare for other STIs resulting in genital lesions and sores that further increase the risk of transmission.
- Criminalization of same sex practices pushes gay men into marriages with women to disguise their sexual orientation thus heightening their risk of transmitting the virus to their wives or girlfriends.
- Criminalization and marginalization also drives these individuals away from accessing timeous, accurate, full health care and diagnosis. The lack of adequate training of healthcare personnel worsens this.
- Low self-confidence, lack of self-acceptance or family and social acceptance of sexual orientation often leads to high stress and a lack of psychological support for gay men. This may lead to the abuse of substances, having multiple sexual partners to lift esteem, inability to negotiate safe sex, and entering into sex work for financial reasons. All of these behaviors place gay men in a higher risk category for transmission of HIV.

The Global Forum states that: "Despite elevated HIV prevalence rates and heightened vulnerability to factors that drive HIV transmission, MSM have been under-recognized, under-studied, under-funded, and under-served historically in the global response to HIV & AIDS. There is therefore an urgent need to prioritize outreach to

Transgender individuals have very specific health needs but still face barriers in accessing healthcare.

MSM with HIV-related services and information that effectively meet their needs in the context of global public health and human rights."[xv]

State-sponsored homophobia

Criminalization of same sex practices

In the 2010 International Lesbian, Gay, Bisexual, Trans and Intersex Association International (ILGA) report on state sponsored homophobia ILGA reports that people can be prosecuted on the basis of their sexual orientation in 76 countries. Homosexual acts remain punishable with the death penalty in five countries: Iran, Saudi Arabia, Yemen, Mauritania, and Sudan as well as 12 northern states in Nigeria and the southern parts of Somalia. In Djibouti, Bahrain and Iraq the legal status of homosexual acts is unclear.[xvi]

On the other hand some countries are making progress in removing state-sponsored homophobia and India in 2009 was an excellent example. The ILGA report goes on to state: "One country less compared to the 2009 list may seem little progress, until one realizes that it hosts one sixth of the human population... The ruling affects the whole of India ... thus freeing one sixth of the LGBTI world population from legal persecution. A historical result, achieved thanks to a decade long battle waged by ILGA member organisations in the country." Additionally Argentina and the Federal District in Mexico recognized equal marriage rights to same-sex couples, thereby setting an example of genuine inclusiveness, which will set the standard for many to follow.

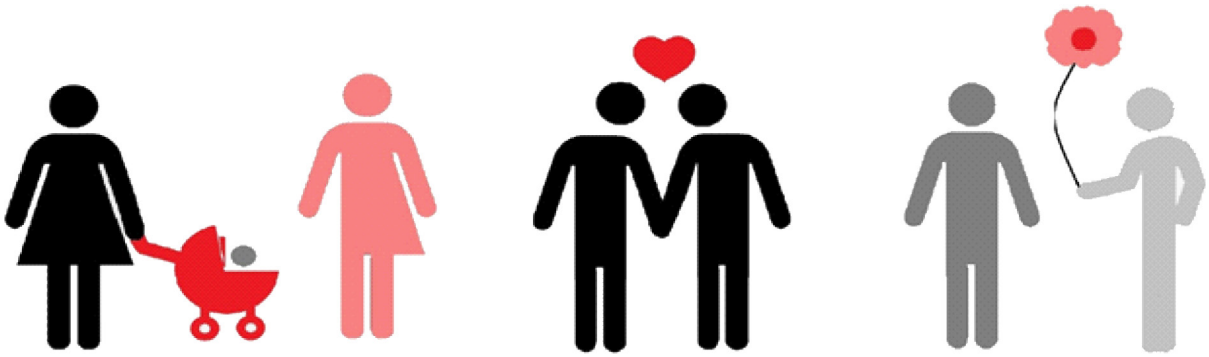
State-sponsored homophobia or the criminalization of same-sex sexuality has the very negative effect of driving LGBT people behind closed doors. Unable to access quality healthcare, in a timeous manner, because of fear of reprisal, either in the form of prosecution or persecution, their vulnerability is heightened considerably.

MSM have been under-recognized, under-studied, under-funded, and under-served in the global response.

