

Achieving an AIDS-Free Generation for **Gay Men and Other MSM**

Financing and implementation of HIV programs targeting MSM

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Acronyms and Abbreviations

AB	abstinence and be faithful
ART	antiretroviral treatment
ARV	antiretroviral drug
CBO	community-based organization
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
COP	Country Operational Plan
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
FSW	female sex worker
HSS	health systems strengthening
IBBSS	Integrated Biological and Behavioral Surveillance Survey
IDU	injecting drug user
LGBT	lesbian, gay, bisexual and transgender
MARP	most-at-risk population
MoH	Ministry of Health
MSM	men who have sex with men
NGO	non-governmental organization
OGAC	Office of Global AIDS Coordinator
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PR	Principal Recipient
PSI	Population Services International
RFA	request for application
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

Note on text: All currency amounts marked with "\$" are U.S. dollar amounts, unless specified otherwise.

Executive Summary

Introduction

The HIV/AIDS pandemic continues to have a devastating, though often invisible, impact on gay men and other men who have sex with men (MSM) around the world. In low- and middle-income countries, MSM are 19 times more likely to be living with HIV than people in the general population and they represent an estimated 10 percent of new infections each year. Yet for decades the epidemic among MSM was officially ignored by governments, donors, and whole societies.

Though there has been a gradual shift in attitudes towards responding to the needs of this population, in many parts of the world a hidden epidemic remains, exacerbated by stigma, discrimination, and violence. Same-sex sexual practices are punished as crimes in more than 80 countries, with penalties ranging from imprisonment to death. In much of the world, national HIV epidemiological surveys do not assess the impact of HIV on MSM and this lack of good data is used to justify chronic underinvestment in the needs of this population.

Lack of good data is used to justify chronic underinvestment in the HIV-related needs of MSM.

This history of legally sanctioned neglect and discrimination is beginning to change in some parts of the world, though at a slow pace. The original research in this report provides the most comprehensive analysis to date of HIV-related funding and programming for MSM. The report also suggests actionable steps to improve the HIV response among MSM. A careful examination of MSM-related policies through donor and multilateral agencies reveals improved efforts but persistently inadequate investments and limited accountability for better results. On-the-ground consultations in eight epidemiologically diverse countries highlighted some models for success combined with persistent, widespread stigma in all contexts and a lack of even the most basic HIV prevention services for MSM in most.

The research in this report confirms what has been long suspected: countries that criminalize same-sex sexual practices spend fewer resources on HIV-related health services

for MSM, do less to track and understand the epidemic in their nations, and are more likely to repurpose donor funds intended to fight the epidemic among MSM. However, criminalization is only one obstacle to effective HIV programs for MSM. Stigma and discrimination in all contexts play equally important roles.

It will be impossible to achieve an “AIDS-Free Generation” if MSM are left behind. Respect for human rights and public health both demand a more equitable and effective response to the AIDS epidemic among this population from both donors and affected country governments. A recent World Bank report demonstrates the critical importance of tackling HIV incidence among MSM to control overall national epidemics, and a new “investment framework” proposed in *The Lancet* emphasizes the need for more strategic use of resources, including increased investment in the HIV-related needs of MSM, injection drug users, and sex workers.

Donor and Multilateral Programming

Research for this report identified important advances in the MSM-related work of the U.S. **President’s Emergency Plan for AIDS Relief (PEPFAR)** program over the last several years. Funds dedicated to MSM services appear to have increased in most of the eight countries studied, though funding for these programs remains limited and inadequate. Though PEPFAR issued field guidance on addressing HIV among MSM in 2011, governments may still restrict PEPFAR-financed MSM-related services. The four countries in this analysis that criminalize same-sex sexual practices proposed far fewer MSM-related activities and dedicated smaller percentages of their country budgets to them. Lack of data about PEPFAR MSM-related funding and



services remains a serious impediment to addressing the needs of this population.

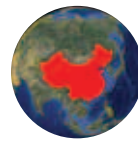
Historically, financing through the **Global Fund to Fight AIDS, Tuberculosis and Malaria** has infrequently addressed the needs of MSM, primarily because country applications have failed to make this population a priority. In 2009, the Global Fund approved a Sexual Orientation and Gender Identities (SOGI) strategy to better respond to the needs of sexual minorities, and enshrined prioritization of most-at-risk populations (MARPs) in its next five-year strategy. However, a previous analysis of Global Fund financing found that only 10 percent of all Global Fund money was directed to MARPs, and, of that small proportion, only two percent was directed to MSM. There is also evidence that MSM-targeted activities are deprioritized during grant negotiations in many countries. Original analysis for this report reviewed the full grant approval cycle and found that attrition rates between application, grant approval, and actual funding for services were higher for MSM-related programming than programs overall in countries that criminalize same-sex sexual practices.

Examples of positive change combined with scientific advances and increased awareness about the needs of MSM, give hope for a more equitable response to the AIDS epidemic among MSM worldwide.

The **UNGASS (UN General Assembly Special Session on HIV/AIDS) reporting system** managed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) is the most visible accountability mechanism in the global AIDS response, attempting to track progress on 25 indicators of AIDS funding and policy in countries worldwide. An analysis of the UNGASS system done for this report found that, though the process has been important in raising the issue of MSM-related services and policy, data reported through UNGASS are often highly questionable and lead to few, if any, positive outcomes for MSM. The continued relevance of the UNGASS indicators requires UNAIDS to consider how global tracking and reporting can lead to greater accountability that drives expanded and improved services for MSM and other most-at-risk populations.

On-the-Ground Research in Eight Countries

Civil society consultants working independently in eight countries used a standardized questionnaire to inquire about the financing and implementation of MSM-targeted HIV programs as well as the challenges and impediments faced. Working in their own communities, these consultants attempted to uncover links between the country's legal framework and MSM-related HIV programming and policy. The HIV epidemic among MSM is distinct in each of these countries, as is the legal and public health status of MSM. Among the findings:



In **China**, government interest in the needs of MSM is characterized as “no support, no objection, and no promotion;” efforts by the Ministry of Health to engage MSM in HIV prevention have been undermined by open hostility from other government bodies; and all HIV prevention funding for MSM is funneled through government-operated organizations with only tenuous ties to legitimate civil society groups.



In **Ethiopia**, the government openly refuses to recognize, track, or provide services to MSM; the few organizations that work with MSM remain silent for fear of official persecution; and many MSM forego seeking medical care because of discrimination.



In **Guyana**, despite HIV prevalence among MSM nearly 20 times that of the general population, prevention efforts are hampered by criminalization that prevents many government bodies from directly addressing the HIV epidemic among MSM; programs, where they exist, are limited to small-scale behavioral interventions.



In **India**, decriminalization in 2009 had a direct, positive effect on the ability of community groups and implementers to access and engage MSM; stigma and discrimination remain real obstacles to MSM obtaining medical care; and the absence of basic necessities in HIV prevention outreach limits the effectiveness of programs for MSM.



Summary of Major Findings

- ▶ With few exceptions, MSM are deprioritized and marginalized by national HIV programs regardless of epidemic type or disease burden. In the most extreme case, funding for MSM programs supported by the Global Fund in Guyana dropped by 96% between initial proposal and final budget.
- ▶ Epidemiological surveillance of MSM in countries around the world is woefully inadequate to determine the true burden of HIV among MSM. This lack of data is used to justify the absence of effective MSM programming and it creates a logical paradox for government and non-governmental actors advocating for increased resources. The UNGASS process provides limited accountability for marginalized or vulnerable groups, and, in its current manifestation, does little to resolve this problem.
- ▶ Decriminalization of same-sex sexual practices is a necessary means of establishing an enabling environment for effective HIV programs targeting MSM but is not sufficient in and of itself. Even in countries with a long history of progressive legal frameworks, stigma and discrimination impede MSM involvement in HIV prevention, treatment, and care.
- ▶ The lack of effectiveness data for HIV prevention programs among MSM leads to an ad hoc approach to program development and some important gaps in service delivery. Condom-compatible lubricant, considered a core commodity for MSM by PEPFAR, is not accessible to MSM in all countries receiving PEPFAR funding.
- ▶ Efforts to streamline donor bureaucracy are being undertaken without careful consideration of their impact on vulnerable populations. Consolidated funding streams, broad health systems investments, and reduced reporting requirements may ultimately undercut efforts to direct money to those most at risk or in need.
- ▶ There are early signs that efforts by the Global Fund and PEPFAR to prioritize programs targeting MSM are having a positive impact on the number of countries seeking resources for these programs.



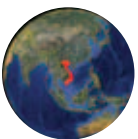
In **Mozambique**, MSM remain uncoun-
ted, unrepresented, and underserved in the HIV
epidemic; there are no official government
programs for MSM despite the millions of
dollars in donor aid for HIV; and stigma and
discrimination keep MSM from obtaining
healthcare.



In **Nigeria**, MSM-targeted programs are
donor-driven, with limited government buy-
in; the few programs that exist are aimed at
largely urban populations; and same-sex sexual
practices, which are punishable by death in parts
of Nigeria, remain highly stigmatized.



In **Ukraine**, HIV programs targeting MSM
benefit from a progressive legal environment yet
are simultaneously undercut by heavy stigma
and discrimination among Ukrainian citizens;
most MSM programs exist only in major cities;
and the excessive cost of lubricant at retail
stores makes appropriate use of condoms
difficult.



In **Viet Nam**, HIV prevention programs
initiated and supported by the government
have contributed to improved surveillance and
a significant reduction in new infections among
MSM; several robust research and program
implementation collaborations exist among
donors, universities, NGOs, and civil society, but
access to services is limited by discrimination
from service providers.

Recommendations

National governments

- 1 Decriminalize same-sex sexual practices and publicly support programs that reduce stigma and discrimination against marginalized groups.
- 2 Include MSM in epidemiological surveillance and make results publicly available.
- 3 Prioritize and fund HIV programs targeting MSM.
- 4 Include civil society in national planning, monitoring, evaluation, and accountability for health programming.

PEPFAR

- 5 Regularly collect data and report on PEPFAR funding that targets marginalized populations and consistently make this data publicly available.
- 6 Provide financial and technical assistance to collect epidemiological data on MSM in all PEPFAR countries.
- 7 Forcefully implement PEPFAR MSM guidance, ensuring country plans adhere to best practices and are backed by epidemiological data.
- 8 Use Partnership Frameworks, official diplomatic channels, and other means to encourage rescission of laws criminalizing same-sex sexual practices.
- 9 Establish a unique funding mechanism for countries with a significant burden of HIV among MSM and other marginalized populations to intensify services available to these populations (as recommended by the PEPFAR Scientific Advisory Board).
- 10 Discontinue PEPFAR funding for non-governmental organizations that actively work against human rights for sexual minorities or appropriate health services for this population.
- 11 Fund operations research to build the evidence base for effective delivery of combination prevention and treatment services to MSM, including biomedical, behavioral, and structural interventions.

Global Fund

- 12 Create internal mechanisms that monitor and report on attrition of programs targeting marginalized populations, especially MSM.
- 13 Ensure that any programmatic changes occurring in proposals after technical review receive further technical validation before final grant approval.
- 14 Require community systems strengthening (CSS) components within existing and new health systems strengthening (HSS) grants, in line with the Sexual Orientation and Gender Identity (SOGI) strategy and the Five Year Global Fund Strategy.
- 15 Strengthen capacity of Secretariat staff—particularly members of Country Teams with direct involvement in grant management—in the areas of most-at-risk populations, human rights, and equity to enable effective and strategic management of grants in contexts where same-sex sexual practices are criminalized or stigmatized.
- 16 Accelerate resource mobilization efforts to continue future funding rounds, allowing for the operationalization of the new five-year strategy and an expansion of the MARPs-targeted funding pool.

UNAIDS

- 17 Reform the UNGASS process to ensure that it more effectively serves as a global accountability mechanism for AIDS-related expenditures, including services and policies affecting MSM.
- 18 Fund civil society accountability efforts, including those regarding MSM services.
- 19 Provide targeted technical assistance to countries to develop Global Fund proposals that adequately reflect epidemiological surveillance, the latest science, and best practice in HIV prevention for MSM.
- 20 Monitor and report on the implementation of the Action Framework for MSM among donors.

Conclusion

Exciting, recent scientific results in the field of AIDS present the opportunity to begin to control and ultimately end the global epidemic. However, if the HIV prevention and treatment needs of MSM do not receive greatly expanded attention, these communities will be left behind and progress against the overall epidemic will be limited. In an era of increasing use of biomedical prevention tools, it is important to identify services that meet the needs of MSM in diverse settings and to bring these lifesaving services to scale.

This report documents the tangible connection between health and human rights, pointing to the need to advance on both fronts in order to make progress. It discusses notable progress among national and multilateral systems in addressing the needs of MSM, but also reveals a public health response that remains dangerously inadequate, stymied, and ultimately undermined by stigma and discrimination. Still, the examples of positive change combined with scientific advances and increased awareness about the needs of MSM, give hope for a more equitable response to the AIDS epidemic among MSM worldwide.

1. Introduction

1.1 Overview and rationale for this report

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) are by far the most important sources of support for the global HIV response. Through 2011, the Global Fund has spent more than \$8.3 billion for HIV/AIDS grants¹ and PEPFAR has approved \$31.9 billion toward programs addressing HIV prevention and treatment in countries most affected by HIV/AIDS.² Such unprecedented support has had a profound impact on the lives of millions of people living with and affected by HIV. However, millions more have not benefited sufficiently or at all based on objective priority and need.

HIV programming in many countries has consistently sidelined most-at-risk populations (MARPs). In numerous countries there are policies that penalize practices associated with being at high risk for HIV, such as same-sex sexual practices among men and sex work. In response to the magnitude of their epidemics, these same countries have long received—and continue to receive—the majority of HIV prevention, treatment, and care funding from global donors such as the Global Fund and PEPFAR. Thus MSM and sex workers continue to be broadly excluded from receiving even a minimum level of sufficient support in settings most affected by HIV/AIDS.

In considering the consequences of such disparities between clear need and actual programming, this report focuses on MSM as a representative most-at-risk population. Not only are their sexual orientation and/or practices often criminalized in countries with generalized HIV epidemics, but they have been found to experience a disproportionate burden of HIV compared with other age-matched men in every setting where they have been studied. Moreover, the significant social stigma associated with same-sex sexual practices in most societies and contexts creates and exacerbates structural barriers to existing HIV prevention, treatment, and care programs and services, thereby increasing HIV risk and intensifying the epidemic's impact on MSM.³

The specific aims of this report are to evaluate the impact of legislation that criminalizes same-sex sexual practices on two key outcomes: i) the efficiency of multilateral funding sources for HIV/AIDS programming, and ii) the effectiveness of comprehensive HIV prevention programs for MARPs (with a focus on MSM). In addition, the report provides an analysis of evidence for the potential positive impacts of decriminalizing same-sex sexual practices on the effective delivery of comprehensive HIV prevention programs for all populations at risk. With these inputs, the report aims to characterize optimal strategies in the global AIDS response that best protect the interests of all those at risk for HIV infection.

1.2 Background

Recent major advances in the legal standing of sexual minorities, most notably the end of criminalization of same-sex sexual practices and diverse gender identities in India and Nepal, have been tempered by sharp rises in homophobic attacks and discriminatory legislative efforts in a number of countries including Burundi, Kenya, Malawi, Nigeria, Russia, Uganda, and Uzbekistan. These developments limit the provision of HIV services for MSM and transgender individuals in settings where unfavorable policies have been implemented and potentially undermine the overall effectiveness of the HIV response.

In the context of generalized HIV epidemics, it is often proposed that MARPs including MSM, do not constitute a significant component of the epidemic—and thus resources should not be diverted from addressing populations deemed to have high priority by influential national stakeholders (nearly always the government). One rationale for such justification stems from the concept of “generalized epidemic” and how the term has been interpreted. It was characterized during the development of second generation HIV surveillance by a collaborative group convened by the World Health Organization (WHO) in 2000. Based on the definition established at that gathering, a generalized epidemic is classified as one where HIV prevalence is consistently higher than one percent in antenatal clinics. In contrast, concentrated epidemics are those in which HIV prevalence is consistently higher than five percent in at least one MARP but less than one percent in antenatal clinics, and in low-level epidemics HIV prevalence is less than five percent in the MARP and less than one percent in antenatal clinics.

This system was developed to more efficiently guide HIV surveillance and to facilitate enhanced use of data to inform prevention strategies. The definitions and documentation behind this classification system were not envisioned as a guide for the development of prevention strategies. However, there is increasing evidence over the last decade that national strategic HIV plans have been developed in direct response to the country’s epidemiological classification.

This pattern is troubling for MSM and other MARPs. As the classification system for generalized epidemics is the only one that does not mention MARPs in its definition, many of these national strategic plans have not included MARPs in their responses. The drafters of these plans are not necessarily seeking to exclude MARPs. However, the practical effect of the reliance on these epidemiological classifications for national strategies is to encourage the assumption that MARPs do not play a meaningful role in generalized epidemics.

Recent modes of transmission studies refute the logic behind this approach. In Mozambique and Nigeria, both countries considered to have generalized epidemics and included in this report, modes of transmission studies have shown that MSM make up 5.1 and 10.3 percent of all new infections.⁴ Meaning, in Nigeria, for every ten people infected, one is through male-to-male sexual contact. This is not uncommon in other countries with large generalized epidemics either.

Regardless of reason or justification, the impact has been dire for MARPs in many countries. UNAIDS has estimated that in generalized epidemics, less than one percent of expenditures support MARPs, with 0.5 percent for sex workers, 0.1 percent for MSM, and essentially negligible amounts allocated for programs benefiting injecting drug users.⁵ Based on these estimates, barely one out of every thousand dollars is spent on issues related to MSM. And, even though the definition of concentrated epidemics takes MARPs into account, they are still under-prioritized; less than 10 percent of HIV-related expenditures focus on these populations. These data highlight a persistent mismatch between the relative burden of HIV disease and expenditures to address the epidemic. There is also very limited understanding of the content of the programming that is targeting these populations.

Seven of the top 10 countries supported by the Global Fund, and more than half of the 88 countries supported through PEPFAR, criminalize consensual same-sex sexual practices.⁶ These figures are important in light of a disturbing trend observed from a review of the burden of HIV and other epidemiologic data among MSM: relevant data are least available in settings where stigma is the most intense and manifested in the form

of criminalization of sexual practices, lack of prevention services, and exclusion from national surveillance systems. This indicates that the existence of these laws, regardless of the extent to which (if any) they are enforced, is strongly associated with the limited data available on coverage of HIV prevention, treatment, and care services among MSM.

This data paradox is circular in nature; the absence of HIV surveillance or coverage data for MSM undermines even well-intentioned efforts to allow data to determine HIV prevention priorities, and the shortage of relevant data also makes it more difficult for civil society groups to undertake data-driven advocacy to harness data regarding the burden of disease or level of risk among MSM in these settings. The challenges associated with this data paradox reinforce the guiding hypothesis — that the stigma attached to homosexuality, as reflected in structural barriers such as the criminalization of same-sex sexual practices, limits the scale and ultimate effectiveness of multilateral HIV investments for MSM.

2. Methods Overview

This section provides a brief overview of the methods used for in-country consultations. More thorough descriptions of the methods for these components as well as the donor and institutional assessments can be found in the respective sections along with key methodological limitations and results.

Country case studies and in-country consultations

Eight countries were chosen for case study examples to represent a range of HIV investments, existing HIV prevalence data, HIV epidemic patterns, geographic locations, and legal environments; those selected were China, Ethiopia, Guyana, India, Mozambique, Nigeria, Ukraine, and Viet Nam. Consultations with key stakeholders were held in each of these countries over a period of several months through September 2011. The goal was to describe the state of HIV research and related programming for MSM and any associated factors.

Stakeholders included country-based donor staff, civil society representatives and networks of MSM and people living with HIV, government officials (specifically those with experience developing HIV strategy or related policies and programs), country-based United Nations staff focused on HIV, international and country-based program implementers (especially those implementing HIV-related programs for MSM), and academic stakeholders actively involved in supporting research studies and programs for MSM. The primary aim was not necessarily to interview the highest level people; instead, specific efforts were made to include people with hands-on experience in developing or implementing these programs. Synthesis of these consultations was led by in-country consultants, themselves members of MSM civil society groups, with technical support from amfAR and the Johns Hopkins School of Public Health.

Quantity of consultations. In each country, more than 10 individual consultations were conducted with discussants from across the aforementioned groups. In-country consultants determined the appropriate number of discussions within each group. Thus, although the consultation team was encouraged to seek a diverse set of discussants and try to consult with as many different types of people encompassing different professional backgrounds as possible, it was acceptable to focus on where the greatest contribution could be harnessed.

Consultation instrument. The consultation instrument included questions from a comprehensive list of topics associated with the overall project objectives. Consultations were each allotted approximately 60 minutes

Ethical review. These consultations did not include any questions on protected health information including past or current medical history, family medical history, sexual practices or orientation, or socio-demographic characteristics. All consultations and associated discussions pertained to participants' general knowledge about MSM-specific expenditures, research, and/or programming rather than personal experiences with HIV or programs.

Note on terminology: MSM

Unless specified otherwise, the term “men who have sex with men,” or MSM, in this report refers broadly to people born as men who have sex with other people who were born as men. Some people within this broad categorization may consider themselves to be “gay men,” “transgender women,” or “transgender individuals,” among other terms. However, those more specific terms are used in this report only in instances when services, programming, laws and source materials refer specifically to such wording. In most cases, the data characterizing budgets and programs used for this report allowed for limited or no distinction within the broadly encompassing “MSM” population; therefore, the broad term “MSM” is mostly used.

3. Introduction: Donor Commitments to Global Funding for HIV Programs Focusing on MSM

Over the past two years, increased attention has been paid by global financing institutions for HIV prevention, treatment, and care programs to the needs of MSM in low- and middle-income countries. In particular, the two largest international AIDS financing programs, the Global Fund and PEPFAR, have each issued new policy guidance to recipient nations on the value of MSM-targeted programming.^{7,8} The Global Fund has even gone one step further, dedicating a particular avenue of funding for MARPs in 2010. While both efforts have greatly raised the profile of the need for evidence-based MSM programming in both concentrated and generalized epidemics, it will be some time before the community impact of these efforts can be assessed in recipient nations.

This is not the first time the international community has focused attention on the need for MSM programming. In July 2001, 189 member nations participating in the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) adopted the Declaration of Commitment on HIV/AIDS,⁹ which included a voluntary commitment to report on national progress against time-bound targets for HIV. To that end, UNAIDS and partners developed 25 core progress indicators—including five specifically focused on MSM—against which countries are asked to report biennially.

The inclusion of MSM in these core indicators was a historic step forward, but questions remain about whether UNGASS reporting has led to any tangible outcomes for MSM. This report therefore examines the correlation among data collection, reporting, punitive policies against MSM, and donor funding for MSM programs. In particular, Section 3.1 focuses specifically on the MSM-related UNGASS indicators and the quality of reporting from the eight target countries. Sections 3.2 and 3.3 respectively examine Global Fund and PEPFAR resource flows to MSM programming. For the Global Fund, researchers were provided final country budgets in an effort to determine more precisely what amount of funding was reaching MSM. For PEPFAR, the researchers relied heavily on publicly available data to draw conclusions about the commitment of country planning processes to programs for MSM.

None of these sections in isolation presents a clear picture of the state of financing and implementation of MSM programs. Together, though, they provide a compelling portrait of the gaps through which MSM fall when budget negotiations, politics, and the realities of implementing public health programs in resource-limited settings combine.

Criminalization of same-sex sexual practices

Determining whether a country criminalizes same-sex acts is not as straightforward as might be expected. Six of the eight countries chosen as part of this research fall into defined categories. Among the three of those six that clearly criminalize, there is an array of potential punitive scenarios. In Ethiopia, MSM are punished with “simple imprisonment.”¹⁰ In Guyana, the prison sentence for same-sex sexual practices ranges from two years to life.¹¹ In parts of Nigeria under sharia law, sentences include death by stoning.¹²

Diversity also exists among the three countries that had decriminalized prior to the period covered by this research. Ukraine was the first former Soviet country to rescind punitive policies against same-sex sexual practices, in 1991, and laws providing protection from discrimination in employment are being considered.¹³ Though China does not have any punitive

policies for same-sex sexual practices—as they were decriminalized in Hong Kong in 1991, and on the mainland and in Macau by 1997—it has no legal protection for employment or access to health services or any laws against discrimination.¹⁴ Viet Nam provides legal protection for employment and access to health services for people living with HIV (PLHIV), but not specifically for MSM.¹⁵

The remaining two countries, India and Mozambique, are ambiguous for different reasons. A penal code in Mozambique, dating back to 1886 and amended in 1954, punishes “acts against the order of nature” with imprisonment and hard labor. However, a separate law prohibits discrimination in employment based on sexual orientation, and several sources, including consultants who drafted the country-specific section in this report, assert that same-sex sexual practices are not penalized.^{16,17} Though laws criminalizing same-sex sexual practices are not enforced in Mozambique, they do exist; therefore, for purposes of this analysis, Mozambique is considered a country that criminalizes same-sex acts.

India is a unique case as well. The Delhi High Court ruled in 2009 that a previous law interpreted as criminalizing same-sex sexual practices could no longer be applied to consensual activity among adults.¹⁸ Therefore, it is the only target country that reversed punitive policies against MSM during the timeframe examined in this report. Where possible, the results and conclusions reflect the changes occurring in India before and after this decision. For purposes of broader analysis, however, Indian law does not criminalize same-sex sexual practices.

Comparing these countries as groups (Ethiopia, Guyana, Mozambique, and Nigeria compared to China, India, Ukraine, and Viet Nam) is an imperfect process. The majority of criminalizing countries have large, generalized epidemics (with Mozambique experiencing the largest adult prevalence rate at 11.5%). The majority of non-criminalizing countries have concentrated epidemics ranging from 0.1% of the adult population (China) to 1.1% (Ukraine).

However, the generalized/concentrated dichotomy hides important similarities and differences. Overall, the estimated number of people living with HIV between the two groups is more similar than one might think. Ethiopia, Guyana, Mozambique, and Nigeria are estimated to have 5.6 million people living with HIV. The other four countries are estimated to have 3.7 million. There are more HIV-positive adults in India than in Mozambique, Ethiopia, and Guyana combined, and, though Guyana and Ukraine have similar adult prevalence rates (1.2% versus 1.1%), Ukraine has nearly 60 times the size of the epidemic as Guyana. Given this, it would be too simplistic to dismiss comparisons because of epidemiological classification, especially since population size estimates of MSM in all of these countries are either entirely absent or insufficient.

3.1 United Nations General Assembly Special Session on AIDS (UNGASS)

3.1.1 Background

MSM and UNGASS indicators

The biennial reports submitted to UNAIDS commonly known as “UNGASS reports” track member nations’ progress against 25 indicators related to HIV funding, prevention, treatment, and care (see Box 1). These reports are voluntarily submitted by national governments, and, though UNAIDS provides a standardized format, countries are not required to respond to all (or any) of the indicators. Similarly, though UNAIDS reconciles the reports with information

Box 1. United Nations General Assembly Special Session on HIV/AIDS (UNGASS)²³

History

The first UN General Assembly Special Session on HIV/AIDS was convened in 2001 and resulted in the adoption of a Declaration of Commitment that set specific targets for the global response to AIDS. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was tasked with monitoring the implementation of the Declaration, with the expectation that the full member body would meet every two years to review progress.

UNGASS indicators

UNGASS indicators were adopted to monitor progress against all areas of the global HIV response including implementation of programs, policy, and financing. The responsibility for building surveillance, data capture, and reporting systems falls to member nations themselves and there is wide disparity between countries in regards to who participates in this work. In 2004, UNAIDS adopted the Country Response Information System (CRIS) to standardize countries' submissions. After each biennial reporting period, the UNAIDS Monitoring and Evaluation Reference Group reviews the reporting to determine if revisions to the indicators are needed.

Starting in 2004, UNAIDS began to offer technical assistance through field staff deployed to help develop data and reporting systems. This assistance includes training in the use of CRIS and UNAIDS' epidemiological estimation methods. Financial support is also available to some low- and middle-income countries.

There are currently 25 indicators that fall into three categories:

1. National commitment and action indicators (funding and spending, national policy, PLHIV receiving treatment, PMTCT, blood testing, HIV education in schools)
2. Knowledge and behavior indicators (orphans in school, knowledge of HIV among youth and MARPs, sexual behavior, condom use)
3. Impact indicators (persons living with HIV disaggregated by population)

Reporting periods vary for each indicator (from annual to every five years). Generally those requiring population-based surveys tend to report less frequently than those for program and impact monitoring.

collected by large HIV financing initiatives (e.g., PEPFAR), they are not linked to any donor funding. Individual country progress reports are publicly available on the UNAIDS website.¹⁹

The share of UN member states submitting reports has gradually increased since the first round of submissions, from 54 percent in 2004 to 94 percent in 2010.²⁰ A similar increase has occurred for several individual indicators as well. As per the 2010 reports, a significant majority of countries now submit responses related to blood safety (86 percent), HIV treatment (80 percent), overall AIDS spending (71 percent), and prevention of mother-to-child transmission (PMTCT) (70 percent). However, reporting levels remain relatively low for indicators related to MSM and HIV. In 2010, just 43 percent of countries reported on condom use among MSM, and an even smaller share (28 percent) reported on two other MSM-specific indicators: MSM knowledge of HIV and prevention program coverage for MSM.²¹

Such limited reporting is consistent with other MARPs. In the aggregate, reporting against indicators for sex workers fares slightly better while reporting on injecting drug users is marginally to substantially worse in comparison with MSM.²² It is important to note that these percentages only reflect the number of countries providing data, not the number of countries showing progress on these indicators.

This analysis examines reporting from eight target countries on the five MSM indicators to determine if punitive policies targeting MSM are correlated with reporting against UNGASS indicators or progress in the reported areas.

UNGASS MSM indicators

The five MSM-related indicators have remained largely unchanged between 2006 and 2010. They are listed below:

Indicator 8 - Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results

Indicator 9 - Percentage of most at-risk populations reached by prevention programs

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

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 who are HIV infected

While indicators for other populations have significantly evolved or been completely removed, MSM indicators have largely remained the same since they were introduced in 2006. Thus changes in how or to what degree countries respond to these indicators, discussed below, should not be considered a reflection of any changes in the indicators themselves.

3.1.2 Methodology

The 2006, 2008, and 2010 UNGASS reports for each of the eight target countries were obtained directly from the UNAIDS website.²⁴ The quantitative portions of these reports were reviewed to characterize responses to each indicator. The quantitative data were drawn from the country UNGASS Indicator Data Tables and narrative portions of the country submissions.

