

The **AIDS** Accountability Scorecard on LGBT **2011**



Element 1: An analysis of global data on HIV testing for Lesbian, Gay, Bisexual and Transgender people

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.

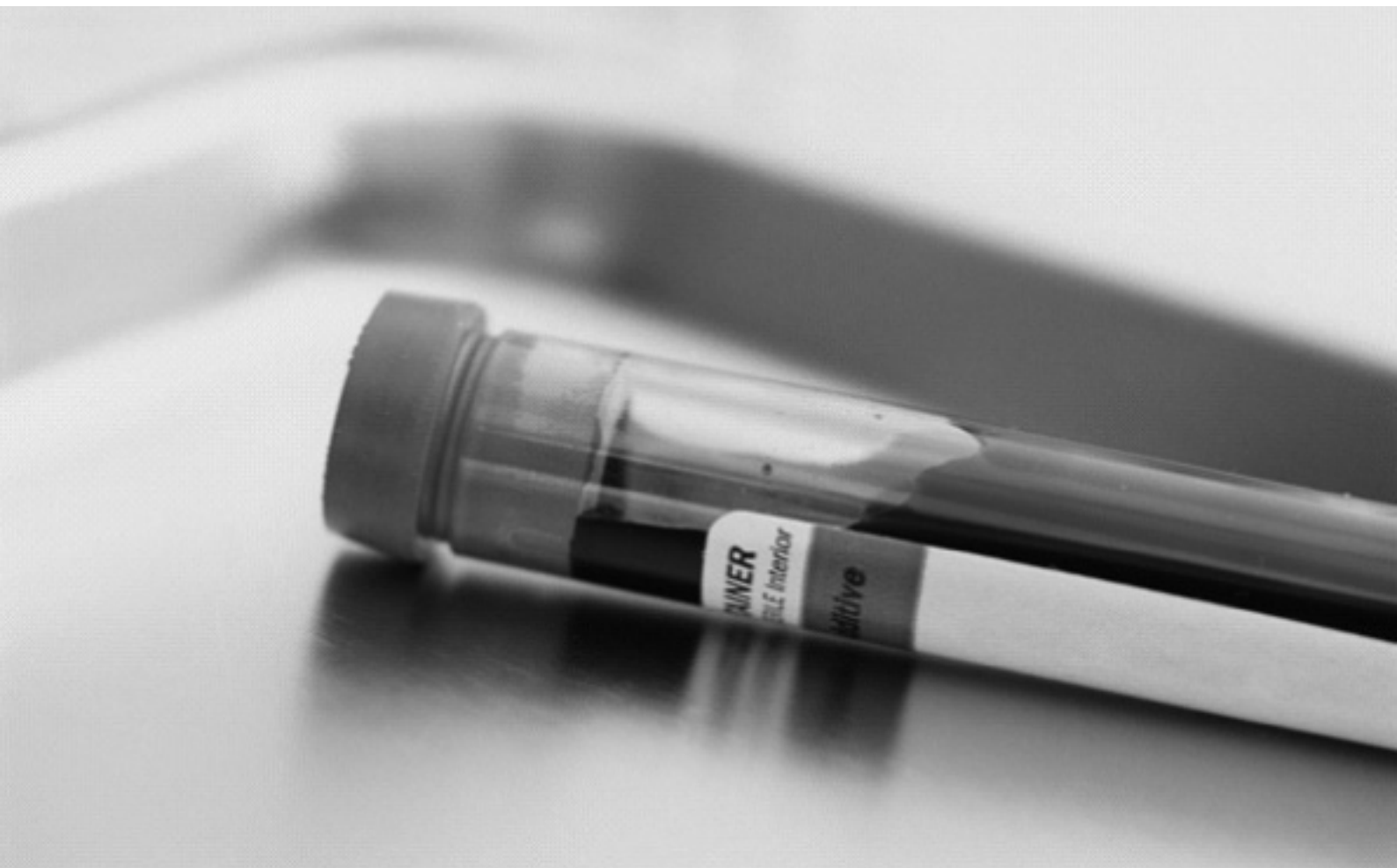
In Loving Memory

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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Acknowledgments

The completion of this report would not have been possible without the contributions of many people, most importantly being the members of the Development Team:

George Ayala (Global Forum on MSM and HIV), Tim Barnett (World AIDS Campaign), Richard Burzynski (UNAIDS), Dawn Cavanagh (Coalition of African Lesbians), Chris Collins (The Foundation for AIDS Research), Pieter Fourie (Macquarie University/AIDS Foundation), Susana Fried (UNDP), Marco Gomes (Centre for Health Policy and Innovation), Robert Hamblin (Gender Dynamix), Lee Nah Hsu (Simon Fraser University), Chris-toforos Mallouris (Global Network of People Living with HIV), Joel Gustave Nana (African Men for Sexual Health and Rights), Alessandra Nilo (GESTOS), Jirair Ratevosian (The Foundation for AIDS Research), Cynthia Rothschild (Center for Women's Global Leadership), Per Strand (AIDS Accountability International) and Vicci Tallis (Open Society Initiative for Southern Africa).

Thank you all for your invaluable input and commitment to this project. The general findings and arguments presented in this report reflect the input of members of the Development Team, but more specific formulations and conclusions are those of AAI alone and cannot be ascribed to any particular member of the Development Team.

Members of the AAI Expert Panel also played a role in sending comments and feedback for which we are grateful. AAI would like to thank everyone who assisted in this effort. As always, any errors or omissions in this document are those of AAI.

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

AMFAR
The American Foundation for AIDS Research

ASAP
AIDS Society of Asia and the Pacific

CBO
Community based organization

CSO
Civil society organization

DHS
Demographic and Health Survey

FHI
Family Health International

FSW
Female sex worker

GHESKIO
Groupe Haitien d'Etude du Darcome de Kaposi et des Infection Opportunistes

HIV
Human Immunodeficiency Virus

HCT
HIV counseling and testing

HSRC
Human Sciences Research Council

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 worker

NCPI
National Composite Policy Index

ND
No data

NGO
Non-Governmental Organization

OSISA
Open Society Initiative for Southern Africa

PAMAC
Programme d'Appui au Monde Associatif et Communautaire

SMS
Short message service

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

VCT
Voluntary counseling and testing

WSW
Women who have sex with women

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.

The element covered in this first report is HIV testing. The LGBT Scorecard Framework Report is launched simultaneously with this first element to provide more information on methodological and analytical issues.ⁱ 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 testing. 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."ⁱⁱ

ⁱ Homophobic rape places WSW at increased risk of HIV infection. Transgender individuals have very specific health needs but still face barriers in accessing healthcare.