Region	Homosexual acts illegal (76 countries)
Africa	Algeria, Angola, Botswana, Burundi, Cameroon, Comoros, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Libya, Malawi, Mauritania (death penalty), Mauritius, Morocco, Mozambique, Namibia, Nigeria (death penalty in some states), São Tomé and Principe, Senegal, Seychelles, Sierra Leone, Somalia, Sudan (death penalty), Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zimbabwe
Asia	Afghanistan, Bangladesh, Bhutan, Brunei, Burma, Iran (death penalty), Kuwait, Lebanon, Malaysia, Maldives, Oman, Pakistan, Qatar, Saudi Arabia (death penalty), Singapore, Sri Lanka, Syria, Turkmenistan, United Arab Emirates, Uzbekistan, Yemen (death penalty), as well as the Gaza Strip in the Palestinian Authority
Europe	Turkish Republic of Northern Cyprus (internationally unrecognized)
Latin America and the Caribbean	Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St Kitts & Nevis, St Lucia, St Vincent & the Grenadines, Trinidad and Tobago
North America	None
Oceania	Kiribati, Nauru, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, as well as the New Zealand associate of Cook Islands

ILGA Table of criminalization of same sex activities.[xvii]

"In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us."
Ban Ki-moon, Secretary-General of the United Nations, August 2008



Criminalization makes no sense from a health perspective. It hurts all of us.

Accountability and UNGASS Reporting

Accountability

Stakeholders at all levels of the global response to HIV and AIDS have long recognized the need for strong leadership in order to ensure universal access to prevention, treatment and care and support services. However, definitions of 'leadership' are as diverse as the groups of stakeholders who demand it and few have devised coherent strategies for how to motivate better leadership. AIDS Accountability International was formed with the express purpose to make a contribution in this regard: to identify and analyze leadership and to develop research-based advocacy tools that can be used to motivate political and other leaders to use their resources optimally for a more effective response to AIDS and related health challenges.

Political accountability is a governance principle based on the argument that those in positions of power must submit to scrutiny and possible sanctions for their use of power. AAI is convinced that we will see stronger leadership on AIDS if people in leadership positions know they will be held accountable for their performance in the AIDS response.

For the purposes of our country scorecard analyses of government performance in the response to AIDS, AIDS Accountability International relies on a succinct definition of accountability. To paraphrase Amartya Sen, 'accountability' is the ability of stakeholders to sanction government for poor performance in an effort to improve the response to AIDS.[xviii]

However, in order for accountability to become a constructive governance principle in the response to AIDS it cannot be reduced to a simplistic 'blame game' between government and other stakeholders. Accountability should instead be understood as a governance 'mechanism' in three steps, as depicted in figure 1 below.

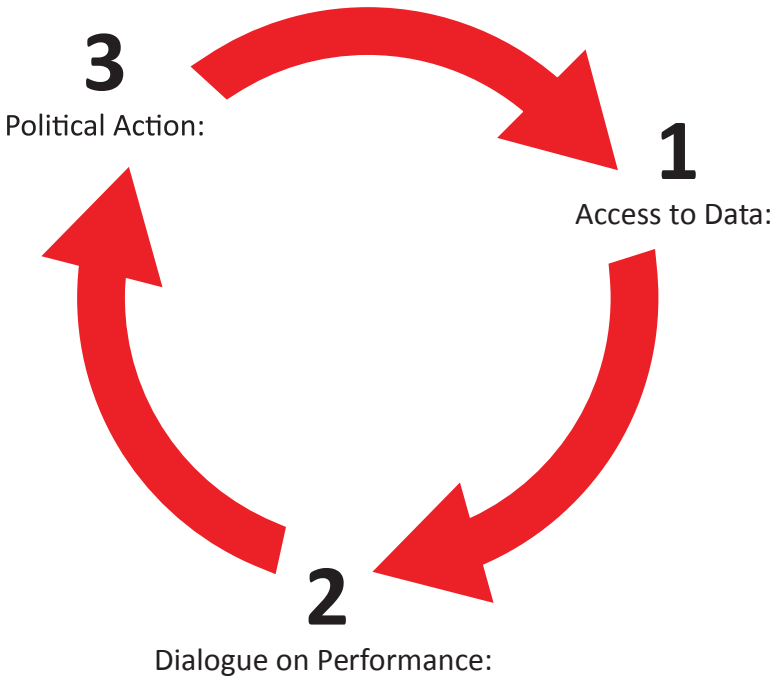


Figure 1. Three-step process of accountability

1. Access to Data: Collect data and make it accessible.

2. Dialogue on Performance: Invite stakeholders to review performance in relation to targets.

3. Political Action: Govts must accept the review of performance and action by stakeholders.

We will see a better response on AIDS if people in leadership positions know they will be held accountable.