After the numerical values of these indicators were recorded in a table, a thorough qualitative analysis of the country report was conducted. Through this analysis, the narratives of each country report were reviewed with special attention to the mention of MSM; common search terms were used to highlight mention of MSM in the narrative portions of the country submissions. Keywords used included “MSM,” “men who have sex with men,” “anal sex,” “homosexual,” and “gay.”

Limitations

Previous analyses have evaluated limitations inherent in both the content and process of reporting on UNGASS indicators.^{25,26,27} Briefly, they include:

- A heavy reliance on national reporting systems to collect data across a wide range of populations. These systems are often influenced by political sensitivities and capacity constraints.
- Limited data quality and a reactive quality assurance process at UNAIDS.
- Concerns regarding the validity of UNGASS indicators to reflect actual progress against HIV on a national level as well as the validity of reported data to reflect on-the-ground realities.

Several other limitations separate from the indicators themselves became apparent during analysis for this report:

- There is limited consistency in country approaches to surveillance, monitoring, and reporting. The variation in methodologies ranges from small convenience samples (surveys of accessible populations with limited representativeness of a larger population) to larger Integrated Biological and Behavioral Surveillance Survey (IBBSS) reports.²⁸
- A decrease in the number of indicators reported on may not reflect diminished attention paid towards MSM. Instead, such a trend may reflect a country recognizing that the quality or quantity of source data was very limited and therefore choosing not to report.

3.1.3 Results

General results

There are two ways to analyze the UNGASS data: first, counting and comparing the number of MSM-related indicators reported on per country per reporting cycle, and second, recording and comparing progress against these indicators over time. Table 1 below summarizes the first piece of this analysis; the total number of MSM-related indicators each country provided updated data for in each reporting period. Numbers range from zero (no response) to five (full reporting against all five indicators). It is important to note that instances in which countries repeated data from a previous reporting period rather than providing updated data are not counted in the chart below (though UNAIDS allows this in their own reporting.)

Table 1. Country reporting on MSM-related indicators by reporting period

Country	2006	2008	2010
China	3	0	5
Ethiopia	0	0	0
Guyana	2	1	4
India	4	5	5
Mozambique	0	0	0
Nigeria	0	5	0
Ukraine	3	5	5
Viet Nam	1	5	5

Of the eight countries selected for this study, none have provided full reporting across all three periods on all UNGASS indicators related to MSM. Two (Ethiopia and Mozambique) have never reported on any of them. Three of the countries that submitted responses for any of these indicators (India, Ukraine, and Viet Nam) reached full reporting in 2008 and remained at that level in 2010. Three others (China, Guyana, and Nigeria) demonstrated inconsistent reporting over the years.

As a comparison, Table 2 shows reporting against other UNGASS indicators (with check marks indicating a submission for that year). These indicators (numbers 3, 4 and 5) were chosen because of the consistency with which the majority of UN member states report on them. They also point to the in-country capacity for conducting the type of data collection and reporting necessary to complete the MSM indicators as well.

Except for China and Viet Nam, all countries reported data regarding blood safety, ART access, and PMTCT throughout the examined time period. Most noticeable, though, is that these target countries were more willing or able to collect data on indicators unrelated to MSM. Nigeria, Ethiopia, and Mozambique all consistently reported on the non-MSM-related indicators in all country progress reports reviewed; however, as observed in comparing Tables 2 and 3, these countries had limited reporting on MSM-related indicators. Thus a demonstrated capacity to report on some UNGASS indicators does not signal willingness or capacity to report on MSM-specific indicators.

Table 2. Country reporting on selected UNGASS indicators

	Blood safety			ART access			PMTCT		
	2006	2008	2010	2006	2008	2010	2006	2008	2010
China			✓	✓		✓		✓	✓
Ethiopia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guyana	✓	✓	✓	✓	✓	✓	✓	✓	✓
India	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mozambique	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nigeria	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ukraine	✓	✓	✓		✓	✓	✓	✓	✓
Viet Nam	✓				✓	✓		✓	✓

For the second component of this analysis, Tables 3 and 4 contain the quantitative submissions provided by countries in their UNGASS reports that characterize progress (or lack thereof) on each of these indicators. Given the significant variation in the quality, representativeness, and timeliness of reported data, cross-country comparisons are of minimal utility.

Because the majority of data informing MSM indicators are generally from convenience samples rather than population-based ones, generalizability to all MSM in a country is limited. Many countries provide a range of values in instances where different surveillance sites provided significantly varying results. Several countries also duplicated an answer in subsequent reporting periods. Notably, many of these duplications came from data more than two years old, a time period greater than the limit set by UNAIDS.

Interpreting this information is difficult, calling into question the data's utility for national and global planners. The accuracy of data presented on MSM in nations that criminalize same-sex sexual practices is also questionable considering outreach to MSM is encumbered not only by stigma and discrimination—which is common in all eight countries reviewed—but also by legal structures.

Table 3. Country reporting on indicators 8 and 9

	UNGASS indicator 8: What percentage of MSM have taken an HIV test in the last year?			UNGASS indicator 9: What percentage of MSM are being reached by HIV prevention programs?		
	2006	2008	2010	2006	2008	2010
China	-	-	44.9%	-	-	75.1%
Ethiopia	-	-	-	-	-	-
Guyana	-	-	87.1%	17.2%	-	-
India	3.7–57%	3–67%	17%	-	17–97%	18.1%
Mozambique	-	-	-	-	-	-
Nigeria	-	30.15%	-	-	54.38%	-
Ukraine	25%	28%	43%	-	50%	63%
Viet Nam	-	16.3%	19.1%	-	25.6%	24%

Table 4. Country reporting on indicators 14, 19, and 23

	UNGASS indicator 14: What percentage of MSM know how to prevent HIV?			UNGASS indicator 19: What percentage of MSM used a condom the last time they had sex?			UNGASS indicator 23: What percentage of MSM are living with HIV?		
	2006	2008	2010	2006	2008	2010	2006	2008	2010
China	37.3%	-	51.1%	44.2%	-	73.1%	1.5%	-	5%
Ethiopia	-	-	-	-	-	-	-	-	-
Guyana	67.1%	-	46.8%	-	-	79.9–84.2%	21.2%	21.25%	19.4%
India	26–58%	16–75%	17.4–56.7%	19–67%	13–87%	48.9–57.6%	-	6.41%	7.3%
Mozambique	-	-	-	-	-	-	-	-	-
Nigeria	-	44.03%	-	-	52.8%	-	-	13.5%	-
Ukraine	49%	47%	71%	72%	39%	64%	-	4%	8.6%
Viet Nam	-	54.9%	60.3%	-	61.3%	66.5%	8%	9%	16.7%

Country-specific results

This sub-section contains a country-by-country analysis of reporting on the UNGASS indicators over three periods (2006, 2008, and 2010). In addition, the analyses below consider both the quantitative and qualitative aspects of the UNGASS submissions.

China

China demonstrated dramatic improvements in reporting across all indicators; in particular, MSM-related indicators showed improved quality and reporting. Extensive data are available for female sex workers (FSWs) and injecting drug users (IDUs), indicating an increase in reporting across several targeted populations. For example, the 2006 report from China has limited data on the epidemic, while the 2010 report describes an HIV epidemic in which 32.5 percent of HIV infections are attributable to MSM.^{29, 30}

Although the epidemic among other MARPs appears to be improving, the data in China's UNGASS reports would appear to indicate a worsening MSM epidemic. New HIV cases among IDUs and FSWs remained relatively stable over the reporting period, while reported prevalence among MSM increased from 1.5 percent to 5.0 percent between 2006 and 2010.^{31,32,33} With more data, it might be possible to assume that an increased proportion of MSM were being reached by HIV programs (and thus more infections identified), but relevant data only appear in the 2010 report.

Ethiopia

Ethiopia was one of the first low- and middle-income countries in the world to identify new HIV cases, yet the country remains deeply resistant to HIV/AIDS programs for MARPs. While the country receives both Global Fund and PEPFAR funding for MSM programs, Ethiopia has not acknowledged the presence of MSM in any official reports, and has gone so far as to deny their existence in that country.³⁴ There is no mention of MSM (or any other MARP) in the 2006 report, and subsequent reports continue to regard MSM as a new, emerging risk group.³⁵

Guyana

The HIV epidemic among MSM in Guyana remains "unknown" according to its own reports though MSM is the largest risk category in Guyana's region. The 2006 report acknowledged that under-reporting was at about 60 percent and MSM-related data were limited.³⁶ Though many indicators not related to MARPs were updated for the 2008 report, MSM and other MARPs-related indicators repeated previous data by citing 2005 figures.³⁷

Despite homophobia and the criminalization of same-sex sexual practices, the 2008 UNGASS report discusses the need for MSM access to "friendly" clinical care and treatment services.³⁸ This contradiction is equally likely to be associated with inconsistent surveillance systems as it is with actual progress.

India

While India consistently reported on MSM-related indicators throughout the study period, the reported data are not representative of the HIV epidemic among MSM.³⁹ The 2006 report specifically discussed how difficult it is to collect adequate data on MSM in a climate of criminalization.⁴⁰ That report also indicated that "homosexual sex" accounted for a mere 0.74 percent of HIV infections,⁴¹ a strikingly low percentage given what other studies have determined with regard to HIV prevalence among MSM in India.⁴²

The disparities for MSM in India extend beyond surveillance and reporting. The 2006 submission reported that only 30 interventions for MSM were occurring throughout all of India in 2005. By comparison, 181 interventions were taking place among FSWs and 93 among IDUs.⁴³ Moreover, that year's report noted that MSM interventions had so far proven of limited benefit: 70 percent of MSM respondents reported access to confidential HIV testing in 2005, but only 35.2 percent had actually taken a test for HIV.⁴⁴

Since decriminalization of same-sex sexual practices in 2009, there have been limited improvements in surveillance of and interventions for MARPs in general and for MSM specifically. The number of surveillance sites for MARPs increased from 488 in 2006–2007 to 555 in 2008–2009, but, strikingly, there was a more than fourfold increase in targeted interventions for MSM.^{45,46} As surveillance improved, so did the estimated percentage of MSM living with HIV: it rose from 6.41 percent in the 2008 UNGASS report to 7.3 percent in the 2010 report.⁴⁷

Mozambique

Despite efforts to quell discrimination against MARPs, including MSM, through the “Defending Human Rights” law of 2002, social discrimination and hostility continue to hinder access to HIV services, according to the 2010 UNGASS report.⁴⁸ As previously mentioned, criminalization of same-sex sexual practices in Mozambique is ambiguous; the language of the Penal Code in regard to “vices against nature” makes the criminalization of homosexuality unclear.⁴⁹ It is unremarkable, therefore, that little information on MSM in Mozambique exists and many MSM remain hidden as a result of hostility and discrimination.⁵⁰ Prevention, treatment, and care services targeting MSM are almost completely absent.^{51,52}

Nigeria

In Nigeria, same-sex sexual practices are illegal under federal law, and there has been serious consideration of enshrining the prohibition against same-sex marriage in the nation's Constitution.⁵³ Given the hostility towards same-sex sexual practices and relationships, it is unsurprising that Nigerian government officials have not made efforts to address the MSM situation in the country. The 2006 report included no information for the MSM-related indicators, and did not indicate whether any policy or strategy was in place to promote interventions targeting MSM. Surprisingly, though, the first and only Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in Nigeria to date (in 2007) included MSM. The results of that study were resubmitted for the 2010 report. Reporting is limited for all of Nigeria, as only one in six Nigerian states participated in the IBBSS. The number is worse for MSM, as only one in 12 states provided reporting on the MSM indicators.

Ukraine

In Ukraine, same-sex sexual practices were decriminalized in 1991.⁵⁴ However, in light of the ineffective anti-discrimination regulations cited previously, MSM continue to face stigma throughout Ukrainian society.⁵⁵ The resulting unfriendly environment promotes under-reporting on the MSM epidemic and a lack of access to prevention, care, and treatment services. In 2007, 48 new cases of HIV infection were reported among MSM in Ukraine for a total of 158 such cases since 1987.⁵⁶ Other studies have shown significantly larger MSM epidemics, however.⁵⁷ Under-reporting is reflected in the fact that prevention programs targeting MSM remain limited.^{58,59} Unsurprisingly, the number of HIV cases among MSM in Ukraine consistently increased from 2005 to 2009.⁶⁰

Viet Nam

Reporting on MSM increased dramatically during the study period, yet progress on reducing infections among MSM in Viet Nam remained limited. MSM were not included in national surveillance until 2005.⁶¹ However, since the 2006 report, Viet Nam has consistently reported on all five indicators related to MSM.

However, the favorable government climate toward reporting on MSM has not translated to adequate programming focused on MSM in Viet Nam. With regard to programming efforts, HIV-positive MSM in Viet Nam are reportedly subject to a “double stigma” for both their HIV status and sexual orientation.⁶² Thus MSM lack access to “friendly” sexual health services and remain a largely “hidden” group in the face of discrimination.^{63,64} Although the number of interventions for MSM increased since the report in 2006, targeted programming was still limited to just five of 64 provinces (according to the 2008 report).⁶⁵

3.1.4 Conclusions

The findings above raise important questions about the purpose and effectiveness of the UNGASS indicators. Without question, the Declaration of Commitment brought about a new era in the global response to HIV, providing a focus for advocacy and a platform to enhance the transparency and accountability of national responses; however, since then, it appears that countries unwilling or unable to gather necessary information about the epidemic within their borders and respond accordingly have had little incentive to act otherwise. Billions of dollars in donor funding continue to flow to countries with limited HIV/AIDS surveillance infrastructure. These funds are allocated based on the burden of disease; however, in the context of sub-optimal surveillance, this is theorized to be low when it is actually unknown. In countries where HIV prevalence among MSM is far higher than the general population, these men often live in fear with limited involvement in HIV surveillance and access or uptake of HIV prevention, treatment, and care services.

The process of establishing surveillance systems and analyzing and reporting on captured data is important; however, without serious accountability systems that hold countries to task, HIV prevention, treatment, and care programs will be of unknown efficiency in providing services to all those at risk, limiting the capacity to reverse the epidemic. In its first decade, the UNGASS process dramatically elevated the visibility of the global HIV response. Yet without tying UNGASS to strong accountability mechanisms—preferably those driven by fully independent civil society organizations in countries, including those comprising and working with MSM—donor funding, in some settings, will only enable stigma and discrimination against MSM by simply ignoring them.

3.2 Global Fund to Fight AIDS, Tuberculosis and Malaria

3.2.1 Background: MSM and the Global Fund

Throughout its history, the Global Fund has sought to encourage applicants to prioritize HIV prevention, care, and treatment services for all people at risk for HIV, including what are commonly known as most-at-risk populations (MARPs)—a category that includes MSM, transgender people and their sexual partners; female, male, and transgender sex workers and their sexual partners; and people who inject drugs and their sexual partners.

Box 2. Global Fund structures and processes

The Global Fund was established as an international financing instrument, a uniquely different entity than many of its peer organizations, which function as service and program delivery agents. Though several changes are being considered as part of the ongoing reform processes at the Global Fund, many of its core, “demand-driven” structures remain the same. This means in particular that applicant countries develop their own national proposals; in doing so, they define targets for their HIV prevention, treatment, and care programs.

The outline below is only a partial overview of Global Fund structures. Additional information can be found at www.theglobalfund.org/en/about/structures and www.aidsplan.org.

Structures

The **Country Coordinating Mechanism (CCM)** is a national-level body that is supposed to comprise representatives from all key stakeholders in the response to AIDS, TB, and malaria. CCMs are responsible for overseeing the entire grant life cycle: drafting and submitting proposals, nominating Principal Recipients, monitoring grant implementation, and submitting requests for future funding. In some cases, multiple countries can apply for funding through a **Regional Coordinating Mechanism (RCM)**. In rare circumstances, non-CCMs are permitted to apply for funding.

Principal Recipients (PRs) and **sub-recipients (SRs)** are the primary actors that implement grants and receive Global Fund money at a national level. Appointed by CCMs, PRs receive Global Fund money directly and often act as both implementers and sub-grantors (to SRs). There can be multiple PRs and SRs in each country for separate Global Fund grants.

The **Technical Review Panel (TRP)**, appointed by the Board of Directors, is an independent body of experts that meets regularly to review proposals, score them based exclusively on technical criteria, and provide funding recommendations to the Board. These recommendations are made regardless of the funding available at a specific time.

In addition to resource mobilization and operations support, the **Global Fund Secretariat** is responsible for managing the proposal application process and final grant negotiations once a grant has been approved by the Board. The Board is composed of representatives from donor and recipient governments, civil society, the private sector, private foundations, and communities living with and affected by the diseases.

Processes

The Global Fund has one funding window, which can contain several different components. The list below is not a full examination of Global Fund funding processes, but, rather, a list of the most salient pieces. Please note, as of November 2011, the Global Fund has suspended any new funding until 2014. Many current programs will continue to be supported under a Transitional Funding Mechanism. For additional details please see the Global Fund’s website.

Rounds-based funding is how a majority of Global Fund grants are awarded. A round is a period in which countries are able to submit new applications for funding, typically lasting about four months. Applications can have up to four components: a proposal for each of the three diseases and one for cross-cutting health systems strengthening activities that are tied to a specific disease. Since the inaugural round in 2002, the Global Fund has opened a funding round approximately once every year.

Performance-based funding is a core component of Global Fund financing. Grants are initially awarded only for two years (Phase I). After 18 months, grant performance is assessed. If there are no or limited performance or funding issues, the grant is extended for another three years (Phase II).

Single-stream funding is the new architecture for funding grants. When funding continues, it is anticipated that the phased, rounds-based funding approach will disappear in favor of a single grant agreement per PR, per disease, per country. Grant agreements will last three years towards the end of which there will be a performance assessment that will help determine future funding. In piloting this effort, several countries have already had single-stream funding agreements negotiated for prior rounds.

National Strategy Applications are a new funding mechanism currently rolled out on a pilot basis. Countries are encouraged to apply for funding to support their national HIV/AIDS, tuberculosis, and malaria strategies. This shift is meant to emphasize the development of a strong in-country planning process instead of a well-crafted Global Fund application.

All country proposals are reviewed by the **Technical Review Panel**, which as noted previously is an independent committee that evaluates the technical merit of each application to ensure it is appropriate for the epidemiological realities in that country. Only proposals that clear the TRP review are considered for funding by the Board.

However, applications from countries with generalized epidemics rarely address the needs of these populations. Several reasons have been cited, including the limited amount of data on these populations; legal systems that criminalize some or all practices associated with these individuals; and social, economic and political discrimination. Regardless of the specific reasons, it is clear that although the Global Fund has been associated with a large expansion of HIV prevention, treatment, and care services throughout the last decade, MARPs continue to have the least access to services and support⁶⁶ even though HIV prevalence among them, where studied, is often several times higher than among the general population.⁶⁷

In response, the Board of the Global Fund approved the Sexual Orientation and Gender Identities (SOGI) strategy in 2009. This strategy outlines concrete actions that various Global Fund bodies and structures, from the Secretariat in Geneva to Country Coordinating Mechanisms (CCMs) at the national level, are required to take to better understand and respond to the health needs and rights of sexual minorities. It directs the Secretariat to provide appropriate guidance, resources, and technical support to CCMs and other national structures to strengthen their ability to meet those responsibilities.⁶⁸

In line with this effort, the Global Fund established a reserved funding stream for HIV interventions among MARPs in Round 10. Applicants from countries with concentrated epidemics could apply for funding specifically for MARPs under this new funding stream. The response was mostly positive: 25 proposals were reviewed by the Technical Review Panel (TRP), of which 12 were approved for a total of \$47 million over two years. The Global Fund intends to continue the funding stream indefinitely when future Rounds are accessible.

Finally, the Global Fund Board went one step further in November 2011 by enshrining the prioritization of MARPs in its next five year strategy.⁶⁹ This is a welcome development that is the result of years of advocacy both internal and external to the organization.

The proximity of these efforts to this research makes it difficult to assess their impact. As of November 2011, many Round 10 grant agreements (the first round to reflect either the SOGI strategy or the reserved MARPs fund) were not formally signed. Therefore it was too recent for the purposes of this report to determine how much money was ultimately available for targeted programming through this funding stream.

However, a study conducted by the Global Fund regarding the extent to which Rounds 8, 9, and 10 proposals addressed the HIV-related needs of MSM, sex workers, and transgender individuals produced interesting findings.⁷⁰ When proposals were considered as a whole (including those deemed ineligible, those not recommended for funding, and those approved for funding), on average less than one-third contained any HIV prevalence data specific to these groups. Over time, though, there was a noticeable increase in the number of proposals including epidemiological data and programming for these populations. The MARPs reserve contributed to an 11 percent increase in programming for these populations compared with HIV/AIDS proposals overall. This is a notable accomplishment given other studies that have found that prevention among MSM accounts for about one-half of one percent of all Global Fund HIV funding.⁷¹

In an effort to make targeted MARPs programming a greater priority, the Global Fund recently published an information note titled "Addressing Sex Work, MSM and Transgender People in the Context of the HIV Epidemic."⁷² The document recommends more strategic targeting of HIV proposals, inclusion of MSM and other populations in CCMs, and improved surveillance systems to better understand the HIV epidemic among MSM and other MARPs.

Submitted proposals are only one part of the Global Fund financing process, however. To obtain a more complete picture of funding available for MSM programming, it is important to analyze the larger grant approval cycle (see Box 2). Every grant undergoes significant changes as it

moves from initial concept to an actual, signed grant agreement; therefore, researchers examined how the budget for MSM-specific programs changed from proposal to funding and the funding attrition that occurred at each step. Determining country commitment to MSM programming requires a close analysis of this process and the factors that influence it.

3.2.2 Methodology

This research focused on three areas:

- the percentage of funding that programs for MSM received compared with the overall financing requested and/or awarded in eight target countries;
- the attrition rate of funding for MSM programs compared with overall attrition rates for funding for all programming within a Global Fund grant in eight target countries; and
- the context in which MSM are discussed in the narrative portion of grant proposals.

The following terminology indicates which aspect of the Global Fund process is referred to throughout the discussion below:

- Requested budget: the amount submitted by CCMs in the initial proposal.
- Approved budget: the budget as approved by the Board of Directors.
- Final budget: the actual budget amount agreed upon by the Secretariat and the CCM or PR after approval. (Note: The final budget amounts are not publicly available. They were provided to researchers for this report by the Global Fund for purposes of this research.)

Attrition is defined as the change in funding from the requested budget to the approved and final budget(s), expressed as a percentage of the requested budget. For example, Guyana requested \$50,072 for MSM programs in Round 8, but only \$1,875 was available for MSM programs in the final budget. The difference is \$48,197, for an attrition rate of 96.3 percent. Where possible, both the approved and final budgets are compared to the requested budget.

Each of these levels is important as it points to a different actor involved in determining the extent to which MSM are incorporated into a budget. CCMs working in country develop the requested budget while the TRP and the Global Fund Secretariat are involved in creating the approved budget. The final budget is negotiated between the PR (if appointed) and the Global Fund Secretariat. For more information on the approval process, see Box 2 above.

In some cases, approved budgets differed from the final budgets provided by the Global Fund.⁷³ In cases of discrepancy, explanations regarding which numbers are used, and why, are noted in endnotes.

It was not possible to examine another possible definition of attrition: the difference between what was proposed and what was actually allocated in a given country. There was no mechanism available to the research team to determine actual allocation amounts or actual financial expenditures, which may differ from budgeted amounts. Similar difficulties were encountered in attempting to analyze programmatic changes. However, the in country consultations provide qualitative insight into the dynamics of Global Fund sponsored programming in country.

For each of the eight target countries, all publicly available Global Fund documents for approved HIV/AIDS grants in Rounds 5–9, including any multi-country proposals, were reviewed. Documents included original proposal forms, program grant agreements (Phases 1 and 2),

grant performance reports, and grant scorecards (evaluations for Phase 2 funding). The document searches were conducted from November 2010 through August 2011. Each document was searched for terms including “MSM” and variations including “men who have sex with men,” “men at high risk,” “most at risk populations,” “homosexual,” “MARPs,” “vulnerable populations,” and “high risk populations.”

When objectives referred to MARPs, including MSM along with other groups, the analysis assumed that funds were divided equally among each group only if MSM were actually mentioned as a potential MARP. For example, if an activity focused on MSM, injecting drug users, and sex workers, the total amount for that activity was divided by three to obtain an amount specifically for MSM. Such an approach is consistent with the Global Fund’s internal resource tracking methodology for most-at-risk populations.

Limitations

This research has several limitations:

- The researchers were provided a significant level of support from the Global Fund, especially in terms of access to final budgets. In some cases, however, the final budgets were not made available to the researchers (for Viet Nam Round 9 and multi-country Americas) and therefore could not be included in the research. Additionally, certain budgets did not contain sufficient detail to determine the amount of funding specifically for MSM. This was most apparent with approved budgets.
- While this research has been able to track funding attrition throughout the negotiation process, it was not possible to track programmatic attrition after funds were allocated using actual expenditure data.
- Budget information from regional proposals was analyzed if one of the eight target countries was included in that proposal. In such cases, however, it was difficult to ascertain if any MSM program funding awarded to the region took place in the specific country.
- Final budgets were not in a consistent format. Even within the same country for the same round, different sub-recipients submitted budgets in different formats. While the Global Fund offers applicants a standard budget template, applicants are not required to use it. As a result, detailed budgets are complex documents that undergo several phases of review and a period of negotiation. According to the Global Fund, “detailed budgets are primarily used as grant management documents rather than for research or analytic functions; moreover, they are not accessible to the public. For these reasons, in some cases there may be slight discrepancies between the ‘final budgets’ and the ‘approved budgets.’”⁷⁴
- Finally, since the countries in this research represent a varying proportion of overall HIV/AIDS funding from the Global Fund for each round examined—19 percent of Round 5, 40 percent of Round 6, 18 percent of Round 7, 7 percent of Round 8, and 18 percent of Round 9—these results should not be interpreted as indicative of overall Global Fund funding.

Given these methodological limitations, the results should be interpreted as case studies of opportunities and challenges for funding MSM programs through the Global Fund and not as representative of all Global Fund financing. Greater detail around actual programming on a country level can be found in Section 4.

3.2.3 Results

General results

Overall investment

Table 5 provides basic information about the eight target countries and their overall and HIV-specific portfolios at the Global Fund.

Two sets of rankings are noted in both figures. The second column presents rankings based on the total cumulative Global Fund investment for Rounds 1–9. The third column presents rankings based on cumulative HIV/AIDS investment over the same period. The U.S. dollar amount of that HIV/AIDS investment is provided in the column titled “cumulative HIV/AIDS disbursements as of October 20, 2011.”

The next five columns refer specifically to Rounds 5–9, which were the main focus of the analysis. Round 10 is included for informational purposes. An “X” in a box indicates that a country was awarded at least one Global Fund grant of any kind in that round; the boxes shaded in gray indicate when at least one HIV/AIDS grant was awarded that round.

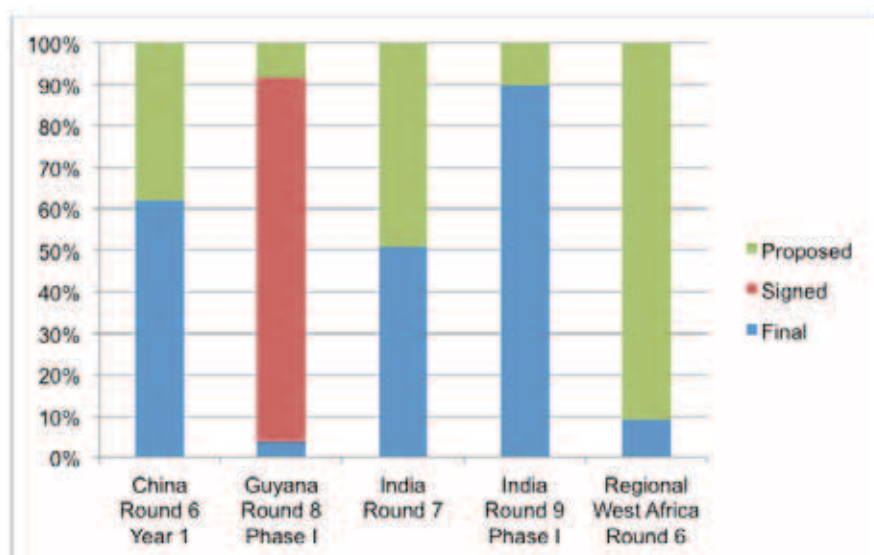
MSM in proposals

Most MSM programming in proposals from CCMs included behavior change communication (India in Round 7, China in Rounds 5 and 6, Nigeria in Round 9, and the multi-country Americas RCM in Round 9). While not as frequent, other proposals included community systems strengthening for MSM and transgender communities, improving sexual health and/or STI services, population size estimation, peer education, and condom distribution. These CCM proposals include MSM activities as part of their HIV prevention work, not for treatment or care programs.

Table 5. Global Fund investments in the eight target countries⁷⁵

Country	Rank: total cumulative disbursements (Rounds 1-9)	Rank: cumulative HIV/AIDS disbursements (Rounds 1-9)	Cumulative HIV/AIDS disbursements as of October 20, 2011 (Rounds 1-9)	Round 5	Round 6	Round 7	Round 8	Round 9	Round 10
China	5	9	\$230,516,242	X	X	X	X		X
Ethiopia	1	1	\$751,570,986	X	X	X	X	X	X
Guyana	82	65	\$28,057,437			X	X		
India	3	2	\$510,754,874		X	X		X	
Mozambique	20	14	\$158,693,316		X	X	X	X	
Nigeria	4	11	\$215,733,297	X			X		
Ukraine	21	10	\$220,771,082		X			X	X
Viet Nam	38	44	\$46,862,524		X	X	X	X	X

Figure 1. Funding attrition for MSM programs



Note: Some approved or final budget amounts are not shown in the chart due to missing data.

Within these proposals, MSM were frequently discussed as part of a broader discussion of MARPs. For instance, in Round 5 China’s proposal included voluntary counseling and testing services targeted for sex workers, migrants, and MSM. In addition, the multi-country West Africa proposal included media outreach to raise awareness of MSM along with eight other target populations.

Attrition

The attrition rates for MSM programs are examined in Figure 1. Global Fund awards to China (Round 6), Guyana, India (Round 9), and the West Africa region had

higher attrition for MSM programs than attrition in the budget overall. As previously cited, the greatest attrition was in Guyana, where the drop-off for funding of MSM programs was six times that of the overall budget. In Ukraine and in the multi-country Americas grant (including Guyana), more money was allocated for MSM than was originally proposed. The best case was the multi-country Americas grant, which allocated 214% more money for MSM programs than originally proposed, even though attrition for the overall grant was 23 percent. For those instances in which attrition rates could be calculated, the average MSM attrition rate was comparable to the average overall attrition rate, about 25 percent.