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 interchangeably. 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 2001 Declaration did not set any precise targets for HIV testing but stated the need for testing and committed governments to ensure that access to confidential and voluntary testing and counseling must be expanded. The provision of HIV testing 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 8: HIV Testing

For the individual, HIV counseling and testing (HCT) is the natural point of entry to the health sector and thus it provides an important opportunity to engage key populations in a constructive, respectful and sensitive way. This is particularly important for LGBT people as it would signal an AIDS response that is free from the discrimination that otherwise permeates society. Unfortunately, the opportunity is often wasted.

Without high quality data on comprehensive HIV testing there is no way a country can claim to 'know its epidemic'. Testing is essential for tracking dynamic trends in HIV incidence in order to implement timely and targeted prevention interventions. And without good data there is no basis for calculating current and future demand for antiretroviral treatment and care and support services.

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 8: Respondents are supposed to be asked the following questions:

1. Have you been tested for HIV in the last 12 months?

If yes:

2. I don't want to know the results, but did you receive the results of that test?

UNAIDS acknowledges that it may be difficult to collect this data on the basis of a sample of MSM that is representative of all MSM in a country. For this reason, countries are asked to provide qualitative information on any concerns with bias in the sample. UNAIDS asks countries to collect this data annually. This concern with sampling will be discussed further below in this report.

The purpose of the indicator is to measure progress amongst most-at-risk populations in terms of HIV testing and counseling. 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 countries with generalised epidemics should also 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 re-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 8 this report will highlight any relevant information on testing for same-sex people that countries included in the narrative reports.

Going beyond the quantitative indicator, we have also included an analysis of country narrative

MSM have been under-recognized, under-studied, under-funded, and under-served in the global response. Sexual diversity is a term that refers to a full range of sexuality.

reports in which countries are encouraged to discuss additional data and issues with particular relevance for their epidemic and response to HIV/AIDS. The analysis captures instances where countries discussed issues relating to HIV testing for LGBT people.

The LGBT Scorecard Framework Report discusses some methodological and other concerns with this data. 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.

This first element assesses country performance in terms of the reported coverage of HIV testing. A later scorecard element will assess performance in terms of the completeness of reporting on all the indicators and questions in the UNGASS M&E framework that are relevant for LGBT people. Countries that are not included in this report did not submit the relevant data for this element.



We will see a better response on AIDS if people in leadership positions know they will be held account-able.
HIV counseling and testing (HCT) is the natural point of entry to the health sector.
Only MSM are covered in the UNGASS set of core indicators.

Scorecard analysis

Women who have sex with women, bisexual and lesbian women

Women are highly vulnerable to HIV infection due to a combination of physiological and societal factors. The gender-based discrimination and unequal power relations that deny women the power to negotiate safe sex is one of the greatest barriers to managing the HIV epidemics in most countries. Women who have sex with women (WSW), lesbian and bisexual women face additional discrimination due to their sexual orientation, and they are vulnerable to the violence of homophobic rape and the related increased risk of contracting HIV.

However, the belief that sex between women carries a low risk 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. Yet their vulnerability shows otherwise.

Due to the lack of indicators that capture WSW, a content analysis for the terms WSW, lesbian and testing was done of the country narrative reports, excluding National Composite Policy Index reports. Out of all country narrative reports, the one and only reference to HIV testing for WSW was made in the

Brazilian report, which includes a description of testing among lesbian women and other LGBT groups during Figue Sabendo's mobilization activities at the LGBT Pride Parades.

The lack of information on testing amongst WSW is testimony to the widespread neglect of this group of individuals and requires urgent attention on an international scale.

Research conducted on WSW, bisexual women and lesbian women and their experience of access to HIV testing is rare and often only available from countries in the global North. This research seldom allows for more general conclusions as it is based on small samples in urban settings. Governments need to invest in better data collection on sexual orientation at testing sites in order to "know their epidemic" and what is required to implement policy, programming and implementation to improve them for all people in the country.

However, this being said, in many countries stigma and discrimination play such a huge role in preventing WSW from accessing their health rights, that governments would have to ensure that WSW would be free to provide accurate information on their sexual orientation without fear of reprisal, both during consultation with the healthcare worker and afterwards in the community.

Currently there is no data on the vulnerability and testing of post-op transgender women who have sex with cis-gendered women (women whose gender identity matches their sex at birth, unlike transgender people). These women are particularly vulnerable as they face several dimensions of discrimination, including from other WSW.

Case Study South Africa

Research currently being conducted by Open Society Initiative for Southern Africa (OSISA) and Human Sciences Research Council (HSRC) on lesbian and bisexual women in seven sites and four countries in Southern Africa, includes data on testing behavior and will be available later in 2011. This is a welcome example of very necessary work.

Transgender Men and Woman

Stigma and discrimination act as a barrier for transgender men and women to accessing HIV counseling and testing. Moreover, inadequate training by health care providers, post-transsexual identity and the desire to live a stealth existence, financial constraints, and the inability to access legal documentation all collude in denying transgender women and men equal access to and full usage of healthcare facilities including HIV testing facilities. This following section seeks to investigate the performance of governments with regard to access to HIV testing for transgender people. Stakeholders that have been consulted for this scorecard analysis have emphasized the point that transgender women are often invisible in HIV-related statistics as they tend to get lumped together with MSM – a problem that is highlighted and discussed in Peru’s country narrative report. This adversely affects the accuracy and relevance of statistics on both transgender and MSM.

A content analysis was done of the Country Narrative reports, similarly as for WSW above. Coverage of transgender issues is sparse yet the following countries have begun to include transgender issues and in some cases plan and implement effective strategies. Country narrative reports from seven countries – Uruguay, Argentina, Bangladesh, Papua New Guinea, Brazil, Mauritius and Thailand – contained information and discussions on transgender men and women in relation to HIV testing.