1. Access to data

The dialogue on accountability cannot start unless stakeholders, including people living with, affected by and vulnerable to HIV, have sufficient and equal access to the relevant data on the national response collected through national M&E systems. Further, it is essential that this data is presented in a way that enables civil society stakeholders to engage with it and draw conclusions from it. It is important to note that the failure by governments to provide transparent access to the relevant data is sufficient grounds for legitimate demands for accountability.

2. Dialogue on performance

Government must commit to and engage in annual reviews of country performance in the response in relation to the relevant national or global targets for service coverage and governance principles with all relevant stakeholders. The reviews will give government opportunities to explain instances of poor performance, and civil society stakeholders can assess whether those explanations are acceptable or whether to demand political accountability. Obviously, the failure of government to participate in such reviews, or a politically biased engagement only with some civil society stakeholders, is sufficient grounds for demands for accountability.

3. Political action

Access to data and dialogue between stakeholders are no ends in themselves but should determine which forms of political action are necessary. Where stakeholders can agree with government that unified action is required in relation to potential funders or global agencies such action will increase the leverage of country demands. Where government accepts responsibility for poor performance in some aspect of the response it should take action to improve that performance. Where civil society actors do not accept government explanations for poor performance, or disagree with government plans to remedy poor performance, civil society stakeholders should take political action to try increase the leverage of their demands for political accountability.

These three steps of the accountability mechanism will transfer the rhetorical reference to 'accountability' into actionable political interventions in order to ensure 'accountable leadership' in the response to AIDS. AAI scorecard analyses are developed with the ambition to strengthen civil society stakeholders' grasp of the best available comparable data on how their respective governments have performed in the response. On the basis of the scorecard analysis, stakeholders are better equipped to enter into a constructive dialogue with governments on the strengths and weaknesses of the response to AIDS.

The commitment to LGBT people without discrimination was unequivocal in both declarations.

Accountability in UNGASS Declarations

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 commitment to LGBT people without discrimination was unequivocal in both the 2001 and the 2006 Declarations (sections 58 and 29 respectively):

"intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic."[xix]

Greater accountability, and the need to ensure that authorities explain publicly how they are carrying out the responsibilities they have been entrusted with, is essential to stimulating progress towards the Millennium Development Goals and the Declaration of Commitment on HIV/AIDS. Without this reporting and evaluation, there is no means to encourage those who are succeeding, put pressure on those who are failing, or stimulate debate about how the factors driving the epidemic can be best addressed in different settings.

Country submission of data to UNAIDS

Countries submitted data online through three mechanisms:

1. The Country Response Information System (CRIS) Data Entry Software for Global reporting

2. The County Progress Reports

3. The National Composite Policy Index (NCPI)

Countries can submit data to UNAIDS through the CRIS (Country Response Information System), in Country Narrative Reports and in the NCPI (National Composite Policy Index).

Country Response Information System (CRIS)

The Country Response Information System is a data management system which is designed to improve the reporting of statistical country data to UNAIDS. Data submitted to the CRIS system has to fulfill certain criteria or guidelines on the construction of the indicators (For more information please see here). Countries who have similar or applicable data but which does not fit these criteria usually report this additional data in their Country Progress or Country Narrative Report.

Country Narrative Report

The Country Report includes such information as an overview of the status of the epidemic in the country, information on the national response, best practices, major challenges and the monitoring and evaluation environment.