Country-specific findings

Individual findings for the eight target countries are summarized in Table 6 below. A country-by-country analysis follows. There is only a brief analysis where little to no MSM programming exists.

China

For China, Round 5, no data are available on the approved or final amounts for specific activities.

For Round 6, Year 1,¹⁵⁰ in the final budget China reallocated funds away from MSM programs and other programs and allocated more money toward Objective 1, capacity building and stigma reduction. For Objective 1, China requested \$282,890 and allocated \$789,475 out of the awarded amount, over 2.5 times more than requested. Although stigma reduction includes MSM, this population is not the primary focus of the objective. There are several inconsistencies within the final budget and within the proposal, thereby limiting the accuracy of an estimated attrition rate for the overall grant. The attrition rate for MSM programming was 1.4 times as high as the attrition rate for other types of programming; this is notable given the disproportionate burden of HIV among MSM (prevalence of 5 percent at least¹⁵¹) compared with 0.1 percent in the general adult population.¹⁵² Same-sex sexual practices are decriminalized in China.

Table 6. Overview of MSM and overall budgets for target countries (Rounds 5–9)

Note: SDA = service delivery area

Country	Round	MSM activities?	Budget requested in proposal	Approved budget	Final budget	Attrition	MSM as percentage of budget
China	5	Yes	Total \$28.9 million ⁷⁶	\$21.5 million ⁷⁷	Unclear ⁷⁸	Total 26% (approved)	20% (requested)
			MSM \$5.7 million ⁷⁹	Unclear ⁸⁰		MSM unclear	
	6, Year 1 ⁸¹	Yes	Total \$3.2 million ⁸²	\$3.2 million ⁸³	Unclear ⁸⁴	Unclear	12% (requested)
			SDA 1-3 \$2.6 million ⁸⁵	Unclear ⁸⁶	SDA 1-3 \$1.9 million	SDA 1-3 27% (final)	
		MSM \$368,826 ⁸⁷	Unclear ⁸⁸	MSM \$228,336	MSM 38% (final)		
Ethiopia	7	No	\$106.3 million ⁸⁹	\$85.6 million ⁹⁰	Unclear ⁹¹	Total 19% (approved)	0%
Guyana	8, Phase I	Yes	Total \$4.6 million ⁹²	Total \$3.9 million ⁹³	Total \$3.9 million	Total 15% (final)	0.04% (final)
			MSM \$50,072 ⁹⁴	MSM \$45,780.83 ⁹⁵	MSM \$1,875 ⁹⁶	MSM 96% (final)	
India	6	No	\$259.2 million ⁹⁷	\$123.5 million ⁹⁸	Unclear ⁹⁹	52% (approved)	0%
	7	Yes	Total \$88.2 million ¹⁰⁰	Total \$45 million ¹⁰²	Unclear ¹⁰⁴	Total 49% (approved)	0.2% (final)
			Total Phase I \$31 million ¹⁰¹	Total Phase I \$32.6 million ¹⁰³			
			MSM \$94,975 ¹⁰⁵	Unclear ¹⁰⁶	MSM \$77,188 ¹⁰⁷	MSM 19% (final)	
	9, Phase I	Yes	Total \$21 million ¹⁰⁸	Total \$18.8 million ¹⁰⁹	Total \$18.9 million	Total 10% (final)	32% (final)
MSM \$6.8 million ¹¹⁰			MSM \$6.1 million ¹¹¹	MSM \$6.1 million	MSM 10% (final)		
Mozambique	6, 8, Phase I; 9, Phase I	No	\$184.5 million ¹¹²	\$128.7 million ¹¹³	Unclear ¹¹⁴	30% (approved)	0%
Nigeria	5; 8, Phase I	No	\$255.7 million ¹¹⁵	\$163.3 million ¹¹⁶	Unclear ¹¹⁷	36% (approved)	0%
	9	Yes	Total \$341 million ¹¹⁸	Unclear ¹¹⁹	Unclear ¹²⁰	Unclear	0.6% (requested)
		MSM \$2 million ¹²¹	Unclear ¹²²	Unclear ¹²³	Unclear		
Ukraine	6	Yes	Total \$151.1 million ¹²⁴	\$131.5 million ¹²⁵	Total \$133.9 million ¹²⁶	Total 11% (final)	3.2% (final)
			MSM \$4.2 million ¹²⁷	Unclear ¹²⁸	MSM \$4.3 million ¹²⁹	MSM -2% (final)	
Viet Nam	6, Phase I; 8, Phase I	No	Total \$24.8 million ¹³⁰	\$18.9 million ¹³¹	Unclear ¹³²	24% (approved)	0%
	9	Yes	Total \$104 million ¹³³	Unclear ¹³⁴	Unclear ¹³⁵	Unclear	Unclear
		MSM unclear ¹³⁶					

Table 7. Overview of MSM and overall budgets for target regions (Rounds 5-9)

Region	Round	MSM activities?	Budget requested in proposal	Approved budget	Final budget	Attrition	MSM as percentage of budget
Americas	9, Phase I	Yes	Total \$14.5 million ¹³⁷	Total \$11.2 million ¹³⁸	Unclear ¹³⁹	Total 23% (approved)	1.8% (approved)
			MSM \$62,601 ¹⁴⁰	MSM \$196,671 ¹⁴¹	Unclear ¹⁴²	MSM -214% (approved)	
South Asia	9, Phase I	Yes	\$18.7 million ¹⁴³	\$13.7 million ¹⁴⁴	16.5 million	12% (final)	100%
West Africa	6	Yes	Total \$45.6 million ¹⁴⁵	\$31.4 million ¹⁴⁶	Total \$38.8 million	Total 15% (final)	0.3% (final)
			MSM \$1.2 million ¹⁴⁷	Unclear ¹⁴⁸	MSM \$103,258 ¹³	MSM 91% (final)	

Ethiopia

Ethiopia is the leading recipient of Global Fund money overall and for HIV/AIDS specifically. Three HIV/AIDS grant applications were approved by the Global Fund in Round 7, each of which mentioned MSM only to say there were none living in the country. Same-sex sexual practices are criminalized in Ethiopia. No HIV prevalence estimates are available for MSM in Ethiopia.

Guyana

In Guyana’s Round 8 proposal, MSM were mentioned as part of Objective 4, psychosocial support. Within that objective, the activity related to MSM was to “develop specific strategies for providing psychosocial interventions for targeted groups, such as women, youth, MSM, addicts and users of harmful substances, healthcare workers, caregivers.”¹⁵³ MSM programs had an attrition rate more than six times that of the overall grant. Guyana estimates HIV prevalence among MSM to be 19.4 percent,¹⁵⁴ in comparison with an overall prevalence of 1.2 percent in the general population.¹⁵⁵ Taking into account official estimates from Guyana that its MSM population stands at 7,171,¹⁵⁶ approximately 1 percent of the population, MSM are disproportionately affected by HIV yet receive a smaller proportion of the final budget (0.04 percent) than their representation in the population. Same-sex sexual practices are criminalized in Guyana.

Guyana is also part of a multi-country regional grant approved in Round 9, titled “*Fighting HIV in the Caribbean: a Strategic Regional Approach*.” The grant covers 29 states and territories, including Guyana. In the proposal, one of the activities under Objective 2 (behavioral change communication—community outreach and schools) was designed to serve five populations, including MSM.¹⁵⁷ MSM in Guyana fared better in the multi-country grant than in the individual country grant. While Guyana’s individual grant had a high relative MSM attrition rate, the final multi-country grant budget allocated more for MSM than originally proposed. The share of funds allocated for MSM in the final multi-country budget, 1.8 percent, was 45 times higher than the share allocated for MSM in Guyana’s final individual budget, 0.04 percent. However, it is notable that although the term “MSM” was mentioned in the multi-country proposal 68 times, MSM programming represents only 1.8 percent of the final budget.

India

In its Round 6 HIV/AIDS grant proposal, India referred to MSM as a risk group, but there were no MSM-specific activities proposed in the grant. In Round 7 the funds were disbursed to three grant PRs. One PR received only Phase 1 funding, which may explain why a higher amount was awarded than requested for Phase 1. MSM activities represented 0.3 percent of the Phase 1 request and 0.2 percent of the Phase 1 award. In Round 9, Phase 1, the attrition rate for MSM activities was the same as the attrition rate for the overall grant. MSM activities represented about 32 percent of India's final budget for Phase 1 of its Round 9 funding. The rest of the funds went to services for injecting drug users and HIV workplace policy and programs. HIV prevalence among MSM in India is estimated to be about 7.3 percent,¹⁵⁸ compared with 0.3 percent in the general population.¹⁵⁹ Same-sex sexual practices were criminalized in India until 2009.

India is also one of the countries associated with a multi-country South Asia regional grant approved in Round 9. The PR of that grant, titled "Reducing the impact of HIV on men who have sex with men and transgender populations in South Asia," is Population Services International (PSI), Nepal. The grant covers seven countries, including India; the entire grant is focused on MSM and transgender populations.

Mozambique

Mozambique received HIV/AIDS grants totaling \$184.5 million from the Global Fund for Round 6, Round 8, Phase I, and Round 9, Phase I. MSM were not mentioned in the Round 6 or Round 8 proposals or other documents. In Round 9, MSM were mentioned as a key risk group, but there were no planned MSM interventions. Same-sex sexual practices are criminalized in Mozambique—although, as noted elsewhere in this report (see Section 4.5), observers do not agree as to whether official legal status is relevant. There are no estimates available for HIV prevalence among MSM in Mozambique, although reports have recommended future research on this issue.¹⁶⁰

Nigeria

In Nigeria's Round 5 grant proposal, MSM were referred to as a key target population, but there were no MSM-specific activities detailed. In Round 8, Nigeria successfully applied for a health systems strengthening (HSS) grant focusing on HIV; no programs for MSM were included in the proposal. In Round 9, the Global Fund awarded grants to five PRs for HIV/AIDS programming through its new single-stream funding mechanism. Due to the nature of that mechanism, which aims in part to streamline and consolidate grants, it is unclear how much new money was awarded in Round 9 and how much was previously awarded. In the proposal, MSM were included in Objective 1 Service Delivery Area 4 (behavior change communication-community outreach). The PR for that area was Civil Society for HIV/AIDS in Nigeria; however, no final budget was provided for that PR. Out of \$341 million requested, just over \$2 million¹⁶¹ was requested for MSM programs. MSM activities thus represented 0.6 percent of the total grant request. HIV prevalence among MSM in Nigeria is estimated at 13.5 percent¹⁶² compared with 3.6 percent among the overall adult population.¹⁶³ Same-sex sexual practices are criminalized in Nigeria.

Nigeria is also part of a multi-country regional grant approved in Round 6, titled "West Africa Corridor Program." In the proposal, Activity 1.1 mass media outreach included nine populations, including "homosexuals."¹⁶⁴ The grant covers five countries, including Nigeria. MSM activities were estimated to represent 0.2 percent of the total approved amount. The attrition rate for activities including MSM was about six times as high as the overall attrition rate.

Ukraine

In Ukraine HIV prevalence among MSM (estimated at 8.6 percent)¹⁶⁵ is higher than among the general population (1.1 percent)¹⁶⁶ but lower than among injecting drug users (estimated at nearly 23 percent).¹⁶⁷ Although a small share (3.2 percent) of the budget was allocated to MSM activities (specifically, community outreach), two percent more money was awarded in the final budget than in the proposal (a negative attrition rate of two percent) while the attrition rate for the overall grant was 11 percent. Furthermore, given that Ukraine's HIV epidemic is more concentrated among injecting drug users than MSM, such a level of commitment to MSM programming is relatively strong, especially in comparison with other countries in this analysis.

Viet Nam

Viet Nam's Round 6 and Round 8 applications to the Global Fund recognized that the country's HIV epidemic is concentrated, with high prevalence among MSM and other MARPs. However, no specific activities were proposed for MSM. In Round 9, Viet Nam applied for and received a grant through the new single-stream funding mechanism; the proposed amount was \$104 million. Several activities for MSM were proposed, including condom use promotion and STI diagnosis and treatment. However, due to the format of the budget, it is difficult to break out the amount(s) proposed for MSM specifically, and the Global Fund did not provide a final budget for that grant to this project's researchers. And finally, due to the nature of the single-stream funding mechanism, which aims in part to streamline and consolidate grants, it is unclear how much new money was awarded in Round 9 and how much was previously awarded. In Viet Nam, HIV prevalence among MSM is 16.7 percent¹⁶⁸ compared with 0.4 percent in the general population.¹⁶⁹

3.2.4 Conclusions

One of the strongest correlations found in the results is that MSM programs tend to represent a smaller share of the budget and/or have higher attrition rates in countries in which same-sex sexual practices are criminalized compared with those without such punitive policies (see Table 8). An exception to this trend is Viet Nam, in which same-sex sexual practices are legal but few MSM programs were included (possibly due to that country receiving substantial MSM funding from PEPFAR).

Table 8. MSM attrition rates correlated with criminalization of same-sex sexual practices

Country	Same-sex sexual practices criminalized?	MSM attrition	MSM programming as % of total budget
Ethiopia	Yes	N/A	0%
Mozambique	Yes	N/A	0%
Guyana	Yes	96%	0.04%
Nigeria	Yes	Unknown	0.6%
India pre-2009	Yes	18.7%	0.2%
India 2009	No	10%	32%
China	No	38%	20%
Ukraine	No	-2%	3.2%
Viet Nam	No	Unknown	Unknown

One of the most startling examples of the difference in funding and attrition between criminalizing and non-criminalizing countries is in India. Table 8 shows that after same-sex sexual practices were decriminalized in India in 2009, a 160-fold greater share of funding was allocated for MSM compared with before: 32 percent of funds were allocated for MSM in Round 9, compared with 0.2 percent in Round 7. These changes are only in part a reflection of the legal framework in India (especially since these awards occurred so shortly after the Delhi High Court decision), but more accurately depict a changing climate for MSM work.

In countries where same-sex sexual practices are not criminalized, MSM tend to receive a larger share of the budget and have lower relative attrition rates. Even the lowest percentage of funds allocated for MSM in countries where same-sex sexual practices are legal (3.2 percent for Ukraine) is higher than the highest percentage of funds allocated for MSM in countries where same-sex sexual practices are criminalized (Nigeria, 0.6 percent). Of course there is the potential that this is confounded by the size of a country's epidemic and the sample of countries this analysis draws from; however, for the data analyzed, the observations appear consistent.

As relative attrition rates indicate, there is some support for the hypothesis that even when countries include MSM programs in their proposals, the MSM-targeted activities are deprioritized during grant negotiations. It is unclear why this occurs or who is responsible. In some countries, the CCM and the Global Fund Secretariat are involved in negotiations that may result in changes from the proposed budget to the approved budget. In others, the PR (if already appointed) and the Global Fund Secretariat are involved in negotiations that may result in changes between the approved budget and the final budget. In Guyana, MSM-targeted activities were deprioritized in both stages. In the West Africa regional grant, MSM-targeted activities were deprioritized between the proposed budget and the final budget, but it is unclear when this occurred because of insufficient detail in the approved budget. However, in other cases such deprioritization did not occur because i) few or no MSM programs were included in the proposals in the first place (for example, Ethiopia and Mozambique); or ii) MSM attrition rates were comparable to or lower than the general attrition rates (for example, Ukraine, the multi-country Americas grant, and India in Round 7). In general, few MSM programs were included in proposals, consistent with another study that found less than one percent of funding was allocated to the interventions targeting MSM.¹⁷⁰

One additional trend became clear in this analysis. Though health systems strengthening (HSS) grants are required to connect directly to a disease strategy in country, they are not required to address MARPs where epidemiologically appropriate. This can result in counterintuitive results for MSM. For example, both Guyana and Nigeria had Round 8 proposals with MSM-specific HIV activities rejected by the Global Fund's review process; however, both countries received Round 8 HSS funding tied to HIV without MSM activities. This raises the question of whether funding health systems strengthening for a disease actually benefits those populations most affected by the disease.

These complications are compounded by the Global Fund Board's November 2011 decision to replace Round 11 funding with a Transitional Funding Mechanism.¹⁷¹ The mechanism will finance only existing programs until 2014. Given that MSM already comprise such a small percentage of Global Fund supported programs, it is likely this decision will only further delay efforts to expand essential services for MSM.

3.3. U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

3.3.1 Background: MSM and PEPFAR

Very little is known about the prioritization of programs for MSM during the initial phase of PEPFAR implementation. That changed with the reauthorization of the program through the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. That legislation specifically directed the U.S. government to provide “assistance for appropriate HIV/AIDS education programs and training targeted to prevent the transmission of HIV among men who have sex with men” and “evaluate the effectiveness of prevention efforts among men who have sex with men, with due consideration to stigma and risks associated with disclosure.”¹⁷²

Almost three years later (eight years after the launch of PEPFAR), the U.S. Office of the Global AIDS Coordinator (OGAC) issued formal guidance on how countries should prioritize combination prevention programs that reduce sexual transmission of HIV among MSM. Through one seminal guidance document and several broader documents, OGAC detailed a core package of combination services for MSM and stipulated which activities should be funded by PEPFAR programs. Those activities are categorized below under two main categories.¹⁷³

PEPFAR core package of services for MSM

- Community-based outreach
- Distribution of condoms and condom-compatible lubricants
- HIV counseling and testing
- Active linkage to healthcare and antiretroviral treatment for MSM living with HIV
- Targeted information, education, and communication
- Sexually transmitted infection prevention, screening, and treatment

PEPFAR support for MSM programs through country budgets

- Implementation of HIV prevention interventions that provide equal and nondiscriminatory access as well as staff time used to assess, plan, implement, monitor, and evaluate these activities
- Promotion of laws, regulations, and policies that support HIV prevention for this population
- Training of health professionals and providers of community-based HIV prevention services to increase the capacity for delivering high-quality prevention and healthcare services
- Collection and use of strategic information
- Epidemiological, social science, and operational research to better understand HIV risk and its prevention among MSM

Box 3. PEPFAR structures and processes

Launched by President George W. Bush in 2003, PEPFAR is a U.S. government initiative charged primarily with developing and implementing a response to the global HIV/AIDS epidemic. Originally a five-year commitment of \$15 billion that focused exclusively on HIV/AIDS, PEPFAR was reauthorized, revised, and expanded in 2008. Now a \$48 billion commitment in 88 countries (including \$4 billion for tuberculosis and \$5 billion for malaria), PEPFAR is the cornerstone and largest component of the U.S. Global Health Initiative and among the largest health-related funding structures globally.

Structures¹⁷⁴

The **Office of the Global AIDS Coordinator (OGAC)** oversees PEPFAR implementation at the State Department. Led by the Global AIDS Coordinator, who reports directly to the Secretary of State, OGAC works in coordination with several PEPFAR **implementing agencies** including the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), the Departments of Labor, Commerce, and Defense, and the Peace Corps.

The 88 **countries that receive PEPFAR funding** include the original 15 focus countries and an additional 16 countries that make up the core of PEPFAR bilateral spending (and for which Country Operational Plans are required). Countries may also receive support through PEPFAR regional plans in the Caribbean, Central America, or Central Asia, or through the 21 Partnership Frameworks that have been signed with individual countries and regions. These categories do not encompass all PEPFAR countries and they are not mutually exclusive.

The **Global Health Initiative (GHI)** is an umbrella initiative started in 2009 that joins more than 80 percent of U.S. global health funding together in an effort to meld the separate external health initiatives into one unified whole. PEPFAR funding accounts for 76 percent of the \$63 billion six-year commitment made through the GHI in 2009.

The **Scientific Advisory Board (SAB)** provides analysis and recommendations to OGAC on issues related to science, policy, and implementation. Though it operates strictly in an advisory capacity, the SAB influences and informs PEPFAR's priorities including those in the areas of evaluation, research, resource allocation, and strategic direction.

Processes

Partnership Frameworks are five-year joint agreements developed collaboratively among the U.S. government, recipient country governments, and other in-country stakeholders focused on service delivery, policy reform, and coordinated financial commitments to combat HIV/AIDS. Countries with a Partnership Framework file a Country Operational Plan as part of the annual work plan process.

Country/Regional Operational Plans (COPs/ROPs) guide the majority of PEPFAR funding. U.S. government agencies in each of the 31 countries requiring COPs and those within the three regions requiring ROPs work together under the direction of the U.S. ambassador to each recipient country. Country teams develop one annual work plan for each country that is then submitted to OGAC and approved by the Global AIDS Coordinator.

- Monitoring and evaluation of programs and interventions through the use of standardized indicators
- Commodity procurement

These documents, especially when considered along with similar recommendations issued for people who inject drugs, signal a new approach to PEPFAR funding for MARPs.

However, neither the Country/Regional Operational Plans (COPs/ROPs) nor the Partnership Frameworks that guide PEPFAR funding (see Box 3 above) mandate the provision of resources for specific HIV/AIDS programming interventions or priorities. As a result, governments that are unwilling to support MSM-specific HIV programming may directly or indirectly restrict U.S.-funded nongovernmental sources from providing such services within their borders. Ultimately, MSM and members of other MARPs are at risk of not benefiting from PEPFAR support despite well-intentioned policy and guidance from OGAC.

Through an analysis of COPs, and the request for funding applications (RFAs) issued to finance them, researchers for this report attempted to determine the extent to which MSM programming is prioritized in PEPFAR countries. Though it is difficult to clearly identify and calculate the impact of PEPFAR programming on MSM (even in countries where funds reach them), it is possible to provide a snapshot of intent by estimating the degree to which recipient countries prioritize this population in their operating plans. Such estimates help inform the congressionally mandated process of evaluating the effectiveness of MSM-specific programming as well as determining the extent to which MSM are accepted and recognized as individuals in need of essential HIV services and support.

3.3.2 Methodology

This research on PEPFAR funding for MSM in target countries was completed in two phases. First, COPs from FY 2007 (October 2006 to September 2007) to FY 2009 (October 2008 to September 2009) were examined for each of the eight target countries considered in this research. For the most part, these documents contained detailed programmatic and funding information for program areas and activities supported by PEPFAR, allowing for analysis across time and among different countries.¹⁷⁵ The COPs, obtained from the PEPFAR website,¹⁷⁶ were searched for common terms associated with MSM including “men who have sex with men,” “homosexual,” “MARPs,” and “most at risk populations”. When such a term was identified, researchers analyzed the individual activity to understand whether MSM were truly a target of the proposed activity, and, if so, several data points about each MSM-related activity were collected. The most salient and comparable areas for the research were “program area” and “planned funding.” Summary tables and graphs were created for each country, as well as for the aggregate group, detailing MSM-related activities by program area and year, and MSM-related funding for each country.

The second phase of this research involved an analysis of U.S. government-issued RFAs from 2007 to 2010. RFAs can serve as an appropriate proxy for MSM program funding since they are a common mechanism used by the government to allocate resources to implementing agencies in PEPFAR countries. It was reasoned that since most COPs would require RFAs in order to implement approved activities, a thorough search of RFAs in the U.S. Federal Grants Database¹⁷⁷ should identify the funding available to countries for these activities. HIV-related opportunities were identified from results from each country. Methodology related to searching and data abstraction was identical to those methods used for COPs.

Limitations

Several important limitations were encountered during this research:

- Analyzing approved proposals is of limited benefit in ascertaining actual expenditures at a country level because this type of reporting only reflects intended budgets and proposed activities, not actual budgets or actual activities. However, public information on PEPFAR spending is difficult to obtain, which reinforces the need for and importance of this type of analysis.
- Not all countries provided the same level of detail in their COPs. In FY 2007 through FY 2009, the China and Ukraine COPs only contained program area summaries, leaving out details on individual activities. No publicly available COP was found for India for FY 2007.¹⁷⁸
- In the COPs, MSM were often included as part of broader programs that served many populations. It was often difficult or impossible to disaggregate what portion of funding or spending went to MSM-specific programs.
- RFAs do not map easily to COPs and there is no correlation between publicly available systems that track these mechanisms. It is impossible to track individual activities from the proposal stage (COPs) to the funding/implementation stage (RFAs). The RFAs in this study were used as proxies for actual MSM programmatic activities.
- While some RFAs did contain the term “MARPs” and/or “most-at-risk populations,” they rarely defined the term. As such, the inclusion of MSM cannot be verified.

3.3.3 Results

General results

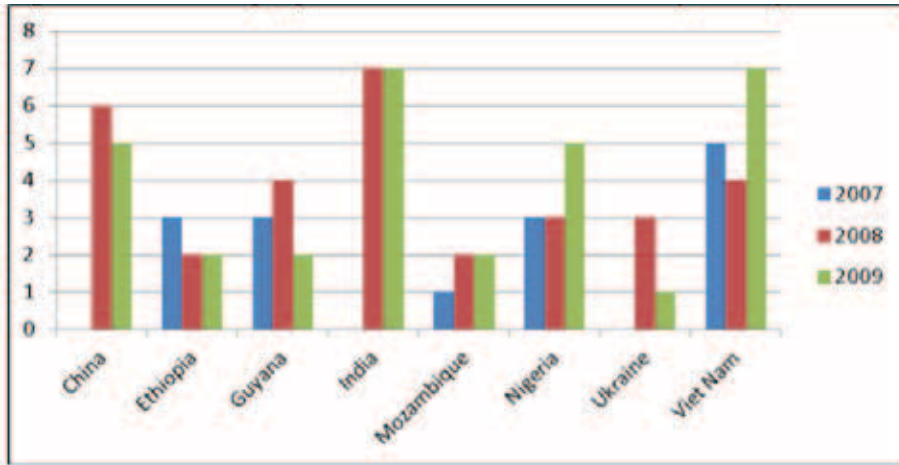
PEPFAR COPs, FY 2007–2009

The eight target countries in this research represent 29.4 percent of the \$11 billion in total approved funding in PEPFAR COPs over the three fiscal years examined (FY 2007, FY 2008, and FY 2009). From a broad perspective, all eight countries mentioned MSM in at least one program area (see Figure 1), but only six of the eight countries provided detail at the individual activity level.

The COPs for the three fiscal years contained two levels of detail. “Program areas” are the categories under which specific “activities” are classified. They include “PMTCT,” “sexual prevention: abstinence and be faithful (AB),” “condoms and other prevention,” “counseling and testing,” “strategic information,” “health systems strengthening,” “TB/HIV,” “orphans and vulnerable children (OVC),” “pediatric care,” “treatment,” “antiretroviral (ARV) drugs,” “laboratory infrastructure,” “management and staffing,” and several “biomedical prevention” sub-groups. Each program area contains a number of different activities, e.g., condom distribution by USAID or epidemiological surveillance by the Ministry of Health. Both the program areas and the activities included planned funding amounts and narratives.

Over the period of study, China, India, and Viet Nam had the greatest diversity in their portfolios of MSM-related programming. In these three countries, MSM were mentioned in at least four different program areas for every year of the analysis. Mozambique had the least diversity in programming, with no more than two program areas mentioning MSM in any given year, while Ethiopia, Guyana, Nigeria, and Ukraine all had at least one year in which three or more

Figure 1. Number of program areas that mention MSM by country

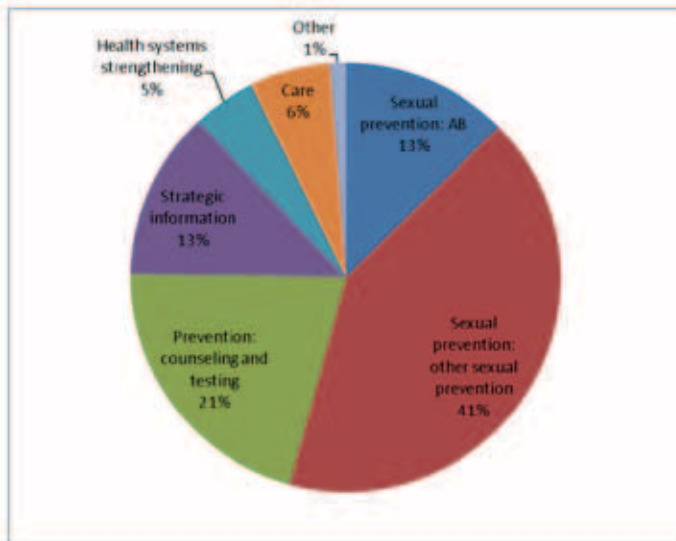


percentage of MSM-related activities, with 21 percent. Its activities included specifically targeted MSM programming through voluntary counseling and testing (VCT) and outreach services. Two program areas, “strategic information” and “sexual prevention: AB,” each contained 13 percent of the MSM-related activities. The activities under “strategic information” were mainly intended to gather more accurate epidemiological data about MSM populations, both regionally and nationally, while the “sexual prevention: AB” activities promoted abstinence messaging to MSM and other populations. Other program areas that contained MSM-related activities included “health systems strengthening,” “biomedical prevention: injecting and non-injecting drug use,” and “care.” The “care” program area encompasses TB/HIV, OVC, and pediatric care and support.

program areas had MSM-related programming.

As noted in Figure 2, among these eight countries, the program area “sexual prevention: other sexual prevention” (which includes condoms but excludes AB programming) was the predominant program area containing MSM-related activities (41 percent).¹⁷⁹ Activities ranged from condom distribution to addressing issues of discrimination and stigma. The program area “prevention: counseling and testing” had the second highest

Figure 2. Program areas with MSM-related activities, FY 2007–FY 2009



Examining specific activities under program areas provided an even more detailed analysis of proposed funding for MSM; however, only six of the eight countries studied were required to submit information on specific activities. Thus, China and Ukraine, which were only required to submit shorter COPs, were excluded from the analysis below.

From FY 2007 to FY 2009, total funds for MSM-related activities¹⁸⁰ in the six countries providing that level of data increased from \$23.3 million to \$35.4 million (see Figure 3). Viet Nam received the greatest amount of funding for MSM-related activities in any one year (FY 2009) and over the entire period—\$14.3 million and \$34.3 million, respectively. Three countries received more than \$15 million in funding for FY 2007 through FY 2009: Viet Nam, Nigeria, and India. Two countries, Guyana and Ethiopia, received over \$5 million for the three years, and Mozambique received more than \$2.2 million.

Four of the six countries had increases in funding for MSM-related activities between FY 2007 and FY 2009, but only Viet Nam and Nigeria experienced an increase from FY 2008 to FY 2009. The two countries that showed a decline in funding for MSM-related activities over the entire period were Nigeria and Guyana. While Nigeria’s MSM-related funding decreased by approximately 7 percent, Guyana’s fell by more than 50 percent.¹⁸¹

Despite the overall increase in funding for MSM-related activities, the proportion of the total PEPFAR country budgets (excluding treatment costs)¹⁸² going towards MSM-related activities remained relatively small for most of the countries (see Figure 4). India and Viet Nam were the two exceptions, both dedicating a significant proportion of their PEPFAR country budgets to MSM-related activities (25.9 percent and 18 percent, respectively). On the other hand, Guyana allocated approximately 10 percent of its budget to MSM-related activities, and Nigeria less than half of that. Ethiopia and Mozambique contributed negligible proportions of their budgets to MSM programming: 1 percent and 0.5 percent, respectively.