- Uruguay in 2008 reported that in the following year data on HCT would be available for transgender men and women.ⁱⁱⁱ
- Argentina reports that the country has not sufficiently

developed HIV prevention policy, including HCT for vulnerable groups including transgender people.^{iv}

- Bangladesh, in 2008, reported coverage for transgender people. In the <25 years cohort the indicator value was 11.8 (n=93), 25+ years was 15.9% (n=333) and so all ages was 15% (n=426).^v
- Brazil, in their 2010 report, includes a description of testing which was promoted among gays, lesbians, transvestites, transsexuals and transgender people.^{vi}
- In the 2010 report, Mauritius the AIDS Unit and the Ministry of Health and Quality of Life have been working on raising awareness, HCT and condom distribution.^{vii}
- In 2010, Thailand reported: “Regarding blood tests for HIV and knowledge of one’s serostatus, the survey in Phuket, Chiang Mai and Bangkok found that only 21.7% of MSM and 20.8% of transgenders said they had been tested for HIV and received the results in the past 12 months.”^{viii}
- Papua New Guinea also included a count of testing coverage reporting that in “the 12 month period from October 2008 to September 2009, 149 MSM, transgender and male sex workers received counseling and testing from FHI supported projects in NCD*.”^{ix}

A further five countries – Peru, Dominican Republic, Venezuela, Malaysia and Indonesia – all discussed transgender issues in their narrative reports, albeit not relating to HIV testing. The efforts by these 12 countries to focus the AIDS response partly on this marginalized group of men and women, and to share

these experiences through their reporting on the global M&E framework, must be recognized and applauded.

Case Study Pakistan

In Pakistan “although the precise number of men who have sex with men (MSM) in Lahore is unknown, according to the Pakistan National AIDS Programme, on the basis of findings by international agencies in 2002, they number around 38,000. This number includes male transsexuals or ‘hijras’, who live in large family groups and have devised their own, unique system of leadership, inter-marriage and complex rituals, and a significant number of masseurs... who can be found in many parts of Lahore and other major cities.”^x Pakistan reported testing data for Hijra’s in 2010, with a value of 4.1%, up from 1.1 in 2005. That this country is aware of this group and actively including them as their research and reporting is a welcome example of best practice globally. Indeed the figures are above those of IDUs and rickshaw pullers, perhaps demonstrating effective prevention strategies aimed at Hijras.^{xi} In an interview with Zahid Hussein, President at AIDS Society of Asia and the Pacific (ASAP), Bangkok, it becomes obvious that the fact that such behavior is illegal does not necessarily make it unacceptable. There may be taboos around talking about sex yet homosexuality is fairly widespread.^{xii} However, this stigma results in a low level of awareness about safe sex practices amongst male sex workers. “The social marginalization of communities such as the hijras and the fact that few male sex workers have access to healthcare or contact with awareness-raising programmes, makes them all the more vulnerable.”^{xiii}

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 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.

The UNGASS database represents the largest global data set on various aspects of country responses to HIV and AIDS and there have been many analyses of the dataset, from Philippe C.G, et al. in "Estimating Levels of HIV Testing, HIV Prevention Coverage, HIV Knowledge, and Condom Use Among Men Who Have Sex With Men (MSM) in Low-Income and Middle Income Countries" to the AmFAR report "MSM, HIV and the Road to Universal Access – How far have we come?". These two reports present two very different methods of analysis. The former is an example of statistical

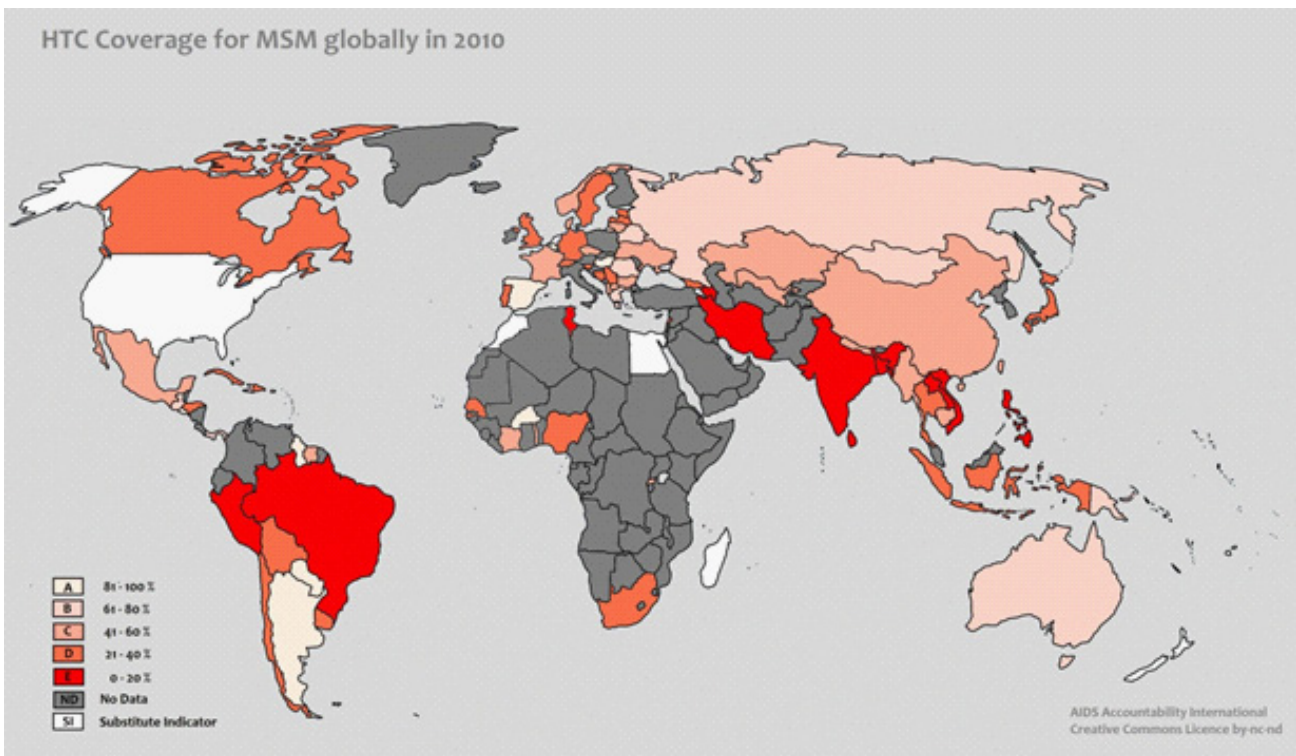
analyses which is based on inclusions of country data based on such criteria as a author-selected sample size and general accordance with guidelines. The analysis is then based on various assumptions, albeit valid ones, and reaches accurate mathematical conclusions, however for many advocacy people it is complex and requires a certain experience in statistics. The second paper analyses the data with almost no discussion of the limitations of the data yet uses significant secondary sources and contextual analysis to expand on the data. Both are useful research papers that each provides tools to a particular audience.