National Composite Policy Index (NCPI)

The process of completing the NCPI is as important as the final result. It aims to foster improved communication and capacity building between government and non-government agencies (Civil Society, bi-laterals and the UN agencies). It includes questions on human rights, strategic plans, political action, civil society inclusion, monitoring and evaluation as well as programmatic issues.

A Note on Reporting to UNAIDS

The information submitted to UNAIDS is both validated and verified by that agency. This includes UNAIDS checking for example illogical data, the degree of completeness of reporting, and perhaps methodological considerations.

Shadow reports

UNAIDS states in the 2009 Guidelines on Construction of Core Indicators that "shadow reports are intended to provide an alternative perspective where it is strongly felt that civil society was not adequately included in the national reporting process, where governments do not submit a Country Progress Report, or where data provided by government differs considerably from data collected by civil society monitoring government progress in service delivery. In accepting shadow reports, UNAIDS acknowledges the 'watchdog' function which many civil society organisations fulfil in their countries."

Relevant indicators to LGBT Scorecard

It can be noted that of the 25 core indicators only 6 deal with most-at-risk populations (MARPs); these include men who have sex with men (MSM), sex workers, female and male (FSWs and MSWs) and injecting drug users (IDUs).

It can be noted that none of the indicators specified by UNAIDS request data on lesbian, women who have sex with women (WSW), gay, transgender, intersex or queer individuals. The only individuals that are included from the sexually diverse group are men who have sex with men (MSM) and male sex workers (MSWs).

The following indicators represent those that deal with these two groups:

- Indicator 8: HIV Testing in Most-at-risk Populations Percentage (SWs, MSM and IDUs)
- Indicator 9: Percentage of Most-at-risk Populations reached with HIV prevention programmes (SWs, MSM and IDUs)
- Indicator 14: Percentage of Most-at-risk Populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (SWs, MSM and IDUs)
- Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client
- Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.
- Indicator 23. Percentage of most-at-risk populations that are HIV infected.

Shadow reporting plays a crucial role in countries where government is not transparent, inclusive or accountable.

The Objective of the LGBT Scorecard

AAI's overall goals

In a ten-year perspective, the overall ambition of AIDS Accountability International is to make a distinct contribution in the effort to realize and sustain the universal access targets. Our unique contribution is to shape the political context that determines the level and quality of leadership that is invested in the response to AIDS. Our strategy for achieving this is to generate research and mobilize stakeholders to ensure that the response is governed through accountable leadership that is motivated by a sustained demand among stakeholders in civil society and the public at large.

AAI's long-term goals are the following:

- That the majority governments report the data on HIV and related health issues that is requested by global and regional monitoring agencies
- That accountability routinely features as a topic for research and advocacy debates at international conferences on HIV and related health issues
- That accountability-based advocacy becomes a core skill and capacity among AAI's key partners in civil society and other stakeholder groups in the AIDS response
- That AAI's research-based advocacy tools become an integral reference and resource for advocacy efforts by our key collaborating stakeholders in the response to AIDS and related health challenges

In order to realize our ambition in the long term we focus on four priority areas:

1. Strengthen global and regional monitoring systems

A strong accountability framework requires a comprehensive monitoring system to assess progress and to enable evaluation of efforts made by nations and the global community. Effective monitoring and evaluation of responses is essential for transparency and the ability to assess claims of improvements in the response. Transparency is partly about making the data publically available (see further below), but also, and critically, about collecting the right kind of data and to validate the data in a way that ensures credibility.

It is crucial that indicators used are attuned to the epidemic and capture necessary nuances. AAI has on the basis of our research findings, argued the need for better indicators for e.g. women and girls to capture the challenging situation they face in some regions and for meaningful, non-tokenistic involvement of civil society in countries' reporting process. Such a contribution was already made in terms of our participation in the Expert Group for the enabling environment track in the UNGASS M&E review process that was led by UNAIDS and UNDP in 2010. We made several suggestions for how accountability could be emphasized in a revised UNGASS framework and suggested the inclusion that, for the first time, would assess the extent to which government had invited stakeholders to discuss the national response in a format that would compel the government to justify any shortcomings or failures in the response. We will continue to highlight gaps in the global and regional monitoring systems of HIV and related health issues and to develop methods for validation.