Since there are few reliable population estimates of MSM in these six countries, it is difficult to evaluate what an adequate proportion of total AIDS spending directed to MSM should be. However, based on country reporting via UNGASS (see Section 3.1), prevalence estimates appear to be disconnected from investment in most of these countries. There is little correlation between reported HIV prevalence among MSM via UNGASS and the PEPFAR prevention funding targeted to them. In Nigeria, where \$688 million of PEPFAR funding for prevention and care was approved over the three years, only 4 percent of the proposed budget was reserved for MSM-related activities, despite the country having estimated HIV prevalence of 13.5 percent among MSM.¹⁸³

The proportional analysis in Figure 4 is only one way to describe MSM activities in COPs. An alternate is to record the simple number of targeted MSM activities per country per year (Figure 5). From FY 2007 to FY 2008, the total number of MSM-related activities increased from 35 to 63 before declining in 2009 to 54. Viet Nam was the country with the largest number of total MSM-related activities across the three years (56), while Mozambique had the lowest tally (8). Despite not having a COP in 2007, India had the second highest number of overall activities, followed by Nigeria, Ethiopia, and Guyana. Of note, Nigeria more than doubled its number of MSM-related activities in FY 2009, the greatest one-year change among any of the six countries.

These figures potentially indicate an environment in which PEPFAR and national government partners are able

Figure 3. Funding for PEPFAR MSM-related activities by country

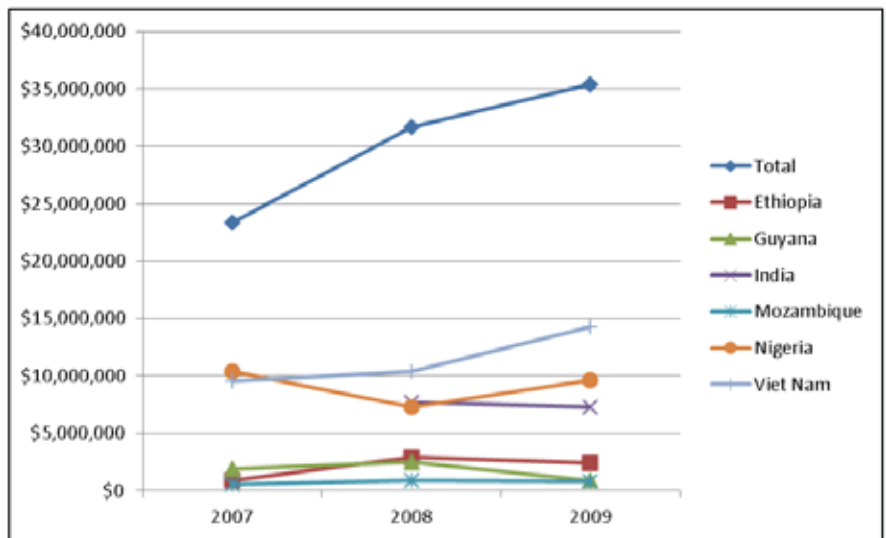


Figure 4. Percentage of PEPFAR country budgets (excluding treatment costs) planned for MSM-related activities, FY 2007–FY 2009

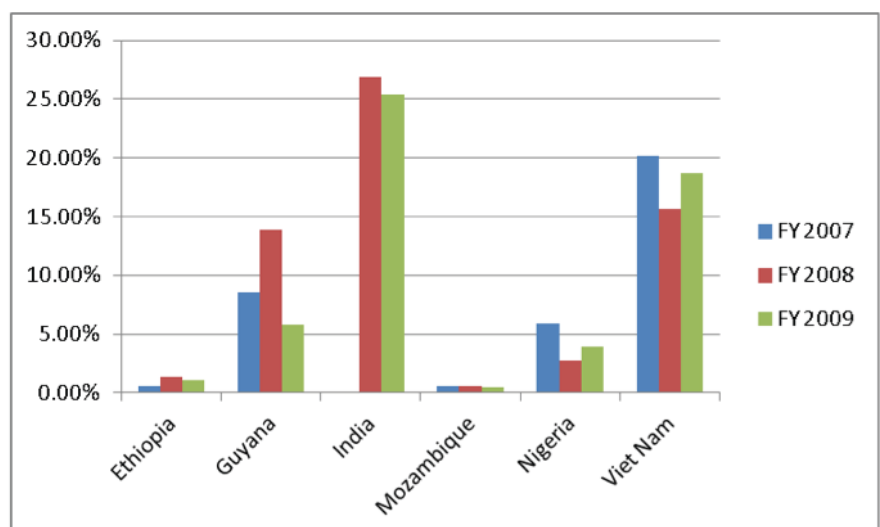
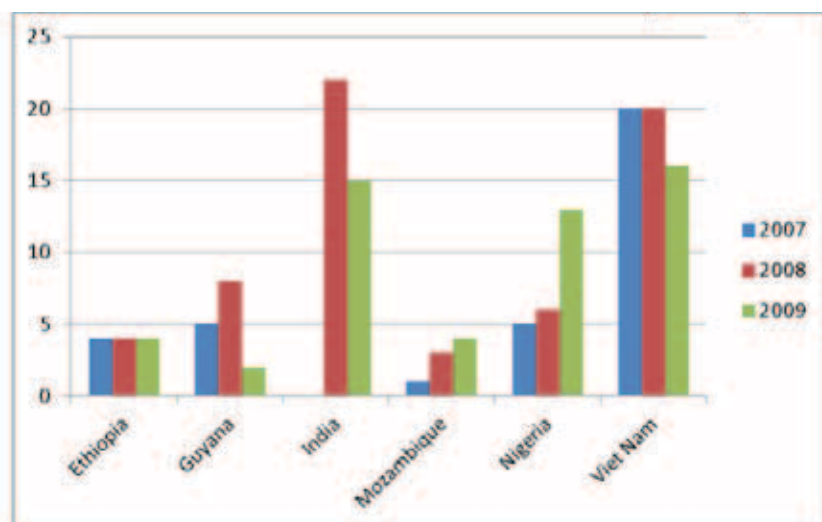


Figure 5. Number of PEPFAR MSM-related activities by country



to target HIV prevention programs to MSM despite national frameworks that criminalize and stigmatize this population.

U.S. government RFAs, 2007–2010

As previously mentioned, researchers' analysis of RFAs was more successful when the search term "MARPs" was applied instead of "MSM" or related terms. This result has significant implications for the analysis, as it is entirely possible that countries with MARPs programming have no activities targeting MSM. Across the target countries, MARPs applied broadly to FSWs, people who inject drugs, MSM, truck drivers, and other mobile populations. In only some cases

were there enough data to determine which populations were being referred to and when. For that reason, researchers divided analysis into two categories. The first category contained any RFA that "mentioned" MARPs, in any context. The second category included those RFAs that not only mentioned MARPs but had a particular "focus" on MARPs programming. These were distinguished by having specific activities targeting MARPs or an overall, comprehensive emphasis on MARPs throughout the RFA (as opposed to a passing mention). In all cases, "focus" is a subset of "mention." The distinction is subtle, but important, and it guides the brief discussion below.

From 2007 to 2010, there were 12 RFAs mentioning MARPs, totaling \$148.6 million. Ethiopia had the highest number—\$77.3 million (52 percent). Though the annual average of RFAs mentioning MARPs remained consistent (three), annual funding rose from \$10 million in 2007 to \$91.6 million in 2010.

Nine RFAs focused specifically on MARPs, totaling \$65 million (44 percent); Ethiopia made up the greatest share of the MARPs-specific RFAs (\$56.7 million, or 87 percent).

China, Mozambique, Nigeria, and Viet Nam each had one RFA, and all but Nigeria's focused on MARPs. The RFA for Nigeria only mentioned MARPs, but it was funded at a significantly higher amount than any of the others: \$62 million. China's RFA focusing on MARPs had no project proposal attached, so no funding information for China could be captured by the authors. No relevant RFAs were found for Guyana, India, or Ukraine.

Country-specific results

This section provides country-specific analysis from reviews of the PEPFAR COPs (FY 2007–FY 2009) and the U.S. government RFAs (2007–2010) for MSM programming in the eight countries. The results described here focus exclusively on budget scale and category rather than programmatic content for reasons previously stated. Additional information on in-country programming is available in the individual country sections in this report.

China

COPs mentioned MSM only within the context of various program area summaries. Information on specific activities was not provided for any program area. One RFA in 2008 focused on MARPs, though funding information was not available.

Ethiopia

COPs included four MSM-related activities for every year from FY 2007 through FY 2009. Funding levels varied from \$911,000 in FY 2007 to \$2.9 million in FY 2008 and \$2.4 million in FY 2009. The program areas containing these activities also varied by year. In FY 2007, MSM-related activities fell under “sexual prevention: other sexual prevention,” “strategic information,” and “health systems strengthening.” In FY 2008 and FY 2009, meanwhile, three activities were categorized under “sexual prevention: other sexual prevention” and one under “sexual prevention: AB.”

Ethiopia had the greatest number of RFAs mentioning MARPs, totaling eight from 2007 to 2010. Funding for the eight RFAs totaled \$77 million. Of these, six RFAs focused specifically on MARPs.

Guyana

COPs included five activities mentioning MSM in FY 2007, eight activities in FY 2008, and two activities in FY 2009. Guyana is the country with the greatest decrease in funding for MSM-related activities when comparing FY 2007 and FY 2009 totals. Funding for MSM-related activities totaled \$1.9 million in FY 2007 and only \$882,189 in FY 2009. The peak was in FY 2008, when \$2.5 million was to be spent on MSM-related activities. Program areas associated with MSM varied by year, but “sexual prevention: other sexual prevention” and “prevention: counseling and testing” were always represented. No RFAs mentioning MARPs were found for Guyana from 2007 to 2010.

India

COPs included 22 activities mentioning MSM in FY 2008 and 15 activities in FY 2009. To the knowledge of the researchers, India did not produce a COP for FY 2007, but the 21 continuing activities reported in FY 2008 indicate that MSM activities were taking place in India in FY 2007. Funding for MSM-related activities totaled \$7.7 million in FY 2008 and \$7.3 million in FY 2009.

India had the greatest variety of activities in terms of different program areas. In FY 2008, activities mentioning MSM fell into seven different program areas, including “sexual prevention: AB,” “sexual prevention: other sexual prevention,” “prevention: counseling and testing,” “strategic information,” “health systems strengthening,” “care: adult care and support,” and “care: TB/HIV.” Of the eight countries, India had the second highest number of MSM-related activities and was third in funding (despite the lack of reporting in FY 2007).

No RFAs mentioning MARPs were found for India from 2007 to 2010.

Mozambique

COPs included one activity mentioning MSM in FY 2007, three activities in FY 2008, and four activities in FY 2009. Most of those activities fell under the program area “sexual prevention: other sexual prevention,” with the remainder under “strategic information.” Funding for MSM-related activities increased from \$580,000 in FY 2007 to \$880,000 in FY 2008, and then declined to \$775,000 in FY 2009. Of the eight countries, Mozambique had the lowest number of MSM-

related activities as well as the least amount of funding. One RFA in 2010 focused on MARPs with \$9 million in funding.

Nigeria

COPs included five activities mentioning MSM in FY 2007, six activities in FY 2008, and 13 activities in FY 2009. The MSM-related activities fell under a range of program areas, with the greatest diversification in FY 2009. The program areas “sexual prevention: other sexual prevention” and “prevention: counseling and testing” were represented each year. Funding for MSM-related activities decreased from \$10.4 million in FY 2007 to \$7.3 million in FY 2008 before increasing to \$9.7 million in FY 2009. Of the eight target countries, Nigeria was second in total funding over the three years and third in number of MSM-related activities.

Only one RFA in 2010 mentioned MARPs. However, funding for the RFA was \$62 million, which represented the single largest amount of any RFA captured.

Ukraine

COPs mentioned MSM only within the context of various program area summaries, and information on specific activities was not provided for any program area. No RFAs mentioning MARPs were found for Ukraine from 2007 to 2010.

Viet Nam

COPs included 20 activities mentioning MSM in both FY 2007 and FY 2008. The largest number of those activities fell under “sexual prevention: other sexual prevention.” Other activities fell under “sexual prevention: AB”, “prevention: counseling and testing,” “strategic information,” and “health systems strengthening.” Funding for FY 2007 and FY 2008 was \$9.6 million and \$10.4 million, respectively. In FY 2009, funding reached \$14.3 million, but the total number of MSM-related activities dropped to 16. Of the eight countries, Viet Nam had the highest number of MSM-related activities as well as the largest amount of funding. One RFA in 2009 focused on MARPs, with a funding level of \$315,000.

3.3.4 Conclusion

There is a correlation between criminalization of same-sex sexual practices and MSM-targeted programming in PEPFAR COPs. The four countries in this analysis that criminalize sexual practices associated with MSM (Ethiopia, Guyana, Mozambique, and Nigeria) proposed far fewer MSM-related activities in a smaller number of program areas. In fact, the combined number of MSM-related activities in the four countries that criminalize same-sex sexual practices (59 activities) only barely surpasses the total for the top country, Viet Nam (56 activities). It is possible that, if detailed data for China and Ukraine were available, those countries combined with Viet Nam and India would have shown a striking difference in the level of engagement occurring in criminalizing versus non-criminalizing countries.

In addition, the four countries that criminalize not only proposed fewer MSM-related activities, but the percentages of their country budgets allocated to MSM-related activities were smaller as well. It is possible that punitive policies combined with a generalized epidemic mask a substantial MSM epidemic. It is too simplistic to divide countries between concentrated and generalized classifications and presume the burden of disease among MSM. With more data it would be possible to make stronger conclusions about the impact of criminalization on MSM.

Regardless of the legal paradigm in-country, this analysis points to other troubling trends. Over the study period, the percentage of PEPFAR country budgets (excluding treatment) directed to MSM-related activities declined for five of the six countries in this analysis. While the proportional decreases were slight, this occurred at the same time that PEPFAR budgets were increasing dramatically. For example, from FY 2007 to FY 2009, Viet Nam's PEPFAR budget (excluding treatment) increased by 62 percent, while the proportion of the budget going to MSM programming decreased 1.6 percentage points. In essence, while PEPFAR budgets rose dramatically, MSM funding stagnated or declined.

Perhaps the most striking challenge raised by this analysis, though, is the lack of accessible data on how PEPFAR allocates its resources. Though OGAC has made significant moves towards greater transparency since PEPFAR's initial authorization, it is still difficult to ascertain the impact of the funds on the ground, including the main beneficiaries. Tracing actual PEPFAR funding through RFAs is cumbersome and ultimately flawed for several reasons: the CDC and/or USAID might publish only a single RFA for the entirety of its HIV program in a given country for a given year; COP activities might be continued from previous years and not require a new RFA; and/or implementing U.S. agencies might have pre-existing working relationships with certain NGOs and thus not publish funding opportunities publicly. The lack of transparency around spending and the paucity of publicly available information make it impossible to assess which COP activities, MSM-related or otherwise, are actually implemented, if at all, from data in the public domain.

Given OGAC's priority for data-driven country spending, this extensive process of searching through government databases should be unnecessary. PEPFAR should be encouraged to build accessible Web-based databases, like the Global Fund, that provide easy access and analysis of country planning and portfolios. Similarly, countries must be strongly encouraged to collect the necessary data to inform programming. There is no legitimate case to be made for not collecting data on MSM and HIV in any PEPFAR country.

4. Introduction to Country Reports

The eight country-specific reports in this publication represent the results of at least 10 consultations per country completed by a consultant—either one individual or a small team—based in the country and with knowledge about, and expertise in, HIV programming for MSM in that country. The consultations took place in the native language of the country in question, though the reports were provided in English.

The novelty of these country reports is that they represent the first multi-country assessment of the content and scale of HIV research and programming for MSM that also considers the extent to which structural barriers affect the scale or evidence-based content of such programs. They therefore provide an important contribution to the other analyses included in the overall report. The donor reviews (Sections 3.2 and 3.3), along with the section on the reporting of indicators to UNGASS (Section 3.1), provide a quantitative assessment of indicators such as levels of investment, type of investment, and level of reporting, as well as changes over time in the reporting of indicators. However, those global-level analyses cannot adequately assess the qualitative content of MSM-specific HIV programming at country level or the impact of the investment and subsequent research.

Few of these country-level programs are represented in the peer-reviewed literature or as abstracts at key international conferences. In addition, few reports in the public domain are available to describe the content or outcomes related to these programs. As such, hosting consultations in each country is crucial for characterizing the situation on the ground in terms of research, coverage, and funding sources for programs for MSM. A further strength of the consultations was identifying the varied target populations, including government officials, international and country-based program implementers, country-based donor staff, civil society representatives, and networks of people living with HIV/AIDS.

However, there are limitations with this approach. In most settings, only a relatively small number of local key informants are willing to discuss issues specifically related to MSM, such as the need for research and programming as well as the scale and quality of current research and programming. Moreover, capacity and infrastructure limitations are common in most countries among the type of groups from which consultants were primarily drawn for the consultations: community-based organizations focused on issues related to HIV among MSM. Such gaps persist because the same resource constraints that broadly affect research and programming for MSM in these countries also have affected the level of investment in those organizations and their members.

In recognition of these limitations, assertions of key informants and consultants were verified, wherever possible, with citations from peer-reviewed literature, surveillance, and programmatic reports and abstracts. However, independent verification was not always achievable.

While working with organizations with limited capacity can be challenging, there are important reasons why the country-level reports are a crucial component of this overall assessment. External consultants generally have less understanding of important economic, cultural, and social conditions of relevance to local MSM and HIV programming. They also tend to have limited access to the main target populations, especially in settings where stigma is intense and same-sex sexual practices are criminalized. In addition, local involvement in, and ownership of, these studies builds capacity for future projects.

In general, the content of these country reports should be considered in tandem with the analysis of the donor reports and the reporting of UNGASS indicators. Together they provide an instructive overview of the discrepancies between reported investments in programs and research and the situation on the ground.

Each country report begins with a comparison of general adult (ages 15 to 49) HIV prevalence, with HIV prevalence among MSM when available, followed by a summary of the report and key recommendations. All general HIV prevalence information is from UNAIDS estimates from 2009—except Ethiopia, which is from 2008. MSM HIV prevalence estimates are from individual countries' UNGASS reports (using the latest available data) unless more recent figures have been provided by country consultants (cited in the body of each country report).

The eight countries vary significantly in terms of HIV impact and response, extent of MSM-specific activities, and challenges and opportunities related to ongoing and future programming. Notable differences are also found in consultants' experience, capacity, and ability to access information and observations. The uniqueness of each context and contributor is reflected in the country reports themselves: although standardized to some extent, each differs in terms of structure and identified needs and priorities.

4.1 China

4.1.1 Introduction and context

Recent data and estimates regarding HIV in China clearly demonstrate that the epidemic is increasingly affecting the MSM population at far greater levels than the general population. The following results are notable:¹⁸⁴

- Of the estimated 740,000 PLHIV in China at the end of 2009, about 14.7 percent were infected through same-sex sexual practices. That compares with 44.3 percent through heterosexual activity and nearly one-third through contaminated drug-injecting material.
- The share of new HIV infections attributed to same-sex sexual practices has increased steadily in recent years. Of the estimated 48,000 new HIV infections in 2009, transmission was attributed to same-sex sexual practices in nearly one-third (32.5 percent) of all cases. That share is nearly three times higher than in 2007 (12.2 percent of all new infections), thus indicating that transmission among MSM has rapidly become one of the most significant modes in China.
- Over the past few years, sentinel surveillance results have shown that the rate of positive HIV antibody test results among MSM has been consistently greater than one percent, and is increasing year by year. HIV prevalence among MSM in large and medium cities reached an average of five percent, according to a survey of MSM in 61 cities carried out in 2008–2009. In several cities of southwest China, such as Guiyang, Chongqing, Kunming, and Chengdu, it was greater than 10 percent. According to a recent presentation from a Ministry of Health (MoH) official, national HIV prevalence among MSM is currently about 5.7 percent.¹⁸⁵

China

Adult HIV prevalence: 0.1%
HIV prevalence among MSM: 5.7%

Summary: Although same-sex sexual practices are not criminalized in China, stigma toward MSM and obstacles faced by NGOs hinder the implementation of comprehensive, effective programs addressing HIV among MSM. The government seeks to control programming by flowing funds through GONGOs, which greatly limits the growth of a robust independent civil society.

Selected country-specific recommendations:

- Prioritize the capacity building and involvement of MSM NGOs;
- Increase the roles and responsibilities of MSM and their NGOs in research.

Methodology

Research for this report included a literature review of reports and documents on MSM and HIV published over the past five years as well as reports on HIV and stigma. The author also participated in a number of meetings on MSM and HIV in Beijing, Nanjing, Lanzhou, and Yinchuan, and met with representatives from NGOs working with and for MSM in those cities. Interviews were conducted with 10 MSM group leaders, three government officials (one at the national level and two at provincial level), two representatives from international donor agencies, two officials from government-organized non-governmental organizations (GONGOs), and one academic expert.

Key stakeholders involved

In China, the main stakeholders in HIV programming among MSM are the China Centers for Disease Control (China CDC) and its branch offices at all levels; international donors and financing mechanisms such as the Global Fund and the China-Gates HIV Program; the China STI/HIV Prevention and Control Association; the China Preventive Medicine Association (CPMA); infectious disease hospitals and affiliated clinicians in all provincial capital cities; grassroots MSM NGOs and urban PLHIV NGOs; and multilateral partners such as UNAIDS, WHO, and several international non-governmental organizations (INGOs).

China CDC is the key operational stakeholder for HIV prevention and treatment in China. An entity under the direct leadership of the MoH, it takes the lead in policy making and implementation through its branch offices at provincial, prefecture, country, and city level. In regards to program evaluation, China CDC and its branches provide technical assistance to implementing agencies. China CDC also has a leading responsibility in intergovernmental and multilateral and bilateral international cooperation and exchange programs, and it has a strong influence on the direction, implementing methodology, and funding allocation of international programs in China.

The National Center for AIDS/STD Prevention and Control (NCAIDS) is located within China CDC. It is the main HIV prevention technical guidance unit, and as such focuses on HIV prevention among MSM. NCAIDS is the key governmental entity engaged in HIV surveillance; currently, there are some 2,000 sentinel spots across the country. A specific MSM category is included in all sentinel databases.¹⁸⁶

4.1.2 MSM-specific HIV programming

In general, there is a wide range of MSM-focused HIV programming in China. Priority areas include the following:

- Prevention: condoms and lubricants promotion, information distribution, venue outreach, peer education, and awareness-raising training
- PLHIV care: for equal access to healthcare facilities, ART compliance education, and income generation
- NGO capacity building: skills training, networking, fundraising, proposal writing, and project management

Support is also provided to some extent for advocacy purposes, including in regards to anti-stigma and anti-discrimination efforts.

China-Gates HIV Program

The Bill & Melinda Gates Foundation provided \$50 million to start an HIV program in partnership with the Chinese government in August 2007. The five-year program, which is currently due to end in July 2012, focuses on prevention services for high-risk groups (including MSM, sex workers, and injecting drug users); increasing access to HIV counseling and testing; prevention and support for PLHIV; and stigma reduction. The program set up local offices in 15 cities and, among its activities, it encourages NGOs to recruit members of vulnerable populations for HIV tests. In 2010, the program re-adjusted its focus from MSM, CSW, and IDU to MSM and PLHIV.

The program has released early results. Between 2008 and the end of June 2011, it mobilized 210,535 MSM to receive an HIV test and, of these, 5,973 tested HIV positive. There was no information about community systems strengthening or MSM leadership in these programs. The Gates Foundation is expected to provide more information on its work in China prior to closing the program.

4.1.3 Challenges and obstacles to adequate services for MSM

Legal situation

Homosexuality and same-sex sexual practices were decriminalized in 1997, and in 2001 homosexuality was deleted from the mental disease list.¹⁸⁷ Decriminalization has not been followed by any proactive official steps to formally legalize same-sex sexual practices, however. Although the legal and social environment for MSM and transgender people has improved in China, ignorance, stigma, and discrimination are still widespread and there is no national law that recognizes or protects the rights of sexual minorities.¹⁸⁸

As a result of the murky legal environment, MSM have limited recourse if harassed by law enforcement. Across the whole country, local police regularly raid many MSM gathering venues, such as cruising parks, saunas, bars, and clubs. In September 2010, for example, Beijing police arrested more than 80 people at a popular outdoor gathering spot for gay men and forced many of them to be photographed, fingerprinted, and even take blood tests.¹⁸⁹ According to informants, MSM volunteers risk being arrested by local police and beaten when they undertake outreach activities in many Chinese cities, including Beijing, Tianjin, Nanjing, and Guangzhou. Such incidents understandably make MSM wary of disclosing or discussing same-sex sexual practices, a trend that can limit the reach of HIV prevention efforts as well as the effectiveness of research and surveillance activities.

Government attitudes and practices

The government does not allow positive images of gay men to appear in the mainstream media, and it suppresses open discussion of same-sex sexual practices throughout society. Moreover, it has also exhibited hostility and opposition to gay rights on a wider scale, as when it voted to deny the application of the International Gay and Lesbian Human Rights Commission (IGLHRC) for consultative status to the United Nations Economic and Social Council (ECOSOC).¹⁹⁰ (IGLHRC nevertheless won consultative status in 2010.)

Such attitudes and actions underscore the inconsistencies throughout the government in terms of how same-sex sexual practices and sexual minorities are approached. At the same time that the Ministry of Health (MoH) is seeking to reach more MSM with HIV prevention,

treatment, and care interventions, other government agencies and departments are encouraging stigma toward same-sex sexual practices and calling it immoral. The MoH and its allies thus find it difficult to mobilize officials from other sectors, particularly local police, to participate in, or at least not obstruct, HIV prevention activities targeting MSM.

Restrictions on independent civil society groups

The Chinese government imposes numerous requirements on NGOs in general, and on organizations seeking to work with MSM in particular. Among the preconditions for registration as an independent civil society association—without which it is difficult to operate openly—NGOs must first obtain approval from a government entity engaged in similar work (e.g., China CDC). Government officials often deny registration applications, and they are not required to provide a reason for doing so. The majority of grassroots NGOs, including those that work with and for MSM specifically, are not recognized by the government. Without legal status, they encounter substantial ongoing difficulties in recruiting staff members, fundraising and HIV project implementation. Most MSM grassroots groups have no bank account to receive funding support. Some have even been blackmailed by local criminal gangs for money and materials—including, for example, Deep Blue MSM Care and Support in Tianjin in 2011.

Such restrictions also limit the ability of Chinese NGOs to conduct advocacy on behalf of the health needs of MSM. Only a few grassroots NGOs and their coalitions, such as China Male Tongzhi Health Forum (CMTHF) and China HIV United Meeting, as well as some individuals, occasionally make advocacy-oriented statements. CMTHF has no legal status so it is difficult for it to fundraise and to sustain its work in general.

Access to and quality of health services

With external projects' mobilization and promotion, a few state-run hospitals, such as the Constructive Hospital in Chengdu, Sichuan province, now employ healthcare professionals who have been specifically trained to respond in a clinically competent and culturally sensitive manner to health issues common among MSM. But generally speaking, most state-run hospitals across the country have no such special arrangement, which means that the quality of care MSM clients receive often depends on the attitude of individual health workers. Attitudes are usually better in the private health sector; staff in such facilities are more inclined to safeguard confidentiality and ensure flexible service delivery. But the quality of services in private facilities is not consistently high, and many men cannot afford to use them.

Real and perceived stigma and discrimination in health service delivery are important considerations for MSM. Most MSM and gay men in China therefore visit hospitals far from their homes when they have an STI or they are HIV-positive. Many people travel to nearby provinces or to Beijing even for simple treatments. They dare not run the risk of having their sexual orientation revealed in their hometown.

Another concern is that prevention commodities such as free condoms and water-based lubricants are not easily obtainable by all MSM in China. Some outreach activities with project support provide both free of charge, but others do not. The government provides free condoms through its family planning system, but it rarely offers easily accessible information regarding where they are available. The poor quality of condoms is another problem. Many MSM and others complain that most condoms available in China lack sufficient lubricant and break easily, among other concerns.

Other challenges associated with MSM-specific programming

In light of the government's inconsistent response to homosexuality and same-sex sexual practices—characterized by some observers as “no support, no objection, and no promotion”¹⁹¹—MSM health, informational, and social services are poorly developed in China. Apart from a handful of gay bars, there are few places where MSM can meet in China. Most thus visit parks and public saunas and toilet facilities. The situation is particularly difficult for MSM in rural areas, who are even more likely to suffer from poverty, isolation, and lack of access to information and friendship. Unlike most of their counterparts in urban areas, they may be unaware of MSM-focused outreach campaigns or where to go for appropriate HIV services (or even why they would need such services).

Lack of awareness and information is also a major problem among young men in high schools and universities. Though they may be aware of same-sex attraction and even already be acting upon their feelings, they usually know nothing about safer sex or MSM-specific health services.

In some societies, the internet is an option for obtaining essential health and social information for MSM. Yet in China, gay-themed websites, including those that provide HIV information, are frequently blocked by internet management authorities.

Social and cultural factors also play a large role in limiting access to, and uptake of, MSM-specific services. Given the significant stigma faced by MSM and the strong social pressure in China to have a child (particularly a son), many choose to marry a woman and have sex with men outside of marriage. According to a report from about a decade ago, up to 70 percent of MSM in China are estimated to be married or planning on getting married.¹⁹² (No specific research has since been conducted, but it is unlikely the overall findings have changed much.) Many men in this situation do not discuss their sexuality with their wives and lead “straight” public lives. One survey of 2,046 MSM conducted by Prof. Zhang Beichuan from Qingdao Medical University (who is the most well-known MSM expert in China), found that as few as 11.2 percent of married MSM informed their spouses about their same-sex sexual practices.¹⁹³ Such a low level of disclosure potentially heightens the potential for HIV transmission to women and newborns.

4.1.4 Government response and engagement

The Chinese government provides financial support for MSM-related research through open bidding arranged by the Ministry of Science. But this support does not go directly to grassroots MSM organizations. Only those with academic titles, such as Zhang Beichuan (mentioned above), are qualified to apply. (Some of the financial support eventually reaches grassroots organizations because Zhang usually partners with them.) NCAIDS also has its own research budget, and through that it has funded research on MSM.