However, significantly, the AAI Scorecard approach is different in that we attempt to walk a middle ground. Because it is fair to say that although the data may not always reflect the realities experienced on the ground, or even be statistically robust at times, it remains the most useful global data available due to its standardized indicators for global and regional M&E. We therefore use the data by placing countries in general grades and yet also draw attention to the limitations of the data so that attention can be brought to a need for improved data quality. Further below, this scorecard report will discuss one of the reasons why this data does not allow for straight-forward comparison between countries however in our grading section we do propose two grounds for assessing country performance on HIV testing for MSM and MSW: the reported coverage of HTC, and, secondly, the size of the sample used for generating the coverage data.

Scorecard grading on reported HTC coverage

The following section seeks to analyze country performance in terms of HTC coverage for MSM 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 grade is based on the percentage of MSM who took an HIV test in the last 12 months and who know the result, 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.

	E	ND
D	ND	ND
D	D	E
ND	C	ND
E	B	C
C	E	D
ND	ND	ND
A	ND	ND
ND	ND	ND
ND	E	E



Map 1: Global map of HTC coverage for MSM in 2010.

Thus the following table captures the grades achieved by governments with regards to HIV testing for MSM as per their own reported statistics in 2010.

An additional set of eight countries reported some information on MSM who had taken an HIV test and who knew the result. However, since this data was reported only in the country narrative report and did not meet one or more of UNAIDS' methodological requirements for the indicator, they have not been included above.

The first very important point to make when interpreting the grades accorded to countries is to say, unreservedly, that all of the countries in the table are to be commended for reporting any data at all on this indicator. Simply by having some M&E of the epidemic among MSM, and by reporting the data through the UNGASS process, these countries represent good practice – most countries did not report at all. (Research evaluating the reporting of countries will be available later in 2011.)

Bearing in mind the limitations included in the following section, it is interesting to note the generally low performance.

An overview of all country grades can be found at the end of this paper.



Eighty-one countries reported data on testing for MSM in 2010.

A		B		C		D		E	
Burkina Faso	100	Belarus	80	Kazakhstan	60	Sweden	39	Brazil	19
Hungary	100	Greece	78	Suriname	59	Bolivia	35	Vietnam	19
Paraguay	100	Mongolia	78	Cambodia	58	Senegal	34	Tunisia	18
Saint Lucia	100	Panama	76	Côte d'Ivoire	57	Canada	34	India	17
Guyana	87	Romania	75	Norway	56	Indonesia	34	Lao PDR	14
Spain	87	Haiti	71	FYRO Macedonia	56	Dom. Republic	33	Sri Lanka	14
Belgium	86	Papua NG	67	Denmark	55	Slovenia	33	Azerbaijan	13
El Salvador	85	Guatemala	64	Jamaica	53	Cuba	32	Iran	11
Argentina	85	Australia	61	Togo	53	Japan	32	Maldives	10
		Russian Fed.	61	Bahamas	50	Switzerland	31	Philippines	7
		Costa Rica	61	Mexico	50	Serbia	31	Peru	6
				Myanmar	48	UK	31	Bangladesh	3
				Rwanda	47	Nigeria	30		
				Albania	45	Lebanon	30		
				China	45	Honduras	29		
				France	44	South Africa	27		
				Uzbekistan	44	Estonia	27		
				Singapore	43	Portugal	27		
				Ukraine	43	Uruguay	26		
				Czech Republic	43	Latvia	26		
				Nepal	42	Timor Leste	26		
				Bulgaria	42	Bosnia & Herz.	26		
				Lithuania	41	Chile	25		
						Georgia	24		
						Germany	23		
						Thailand	21		

Table 1: Grades of the 81 countries that reported data on Indicator 8 for MSM in 2010.

Factors to consider with data on HTC coverage

The most relevant political commitment against which to compare country performance on HIV testing coverage is the commitment to ensure Universal Access to prevention, of which HIV testing is a key component. We need to note, however, that UNGASS indicator 8 is not a perfect measurement of such access. Even if a country ensures full access, i.e. that MSM have ample opportunities to take HIV tests in an environment free from discrimination, MSM may choose not to do so for a number of reasons. For example, if an individual knows that he is HIV positive or is practicing abstinence or safe sex, there is no need for taking up HCT on an annual basis. In the context of a country that can provide sufficient supply of HIV testing opportunities, the indicator rather captures the demand

for HIV testing among MSM. This may lead to misplaced criticism, as governments, arguably, can only be held directly accountable for failing to provide a sufficient supply of testing facilities. Obviously, government has responsibility for prevention campaigns that inform the public and any vulnerable groups of the need for HIV testing. The coverage of such prevention campaigns will be the focus of a forthcoming element of the AIDS Accountability LGBT Scorecard.

The data for indicator 8 should, ideally, be collected in a way that ensures that the coverage percentage is representative of MSM throughout the country, but this is seldom the case. For instance, Brazil states very clearly in its country report that the data reflects HIV testing by MSM in ten cities and that it is not representative of the whole country. On this score, Brazil is exemplary; few other countries are equally transparent. The

methodology that countries use to select the individual MSM who are asked about HIV testing varies greatly, as does the number of MSM who are included in the survey – the smallest sample number was 40 (Saint Lucia) and the largest 19 042 (France).

Further, the number of MSM who were included in the analysis may reflect M&E ambition rather than population size. For example, India, with a population 181 times larger than that of Togo, had sampled fewer MSM (524 in India and 630 in Togo). It is also interesting to note that very large surveys showed that relatively few MSM had tested. The 10 countries that based their analysis on extensive surveys of more than 2000 MSM recorded at the most 61 percent of coverage, with an average percentage of only 33 percent. In sharp contrast, the 7 countries that claim more than 80 percent testing had surveyed on average only 413 MSM.