2. Improve data transparency

Transparency is a key aspect of good governance and essential for accountability; without transparency there can be no accountability. In order to implement an effective response, governments need to know their epidemic and their response, and report regularly on data including how funds are spent. By shedding light on the current situation, actors that demand accountability, such as civil society, parliamentarians and media, can applaud progress or sanction for poor performance. Transparency is also necessary to sustain and scale up the financial support for the response to AIDS which is crucial in the wake of the financial crisis.

AAI is a strong advocate for greater transparency in the AIDS response. Government reporting to UNAIDS has increased significantly from 2008 to 2010, but persistent gaps in the reporting of comparable data continues to undermine the global effort. Our main target groups are intergovernmental bodies such as UNAIDS, OECD, SADC, AU and EU responsible for monitoring the response.

AAI aims to improve the level and quality of leadership that is invested in the AIDS response.

3. Inform discourse on accountability in the response to AIDS and beyond

Over the past decade, accountability has become a central concept in the global discourse of development, aid and not the least in the AIDS response. With a particular skill-base in political science, AAI is well-placed to contribute research analyses and advocacy arguments for what accountability means in the AIDS response and what it implies in terms of good governance. AAI will scale-up our contribution to the global discourse on accountability with analysis and information on existing accountability mechanisms relevant to AIDS and the global health field.

Part of this endeavor includes setting accountability on the global and regional health agenda, and to advocate for accountability to have more prominent position in existing conferences on AIDS and global health. Our main target groups are policy makers, donors and civil society organizations in our focus regions.

4.Empower advocacy stakeholders in the response to AIDS and beyond

Among the variety of stakeholders that are positioned to demand accountability, AAI focuses on civil society, parliamentarians, policy makers and media. While the commitment and involvement of some of these groups is high, we have identified a lack of evidence-based tools for accountability to support their actions. AAI works with selected partners within those groups in our geographical focus areas. By equipping key actors, holding necessary in-depth contextual experience, with our research material in terms of Scorecards and analyses we can catalyze the already ongoing advocacy efforts for universal access.

However, AAI has realized that even reasonable levels of transparency of data and the presentation of that data in accessible Scorecard formats are not sufficient to ensure accountability-based action from national or regional stakeholders. There is a need to build capacity on accountability-based advocacy as such: the meaning of the concept, how it is represented in current governance processes in various countries, and how advocates can use it more effectively to further the cause of a more effective response to AIDS and related health challenges.

Our main target groups include Development Team and Expert Panel members (see below), HIV/AIDS Accountability Forum with constituencies, European Parliamentary Forum on Population and Development (EPF) and SADC Parliamentary Forum global and regional civil society organizations such as World AIDS Campaign and the '50 by 15' prevention movement.

AAI's LGBT Scorecard objectives

AAI hopes that by identifying the gaps between promises made by governments in the UNGASS Declaration of Commitment and the transparency of reporting and coverage of response interventions on sexually diverse people, that the LGBT Scorecard will provide tools and an evidence-base for advocates for stronger leadership and more effective responses to the needs of sexually diverse individuals in the context of HIV and AIDS.

AAI also hopes to fulfill the following objectives with regard to sexually diverse people and their rights:

- Draw attention to lack of reporting and under-reporting by government on MSM and MSW indicators and demand government be accountable where applicable
- Create awareness of need for indicators on all sexually diverse people
- Demand better data quality on LGBT indicators to better inform response
- Highlight the lack of response in Prevention, Treatment, Care and Support for LGBTs
- Create an accessible, powerful, affective new evidence base for LGBT advocates and develop their capacity to open dialogue with other stakeholders on accountability
- Demand stronger leadership from all actors on LGBT issues
- Demand more effective policies, programs and services for sexually diverse people that include de-criminalization and more accountability on issues such as stigma and discrimination.

Improved M&E and increased dialogue around accountability are fundamental to an improved response.

LGBT Scorecard Methodology & Research Limitations

The Scorecard has been developed through a consultative process involving globally acknowledged experts from civil society, UN agencies, and research and public health institutions. It follows on from AAI's previous Scorecards, the AIDS Accountability Country Scorecard and the AIDS Accountability Scorecard on Women.