Another funding resource is the National Social Mobilization Program set up by the MoH.¹⁹⁴ For 2011, the program provided an estimated RMB6.5 million (\$1 million) to grassroots NGOs for interventions, PLHIV care, and NGO capacity building. Of that total amount, approximately RMB2.25 million (\$350,000) went to 19 MSM grassroots NGOs across the country. One of the conditions to receive support is that funds should go through, and be managed by, GONGOs above the provincial level. That condition requires the grassroots NGOs to set up partnership relationships with local GONGOs and jointly draft proposals.

In such relationships, about 15 to 30 percent of the funding is appropriated by the participating GONGOs as a supervision fee or for overhead. Thus the total amount promised for MSM-specific programming by China CDC does not represent the amount actually spent on service provision.

The government has, however, promised to provide more funds to support grassroots NGOs, including MSM NGOs, in the coming years—as much as RMB10 million (\$1.54 million) per year.

In terms of the funded projects' contents, some do not include research components. Most of the MSM-focused HIV interventions and capacity-building projects among MSM NGOs are designed and implemented by MSM organizations themselves.

4.1.5 Global Fund support and engagement

[Note: Since this report was originally written, the Global Fund has announced that it will not provide any new funding to China. That includes new grants as well as Phase 2 renewals.]

The Global Fund has been active in China since its inception, approving HIV/AIDS grants in Rounds 3, 4, 5, and 6. China CDC has been the Principal Recipient for all of the grants, which have recently been consolidated into a single, large-scale funding channel as per new Global Fund funding structures.

Global Fund money has been used to support HIV epidemiological research for MSM as well as targeted prevention, treatment, and care programs. Grassroots MSM organizations have never been involved in Global Fund application and program planning processes. They have, though, been directly involved in research and intervention projects in their own community—including project conceptualization, planning, implementation, analysis, and dissemination. Among the specific activities they have undertaken are situation analysis, data collection and analysis, development of new working models and replication, and sharing of experiences. The involvement of grassroots NGOs in such efforts has been critical; it is difficult to imagine they could have been implemented effectively solely by government entities without community input.

In terms of direct Global Fund support to MSM groups, the level and scope have been much lower than anticipated. According to a recent external evaluation report,¹⁹⁵ “the actual funds allocated in 2010 are still much lower than planned (between 6.3 percent and 11.7 percent, depending on the definition of ‘CSO’ and the definition of ‘activity budget’), and remain far below the minimum 20 percent allocation agreed in the signed grant agreement.” According to the NGO representative on the China CCM, the amount provided to MSM groups in 2010 was RMB4,630,000 (\$725,000) in total.

One of the reasons for this low level of support to legitimate NGOs is that China CDCs at different levels have created “fake” MSM NGOs that apply for and receive resources. Most of those are GONGOs and thus are not truly independent or linked with the community. This occurs in part because China CDC is both the Global Fund Principal Recipient (at the national level) and the main sub-recipient (through local branches) at the provincial level. That controlling structure gives the government opportunities to limit funding to legitimate grassroots NGOs.

In May 2011, the Global Fund temporarily suspended HIV/AIDS grant disbursements to China because of concerns about the lack of participation by NGOs in program implementation, among other problems. That suspension was lifted a month later after China CDC and the MoH vowed to address the concerns. In October 2011, however, the Global Fund announced that it would withhold \$95 million from the \$270 million in total approved funding that was to be eventually disbursed to China. The decision was made partly in response to the belief that China is wealthy enough now to fund its overall response to the three diseases, and partly because of lingering concern that the government had not adequately dealt with the concerns about insufficient support for grassroots organizations. Regardless of the reason, many independent NGOs engaged in the HIV/AIDS response in China are likely to face funding shortfalls as most receive at least some support through Global Fund programs.

In terms of CCM representation, there is currently one NGO representative and one PLHIV representative each on the 22-member body. Neither openly represents the MSM community. The NGO working committee has two MSM representatives, though impact of this working committee has been limited as the China CCM does not recognize its legal status. The NGO representative and others have confirmed that specific MSM issues have not been discussed at any CCM meeting to date.

4.1.6 U.S. government support and engagement

China CDC and the Global AIDS Program (GAP) of the U.S. Centers for Disease Control and Prevention (U.S. CDC) launched a program in March 2004. Through the initiative, the U.S. CDC has provided technical support and other kinds of direct assistance to its Chinese counterpart to help improve its HIV/AIDS surveillance systems and strengthen local public health capacity for HIV/AIDS services, with particular focus on reaching most-at-risk populations such as MSM. The overall program was integrated into the larger PEPFAR initiative in 2006.

GAP initially operated in 15 provinces, but now is active in only five, mainly through local China CDCs. It supported China CDC in designing and implementing several large surveys among MSM, including the 61 cities survey conducted in 2008–2009 that focused on characterizing the burden of HIV among MSM.

The impact of GAP on the MSM community is most extensive in the southwestern part of China. Yet in the research, treatment and other projects implemented so far, MSM groups have had little high level involvement; instead, they only serve as recruiting entities for target populations. Recently the GAP China Office has begun to allow their partnership with provincial China CDCs to seek financial support through an internal competition. MSM-specific programming is one of its main focus areas.

4.1.7 Recommendations

- The roles and responsibilities of MSM and their NGOs in research should be increased. All researchers and institutions doing research on MSM in China should involve MSM and their NGOs in all aspects of research related to them, including planning, implementation, and evaluation, to improve quality and uptake of these studies. Separately, MSM groups should be encouraged and supported to conduct their own research, which may generate different, yet meaningful, data. This could be done by dividing individual research projects into two parts, one conducted by an academic entity and the other by one or more grassroots groups.
- International donors and their Chinese partners, particularly China CDC at all levels, should introduce and uphold policies allowing MSM groups to take the lead in all services targeting the MSM population. For example, prevention, treatment, and care projects targeting MSM should be implemented by grassroots MSM groups. This would require the provision of administrative support to grassroots MSM NGOs to support them in building capacity and sustainability. Greater investment by the government in citizens' groups is also needed. And finally, international contributions should be structured as matching fund mechanisms, which means that the more a local government invests, the more an international financing mechanism will provide.
- Donors and international financing mechanisms should equally prioritize grassroots NGOs and government entities when developing and implementing programs in China.

Currently, the government's involvement, power, and influence are excessive, which is one reason why HIV programs may not be as effective as they could be. This recommendation, like the one immediately above, is based on the recognition that grassroots MSM groups are marginalized; instead, they should be central to all programmatic activities.

- China CDC and international partners should make NGO capacity building a priority. Investing in long-term capacity building of grassroots community-based organizations (CBOs) is critical to sustaining and expanding China's response to HIV. This is particularly relevant for the newly consolidated Global Fund grant because it still seems more designed to support China CDC in achieving its own indicators than addressing the need to provide structural support to CBOs. And, given the Global Fund's recent announcement that it would reduce planned support to China by about one-third, efforts to ensure that a larger share of the disbursed funds go to grassroots organizations are essential. As part of these priority changes, a more systematic approach to capacity building of CBOs should be developed in light of the fact that many services for MSM are best delivered in community-based settings and by civil society organizations.
- Laws and policies that directly affect MSM should be reformed. International partners (including UN agencies, INGOs, and bilateral partners) could leverage their influence and push China CDC and other departments in the MoH to consider prioritizing the reform of laws and policies related to MSM. One priority could be to encourage the Chinese government to pass an anti-discrimination law protecting sexual minorities. The MoH needs to lobby the Ministry of Public Security and the National People's Congress and make the case that these reforms are necessary from the perspective of social stability (and public health).
- The overall list of UNGASS indicators should be altered. Among other things, it should include indicators aimed at clearly showing development assistance allocations by populations and by provinces. This would help readers more easily see where funding flows, and could help individuals and community groups in monitoring the use of such funds by local governments and NGOs as one step in achieving a more meaningful representation of programs in UNGASS indicators. Also, if the financial indicators were better correlated with those focusing on achievements in HIV prevention and control, it would be easier to link financial investment to results. And finally, it is important to remember that China has the largest population in the world. Breaking the indicators down by province would greatly facilitate the ability of readers and reviewers to better understand the HIV situation in their areas.

4.2 Ethiopia

4.2.1 Introduction and context

Adult HIV prevalence in Ethiopia was estimated to be about 2.4 percent in 2010, corresponding to more than 1.2 million people living with HIV.¹⁹⁶ Available data and evidence suggest that although the epidemic is generalized, it is heterogeneous with marked variations across regions and population groups. Prevalence is higher among women (2.8 percent) than men (1.8 percent), according to the most recent estimates.¹⁹⁷ And though rural prevalence is increasing of late, at 0.9 percent it is still much lower than in major urban areas (7.7 percent).¹⁹⁸

A National Prevention Summit attended by key stakeholders held in April 2009 reached consensus to strengthen prevention activities and also increase efforts to reach most-at-risk populations (MARPs) with interventions. They include MSM as well as FSWs, migrant workers, long-distance truck drivers, armed forces, and sero-discordant couples.¹⁹⁹

No reliable data are available as to the size, risk status, and characteristics of MARPs in Ethiopia. MSM are currently not included as a vulnerable population in the country's strategic plan, and no MSM-targeted HIV prevention, treatment, and care programming is funded by the government, the Global Fund, or PEPFAR.

Research studies²⁰⁰ and anecdotal reports from NGOs working with and for MSM suggest that high risk sexual practices are common and that levels of knowledge associated with HIV-related risks are low. This suggests that MSM bear a disproportionate burden of HIV compared with the general population. Studies from other countries in the region with similar epidemics have shown that MSM comprise a substantial portion of new infections. For example, in Kenya, recent studies have found that MSM account for as much as 15.2 percent of new infections.²⁰¹

Methodology

Research for this study included both literature reviews and interviews with key informants. The following publicly available documents were among those consulted:

- 2008 and 2009 PEPFAR and Global Fund Country Operating Plans (COPs) in Ethiopia,
- partnership framework agreements with PEPFAR and the Global Fund,
- partnership framework implementation plans with PEPFAR and the Global Fund,
- the 2010 UNGASS Ethiopia country progress report, and
- peer-reviewed and public health literature.

In addition, 15 interviews with key informants were conducted in April and May 2011 by the consultant researcher and other volunteers from Rainbow-Ethiopia, an NGO that focuses on MSM. The interviews took place in Addis Ababa and other regional towns of Ethiopia including Adama, Awassa, Bahir Dar, Mekele, Dire Dawa, and Jimma. Among those interviewed were:

- senior technical experts from the national HIV/AIDS Prevention and Control Office (HAPCO),
- field-based PEPFAR staff from USAID and the CDC,

Ethiopia

Adult HIV prevalence: 2.4% HIV prevalence among MSM: Unknown

Summary: A lack of data combined with the criminalization of same-sex sexual practices create major barriers to addressing HIV among MSM and to reaching MSM population for all other health, social, or economic reasons. Global Fund and PEPFAR support is extensive in general, but funding from neither initiative reaches MSM directly for the most part.

Selected country-specific recommendations:

- Reform laws and policies related to MSM;
- Increase financial support for MSM groups and research.

- MARPs program managers for major PEPFAR- and Global Fund-supported projects,
- leading epidemiologists and experts on HIV/AIDS issues at Addis Ababa University, and
- frontline community-based MSM and HIV prevention networks and support groups in and outside of Addis Ababa.

Key stakeholders involved

Most of the Ethiopian government's HIV/AIDS budget is covered by international financing mechanisms including the Global Fund and donors such as the U.S. government (through PEPFAR primarily). Ethiopia is the largest recipient of HIV grants from the Global Fund, which together with PEPFAR provided approximately 90 percent of donor support for HIV/AIDS in 2009. Other donors include UNAIDS, the World Bank, UNITAID, and some other bilateral donors. Ethiopia was one of the first signatories to the International Health Partnership and related initiatives (IHP+).

4.2.2 MSM-specific HIV programming

The government has done little or nothing to address the specific HIV prevention and treatment needs of MSM. Few other stakeholders are significantly involved in MSM-targeted HIV programming either, with the exception of a handful of poorly resourced local NGOs. Partly as a result, many MSM in Ethiopia are still not fully aware of most sexual risk factors. Anecdotal reports indicate that unprotected anal sex is common, and that MSM in some contexts engage in transactional sex. Condoms are available at relatively low cost and sometimes for free through certain government sources and NGOs. However, availability of water-based lubricants is more limited; therefore, most MSM reportedly use saliva and oil-based lubricants like Vaseline and lotions, which are riskier in terms of HIV transmission.

Some recent efforts have been undertaken to improve the situation for MSM. In June 2010, local MSM and HIV/AIDS advocates organized a landmark consultation meeting with the support of the Netherlands embassy in Ethiopia. In attendance were 15 representatives from major multilateral agencies and HIV financing mechanisms, including most UN agencies, the Global Fund, CDC, and INGOs including Family Health International and Population Services International. The goal was to create a task force to lobby the Ethiopian government to reframe national HIV prevention, care, and treatment strategies to better integrate MARPs, including MSM. However, most of the organizations have so far failed to follow up and support the nascent efforts of the local advocates and their grassroots, community-based initiatives.

4.2.3 Challenges and obstacles to adequate services for MSM

Legal situation

Same-sex sexual practices are categorized as “indecent acts” and remain criminalized in Ethiopia. Article 629 of the Ethiopian Criminal Code prohibits such behavior, and respondents indicated that violators may be imprisoned for up to 10 years. Furthermore, respondents indicated that the maximum sentence can be applied when a sexual partner transmits a communicable infection such as HIV (and is previously aware of having the infection);²⁰² when an adult is charged with committing homosexual acts with a person under the age of 15; or when distress, shame, or despair drives one partner to commit

suicide. When the Criminal Code was revised in 2005, for the first time in 48 years, the statutes and language criminalizing homosexuality were not changed.

The very fact that homosexuality is criminalized gives license to a wide range of hate crimes and violence against the MSM community, emboldening offenders to act with impunity. Yet there has been no visible support to ease or reform the laws from any government officials or agencies, or even from most national and local civil society organizations. Even NGOs that work with and for MSM have been reluctant to speak out about legal reform in this regard.

It is worth noting that the degree of legal repression and the use of judicial mechanisms against homosexuality in Ethiopia are intensifying, as both enforcement and severity of punishment are increasing. Another significant legal challenge is associated with a new law, “Proclamation for the Registration and Regulation of Charities and Societies,” passed in 2009.²⁰³ The law forbids local civil society organizations working on advocacy and human right issues to receive foreign funding or to enter into partnership with any foreign organization or institution. This law, coupled with the strict Criminal Code prohibitions against homosexuality and widespread stigma, greatly limits the ability of MSM groups to obtain support and financing or to openly work with members of the population. Prevailing stigma and discrimination also prevent MSM from seeking appropriate information, care, and support related to HIV/AIDS.

Widespread stigma and discrimination

In addition to the legal sanctions and criminalization, the stigmatization of homosexuality by religious leaders, government officials, and the general public in Ethiopia complicates efforts to reach MSM and raise awareness about HIV and other health issues. The challenges are just as significant in Addis Ababa, where MSM are likely living in higher numbers, because levels of social, political, and economic stigma are as high there as in the rest of the country.

Access to health and other services

The impact of all these challenges is undeniably negative for MSM and, more broadly, for effective public health policy making. Stigma, violence, detention, and lack of safe social and health resources make it hard for MSM to reach and utilize even the few reliable HIV prevention services that do exist. MSM rarely find non-judgmental, MSM-sensitive, and clinically competent healthcare services. In most facilities, public and private, MSM face insensitivity, discrimination, refusal to provide care, and sometimes physical abuse from healthcare providers. Many are therefore reluctant to seek care or postpone visits to facilities, thereby potentially putting their health at serious risk. (Two private clinics in Addis Ababa are relatively supportive and friendly to MSM, but services there are prohibitively expensive for many members of the community. That is especially true for male sex workers, who are particularly vulnerable to HIV and STIs and would benefit the most, but who cannot afford the clinics’ fees.)

Most MSM have little access to programs and services that address structural drivers such as joblessness, poverty, and depression. Such challenges are especially problematic among specific sub-populations such as young male sex workers in Addis Ababa, a group that is perhaps the most marginalized of the marginalized. They seem to be suffering from a double burden of dealing with their stigmatized sex trade and sexual practices, and neither their health nor economic needs are being recognized or met.

4.2.4 Government response and engagement

As noted previously, the government has largely ignored MSM in all its HIV-related programming, much of which is developed and implemented through HAPCO. In the HAPCO Draft Interim Strategic Plan for Multi-Sectoral HIV Response in Ethiopia 2009–2010/11 drafted in February 2009, MSM are not included as a target population as evidenced by the following quote: “MSM that has not been recognized as a threat for HIV spread in Ethiopia [sic] has been reported to be a concern for the society and public administrators.”²⁰⁴

Yet, though the 2009 draft does not specifically target MSM, the quote above indicates that HAPCO was aware of the particular risks among MSM. MSM were discussed in detail for the first time in the national HIV prevention strategy that remained under development while research for this report was being conducted. However, the strategy as of December 2011 remained only in draft form.

MSM are also not included as a target population in the national HIV/AIDS prevention and surveillance policy. Recently, though, there have been some positive developments. For example, the U.S. Centers for Disease Control and Prevention (CDC), in partnership with the Ethiopian Health and Nutrition Research Institute (EHNRI), is conducting an HIV/AIDS, STIs, and Viral Hepatitis (HSV) assessment among MSM. However, this survey is being developed and implemented without the participation of grassroots NGOs that have links to the MSM community or have been playing a significant role in seeking to raise attention about the disproportionate burden of HIV among MSM in Addis Ababa.

4.2.5 Global Fund support and engagement

No Global Fund money has ever been allocated for MSM-targeted epidemiological research or for prevention, treatment, care, and support programs specifically for MSM. Members of Rainbow-Ethiopia and other grassroots organizations have appealed for MSM-specific support from Network of Networks of HIV Positives in Ethiopia (NEP+), a Principal Recipient of one of the Global Fund HIV/AIDS grants (Round 7). However, to date NEP+ has not been willing to support such programming.

Given the lack of services, resources, and attention in general, it is not surprising that MSM are not represented on the Global Fund CCM or that MSM service issues are not discussed during its meetings.

4.2.6 U.S. government support and engagement

The Ethiopian and U.S. governments signed a partnership agreement through PEPFAR in October 2010 to collaboratively expand and sustain an effective response to the HIV/AIDS epidemic in Ethiopia over the next five years. The framework’s goals and objectives are consistent with Ethiopia’s Strategic Plan for Intensifying Multispectral HIV/AIDS Response in Ethiopia 2010–2014 (SPM II) and the Health Sector Development Plan IV 2010/11–2014/15 (HSDP IV), PEPFAR’s strategic plan, and the principles of the U.S. government’s Global Health Initiative. The partnership framework also seeks to ensure that U.S. government contributions towards the SPM II and broader health sector development programs complement and leverage other stakeholders.

PEPFAR’s current strategic plan promotes HIV prevention for MSM as well as increased epidemiological research to better understand the extent and impact of HIV among the population. It also specifically mentions the importance of paying “due consideration” to stigma and risks associated with disclosure.

Such vital PEPFAR criteria have had some impact on MSM-specific HIV programming in Ethiopia. As noted previously, CDC in partnership with EHNRI is conducting an HSV assessment among MSM; planning was initiated in 2009 for this assessment, the first U.S. government-sponsored national research project on MSM and HIV in Ethiopia. CDC has also provided funding and technical assistance to the government for the development of the latest HIV prevention package for MARPs. And in a third example of support that will focus on MSM at least to some extent, the U.S. agency has partnered with Engender Health-Ethiopia to develop a fixed-term consultancy project to provide Rainbow-Ethiopia with technical support on HIV/STI prevention for marginalized men, including MSM.

It remains unclear whether these nascent initiatives herald the emergence of extensive services or support for MSM. With the exception of the consultancy project for Rainbow-Ethiopia, the representation and involvement of MSM community groups has been insignificant, according to respondents. Several observed that both the EHNRI and MARPs prevention package projects are managed by Ethiopian technical experts who have shown that they are not comfortable working closely with and involving MSM.

4.2.7 Recommendations

The Ethiopian government in partnership with major donors such as the Global Fund and PEPFAR should take the following concrete steps to more effectively reach MSM and other vulnerable populations:

- Change policies and laws that impede effective HIV programming. This should include the repeal of laws that criminalize consensual adult same-sex sexual practices and the implementation of policies that seek to aggressively combat stigma and discrimination aimed at sexual minorities and PLHIV.
- Create an MSM-specific strategic fund to provide resources for supporting in-depth, reliable research on the MSM population in Ethiopia. The results could help guide key programming decisions based on the size of the population, its access to health and social services, and the impact of legal, social, and economic stigma and discrimination.
- Substantially increase financial support for community-based MSM groups and INGOs to provide HIV services to MSM and advocate for human rights. Beyond program support, funding should be dedicated to developing organizational capacity for frontline community groups, including core priorities such as fiscal and personnel management, strategic planning, and computer and social media training.
- Develop policies to guide expansion and uptake of a comprehensive package of health services tailored to the needs of MSM, both through general health systems and targeted initiatives that can be accessed by people who may not feel safe using general health services. In many cases, NGOs will be better positioned to deliver services to MSM than government-run public health settings.
- Provide training and guidance to help providers in local health sectors respond to the specific needs of MSM and offer appropriate services. Training should also focus on improving attitudes regarding MSM, which requires directly addressing stigma within the healthcare system.
- Develop and implement programs aimed at ensuring that policy makers and staff at the federal HAPCO and Ministry of Health understand and respond to the health needs of MSM. The Global Fund and PEPFAR should encourage and support the government in this effort.

The government also should prioritize strengthening surveillance systems and structures to more closely track HIV among MSM and to improve understanding of the social and behavioral risk factors that should inform programming.

- Appoint an MSM coordinator at HAPCO to track and report MSM-specific needs to the federal government in the areas of programming, budget allocations, and policy and program outcomes.
- Increase financial and technical support for operations research that can identify interventions capable of reaching diverse MSM communities in all regions, and disseminate results to inform national and regional policies.
- Work with civil society coalitions—and with bilateral and multilateral partners including European governments, UN agencies, the World Bank, and others—to increase national resources for HIV/AIDS and related programs targeting MSM. Such work should also focus on facilitating the direct and meaningful involvement of MSM in national decision-making bodies.
- Develop programs and structures to assess the degree to which government-run health facilities are able to meet the needs of MSM and other vulnerable populations.

4.3 Guyana

4.3.1 Introduction and context

Adult HIV prevalence in Guyana has been declining over the past few years and is now about 1.2 percent.²⁰⁵ That corresponded to nearly 6,000 people living with HIV in 2009. Prevalence among MSM remains significantly higher, however, and has declined only slightly. According to the Integrated Biological and Behavioral Surveillance Survey (IBBSS) conducted in 2005 prior to the UNGASS Country Progress Report, HIV prevalence among MSM was 21.2 percent; the corresponding estimate in the 2009 IBBSS was 19.4 percent.²⁰⁶

Methodology

Research for this report included a comprehensive literature review and a series of semi-structured interviews with representatives of various stakeholders in Guyana. A total of 12 interviews were conducted between May and September 2011. They included two representatives from the government; six from civil society (including four from MSM and lesbian, gay, bisexual, and transgender (LGBT) organizations); and four from international and bilateral donor entities.

Information and observations from those interviews form the bulk of this report. References are made to “study participant,” “respondent,” and “interviewee” where relevant, although for confidentiality purposes additional identifying information (such as the sector in which a respondent works) is not always provided. In many cases, the comments and assertions are not independently verifiable.

Key stakeholders involved

Key stakeholders working on MSM and HIV issues include civil society organizations, donor entities, and multilateral agencies such as those associated with the United Nations (e.g., UNDP and UNAIDS). Most civil society groups are HIV-oriented, including Artistes in Direct Support, the Guyana Rainbow Foundation (Guybow), United Bricklayers, and the Linden Care Foundation. Other key stakeholders working with MSM in the country include the Society Against Sexual Orientation Discrimination (SASOD) and the Guyana Responsible Parenthood Association (GRPA), while the Guyana Sex Work Coalition works with male sex workers.

In the government sector, the National AIDS Programme Secretariat (NAPS) is increasingly involved as a key stakeholder in MSM-specific HIV work. For example, the secretariat supported a VCT training program for the MSM/LGBT community in 2011. Previously, NAPS would occasionally mention MSM issues and do nothing, but with such developments it is now directly engaged (albeit in a limited manner).

4.3.2 MSM-specific HIV programming

MSM-specific programs in Guyana are, by and large, limited to behavioral interventions; they include community outreach, peer education, peer counseling, VCT, and referrals to health services, almost exclusively provided by civil society.

One major initiative discussed by participants is the Guyana HIV/AIDS Reduction and Prevention Project (GHARP), a multisectoral collaboration involving the governments of Guyana and the United States and implemented on the ground primarily by civil society partners. The first phase of GHARP ran from 2004 through 2009; it has been followed by a second five-year phase (GHARP II) currently ongoing. One study participant associated with the initiative summarized its activities as follows:

GHARP does do some advocacy on behalf of MSM and sexual and gender minorities. We do it below the line—not using mass media or things like that—but by going to institutions and health centers, and doing sensitization training and trying to raise their awareness of issues affecting marginalized groups when they try to access health services. And we are also working with the population on their own self-stigma, in terms of building capacity and awareness on how it can affect their health.

Guyana

Adult HIV prevalence: 1.2%
HIV prevalence among MSM: 19.4%

Summary: There are few prevention or social services targeting MSM, and the HIV prevalence among MSM has declined only slightly. The existing MSM-specific programs in Guyana are, by and large, limited to behavioral interventions almost exclusively provided by civil society. Additionally, the criminalization of same-sex practices negatively impacts the ability and inclination to conduct research and surveillance regarding MSM in Guyana.

Selected country-specific recommendations:

- Increase surveillance of MSM population;
- Improve training for healthcare professionals;
- Implement programs aimed at positive behavior change among MSM.

4.3.3 Challenges and obstacles to adequate services for MSM

Legal situation

Criminalization of same-sex sexual practices has a huge, negative impact on the ability and inclination to conduct research and surveillance regarding MSM in Guyana, and also perpetuates high levels of stigma and discrimination. Most interviewees agreed that the law on same-sex sexual practices influences the government's reluctance to provide targeted health and other support programs to MSM, which are needed to reduce their vulnerability to the epidemic.

With the partial exception of the Ministry of Health, criminalization restricts government entities from being involved in MSM-specific programming in many important ways. One respondent pointed to the reluctance of the Ministry of Home Affairs to provide HIV prevention services (such as condoms) in prisons and the army because of the legal regime criminalizing sex between men. A study participant from the donor community provided an example from the field of how the law limits the impact of health programs in such sensitive areas:

We go to prisons and we find support groups for MSM within the prison system where they speak to us about their behavior, etc. It's good that they can actually find themselves and have a support group, but then when we ask officials about distributing condoms, we are told we can't. It's kind of a paradox. I understand the rules and regulations, but we have to deal with the reality.

Another respondent summarized the complications and complexities in the following manner:

On the one hand, the government realizes that they [MSM] are the drivers of the epidemic, but at the same time they say this activity is not an activity that we support...and then there's the question: so how do we promote effective programming without acknowledging this criminal activity? It becomes a conundrum and is touchy because it's a very political subject; thus I find that people give a lot of lip service about what needs to be done, but they don't actually follow through and do anything.

The government's attitude is often shared by representatives from other sectors. One study participant noted that the existing anti-sodomy legislation is also cited by many civil society groups as a reason for not working with the MSM community in general; they too are concerned about working with a population whose members are engaged in an illegal activity.

Most respondents agreed that decriminalizing same-sex relations would represent an important human rights and public health strategy. A handful of study participants said, though, that a more pressing priority should be to enact legislative protections based on sexual orientation and gender identity to increase the provision and uptake of prevention, treatment, and care services. In the opinion of one respondent, "It is more important to have laws which protect people from discrimination than to have decriminalization of men having sex with men. People want an opportunity to feel safe, to feel protected."

Stigma and discrimination

Most respondents agreed that the criminalization of same-sex activities is a main reason that stigma and discrimination against same-sex sexual practices and MSM are rampant throughout Guyanan society. There was general consensus too that such laws further entrench stigmatizing cultural and social attitudes, which in turn lead to significant self-stigma and limited self-esteem

among members of the population. The high levels of stigma and current legal framework often inhibit MSM from interacting with authorities for any reason, even in response to violence and abuse. One study participant provided the following example:

I remember in one of the interviews I did that a young man told me that he was walking home late one night and was attacked and raped because they [attackers] knew he was homosexual. How can he go into the police station and report it? He can, yes, but it may only be useful if he reaches a police officer who is open to people, who would deal with the crime and not the person. Otherwise you have no guarantee you wouldn't face discrimination and you would be ignored.

The impact is also substantial regarding health and HIV programming and interventions. For one thing, MSM-related stigma and discrimination constrain research and surveillance, including the construction of sound sampling methods, which means that little data or viable estimates exist even as to the size of the population. As observed by one respondent, “Stigma and discrimination hinder persons from doing research on MSM because there is even a stigma attached to working with this community. It also hinders MSM from coming forward to participate in research because they worry about family and friends finding out” about their sexual practices.

More importantly in some respects, stigma also has a direct impact on access to, and uptake of, services. A respondent noted the following from his experience in the field: “Mapping might tell you that you should be targeting a population of 300 MSM, but when you start to work, people don't come forward and you only reach 192 MSM. Stigma prevents people from coming forward as MSM for targeted services.”

Access to and quality of health services

Stigma and discrimination regarding MSM are also rampant in health facilities. According to one study participant, “A big barrier is the stigma and discrimination perpetrated by health workers in the public health system who want to promote their own personal beliefs when providing services, instead of providing non-judgmental and evidence-based care. My own personal experience is that people do not usually verbally express their homophobia, but you see it in their body language and sometimes the way they smirk and laugh to themselves.” Another respondent said that most members of the MSM population do not consider nurses and doctors to be discriminatory in their treatment towards them in general, but that it is often the ancillary staff members (including, for example, security personnel) who behave in homophobic ways.

Some interviewees said that discrimination by health providers has declined in recent years due to training and sensitization work being carried out. One such initiative is stigma and discrimination training conducted through the GHARP program at the National Care and Treatment Center, the main HIV treatment site in Georgetown. Such initiatives face challenges related to high staff turnover in the health sector, however; one respondent involved in the training noted that half of all staff members at the center had changed when she and her colleagues returned one year later for another training.

The Guyana Responsible Parenthood Association was identified by several interviewees as an institution that is friendly towards MSM and known for providing stigma-free services. Also, Artistes in Direct Support started providing VCT targeting MSM in early 2011.