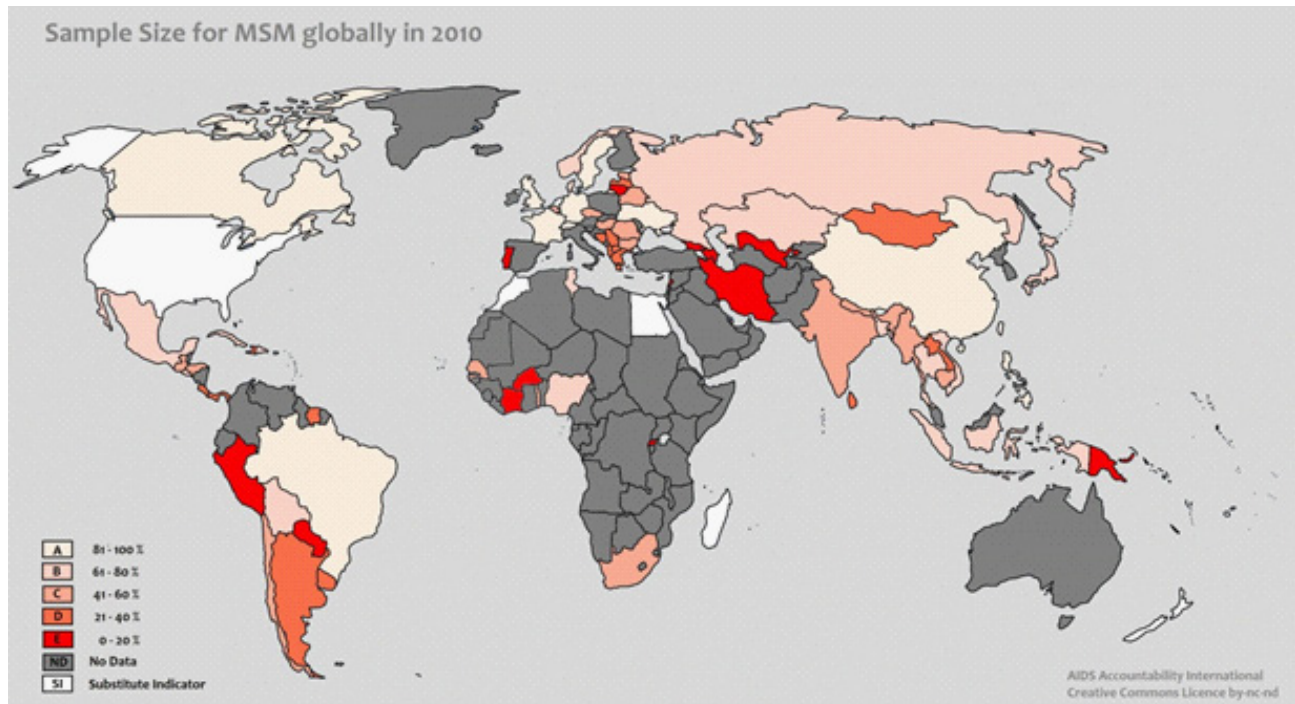
Additionally one would expect HIV testing figures to reach an optimal point and then to drop off marginally with behavior change such as increased condom use. These figures require closer examination by in-country advocacy groups who might find that the coverage their govern-

ment claims does not represent their lived experience.

Some of these methodological points are discussed further in the Framework Report linked to this scorecard. Suffice it to say here that such concerns make it clear why the reported data on

coverage, in and of itself, is not a good enough basis for reaching any final conclusions about the quality of country performance on HTC among MSM. The alternative approach we present in the next section should be understood as a complement to analyzing HTC coverage.

Scorecard grading by sample size



Map 2: Global map of Sample Sizes for MSM in 2010.

For the reasons stated above we propose that sample size is an alternative and complementary way to assess the effort by countries on this aspect of the AIDS response. No doubt, this method is also not perfect and some of its drawbacks will be discussed below. The assessment nevertheless provides information that is relevant for stake-holders to have in order to assess country performance in a comprehensive and relevant fashion.

Note: Data from 2010 round of UNGASS reporting as provided by UNAIDS. The sample sizes used by countries fall within the range detailed in the parentheses for each grade.

Country performance in this regard is graded in the same way as in table 1 above, but based on the rationale that a larger sample gets a better grade. Since no country applies nationally representative

random sampling of MSM – in which case a relatively small sample would suffice to generate representative data – a larger sample is more likely to better reflect the true coverage of HTC among MSM. For our purposes here we will refer to sample size as a proxy indicator of country effort to generate the best possible data.^{xiv}

Eight-one countries reported data on testing for MSM in 2010.

A		B		C		D		E	
(>2000)		(801 – 2000)		(351 – 800)		(151 – 350)		(< 150)	
France	19042	Singapore	1891	Cambodia	729	Costa Rica	311	Papua NG	149
UK	11987	Viet Nam	1578	Belgium	658	Uruguay	309	Georgia	136
Germany	8170	Dominican Rep.	1565	Togo	630	Argentina	307	Maldives	126
China	6319	Thailand	1500	Guatemala	598	Sri Lanka	302	Bahamas	121
Canada	4838	Japan	1463	Honduras	589	Lao PDR	300	Lebanon	120
Philippines	4367	Indonesia	1448	Myanmar	550	Panama	285	Uzbekistan	118
Sweden	3826	Norway	1418	India	524	Latvia	250	Paraguay	115
Brazil	3617	Denmark	1310	Senegal	501	Suriname	250	Azerbaijan	100
Switzerland	2929	Tunisia	1178	Chile	471	Haiti	248	Co'te d'Ivoire	93
Ukraine	2300	Bolivia	1019	Bulgaria	452	Serbia	246	Rwanda	88
		Cuba	1001	South Africa	412	Greece	234	Burkina Faso	87
		Russian Fed.	970	Belarus	407	Bosnia & Herz.	224	Iran	83
		Kazakhstan	880	Nepal	400	Jamaica	201	Portugal	79
		Nigeria	879	Romania	398	Albania	198	Peru	49
		Bangladesh	843	Hungary	388	FYRO Macedonia	195	Lithuania	46
		Mexico	833	Czech Rep.	387	Mongolia	192	Saint Lucia	40
		El Salvador	824	Estonia	361				

Table 2. Scorecard grades based on number of MSM surveyed

Factors to consider with data on sample size

We will highlight four points that should be considered in relation to the table above. The first is that the level of effort by government in this regard is not determined by sample size alone. A relatively small survey that was carried out in a respectful way among MSM living in a society defined by homophobia can well be said to reflect a greater effort in a political sense. With the exception of the Philippines and Ukraine, and to some extent Brazil, all countries that achieved the highest grade are high-income countries with an established liberal tradition that includes sexual diversity. A greater political effort can probably be found in countries with the grades A or B that have less resources and considerable social stigma towards MSM.

The second important point is that in many cases the achievement of a high sample is not due to efforts by the government alone. The country narrative reports give several examples of how surveys were conducted with only partial or even minimal direct government effort. A related point is that, in countries with close to complete internet coverage, internet-based surveys can easily attract several thousand MSM with no additional effort from government. Eight countries, all of them in Western and Central Europe, used the internet to recruit respondents for self-administered questionnaires. This methodology generated high return at a low cost and with little effort.

Thirdly, the cut-off points for the grading in the table above have no methodological basis but were set to generate a reasonably even distribution of

countries across the five grades. The grading should therefore be seen as a more or less impressionistic attempt at generating a basis for a politically relevant comparison of country effort for the purposes of a more informed discussion among stakeholders.