The LGBT Scorecard Elements

The AIDS Accountability LGBT Scorecard contains ten elements each of which evaluates a different aspect of government response to HIV for sexually diverse individuals.

These elements are:

Element	Data Source
Testing: Indicator 8	Country UNGASS reporting
Prevention: Indicator 9	Country UNGASS reporting
Knowledge: Indicator 14	Country UNGASS reporting
Behavior: Indicator 18 and 19	Country UNGASS reporting
Reporting: all 5 Indicators above	Country UNGASS reporting
Policy Environment	Country UNGASS reporting (NCPI)
Legal Environment	AAI Data Collection
Transgender and Intersex Element	AAI Data Collection
Homophobic Violence	AAI Data Collection
Impact	Country UNGASS reporting & AAI Data Collection

Elements marked 1-6 are based on data reported by countries in their submissions to the UNGASS reporting process by countries against the core indicators used for monitoring an effective national response, as laid out in the United Nations Declaration of Commitment on HIV/AIDS. Notable is that Elements 7, 8, 9 and 10 are based on other or additional sources independent of the UNAIDS reporting process.

Need to place greater emphasis on needs of LGBT people in response to HIV and AIDS

AAI Scorecard Grades

Based on the limitations of the data (discussed in detail below), AAI places countries in five broad 'grades', from A to E. The grade is based on the percentage reported by the country according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor).

Score	Grade
81-100%	A
61-80%	B
41-60%	C
21-40%	D
0-20%	E
No Data Submitted	ND
Substitute Indicator	SI

If a country has not reported on a particular element then the score will be marked as ND for No Data. Where countries have submitted substitute data in the Country Narrative Reports it has been marked as Substitute Indicator (SI) where relevant.

Data limitations

The UNGASS database represents the largest global data set on various aspects of country responses to HIV and AIDS. UNAIDS performs a verification and validation process thereby removing significant inaccuracies where possible. However, although data may not always fulfill reporting criteria, it remains the most useful global data available with standardized indicators for global and regional M&E comparisons. Yet, further below, this scorecard report will discuss reasons why this data does not allow for straight-forward comparison between countries or other more rigorous and detailed forms of analyses.

The first reason for skepticism surrounding data submitted by some countries is that governments submit the data directly to UNAIDS and may or may not include civil society stakeholders in the process. UNAIDS strongly encourages the meaningful participation of civil society in the reporting process and in many countries this has been the reality and thus contributed not only to better reporting, better data quality but positively impacted on relations between stakeholders leading to more effective and integrated partnerships beyond the reporting process.

However, in some countries civil society has found it necessary to submit shadow reports (see section above) as a means to contend government data submission. Furthermore, questions around data have been raised even by civil society stakeholders that have not, for a variety of reasons, submitted shadow reports. These reservations need to be noted when working with the data and carefully considered when using it for analysis.

The second limitation of the data refers to data quality. A variety of issues exist, including but not limited to:

- Sample size: Sample sizes of respondents vary and in some cases cannot be said to be robust.
- Geographic coverage: Some data reflects only urban statistics and not rural circumstances, for example.
- Income and class differences: Data collection methods may lead to data being skewed in terms of class and income if concerted efforts are not made to reflect the full spectrum.
- Data collection methods: Data that is collected in face to face interviews in government surveys may not reflect reality. For example, countries where same sex activities are illegal may not completely capture truly accurate data. Similarly online surveys cannot guarantee that individuals with homophobic ideals do not log on and attempt to influence data outcomes.

A third and important component of data reporting is that of whether countries consider it necessary to report on all indica-

Based on the limitations of the data, the scorecard places countries in five broad 'grades', from A to E

tors and how often they choose to do so. Bio-behavioral surveys are expensive and time-consuming and may not be the most appropriate use of limited government budgets in countries that are trying to roll out other parts of HIV prevention, treatment, care and support campaigns. For this reason AAI is aware that as we call for governments to improve reporting to UNGASS, we acknowledge that at country level leaders may not deem it a top priority. In providing national and global advocacy groups and other stakeholders with the scorecard analysis they are able to determine as experts in their field whether government decisions were well-based or indeed a sign of a lack of accountability.