Although some HIV services in Guyana are open to all in need, and many MSM access them, few prevention or social services targeting MSM currently exist. This is a problem, as noted by one respondent:

Gay men and other MSM may need special services. They must be able to feel comfortable to say to any healthcare professional that they have an issue that relates to being MSM. It may be anything physical, related to comprehensive health services or emotional or related to the mental health of MSM....There are general services but there is nothing that exists to deal with special needs of MSM related to their mental health and comprehensive services.

The availability of essential commodities varies, with limited access to water-based lubricants among the most notable. As observed by one study participant:

Condoms are freely available. Water-based lubricants though have been a challenge. Lubricants initially were not available at all from any source, local or international. Recently, though, lubes have been available through GHARP and NAPS...[but] still in very small quantities only.

Other challenges associated with MSM-specific programming

Urban and rural issues. Respondents offered mixed observations regarding availability of, and access to, HIV services for MSM in rural areas compared with urban ones. Some said that such services were disproportionately limited outside of the capital, Georgetown. Others, though, did not think there was much of a gap when actual need is considered. One said, for example: “There is a great deal of equity in terms of coverage of services between rural and urban areas with the work being done by GHARP and their funded NGOs. Georgetown might have more services, but that’s because there is a greater concentration of MSM in the capital city.”

Another respondent expressed an opinion that although urban areas had quantity, rural areas had quality: “While there might be greater availability of services in urban areas, the services [in rural areas] are of a better quality in terms of professionalism, confidentiality, and outreach to MSM. I don’t know if it’s because of the smallness of these communities that they feel a greater need to ensure quality services so that people come to use them.”

Structural drivers of HIV. There was general consensus that i) few programs address structural drivers associated with HIV risk, such as poverty and unemployment, and ii) that the programs that do exist are rarely accessed by MSM. One interviewee summarized the current situation and challenges as follows:

Some programs have evolved to include underlying social issues such as drugs, alcohol, etc., so in this sense they do address structural drivers of the epidemic to a certain extent. They do not provide a lot on poverty reduction and job skills training, however. I think it will be difficult in a country such as ours that has serious issues with economic resources to be able to tailor the programs to deal with these issues, but I think there can be links with existing social support programs. However, it’s not feasible for us to build them into existing programs...after all, most of the money that comes from donors is for HIV, so it would be a little strange.

Another study participant noted that job skills training became available recently for some key populations at greater risk for HIV, but “only for FSWs” (and thus not MSM). She also recounted half-hearted attempts at developing anti-violence programs:

All of those programs [that address structural drivers of HIV] are not considered to be important for MSM. People are still wrapped up in [the debate about] who chooses to be gay or not....Addressing issues of violence came on board recently. There was a discussion at GHARP about how they could address violence among and against

MSM and sex workers. GHARP had some money left over near the end of a recent cycle, but the initiative did not get off the ground due to the short period of time left for implementation.

4.3.4 Government response and engagement

As noted previously, the government provides extremely limited support for MSM-specific HIV programming. Nor does the government provide funds for MSM research directly—largely because most, if not all, HIV research is donor funded. The government provides support for research indirectly through the work of NAPS staff, but no direct funding is provided. According to one respondent, the government’s reluctance to get directly involved underscores its overall discrimination against the MSM population even in comparison with other at-risk groups. He said, “They [the Guyana government] only do the pre-requisite BSS/IBBSS research on the MSM population. They do other kinds of research with other populations, but not with the MSM population.”

Another study participant from the government sector claimed, however, that the government has been directly engaged at times. He said that “the first technical working group at NAPS was on MSM. It was made up of GHARP and [Artistes in Direct Support] in those days before MSM work was being done on such a wide scale.” While coverage of services for MSM remains limited, this quote was interpreted to mean that there are additional providers for MSM compared with past experience.

4.3.5 Global Fund support and engagement

Global Fund programming in Guyana is mostly broad-based and targeted at the general population—and thus not toward any special populations, such as MSM. One respondent explained the situation as such: “There are other players in country targeting special populations so it may be a function of that.” But another study participant indicated that NAPS has been working to fill the significant coverage gaps of MSM services with Global Fund support in those regions (mostly rural areas) where no USAID-funded NGOs are working.

There was general consensus across interviewees that MSM interests and needs are not reflected in the composition and deliberations of the CCM in Guyana. According to one respondent from the donor sector, “There is no dedicated representative of MSM on the CCM and the issue has never been discussed in any of the meetings I have been to.” This was corroborated by another interviewee, who noted that the civil society representative (Artistes in Direct Support) does, however, work with MSM. A third respondent stated that the two leading MSM/LGBT organizations, Guybow and SASOD, were “left out of the process of determining CCM representation... [even though] both organizations were invited initially.”

4.3.6 U.S. government support and engagement

U.S. government support for HIV services is provided primarily through the GHARP initiative; most of the funding flows through the PEPFAR program. PEPFAR funding has been the main source for Guyana’s IBBSS reporting conducted in advance of the UNGASS reports. Several participants confirmed that MSM were involved in recruiting and executing the research for all IBBSS reports.

In terms of programming, one interviewee indicated that MSM peer education and outreach programs have been a main priority area for all NGOs doing work with MSM that is funded by PEPFAR. Another, a representative from the donor community, provided a lengthy example of PEPFAR-supported work:

Our program at GHARP, which is implemented in collaboration with NAPS, is striving to be comprehensive prevention-wise in that we look at bio-medical, behavioral, and structural interventions. We promote risk-reduction behaviors, condom use, and condom availability. We build capacity for peer outreach workers to educate other MSM in areas as basic as how to use condoms, and we also instruct them how to provide referrals for health and screening services. We work with the health centers to ensure that they are receptive and open to working with these special population groups...

She also noted some restrictions to her organization's PEPFAR-funded work based on government policy: "We do some ground work in terms of developing behavior change communication [BCC] materials, but the actual production of materials is left to the government; we are not allowed to do that. We can actually make revisions, upgrades, and so on, but not develop from scratch."

Another interviewee from an NGO also noted some restrictions tied to PEPFAR funding: "When we get funding from PEPFAR, we have to sign a document which says we will not promote homosexuality and prostitution in our work. We were invited to the Gay Awards Ceremony, but we felt, as a PEPFAR-funded NGO, that we couldn't go because that was a gay event." He noted that NAPS has sought to avoid such potential obstacles by, for example, providing VCT at gay-themed events such as the Gay Day of Sports: Adding VCT made it an HIV event, so a government entity could legitimately participate. He said that NAPS "used the same strategy to be present at the Guyana Gay Glory Pageant."

A study participant from GHARP acknowledged such limitations and gaps in programming for MSM. He added that to some extent the limitations stem from a strategic decision regarding which populations seemed most in need:

We [GHARP] are aware of some of the structural problems facing MSM, but to be honest, so far our program has only been dealing with structural issues with female sex workers, and not MSM. As we strengthen our program, we may have some more scope for us to be able to do that sort of thing. But our general impression was that it was more crucial for us to divert capacity-building resources for sex workers, because it seemed as though they have lower literacy levels and fewer alternative skills than MSM.

One result of such decisions by GHARP programmers is that, as one interviewee indicated, "very little funding is reaching MSM organizations. I would say five to 10 percent." The few MSM-specific groups that do exist therefore are further marginalized: They not only are barely involved in direct HIV-related programming in general, but also in regards to services and support targeting MSM. Thus, though MSM are often consulted at a lower level, they are rarely in leadership positions—with the possible exception of SASOD.

4.3.7 Recommendations

Study participants identified a number of recommendations aimed at improving the access of MSM to comprehensive HIV services. Most focused on eliminating current barriers and/or creating new opportunities for greater awareness of MSM-specific issues in the health sector and overall society. Several of the most notable recommendations are listed below, by category.

Law reform

Policy recommendations related to legal issues were twofold:

- The government and Parliament should repeal laws criminalizing same-sex sexual practices and cross-dressing. Civil society advocates working on HIV issues should consider this to be a major advocacy priority.
- The government and Parliament should consider and pass laws prohibiting all forms of discrimination against sexual and gender minorities. Such steps are critical to reducing stigma against MSM, which greatly limits their ability to access health and social services in Guyana.

Greater involvement of MSM

MSM and groups working directly with and for them must play a leading role in the conceptualization, development, and implementation of all research and service programming targeting the population. This is relevant for all governmental and non-governmental initiatives, especially those associated with HIV. Given that the resources for doing HIV prevention for MSM are both limited and donor funded, it is imperative that MSM guide the allocation of these resources in order to ensure that the support is optimized to their benefit.

Research and surveillance

The Ministry of Health (MoH), working in conjunction with NAPS, should make it a priority to develop and introduce surveillance systems aimed at determining the size of the MSM population (including individuals who are not open about their sexual practices); the extent of HIV prevalence within it; and the main risk factors that should be addressed in future programming targeting MSM. This effort should be undertaken simultaneously with a vow by the MoH to introduce MSM-specific programming as part of a comprehensive HIV/AIDS response. MSM groups should be consulted and engaged throughout this research, from conceptualization to dissemination.

Training for healthcare workers

Two kinds of improved training for healthcare workers are necessary; both should be developed and implemented by the MoH with consultation from MSM groups and with the support of donors:

- Improved sensitivity and human rights training should be provided to all healthcare workers (including non-professional staff) on a regular basis. Similar programs, including improved clinical competencies, should be institutionalized at medical and nursing schools. Stigma, discrimination, and issues specific to MSM should be discussed candidly and thoroughly.
- Healthcare workers need to be trained to recognize and respond to mental health issues faced by MSM in an effective, non-judgmental manner. This effort should be undertaken as part of a larger initiative to improve the availability of mental health services in Guyana for all in need.

Behavior change

In consultation with MSM groups and public health personnel, the MoH should develop and implement programs aimed at positive behavior change among MSM and others at heightened risk for HIV. It is also important to note that such efforts will only be effective if accompanied by greater access to prevention commodities such as condoms and water-based lubricants for all who want and need them.

Sustainability

NGOs working in the HIV/AIDS response and with MSM should collaborate and develop plans aimed at ensuring sustainability after donors (including the Global Fund) cease providing support. This may require working closely with current funders to enhance human resource capacity moving forward.

UNGASS reporting process and indicators

The UNGASS reporting process should be more inclusive (i.e., a joint effort between government and civil society) so that civil society has no need to do shadow reports. Concurrently, there is a need to re-evaluate the UNGASS indicators to better reflect the priorities and needs in-country. A transparent, comprehensive national-level consultation should be organized by the MoH to review the current indicators and inform the development of new ones.

Several respondents to this study proposed new indicators and focus areas for the UNGASS reporting process. One said, for example, that all indicators should be “more holistic” and “measure both knowledge and skills.” Another urged greater emphasis on evaluating the quality of interventions, including their ultimate effectiveness.

4.4 India

4.4.1 Introduction and context

UNAIDS estimates that about 2.4 million people were living with HIV in India in 2009, which corresponds to an adult HIV prevalence of about 0.3 percent.²⁰⁷ While that estimate is approximately half of earlier estimates of absolute infections, it still represents the third most infections in a country globally. Recent data suggest that the HIV epidemic has stabilized/declined among heterosexual populations in southern states²⁰⁸ where a disproportionate burden of disease exists, including Andhra Pradesh, Karnataka, Tamil Nadu, and Maharashtra.²⁰⁹

The predominant route of transmission in India is heterosexual (more than 87 percent); however, as many as 1.5 percent of cases are attributable to same-sex sexual practices.²¹⁰ It was not until the late 1990s that the HIV epidemic in the MSM community was acknowledged by the larger public health community in India. Most stakeholders now agree that the population continues to be at greater than average risk and difficult to reach. Many MSM are married and reluctant to disclose their sexual practices due to cultural and social stigma and discrimination; as a result, both their male and female partners are also at heightened risk for HIV.

Estimates as to HIV prevalence among MSM vary considerably, with different clinic- and population-based studies providing rates ranging from 11 percent to 22 percent. A meta-analysis of many of these studies in 2008 estimated the pooled prevalence to be 16.5 percent.²¹¹ The most recent surveillance by the National AIDS Control Organization (NACO) in 2009 estimated

prevalence among MSM in India to be 7.3 percent.²¹² Even the lowest estimate is several times higher than estimated overall HIV prevalence, thereby underscoring the major ongoing impact of HIV throughout the population.

Methodology

Two different types of data collection were used to conduct research for this country report: i) interviews with key stakeholders, and ii) a review of documents prepared by, and websites of, key national and international entities involved in the HIV response in India. A total of 13 individuals were interviewed between March and August 2011. They included three from government agencies, two from international NGOs, four members representing the MSM community and organizations, one MSM living with HIV, two pioneers of the gay movement and MSM HIV/AIDS interventions in India, and a clinical researcher.

The literature included, among many sources, dissemination reports and position papers by a range of organizations (e.g., The Humsafar Trust, a gay and transgender advocacy and service delivery group, and DFID).

4.4.2 MSM-specific HIV programming

Through NACO, which works through State AIDS Control Societies, the Indian government frames national HIV/AIDS policies and provides funds and technical assistance to various organizations to implement MSM-specific HIV programs and interventions in the country. About 16.5 percent of the total budget for HIV/AIDS programs in India was domestic public money in the year 2009. NACO's total expenditure was about 1,037 crores (\$207.4 million) in fiscal year 2008–2009.

Over the term of the National AIDS Control Programme-III (NACP-III), which runs from 2007 through 2012, about 67 percent of funds are allocated to prevention and about 17 percent to care and support (including provision of ART) for HIV-positive individuals.²¹³ While designing NACP-III, NACO had estimated the number of MSM and transgender individuals at “maximum risk” to be about 350,000; subsequently that estimate was changed to 412,000 in 2009.²¹⁴ At present, NACO estimates that about 69 percent of all most-at-risk MSM and transgender individuals have access to prevention and care services.

According to one respondent, the first government-supported targeted intervention for MSM in the country was implemented by the Mumbai Districts AIDS Control Society in 1999. That initial intervention for MSM in Mumbai included provision of HIV testing facilities, prevention messaging, and condom distribution. Shortly thereafter, NACO finally developed and implemented surveillance mechanisms focusing on MSM—several years after it was clear that the population was among those of greatest risk for HIV.

India

Adult HIV prevalence: 0.3% HIV prevalence among MSM: 7.3%

Summary: In 2009, the criminalization of same-sex sexual practices was repealed, and nearly three-quarters of most-at-risk MSM and transgender individuals have access to prevention and care services. Despite the recent progress, there remains cultural and social stigma and discrimination against sexual minorities; for example, there is a lack of legal aid and support available to those MSM who face violence or violation of their rights.

Selected country-specific recommendations:

- Increase the number and scope of National AIDS Control Organization (NACO) programs targeting MSM and ensure that they provide more than just HIV and STI services;
- Encourage discussion of sexuality issues in medical, nursing, and public health school curriculums.

The Bill & Melinda Gates Foundation has a specific MSM component under its comprehensive Avahan initiative in India, which was launched in 2003 under the foundation's India AIDS Initiative.²¹⁵ Avahan works in six Indian states—Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Nagaland, and Manipur—which together account for more than half of HIV cases in the country. The program aims to scale up HIV prevention programs, help others to replicate the models, and disseminate the knowledge gained. MSM form a priority population for the Avahan program in four states (Karnataka, Andhra Pradesh, Maharashtra, and Tamil Nadu); as of 2008, about 70 percent of known high-risk MSM and transgender individuals in those four states had been reached with Avahan's prevention service package (the per state percentages ranged from 50 to 87 percent).²¹⁶ The package has four main components: i) outreach education by peers; ii) clinical services for STI care and treatment; iii) promotion and distribution of condoms; and iv) facilitation of community ownership of NACO's Targeted Intervention (TI) programs. A transition plan calls for State AIDS Control Societies to take over the Avahan-sponsored TI initiatives by the end of NACP-III (i.e., 2012). The process has already started in some states, and TIs are being evaluated to ensure they meet national guidelines.

Bilateral support has been provided by the United Kingdom under the DFID Technical Assistance Support Team Project to seek out unreached MSM and transgender individuals. That initiative is currently under way in four states: Maharashtra, Tamil Nadu, Andhra Pradesh, and West Bengal. Also, Swedish International Development Cooperation Agency (SIDA), Hivos, and the European Union support some advocacy programs and legal help for MSM in India. One of the NGOs supported by SIDA, for example, was a key player in the successful effort to decriminalize same-sex sexual practices in 2009. UNDP, meanwhile, is one of the major supporters of transgender/hijra programs in India. For instance, UNDP in collaboration with the National Legal Services Authority conducted a workshop for judges in February 2011 in Delhi on health and legal issues of male-to-female transgender individuals and hijras. It is also working in collaboration with NACO to develop operational guidelines for transgender interventions.

Other sources of support for MSM-specific HIV programming include various national and international research bodies such as the Indian Council of Medical Research and the U.S. National Institutes of Health. They have funded Indian and U.S. universities on basic, behavioral, social, and clinical research on MSM and transgender issues in India. Some organizations such as SAATHII have focused on poverty reduction in the MSM and transgender communities, and the Tamil Nadu Aravani Welfare Board provides loans and microcredit to transgender individuals to address economic issues.

Involvement of community in targeted programming

Community members have played an increasingly important role in identifying MSM-focused HIV program priorities and developing interventions. For example, the government's NACP was formulated with the active participation of MSM groups and networks from across India; thus, they were instrumental in estimating the sample of high-risk MSM, developing program priorities and implementation strategies, and providing feedback to NACO on priority issues to be addressed in the program. Moreover, multiple community consultations have been held to devise the priorities, strategies, and program implementation for NACP-IV, which will run from 2012 to 2017.

The Pehchan project being implemented by the International HIV/AIDS Alliance in India (funded through Round 9 of the Global Fund) represents one of the most inclusive programs for MSM and transgender individuals/hijras in India. The entire grant was written with active involvement of the community members; the program was designed by the community members themselves; and the majority of secondary grant recipients are MSM and transgender/hijra organizations. Similarly, two important U.S. government-funded projects—Impact and Samarth—have been implemented by MSM organizations and community members.

4.4.3 Challenges and obstacles to adequate services for MSM

Legal situation

One of the most important milestones for the Indian MSM and transgender/hijra communities occurred on July 2, 2009, when the Delhi High Court “read down” Section 377 of the Indian Penal Code. Essentially that decision implies that although the law exists, it will not be applicable to consenting adults. The colonial-era law was long interpreted as criminalizing all sexual acts except peno-vaginal sex between men and women; it states that “whoever voluntarily has carnal intercourse against the order of nature with any man, woman, or animal shall be punished with imprisonment to life or imprisonment of either description for a term which may extend to ten years and shall also be liable to fine.”

The ruling was also welcomed by public health professionals and NACO. Representatives from that government agency, for example, argued that the law negatively affected their ability to reach out to and provide HIV prevention, treatment, and care services to members of the MSM and transgender/hijra communities. Obstacles and challenges were common prior to the high court’s 2009 ruling. For instance, reports regularly surfaced of outreach workers being detained by police and men being arrested on the suspicion of having engaged in same-sex sexual practices. Most MSM were reluctant to seek out HIV and other health services, thereby increasing risk in the community and in the overall population. Healthcare providers were unclear as to their legal and ethical responsibilities, with many uncertain as to whether they were obliged to inform authorities if they had evidence that patients had engaged in actions violating the Indian Penal Code. Community groups, including HIV- and MSM-focused CBOs, found it difficult to structure and conduct advocacy and service delivery efforts.

Community respondents said that since the high court’s ruling, reported incidents of police harassment of CBOs’ outreach staff have declined substantially, and the police have been more cooperative. They also observed that more people are comfortable accessing services from MSM organizations and, in many cases, being open about their sexual practices. An online survey conducted by The Humsafar Trust found that about 24 percent of MSM respondents had decided to “come out” as gay after the high court judgment, and that 56 percent of MSM and 75 percent of male-to-female transgender respondents felt that the state had acknowledged their presence post-judgment.²¹⁷ MSM respondents, furthermore, felt that their friends, family, and police had become less discriminatory after the judgment (42 percent, 39 percent, and 35 percent, respectively). The Humsafar Trust survey also noted anecdotal reports that the number of MSM and transgender individuals accessing services had increased since the ruling.

It is also worth noting that NACO has reported a significant increase in the number of MSM getting tested for HIV in Integrated Counseling and Testing Centers (ICTCs). According to national data, a total of 62,492 MSM had tested for HIV in the period from April to September 2009. Over the same period in 2010, records indicate that a total of 108,977 MSM were tested for HIV—a 74 percent increase from the previous year.²¹⁸ That change could be the result of multiple factors including increased outreach, improved services, etc., but it is also likely to stem in part from the change in the legal status.

Developments on the legal front have not all been successful in recent years, however. Many interviewees highlighted the lack of national anti-discriminatory legislation for individuals living with, affected by, and at heightened risk for HIV. NACO, along with the Lawyers Collective, initiated a consultation process to draft legislation containing anti-discrimination provisions nearly a decade ago, in May 2002. Known as the HIV/AIDS Bill, it was drafted

through a national consultation process involving various community groups, NGOs, other non-governmental stakeholders, and officials from many State AIDS Control Societies. Some of the key provisions of the bill are as follows: prohibition of discrimination on the basis of actual or perceived HIV status; consent process for HIV testing, treatment, and research; non-disclosure of HIV-related information; access to treatment; right to safe working environment; promotion of risk reduction strategies; and access to essential information and education for all HIV-affected individuals.²¹⁹ The bill has yet to be tabled in Parliament, however.

Stigma and discrimination

The victory regarding Section 377 is an important step toward reducing stigma and discrimination against sexual minorities. However, the overall process will likely take considerable time and be difficult in what remains a relatively conservative and traditional society. Community representatives interviewed generally agreed that despite the welcome changes in Indian legal structures, homophobia is common in much of Indian society. For example, transgender people and effeminate men continue to be harassed in public areas because they exhibit their gender orientation and/or their presumed sexuality in public. Such reactions indicate that stigma and discrimination towards MSM and transgender individuals/hijras is pervasive in the general community. Leaders of many religious groups have condemned the high court's decriminalization of same-sex sexual practices, as have many media outlets. Such negative rhetoric has been associated with an increase in threats levied against MSM in general as well as against staff of the CBOs working within and among the community.

Stigma against sexual minorities directly limits their access to healthcare services. Respondents noted that many MSM (particularly effeminate MSM) and transgender individuals/hijras do not use healthcare services due to overt/perceived discrimination in healthcare settings. Such reluctance may be due to experiences that they themselves have had or stories they may have heard from other community members. A report published in 2007 found that kothi-identified men were labeled in derogatory manners in healthcare systems; were asked questions about why they wanted to have sex with men when they were men and even had moustaches; and were even physically abused by healthcare personnel.²²⁰

The representatives interviewed from State AIDS Control Societies acknowledged the widespread stigma and discrimination against sexual minorities; however, they also stated that they have been actively working to address the problem. One important step, they said, was the recognition in 1999 of MSM and transgender individuals as a risk group in the National AIDS Control Programme and government agencies' commitment to providing services to them. However, they also said they recognize the need for greater overall awareness about MSM issues; in their opinion, obstacles to increased work with MSM are due largely to lack of knowledge in the general population.

In some cases, State AIDS Control Societies have actively tried to address stigma-related challenges in innovative yet direct ways. For example, in two relatively rare examples of effective cross-ministerial cooperation, the Tamil Nadu government i) has set up a transgender welfare board²²¹ (within the Ministry of Welfare) that works closely with the local State AIDS Control Society, a relatively rare example of effective cross-ministerial cooperation; and ii) has begun cooperating with the Ministry of Labour in addressing same-sex sexual practices among migrants. Both Maharashtra state and Tamil Nadu state have initiated programs aimed to change attitudes and reduce stigma associated with sexual minorities among police forces; in both cases there are ongoing programs of regular workshops for this purpose with specific funding allocated for such training.

Community sector representatives generally agreed that while progress has been made, much more needs to be done to confront stigma and discrimination against sexual minorities. One of the areas of concern they raised is the lack of legal aid and support available to those MSM who face incidents of violence or violation of their rights. The fact that provision of legal support has not been included as part of the services provided in NACO-supported targeted interventions is seen by many as an example of discrimination by the state. They also claim that lack of such support amounts to a tacit agreement by the state to allow violence to continue with impunity.

Access to and quality of health services

MSM-specific interventions vary in terms of impact and quality across the country. Some states such as Tamil Nadu, Maharashtra, and Gujarat have made notable strides in MSM intervention efforts. They have long recognized MSM as an important target group, have included MSM as a part of HIV surveillance efforts for several years, and have been implementing public health interventions targeting the population for at least a decade now. In Tamil Nadu, for instance, recent data indicate that MSM-specific Targeted Interventions (TIs) constitute about 28 percent of the 53 existing TIs in the state.²²² On the other hand, the same recent source notes that Punjab and Himachal Pradesh have no MSM TIs, and Jammu and Kashmir has only one. A possible reason for such discrepancies could be due to the fact that “health” is a state-level responsibility in India. This essentially means that, although the national government frames policies and laws, it is ultimately up to individual states to follow through and implement those health policies and programs. Political, cultural, and economic considerations influence implementation decisions in different states.

Regardless of state, an important concern noted by most respondents is that MSM-specific programs tend to have only limited budgets for water-based lubricants. As one of the interviewees observed, “Lubricant is not seen as important in preventing HIV infection among MSM...instead, it is considered to be an object of pleasure, an indulgence so to speak, and therefore not the responsibility of the state to fund. It is not seen as an essential health service product.”

Among other concerns noted by respondents is that although members of sexual minorities (including MSM, transgender individuals, and hijras) are seen as being part of project management teams in many of the projects funded by international bodies and organizations (such as the Global Fund), they are not as visible in the State AIDS Control Societies.

Other challenges associated with MSM-specific programming

Many respondents observed that most of the national and NGO programs are focused on HIV and STIs, and that few are holistic programs. Some noted, for instance, that hardly any programs consider the roles of sexuality, gender, rights, life skills, economic issues, negotiations, and power dynamics in society (i.e., social determinants).

Furthermore, several interviewees said there is very little support from external sources to the public health system in India apart from helping develop STI/RTI infrastructure, HIV counseling and testing services, and the provision of ART. As a result, they said, the existing system is inadequately equipped to handle many specific MSM and transgender issues because there is a lack of knowledge about sexuality/gender issues, insufficient manpower, and poor infrastructure.

In addition, although the number and scope of research programs focusing on the MSM community have increased, they are still not adequate and more needs to be done. For example, few cohort studies have been undertaken and little information is available regarding the success of interventions, risk behavior, and prevention needs of HIV-positive MSM. The situation is even worse regarding transgender and hijra populations: Negligible extensive research has been conducted among them even though they constitute populations at heightened risk for HIV in India.

4.4.4 Government response and engagement

Under the NACP-III, which runs through 2012, MSM have been a priority group for HIV prevention and care efforts. Furthermore, NACO identifies MSM who practice receptive anal sex and have multiple partners as “most-at-risk” MSM; thus they are the most important target sub-groups.

Today, an important component of NACO’s HIV/AIDS program is its Targeted Intervention (TI) program for high-risk groups, including MSM and transgender individuals, FSWs, IDUs, migrants, and truckers. As reported in May 2011, NACO through NACP-III had rolled out a total of 1,447 targeted interventions in the country; of those, 155 (10.7 percent) were for MSM.²²³

The standard TI package includes treatment of STIs/RTIs,²²⁴ condom promotion and distribution, behavior change communication, community involvement enabling, and linkage to services for testing and care. NACO also provides HIV testing and counseling services through 7,617 Integrated Counseling and Testing Centers (ICTCs) in various forms (stand alone, integrated into existing primary health centers, public private partnership models, and mobile ICTCs) across the country.²²⁵

4.4.5 Global Fund support and engagement

The Global Fund has long been one of the most important sources of HIV programming support in India. The country has received a total of 12 Global Fund grants for HIV/AIDS projects in Rounds 2, 4, 6, 7, and 9. Among the priorities in earlier rounds have been improving care and increasing access to ART (Round 4), promoting and expanding access to ART (Round 6), and strengthening institutional capacities to improve NACO (Round 7). The areas strengthened in the overall HIV/AIDS response (e.g., access to care, counseling, and nursing) have played a role in developing effective targeted programming for MSM as well, especially in the public sector.

In Round 9, the International HIV/AIDS Alliance in India received a grant of more than \$5.5 million to “accelerate the national program with difficult-to-reach populations in underserved areas.” Under its Pehchan project launched in October 2010, which is focusing on 17 Indian states, the Alliance is partnering with a core group of Indian NGOs that have pioneered programming for MSM, transgender, and hijra populations. The five-year project aims specifically to provide HIV prevention services to those populations.

As noted in Section 4.4.2, among the priorities of the project are to create community-based organizations (CBOs) where none exist and provide services such as outreach, HIV counseling and testing, prevention (such as condom distribution), and advocacy. The idea is to make these CBOs self-sufficient to handle targeted interventions in the future. The project also seeks to strengthen existing CBOs so that they can add new services for violence and trauma, family counseling and other identity issues, mental healthcare, and legal and advocacy services. One notable element of the project is that it places particular emphasis on rural areas and other places that have rarely if ever been reached by such programming.

Through the Pehchan project, the Alliance and its partners aim to support about 200 CBOs over the first two years of the grant (Phase 1), which ends in September 2012. Among the activities undertaken to date are a baseline needs assessment, which consists primarily of a survey on sexual behaviors and knowledge, and the development of training modules for community partners. Those modules focus particularly on building awareness and knowledge of key issues of relevance to effective programming (such as identity and gender, mental health, and positive living) for MSM, transgender individuals, and hijras.

4.4.6 U.S. government support and engagement

U.S. government support for MSM-specific HIV programming flows through USAID and PEPFAR. For five years through September 2011, the USAID-supported Samarth project,²²⁶ one of three components of the \$49 million Enhance program, supported the implementation of quality HIV/AIDS prevention, care, and treatment through technical assistance, capacity building, and institutional strengthening of private and public sector agencies. FHI 360 (formerly known as Family Health International) implemented the project in partnership with the Indian Network for People Living with HIV/AIDS (INP+) and Solidarity and Action Against the HIV Infection in India (SAATHII). An example of a Samarth-supported project was the provision of financial and technical assistance for setting up a learning site at Naz Foundation in Lucknow.

Under USAID's Implementing AIDS Prevention and Care (Impact) program, which ended in 2007, three CBOs were supported for MSM-specific intervention programs. The support given to The Humsafar Trust was for a prevention program and an STI clinic with a minimal component of care and support services for PLHIV. The other CBOs supported were SWAM (for care and support) and Sahodaran (mainly prevention) in Chennai. The Impact program also supported the first conference of India Network for Sexual Minorities (INFOSEM) in Mumbai in August 2004.