Finally, it is important to reflect on countries whose reported data seems 'too good to be true'. Burkina Faso, Hungary, Paraguay and Saint Lucia all reported 100% coverage based on samples no larger than 388 (Hungary) and as small as 40 MSM (Saint Lucia). It stands to reason that this may reflect data collection errors, or that the samples may be biased.

Indicator 8 is not a perfect measurement of access to HCT.

HTC Coverage and Sample size combined

As discussed above the two methods of measuring country performance with regard to HTC coverage for MSM have both strengths and limitations. We have pointed out above why the reliance of only one of these methods can be problematic and why it may not accurately reflect the experience of MSM in the country or fairly reflect the level of government effort. However, when viewed together it becomes apparent that some countries perform well on both methods. Australia and El Salvador are the only two countries that achieve high grades (an A or a B) on both methods. Australia gets an A for sample size and a B for HTC coverage. El Salvador gets an A for HTC coverage and a B for sample size. This would suggest that the two countries have policies and systems in place that can inform other countries' on how to improve their performance in terms of HTC for MSM.

Case Studies Australia:

In 2008, Australia did not have data that was consistent with the UNGASS indicator guidelines yet still included significant information on coverage of testing in their Country Narrative Report. This may be interpreted as an indication that Australian leaders acknowledged the relevance and importance of the indicator in 2008. In 2010 Australia submitted data which is fully in line with the guidelines.

In late 2008, the Australian Federation of AIDS Organizations campaign and Victorian AIDS Council/Gay Men's Health Centre began an SMS (short message service) reminder program at a large Australian sexual health clinic.^{xv} Text messages are sent to people who have been for testing, or who subscribe for the reminder service online, every three to six months. Testing rates were twice as high among the men who received the text message reminder service than for those who did not. "The investigators believe that the text reminder service has a number of attractive features: "it allowed large numbers of messages to be sent simultaneously and automatically, reminders were direct, immediate and cheap to send and demanded minimal labor."^{xvi}

El Salvador

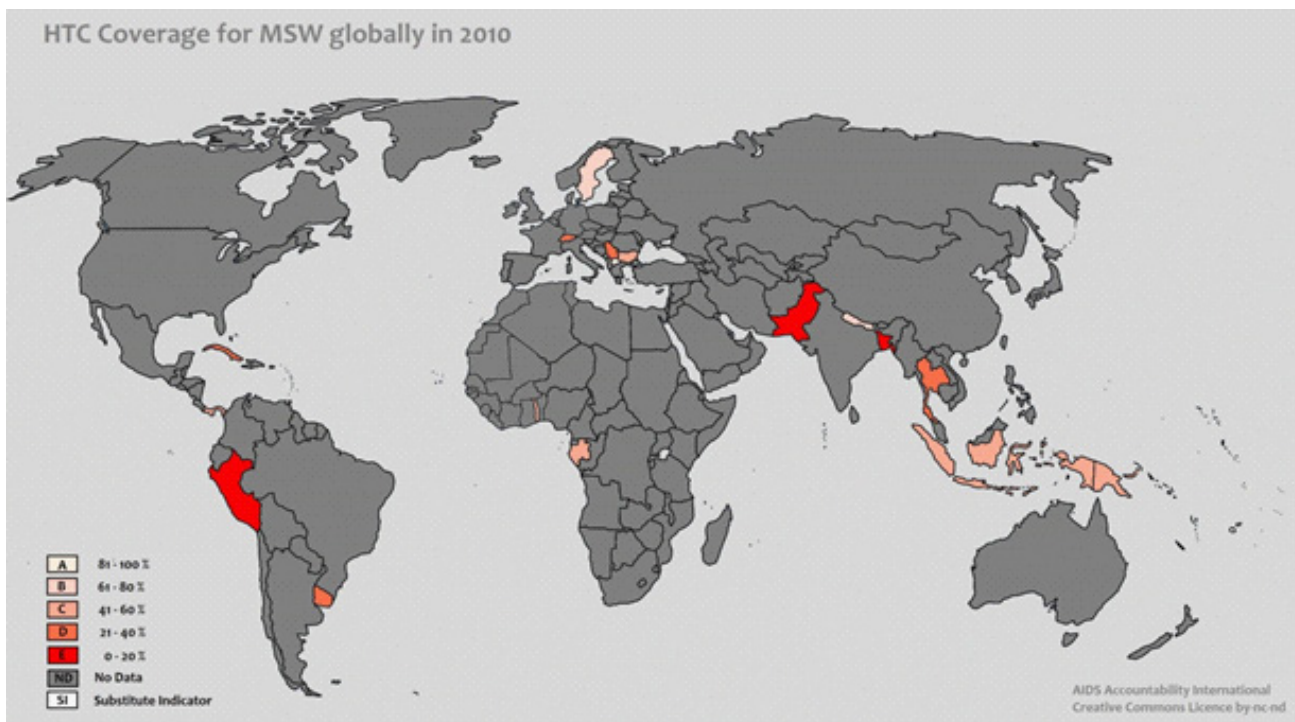
El Salvador has the second-largest number of people living with HIV/AIDS (PLWHA) in Central America^{xvii} and the highest seroprevalence amongst MSM in the region at 15%.^{xviii} Economic migrancy and stigma and discrimination around HIV play a large role in deterring people from getting tested.

Strategies relevant to testing in El Salvador include: In 2006, El Salvador introduced legislation which forbade HIV testing for job applicants to reduce discriminatory hiring practices against PLWHA. The country also introduced a 2005–2010 National Monitoring and Evaluation Plan and System in 2007 which includes the creation of a subcommittee which tracks the UNAIDS HIV indicators. Free HCT began as early as 1997 and free antiretroviral therapy (ART) in 2002 and in 2007, El Salvador declared June 27 as National HIV Testing Day. "The campaign resulted in 54,461 tests, which exceeded the target of 40,000 tests."^{xix}



Combining coverage and sample size may be a more accurate reflection of government response.

Male Sex Workers



Map 3: Global map of HCT Coverage for MSW in 2010.

Male sex workers remain one of the most difficult groups of MARPs to access for re-search purposes, yet some countries, for example Pakistan, are setting the example of what can be done to better understand these individuals behavior and thus needs in order to better plan and implement policy, programming and implementation to reduce risk.

Bearing in mind earlier constraints of data limitations, when we evaluate the data re-ported by countries on testing for MSW to UNGASS we discover that Macedonia (87%), Sweden (70%) and Nepal (65%) are the top three performers globally. Coverage is

considerable, and demonstrates the possibilities when leadership is committed to MSW issues with regard to rolling out HCT.