A further limitation of the data is that the AAI Scorecard methodology reflects a measure of government performance based on one indicator in one reporting process. For this reason a country may receive a top score (A) on a particular indicator in the LGBT Scorecard yet at local level circumstances for LGBT people may be dire. This limitation of the work should be kept in mind when reading the element reports. The Scorecard methodology is a limited snap-shot assessment of a deep and complex issue. Thus it remains just one way to measure performance and that other issues, such as policy, criminalization etc in countries may differ either slightly or significantly from the grades viewed in each element and reported by countries.

For these and other reasons, some of the LGBT Scorecard Element Reports will focus on a particular limitation of the data. This is done with a view to creating and feeding into a dialogue around the UNGASS Reporting process.

Important methodological notes

Sometimes 100 percent coverage may indicate a methodological issue in the collection of the data. For example 100 percent coverage on testing: very often these high figures represent the percentage of men who attend a Voluntary Counseling and Testing clinic and who agree to be tested and receive their results rather than the real denominator which is supposed to be Number of most-at-risk population included in the sample of a Bio-Behavioral surveillance survey.

It is worth noting that some countries conflate MSM and MSW as well as MSW and FSW thus making it difficult to distinguish if male data presented is that applicable to MSM or MSW, note Algeria for example. In the Peru Country Report the authors discuss the inability of the data to separate out MSWs and MSM, hence the same figure was provided for both sub-groups. This is problematic for many reasons; however, AAI does not have resources to investigate data that has already been verified and validated by an agency with the resources such as UNAIDS has and thus decided to include this data.

In the 2010 round of reporting UNAIDS moved Mexico from the Latin American region to join Canada and the United States of America (USA) to be part of North America. The remaining Latin American countries were renamed central and Southern America.

For our purposes we have not moved Mexico as it is more useful to include them in Latin America for comparative purposes, considering the low reporting from the North American countries on the indicators studied by this research.

For the purposes of our research female sex workers and IDUs have been excluded. The rationale for this has been that although we acknowledge that some female sex workers may be having sex with women, and that some male sex workers have female clients, we have assumed that the majority of male sex workers have male clients and that the majority of female sex workers also have sex with male clients, thus have included only the male sex workers as sexually diverse.

We also acknowledge that in some research the correlation between injecting drug users and sex workers has been recognized as being fundamental to the epidemiology of HIV for LGBT individuals yet we have excluded it as a result of being unable to ascertain sexual behavior from drug behavior and that country to country variations are too large and complex to factor in.

The UNAIDS dataset remains the most useful global data on HIV available due to its standardized indicators.

The AAI Collaborative Research Process

All AAI research and Scorecards are created in a consultative process with experts from various applicable fields. AAI is determined to conduct needs based research that produces effective and useful advocacy tools and in doing so consults with a wide variety of experts in order to achieve this goal. In the development of our ratings and communication initiatives, AAI relies on the active participation of a broad group of stakeholders with extensive experience and different types of expertise.

In assembling our Panels and Forum we make sure that the knowledge and experience of people in the global South, and especially of women, is given prominent representation. This process takes place with three groups of experts each with specific roles:

1. AIDS Accountability Expert Panel: a multi-stakeholder group of about 100 invited experts with whom we regularly consult in our research process to review AAI's ratings. The Expert Panel continues to play an important role in both the research and output processes.

2. Development Teams: rating-specific teams of some 6-10 people who develop Scorecards.

3. Group of 9: a small group of experts that reviews ratings at a late stage in the process to make recommendations to AAI regarding the launch of the tool.

The Development Team for the AIDS Accountability LGBT Scorecard:

Name	Position, Organization
George Ayala	Executive Officer, Global Forum on MSM and HIV
Tim Barnett	Global Programme Manager, World AIDS Campaign
Richard Burzynski	Senior Advisor, Universal Access Partnerships, UNAIDS
Dawn Cavanagh	Executive Committee Member, Coalition of African Lesbians
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The AAI scorecard methodology provides a snapshot view of data submitted by governments.

Endnotes / References

Endnotes

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Consultation with experts globally leads to and informs AAI’s needs driven research.

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