According to PEPFAR, it provided \$167 million from 2004 through 2009 for comprehensive HIV prevention, care, and treatment initiatives in India.²²⁷ Among its numerous partners have been the Avert Society, which has co-funded intervention programs with The Humsafar Trust, and the Karnataka Health Promotion Trust, a partnership between Karnataka State AIDS Prevention Society and the University of Manitoba (of Canada).

4.4.7 Recommendations

Priority for further legal reform (joint responsibility):

- At the national level, the government should prioritize the passage of the HIV/AIDS Bill in Parliament. Though decriminalization is an important step in the right direction, even more positive steps can be achieved for the health of sexual minorities with a strong HIV-related anti-discrimination law on the books. Once this bill is passed, the government should aim to raise awareness about the law and ensure that it is enforced across the nation.

This effort also requires concentrated attention and resources from non-governmental sources. Members of the sexual minority community, including organizations working with and for them, should partner with multilateral entities (such as UNDP, UNAIDS, and the Global Fund), NGOs, and other civil society groups to impress upon the government and parliamentarians the clear need for a robust anti-discrimination law.

Priorities for NACO:

- NACO should seek to improve situations in states where none or few MSM-specific targeted interventions have been implemented (e.g., Punjab, Jammu and Kashmir). One approach might be to better estimate the size of MSM and other populations at heightened risk in these states and then work directly with relevant State AIDS Control Societies to develop and implement more targeted interventions. As part of this process, NACO should consider facilitating information exchange between the lagging states and those that have more comprehensive and robust MSM-specific programming (e.g., Tamil Nadu and Maharashtra). Such efforts can greatly enhance the capacity and inclination to identify impediments and overcome them in the poorly performing states.
- NACO's programs should not be limited to direct HIV and STI services and prevention. They should place a greater emphasis on sexuality, gender, mental health, violence and trauma, skills building, community employment, and negotiating skills, among others given the relationship between structural factors and HIV risk. NACO's existing collaboration with the public health sector in general should be strengthened to address health (physical and mental) concerns of MSM and transgender individuals/hijras with adequate sensitivity.
- NACO should provide legal aid, or direct referrals to such aid, to community organizations as a part of the core package of services of targeted interventions.
- NACO should encourage organizations implementing targeted interventions to hire MSM, transgender individuals, and hijras, and to increase their visibility at the managerial level. It should take as a model the International AIDS Alliance in India's Pehchan project, which prioritizes the hiring of community members as part of project development and management teams.
- NACO should provide water-based lubricants along with condoms, given the evidence supporting the increased effectiveness of condoms during anal sex when combined with condom-compatible lubricants.

Priority for the community:

- Sexual minority communities should work with health, legal, and constitutional experts to ensure representation in the National Commission for Minorities, and in similar state-level bodies.

Priorities for other stakeholders:

- Law-enforcement agencies should proactively investigate cases of violence against MSM and transgender individuals/hijras. State and local governments, as well as ombudsman's offices, should be directly involved in ensuring that such abuses and crimes are not ignored. One potentially useful initial step would be to replicate the new training programs for police in Maharashtra and Tamil Nadu that focus on reducing stigma toward sexual minorities.
- Researchers in both the public and private sectors (including academia) should recognize that although substantial behavioral research has been conducted and published on the MSM community, there remains a paucity of clinical data regarding the population. They should also be encouraged to focus on male-to-female transgender and hijra populations as there are even less published data on those population groups. Among the priorities should be analyses of the extent to which sexual minorities have sufficient and non-discriminatory access to all essential HIV prevention and treatment services, including ART management and adherence.

- Healthcare workers should encourage the addition of sexuality and gender-related issues in medical, nursing, and public health school curriculums. This can be done by working with the Medical Council of India and academic experts. Healthcare policy makers should also assess the level and types of stigma in healthcare settings. This can be achieved by working with researchers and NACO officials to conduct operational research on stigma in such settings. Furthermore, specific education programs should be designed for healthcare professionals to help them understand various types of stigmatizing behaviors and how to reduce them while also increasing the clinical competence of these practitioners.

4.5 Mozambique

4.5.1 Introduction and context

Over the past 25 years, it has become clear that while HIV/AIDS is fundamentally a health-related problem in Mozambique, fighting the epidemic and its adverse effects requires the collaboration of a variety of partners and a multi-varied approach from social, economic, and political perspectives. Although a great amount of emphasis has been placed on research relating to all populations and on general education and prevention messaging, limited attention has been directed toward the sexual minority population. That omission persists even though the impact of HIV on MSM and other sexual minorities continues to increase, thereby hindering the efforts of researchers, policy makers, and health service providers to adequately respond to the epidemic.

The need for improved responses is clear. The epidemic has long been an obstacle to the country's social and economic development. Estimated adult HIV prevalence in Mozambique currently exceeds 11 percent, one of the world's highest levels.²²⁸ Some 1.4 million Mozambicans are HIV-positive; about 74,000 deaths from AIDS occur every year; and 120,000 new infections take place annually, in most cases among young people aged 25 or younger.²²⁹ The epidemic is exacerbated by gender disparity, HIV-related stigma and discrimination, lack of access to information and essential health services, and inadequate social support for individuals, families, and communities affected.

Reliable data and estimates are difficult to obtain regarding HIV prevalence among MSM and other sexual minorities in Mozambique. A report from 2010 recommended future research to measure HIV prevalence among MSM;²³⁰ a 2008 UNAIDS report concluded that approximately five percent of HIV infections result from sexual relations between men.²³¹

Mozambique

Adult HIV prevalence: 11% HIV prevalence among MSM: Unknown

Summary: Reliable data and estimates are difficult to obtain regarding the HIV prevalence among MSM and other sexual minorities in Mozambique. Few initiatives target MSM and other sexual minorities, who also have no targeted health support and face legal, social, and economic stigmatization and discrimination. The criminalization of same-sex sexual practices in Mozambique remains ambiguous, and there are no policies or laws in place to protect the rights of MSM.

Selected country-specific recommendations:

- Increase government engagement in the following areas: funding, research and surveillance, addressing stigma and discrimination, quality of services, and legal protections of MSM rights;
- Donor and international funding mechanisms should target more funds for HIV prevention, treatment, and care programs that target MSM, and they should also support HIV research projects that focus on the population.

Despite such high risk and vulnerability, most HIV prevention strategies and interventions focus solely on the general population. Few initiatives target MSM and other sexual minorities, who also have no targeted health support and face legal, social, and economic stigmatization and discrimination. The relative lack of services or specific HIV surveillance data for MSM across the continent, including in Mozambique, keeps members of the population both invisible and deprived of relevant information and support. The needs are far too great to be addressed comprehensively by the small and limited MSM-targeted prevention programming currently available in Mozambique.

Same-sex sexual practices are not criminalized in Mozambique.²³² However, no policies or laws exist that specifically provide rights protections for MSM. One partial exception is the Mozambique labor law (no. 232007), which in Article 4 includes language that aims to limit work-related discrimination based on sexual orientation and HIV status.

Methodology

This report is based on research among four broadly defined categories of stakeholders in the HIV/AIDS response in Mozambique: government, HIV program implementers, MSM-led community groups, and academia. A total of 11 semi-structured interviews were conducted across individuals from those four groups.

The focus within government was on those with experience in developing HIV strategy, related policy, or programs. Among those interviewed were members of the National AIDS Council (CNCS) at the local level in Sofala province and that province's health director.

Respondents in the HIV implementers category included individuals from organizations that implement MSM-related programming with support from the Global Fund, PEPFAR, and various NGOs and associations. Among those interviewed were representatives from the U.S. Centers for Disease Control and Prevention (CDC) in Maputo, the Mozambican Network of AIDS Service Organizations (MONASO) at both the national level in Maputo and the local level in Sofala province, the Academy for Educational Development's Capable Partners Program, Population Services International (PSI), and Pathfinder International.

Interviews were conducted with representatives from MSM and LGBT-led community groups to assess their level of involvement in research studies and programmatic interventions. Among those interviewed were representatives from Associação para Defesa das Minorias Sexuais (Association for the Defense of Sexual Minorities)—also known as Lambda—in Maputo (national level) and at the local level in Sofala province.

Academia was an important group for inclusion in this study given its role in developing the evidence base for, and supporting, research studies and programs targeting MSM in certain countries. Among those interviewed was a member of the sociology faculty at Eduardo Mondlane University in Maputo who has researched issues associated with sexual practices.

Key stakeholders involved

The following are among the key stakeholders involved in the response to HIV among MSM in Mozambique:

- Lambda (a community group)
- PSI (provides technical support and evaluation)
- Pathfinder (provides technical support, evaluation, and research)
- CDC (provides funds for research projects as well as technical support)

- United Nations Population Fund, or UNFPA (supports research projects)
- Hivos (supports Lambda organizational costs and project activities)

4.5.2 MSM-specific HIV programming

There are no programs, HIV-related or not, specifically targeting MSM in Mozambique that involve the government. Even though it is not officially recognized, the civil society group Lambda carries out programs with activities such as raising awareness about HIV prevention, peer education, and distribution of water-based lubricants and condoms. PSI and Pathfinder also have condoms and lubricants available free of charge to anyone who wants them, and respondents note that MSM comprise a sizable share of those accessing the free sex-related commodities. Neither the government nor any bilateral funders support such activities.

Lambda is also conducting research projects in three main cities in Mozambique—Maputo, Beira, and Nampula—in partnership with CDC, PSI, and Pathfinder. The research is focused on vulnerability and risk of HIV infection among MSM. None of the programs organized by Lambda and/or supported by partners provide services addressing structural drivers of risk such as exclusion from healthcare services, poverty, or lack of job skills and employment. According to participants, stigma against MSM is the main reason such services do not exist.

Other activities undertaken by Lambda include peer education, which includes raising awareness about HIV and STIs. PSI and Pathfinder both provide technical support for such activities, most notably in Beira.

It is worth noting as well that two healthcare clinics in Beira (Centro de Saúde Urbano de Ponta Gea and Centro de Saúde de Chingussura) are considered clinically competent and sensitive in regards to providing services for MSM. That perception is based on the fact that Lambda trained the staff of the two clinics, both government-run, on MSM health and social issues.

4.5.3 Challenges and obstacles to adequate services for MSM

Access to and quality of health services

Study participants provided several examples of the kind of stigma and discrimination experienced by MSM in Mozambique on a regular basis, including in regards to obtaining quality healthcare. Common problems stem from the discriminatory and stigmatizing attitudes of health personnel. Informants said that MSM regularly experience delays in care provision and verbal abuse, especially if they have discussed same-sex sexual practices with a doctor or other professional. Such changes in attitudes and behavior indicate that confidentiality is regularly violated in healthcare facilities.

In general, services tailored for MSM are rare in Mozambique in both urban and rural areas—although they are marginally better in cities. Many study respondents also acknowledged that most MSM remain unaware of the services that do exist, including the HIV prevention and peer-education activities in Beira. Yet even if they are aware of the services, many MSM reportedly are reluctant to seek them out because of concerns about confidentiality and potential harassment on the part of authorities.

Study participants noted the low coverage of HIV prevention programs, strategies, and actions in terms of reaching the MSM population. Programs that currently exist are, though, mostly perceived as being of decent quality: most include specific interventions aimed at responding to unprotected oral or anal sex or other drivers of HIV risk in the MSM population. Among the overall weaknesses is that many MSM do not have regular access to water-based lubricants.

Other stigma-related challenges

Other respondents noted that nearly all references to MSM and same-sex sexual practices in the Mozambican media are negative and stigmatizing. According to one participant, a typical example was a TV interview with a member of an MSM group in 2010 that focused on belittling the interviewee's sexual interests and orientation. Such attitudes reportedly are common in Mozambique throughout society.

Limitations regarding data collection and surveillance systems

The government does not collect data on MSM in its HIV surveillance activities. The main reason is that government policy makers do not include MSM as a target population in the primary HIV surveillance systems; this practice continues to be followed even though policy makers realize (according to several study participants) that sexual minorities are at heightened risk for HIV. The result is that reliable data and estimates as to HIV prevalence among MSM are mostly lacking. Similarly, the size of the MSM population in Mozambique is largely unknown because few extensive surveys have been conducted by either governmental or non-governmental sources.

One of the few efforts to study MSM populations occurred in May 2010 when Lambda conducted research on vulnerability and HIV infection risk among MSM in Maputo. USAID provided partial support for the study, which was conducted in partnership with Pathfinder, PSI, and UNFPA.²³³ Among the most notable findings were that MSM-specific prevention services were mostly lacking and that health services were difficult to access for MSM and all individuals in need because facilities were usually overcrowded and understaffed.

4.5.4. Government response and engagement

Respondents agreed that the government has never provided funding or support for research regarding MSM in Mozambique, HIV-related or not. Moreover, MSM are not included in any programming or research projects managed by the government. The only thing of note is indirect: the government provides allowances (credentials) to interested NGOs for research projects.

In addition to not being proactive themselves in regards to MSM-specific programming, government agencies have at times directly or indirectly blocked the ability of other stakeholders to work with and for MSM. One of the major obstacles is that bilateral partners can only fund organized groups or NGOs that are officially recognized by the Ministry of Justice. Perhaps the most important MSM group in the country, Lambda, has yet to be recognized as an official association four years after first submitting paperwork. Most respondents agree that such barriers underscore the extensive discrimination and bias against MSM within the government.

4.5.5 Global Fund support and engagement

Mozambique ranks among the top countries in terms of resources committed by the Global Fund. It has successfully applied for HIV/AIDS grants in Rounds 2, 6, 8, and 9, for example. However, informants noted that none of the HIV/AIDS grant proposals specifically mentioned MSM or proposed targeted programming to benefit the population. Moreover, no Global Fund money has been used in Mozambique to support targeted HIV epidemiological research focusing on MSM.

The Mozambique CCM does not include representatives from any MSM group or, according to respondents, of groups that understand the needs of MSM. This lack of interest and awareness is thought to be a key reason that the issue of MSM services is not discussed by the CCM.

4.5.6 U.S. government support and engagement

Some USAID support was made available for Lambda's study regarding the vulnerability and HIV infection risk among MSM in Maputo in 2010.²³⁴ Another survey was conducted between June and August 2011 through a partnership comprising the U.S. government (through CDC), Pathfinder, PSI, and Lambda. Research for that survey, which aims to evaluate risk behavior among MSM, was conducted in Maputo, Beira, and Nampula.

For the first report, which was published in May 2010, Lambda was involved in all levels of research including conceptualization, planning, implementation, analysis, and dissemination. It was also involved extensively during the preparation and implementation of the second project, which covers a sample of 500 MSM. (Lambda's involvement in data analysis and dissemination had yet to be determined when study participants discussed the matter during research for this report.)

Little money from any other U.S. government entity working on HIV in Mozambique reportedly has been used to support targeted HIV prevention, treatment, and care programs for MSM in the country. Few funds have been directed to MSM community groups, with the exception of the small level of support to Lambda for the research projects. That situation persists even though Mozambique is a PEPFAR focus country that has reportedly received more than \$800 million through PEPFAR to "support comprehensive HIV/AIDS prevention, treatment, and care programs from FY 2004 to FY 2009."²³⁵

4.5.7 Recommendations

The most important responsibility for improving the HIV response among MSM lies with the government. It should improve its engagement in the following areas:

- **Funding.** The government should provide more funds through the Ministry of Health (MoH) because HIV/AIDS programming and health services are directed largely through that agency.
- **Research and surveillance.** The government must acknowledge that the MSM population is at high risk, a step that should lead to it supporting HIV research projects targeting MSM, acknowledging and addressing bias on the part of some researchers, and creating partnerships with MSM groups or associations. All relevant government entities involved in HIV research, including the MoH, should include MSM as a primary target group in HIV surveillance regarding attitudes, behaviors, and practices. It should involve groups or associations of MSM in conceptualizing, planning, and implementing all research projects related to HIV.
- **Addressing stigma.** The government should take steps to reduce stigma and discrimination directed toward MSM. One good start would be for the MoH to expand HIV and anti-stigma sensitization campaigns beyond the main cities so that they reach rural areas as well as other important sites such as prisons.
- **Quality of services.** As part of its HIV prevention, treatment, and care program, the MoH should provide water-based lubricants and condoms free of charge, raise awareness about HIV infection risks, and train health clinic staff to provide better quality and non-stigmatizing

care and treatment services for MSM. At the same time, the MoH should identify strategies to reach MSM with sufficient and updated information regarding which clinics and facilities provide comprehensive services for, and are sensitive to, MSM. This effort should focus on those in need in both urban and rural areas.

- Legal rights. In consultation with MSM representatives, the government should draft a law guaranteeing equal rights for sexual minorities. Such a law would help protect the LGBT community's right to access to adequate health and social services. The law should include provisions making it absolutely clear that same-sex sexual practices are not criminalized in Mozambique and that those who violate the law by discriminating against LGBT individuals will be punished.

Donors and international funding mechanisms should provide more funds for HIV prevention, treatment, and care programs, and they should also support HIV research projects that focus on MSM. Donors should advocate on behalf of MSM groups in order to prompt the government to implement policies that ensure improved health services for MSM, including harm reduction interventions based on specific MSM risks.

In an effort to overcome self-stigma and self-discrimination, MSM should advocate so that organizations representing them (e.g., Lambda) are officially recognized by the government. This effort will likely require support from other stakeholders, including other civil society groups in the country, to make the clear case to provide such support from a public health and human rights perspective. Similarly, Lambda should initiate an advocacy campaign to lobby the Ministry of Justice to address the rights of the LGBT community. It should seek to involve other stakeholders in this effort.

UNGASS indicators should be improved. The current indicators should not be the only ones associated with MSM as they do not provide a representative assessment of HIV risk among and service provision for MSM. UNGASS indicators should focus on the following:

- Percentage of most-at-risk populations on antiretroviral treatment (ART);
- Percentage of most-at-risk populations receiving home-based care services;
- Amount of funds available for research projects on HIV prevention, care, and treatment for MSM;
- Developed and implemented policies that support health services for MSM.

Other recommendations:

- The Global Fund CCM in Mozambique should include a representative of the LGBT community or an MSM group. This could help increase Global Fund support for MSM-specific research and health provision (including HIV prevention, treatment, and care).
- The U.S. government, through PEPFAR, should be more open to supporting initiatives prioritized and either run by MSM groups or designed as balanced partnerships with these groups, including i) research on HIV epidemiology, treatment, and care; and ii) provision of funds for HIV prevention, treatment, and care.

4.6 Nigeria

4.6.1 Introduction and context

Initially the Nigerian government was slow to respond to the epidemic. It was only in 1991 that the Federal Ministry of Health (MoH) first attempted to assess the HIV situation; the results showed that around 1.8 percent of the population was infected with HIV. Subsequent surveillance reports revealed that during the 1990s HIV prevalence rose from 3.8 percent in 1993 to 4.5 percent in 1998 before stabilizing and then declining slightly. According to the most recent data from UNAIDS (for 2009), adult HIV prevalence is about 3.6 percent.²³⁶ That corresponds to about 2.9 million adults living with HIV in the country, of whom nearly 60 percent are women; Nigeria's disease burden comprises just under one-tenth of the global burden of HIV.²³⁷

Increasing surveillance data indicate that MSM are at very high risk for HIV infection. The 2007 HIV/STI Integrated Biological and Behavioral Surveillance Survey (IBBSS) and an Abuja-specific study released in 2009 by the Center for the Right to Health (CRH) reported HIV prevalence among MSM of 13.5 percent and 36.4 percent, respectively.²³⁸ (The IBBSS estimated national prevalence—although it reportedly based its results on surveys in three states only, Lagos, Kano, and Cross Rivers—while the CRH study focused exclusively on Abuja.). While the results of the 2010 IBBSS have not been made public during the research period for this report, personal communications with study staff suggest that HIV rates were very high among MSM in numerous regions of the country.

In light of such surveys showing that MSM are among the populations at greatest risk for HIV in Nigeria, it would seem that the government would be a major stakeholder in implementing, promoting, and funding MSM-targeted interventions in Nigeria. That is not the case, however, as the government has largely ignored the population in its HIV programming.

Methodology

Field operations research was conducted from April to June 2011. During that period, 15 interviews were conducted with stakeholders from government agencies, implementing partners, academia, MSM organizations, donor agencies, and activists. The research instrument included several questions evaluating the impact of stigma and discrimination on the response to HIV among MSM and the role of key multilateral funding bodies such as the Global Fund and USAID. The greatest challenge faced during the interview process was getting active participation from government agencies and major implementing partners.

Nigeria

Adult HIV prevalence: 3.6%
HIV prevalence among MSM: 13.5%

Summary: In Nigeria, HIV-related activities targeting MSM are mainly conducted by NGOs, with support from foreign donors, particularly through USAID and the U.S. Centers for Disease Control and Prevention. The legal criminalization of same-sex sexual practices in several sections of the Criminal Code prevents the government of Nigeria from supporting any MSM-targeted HIV interventions, at either the federal or state level, despite a prevalence rate among MSM of 13.5 percent. Furthermore, stigmatization, homophobia, and outright denial of same-sex sexual practices throughout the government limit the ability of all stakeholders, including civil society groups, to effectively reach MSM in need of HIV information, health, and other services.

Selected country-specific recommendations:

- Legal reform must be initiated to ensure the equal rights of MSM and other sexual minorities;
- Healthcare providers must be trained to understand the needs of MSM and other vulnerable populations.

4.6.2 MSM-specific HIV programming

HIV-related activities in Nigeria targeting MSM are mainly conducted by NGOs and are generally foreign-donor driven. The major stakeholders in the MSM-targeted response are local implementing partners that receive financial support from the U.S. government (generally through USAID and other federal agencies such as the U.S. Centers for Disease Control and Prevention). Those local partners include some organizations that focus exclusively on and/or are run by MSM. Among them are the Men’s Health Network Nigeria Project (MHNN), which is implemented through the Population Council; the Institute of Human Virology, Nigeria (IHVN), through the PEPFAR-supported AIDS Care and Treatment in Nigeria (ACTION) project; and the Heartland Alliance project, an initiative that supports the institutional and capacity needs of mainstream local MSM organizations through its Integrated MSM HIV Intervention Prevention Programme (IMHIPP). Local groups supported through the IMHIPP program include the Initiative for Equal Rights (TIER), the International Center for Advocacy on the Right to Health (ICARH), and the Initiative for Improved Male Health.

Two other organizations are important to mention. The International Center for Reproductive Health and Sexual Rights (INCREASE) provides technical support to organizations composed of and working for the rights and needs of sexual minorities, and Center for Right to Health (CRH) is a mainstream Nigerian organization providing HIV prevention and support services to MSM individuals and organizations.

The activities undertaken through most of these programs focus on provision of condoms and lubricants as well as information on the ABC approach—abstain, be faithful, use condoms—through peer education.

4.6.3 Challenges and obstacles to adequate services for MSM

Legal situation

Several sections of the Criminal Code can and are used against people who have engaged in same-sex sexual practices. For example, prohibitions on acts against “the order of nature” and acts of “gross indecency” are noted in Sections 214 and 217 of Chapter 21 (entitled “Offences against Morality”), respectively.²³⁹ Section 284 of the Penal Code states that “whoever has carnal intercourse against the order of nature with any man ... shall be punished with imprisonment for a term which may extend to 14 years and shall also be liable to a fine.” Twelve northern Nigerian states, all Muslim-majority, have adopted forms of strict sharia law specifying that same-sex sexual practices can be punished with 100 lashes (for unmarried Muslim men) and death by stoning for married or divorced Muslim men.²⁴⁰

These statutes unambiguously criminalize same-sex sexual practices and inhibit the development and implementation of research studies and programming interventions for MSM individuals and communities in Nigeria.

Access to and quality of health services

Homophobia and stigmatization of sexual minorities are rampant in healthcare facilities. For instance, according to respondents, most client assessment forms in health facilities do not have a column that addresses sexual orientation and specific MSM health issues. This leaves MSM accessing services at the mercy of providers who are not sensitized, clinically competent, or obliged to provide adequate services for members of the population. Cases

have been reported of MSM individuals' confidentiality being violated. It is worthwhile noting that one independent group, IHVN, has tried to provide clinically competent services to MSM by funding a mobile health center at ICARH—a facility managed with support from Garki Hospital in Abuja. While this is an important intervention, its scale is limited, and it has not been replicated elsewhere.

Limited effort has been made to address the massive overall challenges faced by MSM, according to most respondents. Some respondents contrasted the lack of action to the large investments in retraining healthcare providers to address the fears and challenges of working with PLHIV in general. These retraining efforts have led to significant changes in attitudes among healthcare workers towards HIV-positive individuals in Nigeria and subsequently improved care. As yet, though, no similar structured mass trainings of healthcare providers have been considered in regards to the needs of MSM and other vulnerable populations (including sex workers and people who use drugs).

Stigma and discrimination

Stigmatizing and discriminatory attitudes and practices represent major challenges to HIV-related interventions for MSM and other sexual minorities. They include cultural, traditional, religious, and societal norms and belief systems that consider same-sex sexual practices to be ungodly and un-African, among other things. The depth and pervasiveness of the stigmatizing environment are further exacerbated by the fact that, according to some study participants, Nigerian government officials have on several occasions denied that same-sex sexual practices even exist in the country. Such overarching denial—coupled with the fact that in response to stigma, MSM are clandestine about their activities—greatly limits the ability of all stakeholders, including civil society groups, to effectively reach MSM in need of HIV information, health, and other services.

The government has been outspoken in its opposition to the rights of sexual minorities on the global stage as well. In 2010, for example, Nigeria voted against a South Africa-sponsored resolution that endorsed the rights of gay, lesbian, and transgender people for the first time ever at the UN Human Rights Council.²⁴¹

4.6.4 Government response and engagement

Study respondents were unanimous in their conclusion that no Nigerian government, either at the federal or state level, has ever provided funds to support MSM-targeted HIV interventions. According to one respondent, “The main reason the government cannot provide funding support for MSM activities is the fact that same-sex sexual practices are illegal in the country. So the government cannot be seen to be supporting what the law forbids.”

While acknowledging the impact of stigma and the repressive legal situation, some respondents added that the lack of direct government funding for MSM programs also results from the government's generally limited funding for HIV programming in general as most HIV programs in Nigeria are donor funded.²⁴² It is important to note, too, that although MSM issues are mentioned in the National Policy on HIV/AIDS and the National Strategic Plan, the national response remains silent regarding MSM.

The government's limited response is particularly noticeable in rural areas, where residents rarely have access to information, care, and support. HIV outreach efforts and interventions are concentrated in Abuja, Lagos, and lately in Calabar, Kaduna, and Port Harcourt (all relatively large cities). MSM in more than 90 percent of the country, including all rural areas, have no direct and easy access to information, support, and services. One respondent noted that

nationwide coverage by some media outlets is of little help: “The main sources of information for majority of Nigerians are radio and television. Unfortunately, these media are not used to raise and address MSM issues.”

4.6.5 Global Fund support and engagement

All study respondents said that they were not aware of any MSM-specific interventions that have been implemented in Nigeria through programs supported by the first three HIV/AIDS grants—in Rounds 1, 5, and 8—approved by the Global Fund. The more recent Round 9 grant does, however, provide for HIV prevention and support activities targeting MSM. As of August 2011, MSM-specific interventions supported through the Global Fund grant reportedly had been initiated in 13 states.

Respondents also noted that no MSM organization had ever received funding through a Global Fund grant as a Principal Recipient or sub-recipient. The MSM-specific programming supported through the Round 9 grant has so far been received and utilized only by mainstream organizations.

No MSM individual or representative from an MSM organization is a member of Nigeria’s Global Fund CCM. The majority of respondents said they were not certain whether MSM issues had ever been discussed in the CCM.

4.6.6 U.S. government support and engagement

As noted previously, the U.S. government has been the major benefactor of MSM-specific programming in Nigeria. It has supported implementing partners including IHVN, the Population Council, the Heartland Alliance, and Family Health International (among others) in providing HIV prevention, care, and support specifically for MSM, as well as research regarding the population. The PEPFAR project has supported ART provision in Nigeria, which has benefited MSM and non-MSM alike. The CDC, meanwhile, is supporting the MSM-specific mobile health clinic in Abuja being put into place by IHVN.

Three respondents signaled out the Integrated MSM HIV Intervention Prevention Programme (IMHIPP) that the U.S. government is supporting through the Heartland Alliance. This program is the first to provide local MSM organizations with institutional capacity to design and implement projects; the core funding support also enables them to rent office spaces and improve their infrastructure, etc. Other national and local organizations with MSM-specific projects supported by various U.S. government entities include the Men’s Health Network Nigeria and IHVN. All such projects seek to mitigate the impact of HIV among MSM through targeted prevention efforts that predominantly use peer education as an information distribution and outreach strategy.

4.6.7 Recommendations

The following are among the main recommendations from respondents aimed at improving the HIV/AIDS response among MSM in Nigeria:

The involvement of MSM and/or MSM organizations in programmatic decision-making must increase. In order to achieve optimal impact and expanded reach across all MSM communities:

- Research initiatives targeting MSM should be undertaken by MSM themselves, or at least they should play central roles in the design, implementation, and analysis of these studies.

- MSM individuals and mainstream MSM organizations should be involved in developing and implementing MSM-focused programs and interventions. They are best placed to know the main needs and how to meet them.
- Services should have a broader reach. Most of the programs designed and implemented to date are over-concentrated in urban areas and thus do not reach many MSM in need. Services should be extended to other regions and states currently not benefitting from ongoing interventions.
- The institutional and fiscal capacity of MSM organizations must as a matter of priority be improved to position them to receive and administer large-scale grants from the likes of USAID and the Global Fund.

Healthcare providers must be trained to understand the needs of MSM and other vulnerable populations. All respondents agreed that such training and capacity building are critical to ensure that healthcare workers at all levels provide competent, non-discriminatory services and care for MSM individuals. The training should aim to address and eliminate stigmatizing attitudes, improve clinical competence, and ensure that health services are provided equitably to all. The Federal MoH should take the lead in meeting this objective. Organizations such as IHVN and Population Council, which already are engaged in this process, should scale up training to cover most of the states in Nigeria.

Legal reform must be initiated to ensure the equal rights of MSM and other sexual minorities. The laws and statutes criminalizing sodomy and other same-sex sexual practices should be removed. These laws not only violate the rights of MSM but also conflict with public health principles. MSM and other sexual minorities will never be able or willing to seek out comprehensive HIV prevention, care, and treatment services until the criminal and penal codes are reformed. In turn, the HIV epidemic in Nigeria can never be adequately addressed until MSM can fully and safely engage with the public health system. Therefore, the National Assembly and the Federal Ministry of Justice should make it a priority to repeal all laws that discriminate against sexual minorities in Nigeria. The civil society sector should mobilize as well to undertake advocacy and education campaigns targeting legislators and government officials in an effort to urge them to repeal the laws and statutes.