A comparison of data for MSW on indicator 8 from the 2008 and 2010 rounds of UN-GASS reporting shows that two African countries have improved their statistics more than any other countries globally. Togo figures for testing of MSWs have improved more than any other country, almost doubling testing for MSWs from 22 to 43 percent, and following closely as top performer is Gabon with a dramatic increase from 33 to 52 percent. Nepal also demonstrates a significant increase from 52

to 65 percent. Whether these increases can be attributed to an improved performance or rather reflects a change in data collection methods, sample size, geographic coverage etc, cannot be determined by this analysis. We highlight these improvements as they may signal a greater effort that can set examples for other countries to follow. AAI calls on civil society and researchers to explore these cases further and to insist that their respective governments and the relevant global agencies put much greater effort in monitoring the epidemic in this vulnerable group and to ensure access to prevention, treatment and care and support services.

Sample size may be an alternative and complementary way of measuring country responses.

A		B		C		D		E	
FYRO Macedonia	87	Sweden	70	Bulgaria	60	Switzerland	38	Pakistan	13
		Nepal	65	Panama	59	Thailand	35	Peru	6
				Indonesia	57	Serbia	35	Bangladesh	4
				Gabon	52	Cuba	35		
				Papua NG	47	Uruguay	26		
				Togo	43				

Table 3: Grades of the 17 countries that reported percentage data on Indicator 8 for MSW in 2010.

Of great interest and significance are the five new countries which have begun reporting on testing MSWs in the 2010 round: Bulgaria (60%), Papua New Guinea (47%), Serbia (35%), Uruguay (26%) and Peru (6%). It is to be noted that not only have

these countries begun reporting on this indicator but have apparently already made inroads into the actual testing. These may be the countries and leadership to watch in the future, both to monitor their performance on coverage but to closely examine

new best practices for countries just beginning to work in this area, always bearing in mind the constraints mentioned above of simplistically interpreting this data.



Seventeen countries reported data on testing for MSW in 2010.

Conclusions and Recommendation

Conclusions

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

- **Low-level response on Indicator 8 for MSM and MSW:** To date there has been an in-sufficient response to indicator 8 globally. Far too many countries have failed to report data on the existing MSM and MSW indicator for testing.

- **Inadequate attention to quality of data for indicator 8:** Those countries that do report data on MSM and MSW testing uptake need to upscale data collection methods, sample sizes, geographic coverage and various other methodological issues to be able to effectively use the data that is reported.

- **There is a lack of lack of indicators in global M&E that apply to WSW & transgender people:** The lack of information on testing amongst WSW and transgender men and women reflects the widespread neglect of this group of individuals. This situation is unacceptable and it demands attention by stakeholders that have decisive influence over the response to HIV and AIDS at national and global levels.

- **Widespread and acute stigma and discrimination create barriers to uptake of testing for LGBTs:** Both UNGASS data and anecdotal evidence, combined with high sero-prevalence rates indicate a need for governments to remove legal, social and other barriers to LGBT people in accessing testing.

Recommendations

- There needs to be an increased demand from civil society, multi and bilateral agencies, funders and government representatives for LGBT inclusion in all aspects of HCT planning and implementation, including but not limited to: formulating indicators for reporting on international commitments, financial resources and related capacity building to complete this data collection and analysis, the creation of LGBT-safe societies so that fear of reprisal does not limit access to full and accurate data collection.

- LGBT people need to be given representation in government AIDS committees to provide capacity building of non-LGBT stakeholders. This would include sharing global and regional best practice examples with decision makers, advising on country-specific barriers to improving coverage, and ensuring that an LGBT lens is used in all aspects of universal access, not only HCT.

- There is a need for both epidemiological and human rights approaches to LGBT with regard to M&E on testing: All leaders, governmental, funders and civil society, need to acknowledge and actively support the M&E improvements which record the impact of LGBT behavior on the HIV epidemic. There needs to be improved awareness of the impact of sub-epidemic impact on generalized epidemics and the removal of the criminalization of same-sex relationships needs to be prioritized.

More focus needs to be placed on LGBT people in the HIV response.

Key questions for advocates to ask their government

- Which LGBT stakeholders were consulted in the formulation of the National Strategic Plan as it relates to ensuring access to HIV counseling and testing?

- Why has our country not reported on testing for LGBT people to UNAIDS?

- If my country does not report on UNGASS indicator 8, which national M&E efforts are in place that capture the coverage of HIV counseling and testing for LGBT people? How can we access that data?

- Does government data on HIV testing reflect the experiences of LGBT representatives in the country? If not, why?

- Has government adequately created sufficient awareness of the need for testing for LGBT people and made the uptake of this testing easily accessible?

- Which guidelines does the government use to ensure that HIV testing is accessible to LGBT people and of an adequate quality?

- Do laws or policies exist which create barriers to LGBT in accessing testing? What is government doing to change this?

- What steps is government taking to improve data quality on testing uptake by LGBT?

- What is government's standpoint on demanding the creation of indicators relevant to WSW and transgender people in the UNGASS reporting process? What active steps are being taken to ensure the inclusion of this in future M&E rounds?

Country	HCT Coverage			
	MSM	MSW	MSM	MSW
	2008	2008	2010	2010
Caribbean				
Antigua & Barbuda	ND	ND	ND	ND
Bahamas	B	ND	C	ND
Barbados	ND	ND	SI	ND
Cuba	D	D	D	D
Dominica	ND	ND	ND	ND
Dominican Republic	ND	ND	D	ND
Grenada	ND	ND	ND	ND
Haiti	C	ND	B	ND
Jamaica	ND	ND	C	ND
Saint Kitts and Nevis	ND	ND	ND	ND
Saint Lucia	ND	ND	A	ND
Saint Vincent and the Grenadines	ND	ND	ND	ND
San Marino	ND	ND	ND	ND
Trinidad and Tobago	ND	ND	ND	ND
East Asia				
China	D	ND	C	ND
DPR Korea	ND	ND	ND	ND
Japan	D	ND	D	ND
Mongolia	C	ND	B	ND
Republic of Korea	ND	ND	ND	ND
Eastern Europe and Central Asia				
Armenia	E	ND	SI	ND
Azerbaijan	ND	ND	E	ND
Belarus	C	ND	B	ND
Bosnia & Herz.	E	ND	D	ND
Bulgaria	D	ND	C	C
Croatia	SI	ND	ND	ND
Estonia	D	ND	D	ND
Georgia	D	ND	D	ND
Kazakhstan	D	ND	B	ND
Kyrgyzstan	B	ND	ND	ND
Latvia	ND	ND	D	ND
Lithuania	D	ND	C	ND
Moldova	D	ND	ND	ND
Romania	C	ND	B	ND
Russian Fed.	D	ND	B	ND
Tajikistan	ND	ND	ND	ND
Turkmenistan	ND	ND	ND	ND
Ukraine	D	ND	C	ND
Uzbekistan	D	ND	C	ND

Latin America				
Argentina	A	D	A	ND
Belize	ND	ND	ND	ND
Bolivia	A	A	D	ND
Brazil	SI	ND	E	ND
Chile	D	ND	D	ND
Colombia	B	B	ND	ND
Costa Rica	C	ND	B	ND
Ecuador	C	ND	ND	ND
El Salvador	C	ND	A	ND
Guatemala	B	ND	B	ND
Guyana	C	ND	A	ND
Honduras	D	ND	D	ND
Mexico**	C	B	C	ND
Nicaragua	ND	ND	ND	ND
Panama	B	C	B	C
Paraguay	A	A	A	ND
Peru	D	ND	E	E
Suriname	ND	B	C	ND
Uruguay	ND	ND	D	D
Venezuela	ND	ND	ND	ND
North Africa and Middle East				
Algeria	ND	ND	ND	ND
Bahrain	ND	ND	ND	ND
Cyprus	ND	ND	ND	ND
Egypt	ND	ND	SI	ND
Iraq	ND	ND	ND	ND
Jordan	ND	ND	ND	ND
Kuwait	ND	ND	ND	ND
Lebanon	E	E	D	ND
Libya	ND	ND	ND	ND
Morocco	SI	ND	SI	ND
Oman	ND	ND	ND	ND
Qatar	ND	ND	ND	ND
Saudi Arabia	ND	ND	ND	ND
Sudan	ND	ND	ND	ND
Syrian Arab Republic	ND	ND	ND	ND
Tunisia	D	ND	E	ND
Turkey	D	A	ND	ND
UAE	ND	ND	ND	ND
Yemen	ND	ND	ND	ND
North America				
Canada	C	ND	D	ND
USA	SI	ND	ND	ND

Oceania				
Australia	SI	ND	B	ND
Fiji	ND	ND	ND	ND
Kiribati	ND	ND	ND	ND
Marshall Islands	ND	ND	ND	ND
Micronesia	ND	ND	ND	ND
Nauru	ND	ND	ND	ND
New Zealand	SI	ND	SI	ND
Palau	ND	ND	ND	ND
Papua New Guinea	C	ND	B	C
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
Afghanistan	ND	ND	ND	ND
Bangladesh	E	E	E	E
Bhutan	ND	ND	ND	ND
Brunei Darussalam	ND	ND	ND	ND
Cambodia	C	ND	C	ND
India	SI	ND	E	ND
Indonesia	D	C	D	C
Iran	SI	ND	E	ND
Lao PDR	E	ND	E	ND
Malaysia	A	ND	ND	ND
Maldives	ND	ND	E	ND
Myanmar	ND	ND	C	ND
Nepal	D	C	C	B
Pakistan	ND	E	ND	E
Philippines	E	ND	E	ND
Singapore	C	ND	C	ND
Sri Lanka	E	ND	E	ND
Thailand	D	C	D	D
Timor Leste	ND	ND	D	ND
Viet Nam	E	ND	E	ND
Sub Saharan Africa				
Angola	ND	ND	ND	ND
Benin	ND	ND	ND	ND
Botswana	ND	ND	ND	ND
Burkina Faso	ND	ND	A	ND
Burundi	ND	ND	ND	ND
Cameroon	ND	ND	ND	ND
Cape Verde	ND	ND	ND	ND
CAR	ND	ND	ND	ND
Chad	ND	ND	ND	ND
Comoros	ND	ND	ND	E
Congo	ND	ND	ND	ND

Côte d'Ivoire	C	ND	C	SI
DR Congo	E	ND	ND	ND
Djibouti	ND	ND	ND	ND
Equat Guinea	ND	ND	ND	ND
Eritrea	ND	ND	ND	ND
Ethiopia	ND	ND	ND	ND
Gabon	ND	D	ND	C
Gambia	ND	ND	ND	ND
Ghana	D	ND	ND	ND
Guinea	ND	ND	ND	ND
Guinea Bissau	ND	ND	ND	ND
Kenya	D	ND	ND	ND
Lesotho	ND	ND	ND	ND
Liberia	ND	ND	ND	ND
Madagascar	ND	ND	SI	ND
Malawi	ND	ND	ND	ND
Mali	ND	ND	ND	ND
Mauritania	E	ND	ND	ND
Mauritius	E	ND	ND	ND
Mozambique	ND	ND	ND	ND
Namibia	ND	ND	ND	ND
Niger	ND	ND	ND	ND
Nigeria	D	ND	D	ND
Rwanda	ND	ND	C	ND
ST & Principe	ND	ND	ND	ND
Senegal	E	ND	D	ND
Seychelles	ND	ND	ND	ND
Sierra Leone	ND	B	ND	ND
Somalia	ND	ND	ND	ND
South Africa	ND	ND	D	ND
Swaziland	ND	ND	ND	ND
Togo	ND	D	C	C
Uganda	ND	ND	ND	ND
Tanzania	ND	ND	ND	ND
Zambia	ND	E	ND	ND
Zimbabwe	ND	ND	ND	ND
Western and Central Europe				
Albania	ND	ND	C	ND
Andorra	ND	ND	ND	ND
Austria	C	ND	ND	ND
Belgium	ND	ND	A	ND
Czech Republic	ND	ND	C	ND
Denmark	ND	ND	C	ND
Finland	ND	ND	ND	ND
France	ND	ND	C	ND
Germany	E	ND	D	ND
Greece	D	ND	B	ND
Hungary	ND	ND	A	ND
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	A	ND	ND	ND
Netherlands	ND	ND	SI	ND
Norway	ND	ND	C	ND
Poland	E	ND	ND	ND
Portugal	ND	ND	D	ND
Serbia	C	ND	D	D
Slovakia	ND	ND	ND	ND
Slovenia	ND	ND	D	ND
Spain	C	ND	A	ND
Sweden	C	A	D	B
Switzerland	D	D	D	D
FYRO Macedonia	C	A	C	A
United Kingdom	E	ND	D	ND

Endnotes / References

Endnotes

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