The National Agency for the Control of AIDS (NACA) should specifically state that HIV programming for MSM and other sexual minorities is a priority. That step is critical to beginning a process of improving and expanding the response to members of those populations.

A majority of respondents also said they supported a progressive shift in social and religious attitudes to same-sex relationships because such attitudes drive MSM underground and fuel HIV prevalence not only in that population, but among the general population as well. To that end, they urged the government, through NACA, to work with civil society organizations to mount a comprehensive national campaign targeting religious and traditional leaders on the acute need for comprehensive and inclusive HIV/AIDS prevention programming in the country. That campaign should include efforts to directly address stigma and discrimination against MSM.

4.7 Ukraine

4.7.1. Introduction and context

Adult HIV prevalence in Ukraine is about 1.1 percent, according to the most recent UNAIDS estimates.²⁴³ Of the more than 350,000 HIV-positive individuals over the age of 15, slightly more than half are men.

Like many other countries in the region, the HIV epidemic in Ukraine has largely been concentrated among injecting drug users (IDUs) and their sexual partners. The share of PLHIV infected by sexual transmission has been increasing in recent years, however; in 2008, for the first time since 1995, the number of new infections attributed to sexual transmission was higher than those associated directly with injecting drug use.²⁴⁴

Ukraine

Adult HIV prevalence: 1.1%
HIV prevalence among MSM: 8.6%

Summary: The HIV epidemic in Ukraine has largely been concentrated among injecting drug users (IDUs) and their sexual partners. At the same time, MSM represent another group in Ukraine at especially high risk, with an HIV prevalence several times greater than that of the general population. Nevertheless, the government of Ukraine has refused to prioritize MSM-targeted programming, and the stigmatization of homosexuality persists despite decriminalization of same-sex sexual practices since 1991. Social stigma, discrimination, and lack of access to HIV prevention and treatment services lead many HIV-positive MSM in Ukraine to live in complete isolation.

Selected country-specific recommendations:

- Civil society groups should develop and seek support for stronger advocacy with public campaigning to draw attention to the “invisible epidemic;”
- The national government, through the MoH, should take the lead in developing programs to train health professionals on reducing stigma, improving access to quality services, and ensuring MSM are comfortable discussing sexual behavior.

According to recent estimates, nearly one quarter (22.9 percent) of all IDUs are HIV-positive. MSM represent another group at high risk for HIV: an estimated 8.6 percent are living with HIV, a rate that is also far above that of the overall population.²⁴⁵ Official government statistics indicate that the absolute number of new HIV cases among MSM has risen every year since data regarding the population were first collected in 2005. Because official government reports are assumed to vastly undercount all HIV-related data, it is assumed that the number of new infections in 2009 was several hundred.²⁴⁶

Same-sex sexual practices were decriminalized in Ukraine in 1991. The law abolishing the Soviet Penal Code clause was among the first of 20 adopted after Ukraine became independent. Respondents agreed, though, that the Ukrainian legal framework also does not assume that discrimination based on sexual orientation really exists. No laws or policies specifically mention the rights of sexual minorities, including LGBT individuals, in any areas such as protection against discrimination at work. This is reiterated in the 2010 UNGASS Country Progress Report, in which authors acknowledge that the country does not have “non-discrimination laws or regulations which specify protections” for MSM.²⁴⁷

Methodology

Research for this report included a comprehensive literature review and a series of semi-structured interviews with various stakeholders in Ukraine. A total of 10

interviews were conducted between February and May 2011. Those 10 interviews included representatives from the government, civil society (including MSM organizations), and international and bilateral donor entities.

Information and observations from those interviews are noted in the references in this report to “study participants” and “respondents.” In many cases, the assertions of the respondents are not independently verifiable.

Key stakeholders involved

Listed below by category are the key stakeholders within Ukraine in responding to HIV among MSM:

- International donors include the Global Fund, USAID, the Elton John AIDS Foundation, Germany’s Gesellschaft für Internationale Zusammenarbeit (GIZ), the Heinrich Böll Foundation, and various other government sources from Germany, the Netherlands, and Norway. Other donors do not directly focus on MSM, but MSM can benefit from their programs—such as the USAID-funded capacity-building and training programs for NGOs.
- The two Principal Recipients of the active Global Fund HIV/AIDS grant (approved in Round 6) are the All-Ukrainian Network of PLHIV and the International HIV/AIDS Alliance in Ukraine. As all MSM-related activities are exclusively donor-funded, with most funding coming from the Global Fund, these two organizations are key stakeholders with regard to HIV and MSM.
- Currently there are five national NGOs (associations and charities) officially self-identifying as LGBT and working for and with the MSM community. They include the Gay Forum of Ukraine, AUCO “Fulcrum,” and Gay Alliance Ukraine. Two other groups, Nash Mir (Our World) Gay and Lesbian Center and Donbas-Soc-Project, are both registered as regional but have impact at the national level.
- Regarding regional and local LGBT/MSM NGOs, there are currently more than 30 regional and local associations and charities officially self-identifying as LGBT-run and working for and with the MSM community. Among those are Gay Alliance (Kyiv), Gay Alliance (Cherkassy), Za Rivni Prava (Kherson), Total (Lviv), and LIGA (Mykolaiv), which also serves as a regional resource center for southern Ukraine.
- Several NGOs that are not LGBT/MSM-run are currently implementing HIV prevention projects targeting MSM. Partner (Odessa) and Avante (Lviv) are among the 15 in this category.
- Also of note are expert and coordination mechanisms of LGBT/MSM NGOs, including the Standing Reference Group on LGBT issues and MSM projects in Ukraine and the Council of LGBT Organizations of Ukraine, which was legalized by the Ministry of Justice in early 2011.

4.7.2 MSM-specific HIV programming

All HIV prevention, care and support, and community mobilization programs targeting MSM in Ukraine are exclusively funded by international donors and implemented by NGOs. For example, through the Global Fund Round 6 program, the International HIV/AIDS Alliance in Ukraine is supporting 13 prevention projects. In 2010–2011, the NGO “Fulcrum” has supported care and support programs in 11 cities.

Most projects are based in the national capital (Kyiv) and major oblast/regional centers, leaving MSM in smaller towns with no easy access to services. The package of services for MSM typically includes community-based and peer-led outreach and education, access to VCT (referrals and increasingly with onsite rapid testing), referrals to other health and social services, HIV prevention information (brochures), and commodities for prevention of sexual transmission (lubricants and male condoms).

Study respondents said they were unaware of any healthcare clinic that provides clinically competent and sensitive services for MSM. There are, however, some open-minded doctors who cooperate with NGOs and have obtained sensitivity training regarding MSM. Some respondents mentioned two projects that aim to build a network of “friendly doctors and professionals”—one is being undertaken jointly by the Gay Alliance Ukraine and AIDS Foundation East-West (AFEW), and more recently a similar GIZ-funded project was initiated by Nash Mir. Both projects focus on training particular doctors on MSM needs and identifying doctors who are sensitive to MSM or are MSM themselves.

4.7.3 Challenges and obstacles to adequate services for MSM

Stigma and discrimination

Stigma regarding “homosexuality” remains strong in Ukraine, and it is increasing. Nash Mir, which tracks the results of public opinion surveys regarding LGBT issues, notes that nearly half (46.7 percent) of Ukrainians do not think homosexuals should have the same rights as other citizens.²⁴⁸ Another survey cited by the organization found that 65 percent of Kyiv residents “consider homosexuality a perversion or mental disease.”²⁴⁹

Stigma based on sexual orientation also means that MSM are at a disadvantage when they seek legal redress for discrimination. For example, most study respondents agreed that an attempt to defend one’s own dignity through present norms of law by an openly gay person in court is not encouraged by the state and society, even in cases when an offense, abuse, or other violation of rights (e.g., robbery, violence, and murder) was not connected with sexual orientation.

Most respondents also agreed that high levels of stigma and discrimination associated with same-sex sexual practices affect the ability and inclination of government entities to be involved in implementing HIV programs specifically targeting MSM. One NGO representative recalled a member of the Global Fund CCM asking, during discussions leading up to the application for Round 6 funding, why so much funding was going to “queers and street children.” That individual, who was also a Member of Parliament, wanted to cut the MSM-focused budget simply because he did not approve of such a priority—a desire that had nothing to do with epidemiological data or evidence.

Access to and quality of health services

MSM tend to avoid government healthcare facilities out of fear of being discriminated against by health providers at all levels, from doctors to nurses. According to study participants, some healthcare providers think MSM are not as “important” as some other groups, such as pregnant women or HIV-positive children—and sometimes will even say that directly to patients who “look gay.” Cases have been reported where MSM have been asked to wait to receive ARVs until after other patients get them.

Confidentiality is a concern: Many HIV-positive gay men and MSM are reluctant to seek out medical care (including for HIV-related illnesses) because of concerns that their status will be

revealed without their consent. The same confidentiality-related fears prevent many from being seen near an AIDS center. The complexity of social stigma in general is encapsulated in the observation by some participants that many gay men and other MSM are unable or unwilling to access services for PLHIV because such services are perceived to be available only for drug users. As a result, many live in complete isolation.

Another ongoing concern is the “non-professional” provision of medical services—e.g., doctors who do not refer their MSM patients to additional medical services when they are clearly needed. This occurs, for example, when patients are diagnosed with STIs; in such cases, doctors should (but often do not) recommend HIV tests and discuss the patients’ sexual behavior in a competent, comprehensive, and confidential manner.

According to respondents, another issue that occurs from time to time is that doctors, upon learning that a patient engages in same-sex sexual practices, offer him some “extra” medical services or examinations that the patient must pay for. Often these additional services are usually available to “normal” people free of charge, though the patient might not be aware of that. Some respondents said that such behavior stems from some doctors’ erroneous belief that MSM are wealthier than other patients.

It is important to note that although the overall situation remains extremely challenging, there are small signs that it is changing for the better. In Kyiv, for example, MSM are usually able to access all the services they want and need without experiencing any discrimination at the well-known “Lavra” clinic as well as at the city AIDS center.

Effective research and surveillance

Stigma against MSM greatly affects the scope and effectiveness of HIV-related surveillance in Ukraine. It affects the quality of samples, as bio-behavioral surveys cannot reach out to MSM who are not willing to be a part of any research because of a fear of confidentiality breach. Such fears are not unfounded. Reports have surfaced from some cities (including Kyiv, Dnipropetrovsk, and Lviv) of police officers trying to identify MSM and LGBT people based on the names in others’ telephone contact directories or address books.

Better documentation of the true extent of stigma and discrimination in health access may soon be available. Some work has been supported by the UN Development Programme (UNDP) to assess the needs of MSM in relation to exclusion from healthcare services. The report is expected to be available soon.

Cost of prevention commodities

Many projects targeting MSM do not provide all or even most of the services they intend to offer, usually because of cost-related obstacles. Generally, except for Global Fund-supported prevention programs, water-based lubricants are not available for two main reasons: the cost and non-availability of single-use lubricants. The price of one 100 ml tube of lubricant is as much as 80 UAH (\$10); that is extremely costly given the country’s average monthly wage of less than \$150.

Condoms are slightly more available to MSM in Ukraine, as they are easy to buy at pharmacies and supermarkets. However, in 2009 condom prices almost tripled for most brands, putting them out of reach for many MSM on a regular basis (especially for those who are unable or unwilling to be a client of an HIV-related project). Some MSM also worry about carrying condoms in case they are searched by the police; to many law enforcement officials, condoms indicate membership in a “risk group” and thus a potential target for harassment and abuse.

Other challenges associated with MSM-specific programming

Respondents noted other limitations to some existing MSM-focused programs. In general, outreach programs focus primarily on MSM who go to bars/clubs or cruising places but do not yet reach out to those who arrange sexual encounters on the internet. The lack of sufficient information and resources online is a major gap because so many MSM have “migrated” there. Also, most MSM-targeted programs do not include any poverty reduction/job skills training programs, which many study participants agreed would help address some of the most important underlying economic and social problems among the population.

And finally, according to most study respondents, services primarily target MSM who self-identify as “gay.” This means that few interventions therefore reach MSM who do not self-identify but may engage in episodic and high-risk sex.

4.7.4 Government response and engagement

Most respondents, especially those from the civil society sector, stressed that the government is not involved in the response to HIV among MSM. Government representatives defended the state, arguing that the government’s main responsibility is to work “with the general population,” while NGOs focus on key populations. One official claimed that the distinction is no longer relevant anyway because MSM are not a “risk group” since the epidemic has moved into a generalized stage. Whatever the rationale, the government remains largely uninvolved and disengaged. It does not provide any direct funding for MSM research, all of which is funded instead by international donors. It also does not support HIV prevention programs targeting MSM.

On the positive side, a few government respondents indicated their support for increased involvement in the future. A representative from the Ukrainian National AIDS Center, for example, said that some prevention interventions, such as those provided at MSM community centers, should in the future be state-funded. He agreed though that they should be implemented and run by NGOs, which are “more flexible” and can reach out to MSM and other “marginalized groups.”

The government, meanwhile, has made some specific additional claims recently that point to potentially beneficial changes. In the 2010 UNGASS Country Progress Report, for example, drafters specifically stated that “the multisectoral strategy [does] address” MSM along with other target populations.²⁵⁰

However, several study respondents stated that MSM are not explicitly mentioned in the text of the law approving the National Program for the Prevention of HIV Infection, Treatment, Care and Support for People Living with HIV and AIDS Patients 2009–2013. The population is only mentioned once, along with estimated targets, in the addendum to the law. MSM are mentioned as a vulnerable group only in the counseling and testing protocol, which includes specific counseling and testing procedures for different most-at-risk populations (MARPs).

According to some respondents, such examples indicate that government agencies’ lack of willingness to prioritize MSM has not changed since the release of the Comprehensive External Evaluation of the National AIDS Response in Ukraine, facilitated by UNAIDS in late 2007 and early 2008. That evaluation concluded that the national response is not adequate to have an impact on the epidemic. It noted the extremely low level of current coverage of services for MSM, adding that the only sustained prevention programming for MSM is supported by the Global Fund grants.²⁵¹

Many respondents do not believe the government's response will soon improve because there is no political will to work with or support MSM. Most agreed that the only hope for change is through campaigning and advocacy similar to that undertaken by drug users and people living with HIV in recent years. Though there is a long way to go for the achievement of full rights, such efforts have led to significant improvements in health access and support for members of those populations.

4.7.5 Global Fund support and engagement

The Global Fund HIV/AIDS grant approved in Round 6 remains active. A Ukraine HIV/AIDS application in Round 10 was approved, but it had yet to be signed by the end of October 2011.²⁵² The National Council to Fight Tuberculosis and HIV/AIDS is proposed as the Principal Recipient of that grant. All MSM-related activities are exclusively donor-funded, with most funding coming from the Global Fund; therefore, the Global Fund is critical to the population.

Through two HIV/AIDS grants to date—one from Round 1 (which has ended) and another from Round 6—Global Fund money has been used to support targeted HIV epidemiological research, treatment and care programs. Apart from relatively limited funding from a handful of other international sources, Global Fund financial support is virtually the only source of funding for MSM-targeted interventions. The coverage of MSM programs through the Global Fund grants has been expanded from three to 15 different cities recently; among the newer projects are those in smaller towns of the Donetsk and Odessa regions.

Through the Round 6 grant, some \$3 million has so far been spent for prevention activities for MSM; this sum accounts for approximately 4.5 percent of the entire grant. The amount allocated for MSM-specific HIV care and support programs was far less, however, with some respondents claiming that it amounted to only about \$5,000 a year. (It is difficult to determine the specific amount of Global Fund money used to fund antiretroviral treatment for MSM, as this statistic does not exist.) Global Fund-supported programs also include funding for educational and informational materials, trainings, and annual national LGBT conferences.

Some Global Fund-supported projects have been implemented by LGBT/MSM organizations. According to respondents, MSM are also often employed as social and outreach workers by non-LGBT/MSM HIV service organizations—though most of these groups do not include MSM on their governing bodies.

Some respondents were critical of MSM community groups, contending that they have not been proactive in seeking to be involved in the process of conceptualizing and planning Global Fund-supported projects. In their view, the level and extent of many of these groups' engagement has been insufficient, a situation they attribute to lack of understanding of the importance of their role in service delivery.

One of the Principal Recipients of the Round 1 and 6 grants, the International HIV/AIDS Alliance in Ukraine, has commissioned three bio-behavioral surveys on MSM, with another one scheduled to be released by the end of 2011. Some MSM community groups were involved in implementing these surveys, while regional and local NGOs were more involved in MSM recruitment. In 2007 and 2009, the analysis and dissemination also involved MSM groups, such as Donbas-Soc-Project and the Gay Forum of Ukraine.

In general, MSM participation in the Global Fund CCM has been inconsistent. The current representative from the NGO constituency is a member of one of the leading MSM networks and a staff person at an MSM NGO. However, most respondents concurred that issues specific to MSM services have rarely been discussed in detail during CCM meetings. They noted that this is

a major challenge, and one that is related to lack of understanding among many CCM members of the HIV risks and needs associated with MSM in Ukraine, as well as persistent stigma and discrimination.

4.7.6 U.S. government support and engagement

Some U.S. government money has been used to support targeted HIV prevention, treatment, and care programs for MSM in Ukraine. In particular, the SUNRISE project, implemented by the International HIV/AIDS Alliance in Ukraine and funded by USAID, is providing prevention services to MSM in several smaller towns in Ukraine that are not reached by Global Fund projects. A few publications, including one on social work with LGBT and a handbook for HIV-positive MSM, have also been published in the framework of the SUNRISE project.

According to many study respondents, U.S. government funds have not been used to support targeted HIV epidemiological research for treatment and care programs in Ukraine. One MSM-specific research project was reportedly commissioned by the USAID mission in Ukraine and carried out by the Kyiv International Institute for Sociology, but its results apparently were never disseminated. Some MSM groups were involved in the implementation of this research.

4.7.7 Recommendations

Recommendations to improve HIV research targeting MSM in Ukraine

- Currently, there are no reliable population estimates for MSM. This gap influences programming and budgeting and impedes effective interventions and advocacy. The national government (through the MoH) should undertake the following to overcome these challenges:
 - carry out national sexual behavior surveys to produce reliable data regarding the number of MSM in Ukraine and their risk factors;
 - improve the methods of population estimates, based on international best practices; and
 - ensure that LGBT/MSM organizations are involved in research on population estimates at all stages.
- Reliable data regarding the epidemic among MSM are not sufficient as official national statistics do not reflect the reality of the HIV epidemic among MSM. To improve the situation, the MoH and other relevant government agencies should ensure that:
 - MSM are meaningfully included in national surveillance;
 - the results of bio-behavioral studies are widely published and disseminated;
 - more research is funded on the HIV epidemic among MSM, its trends and projections for the future; and
 - more research on services tailored to the needs of MSM is carried out. Such efforts should also seek to identify ways to effectively address stigma and discrimination associated with MSM and HIV, and to identify possible actions to overcome them.

- Civil society groups (especially those comprising and working among MSM) should develop and seek support for stronger advocacy. Public campaigning is needed to draw attention to the “invisible epidemic.”
- LGBT/MSM organizations should be more proactive in developing research tools and undertaking research, including in partnership with donors. They should also plan to base subsequent programming on the data.

Recommendations to improve HIV prevention, treatment, and care programs targeting MSM in Ukraine

- The national government (through the MoH) should take the lead in developing programs, allocating resources, and forming partnerships with civil society for the following:
 - training professionals in the health and mental health systems (psychologists, doctors and nurses, etc.) as part of a comprehensive effort to improve the quality of MSM-focused programs. Such training should focus on reducing stigma, improving access to quality services, and ensuring that MSM are comfortable discussing sexual behavior;
 - directing additional funding to care and support programs. Currently, HIV care and support programs are not MARPs-specific;
 - funding and supporting positive prevention programs for MSM; and
 - ensuring that services are more accessible for hard to reach MSM, including those who do not self-identify as gay, those in prisons, and those in the armed forces.

Recommendations to establish a more sustainable, country-owned approach

- International donors and funding mechanisms should:
 - Encourage the national government to fund MARPs-specific programs. As part of this effort, they should identify useful strategies and interventions that would improve the impact of these steps; and
 - Prioritize capacity building of national and local NGOs to ensure sustainability of programs without donor funding.

Recommendation for legal reform

- The national government and Parliament should prioritize the development and passage of anti-discrimination legislation that includes protections for all sexual minorities in a wide spectrum of areas, from employment to healthcare access to the judiciary system. Such legislation should be developed with the direct and ongoing participation of MSM groups and other civil society organizations with expertise in human rights.

Viet Nam

Adult HIV prevalence: 0.4% HIV prevalence among MSM: 16.7%

Summary: Since 2007, HIV prevention programs in Viet Nam—including those initiated and supported by the government—have specifically targeted MSM, contributing to a significant reduction of new infections among this population. Although same-sex sexual practices are not formally criminalized in Viet Nam, high levels of stigma and discrimination have a major impact on access to services and participation in policy development.

Selected country-specific recommendations:

- Increase scope and coverage of service provision targeting “hidden” MSM and transgender individuals, both in PEPFAR-covered provinces as well as nationwide;
- Make health services more accommodating and friendly to MSM, through trainings and education for health services providers at all levels regarding same-sex sexual practices.

4.8 Viet Nam

4.8.1 Introduction and context

In Viet Nam, MSM have been included as a target group for HIV prevention since 2007. Three developments shortly before then helped prompt an increase in services: i) the promulgation in 2004 of the “National Strategy for the Prevention and Control of HIV/AIDS until 2010 with a vision to 2020;” ii) the government’s passage in 2006 of the Law on Prevention and Control of HIV/AIDS; and iii) the launch in 2007 by the Ministry of Health (MoH) of nine “programs of action” to implement and support the National Strategy and the law.

According to the National Strategy, “all people with behaviors at [sic] HIV/AIDS infection risk shall be covered by intervention measures,”²⁵³ and the law states that “homosexual people” are among the populations to be given “priority access to information, education, and communication on HIV/AIDS prevention and control.”²⁵⁴ More pointedly, the national program of action referring to information, education, and communications (IEC) activities has specific objectives and targets for condom use among MSM.²⁵⁵ In addition, the National Monitoring and Evaluation Framework for HIV Prevention and

Control Programs (launched in 2007)²⁵⁶ and the Viet Nam 2010 UNGASS Country Report have particular indicators for condom use among MSM.

Informants for this study agreed that HIV program responses, local policies, and practices have contributed to a slowdown of new HIV infections among MSM as well as a reduction of stigma and discrimination against members of the population. Even so, HIV prevalence among MSM in some areas (including Hanoi and Ho Chi Minh City) is estimated to be several times higher than among the general population, for which prevalence just under one percent.²⁵⁷

Same-sex sexual practices are not criminalized in Viet Nam. Yet at the same time, they are not accorded legal status or recognized as having rights under any existing laws.

Methodology

Two primary research methods were employed. One focused on reviewing printed and electronic documentation, and the other consisted of interviews. Included in the reviews were i) a literature review that prioritized key law and policy documents, ii) reports provided by key informants, and iii) a comprehensive internet search.

Extensive information and observations were also obtained through structured interviews with a total of 12 informants. They included representatives from diverse sectors working in HIV in Viet Nam and included government policy makers, program implementers, donors, multilateral

agencies (e.g., UNAIDS), and MSM representatives. All respondents were based in either Hanoi or Ho Chi Minh City, the country's two largest cities; the interviews were conducted in person in those two cities in July 2011.

4.8.2 MSM-specific HIV programming

Major supporters of MSM-targeted HIV responses in Viet Nam include international INGOs, national and local NGOs, governmental agencies, mass organizations (which are quasi-governmental), and activists. Their engagement, in various forms and to a varied extent, has had notable impact. In many cases, the summaries below of some of those stakeholders' responses are based at least partly on study informants' perspectives.

INGOs have played a major role in capacity building and advocacy for improved responses to the needs and rights of MSM and transgender individuals. Among them are the following, all of which were noted by study participants:

- The Health Policy Initiative (HPI) project in Viet Nam has two phases, HPI 1 and HPI 2. The first phase, completed in 2008, helped facilitate the effective inclusion of representatives of populations greatly affected by HIV, including MSM, in the development of the 2006 national HIV law and the 2007 programs of action. HPI 1 also laid the groundwork for the development of a network of CBOs and self-help groups that have increasingly raised their voices in policy advocacy. HPI 2, which began in 2008 and is scheduled to end in 2013, has focused on providing organizational development assistance for selected MSM groups.
- FHI 360 (formerly known as Family Health International) plays major roles in engaging the Viet Nameese government to implement structured interventions targeting MSM. For example, the organization works with provincial AIDS centers and Public Security Departments at national and provincial levels to allow the provision of condoms in saunas and massage parlors and to allow outreach workers to distribute condoms to street-based male sex workers (even though sex work is illegal). FHI 360 also provides technical and financial support for such efforts. In addition, FHI 360 supports provincial AIDS centers in selected provinces (e.g., Ho Chi Minh City and Hanoi) to set up friendly, professional, and effective STI clinics for MSM.
- Under its Community Reach program, which is funded by PEPFAR, Pact Viet Nam has provided grants to local NGOs to conduct community-based peer education activities, purchase and distribute condoms, and provide referrals to VCT and STI services. (VCT services are provided in public health facilities only, although some NGOs offer STI services in addition to the government.) Pact also supports NGOs in this initiative with technical and managerial support. Of the NGO grantees, the Viet Nam Community Mobilization Center (VICOMC), the Community Health Promotion Center (CHP), and the Center for Quality of Life Promotion (LIFE) are among those that focus on MSM.
- Through its MSM-targeted program, Population Services International (PSI) focuses on social marketing of condoms and lubricants and VCT services. Most PSI condoms are sold at subsidized prices in MSM establishments such as saunas and massage parlors.

A number of local civil society groups (mostly NGOs) and independent research institutes have worked in the areas of sexuality, including homosexuality, and HIV. They include the following.

- The Institute for Social and Development Studies (ISDS) has conducted a number of studies in the area of sexuality, including documentation of stigma and discrimination against MSM. With support from PEPFAR and UNAIDS, it developed a toolkit titled "Understanding and Reducing Stigma Related to Men Who Have Sex with Men and HIV" that was released in 2010.²⁵⁸

- The Institute for Studies of Society, Economy and Environment (iSEE) has conducted a number of Web-based studies on public awareness and attitudes towards homosexuality.
- The Viet Nameese Civil Society Partnership Platform on AIDS (VCSPA) includes hundreds of established NGOs and self-support groups, including those working with and run by MSM. Many of the MSM-focused members provided input during the development of the draft national guidelines on MSM responses. On an ongoing basis, most organize advocacy campaigns and events among communities in an effort to lessen stigma and discrimination.

Mass organizations are quasi-governmental agencies that play important roles in responding to social issues faced by disadvantaged populations. According to study participants, among the mass organizations, the Women's Union is the most progressive in advocating for the health and well-being of MSM and providing counseling and information services for MSM and their families. Examples include the Women's Union in Hai Phong, which has participated in a campaign to end stigma and discrimination against gay sons.

Other initiatives include underground HIV education activities organized by individuals and Web-based interventions. These include condom distribution at gay cafés and sex establishments, as well as small workshops to address stigma and discrimination against MSM that are sponsored by iSEE, a Viet Nameese NGO mentioned above, and other groups. These smaller initiatives face ongoing challenges due to lack of financial support, lack of capacity, and lack of legal status (which makes them susceptible to arbitrary crackdowns by authorities).

4.8.3 Challenges and obstacles to adequate services for MSM

Legal issues

As noted previously, there are no laws specifically criminalizing same-sex sexual practices or expression in Viet Nam. (The one major exception is the sex trade, which is criminalized for both heterosexual and homosexual relations through the Law on Prostitution.) Yet study informants shared concerns that although neither the law nor the policy specifically criminalizes same-sex sexual practices, they do not specifically recognize such acts either. The situation implies that people engaged in same-sex sexual practices of any sort are not protected by law.

Some participants observed that the uncertain environment is a reason that a number of gay men who have been physically attacked and harmed are reluctant to contact law enforcement. An informant from the Lawyers' Association added that because there is no law recognizing transgender and transsexual people, there is also confusion associated with gender identities.

The uncertain legal situation also poses significant challenges to MSM-specific projects. Authorities sometimes refuse to issue permits for NGOs working with and for MSM based on the argument that the target population is not legally recognized. The fact that same-sex sexual practices are decriminalized makes little difference in such cases.

A representative from the Ho Chi Minh City Lawyers' Association warned about another law-related threat to improved and expanded MSM-targeted programming. He noted that because Viet Nam has a centralized budget, the lack of recognition of same-sex sexual practices in the national legal framework could represent a barrier to the ability of local governments to allocate funding for MSM programming. The fact that the draft national guidelines for the MSM responses have not been approved underscores the seriousness of this challenge.

Stigma and discrimination

All study participants agreed that high levels of stigma and discrimination in the public health and social service system, general society, families, the mass media, and among government officials remain a major threat for MSM, transgender individuals, and organizations that provide services to them. Stigma stems from the belief across most of Viet Nameese society that same-sex sexual practices violate family and social values and are not “natural.” Some participants noted that many high-ranking officials have publicly stated that same-sex sexual practices are immoral.

Several informants also warned of the possibility that MSM would eventually be deemed a “social evil” by the government and the public, as has happened in the past regarding drug users and sex workers among other vulnerable populations. The persistence of such terminology and beliefs represents one of the biggest challenges to the effective implementation of HIV prevention initiatives among those two populations in particular. Although some improvement in attitudes has occurred, according to some participants, many government officials continue to emphasize the negative social impacts of same-sex sexual practices. One study informant shared some articles from local newspapers claiming that gay prostitution is on the rise and that this “evil” act is a threat to society.

Informants provided numerous examples of challenges to MSM-specific HIV programs’ reach and effectiveness that are associated with stigma and discrimination. According to some study participants (including those from LIFE and the Ho Chi Minh City HIV/AIDS Prevention and Control Association), several owners of sex establishments have reported being wary about making condoms and lubricants available because doing so would make them vulnerable to being accused of being sex establishments—and thus liable to crackdowns under the law. As a result, these establishments cannot place condoms and lubricants freely in bathhouse locker rooms but can only provide them at customers’ request. One consequence is that a majority of MSM customers do not feel comfortable asking for condoms. Another is that once any establishment is perceived to be a venue for MSM, it faces the threat of disclosure by the media and then being closed down by local authorities.

Access to and quality of health services

Study participants agreed that over the past few years, there has been an increase in number and improvement in quality of the health services available for MSM. These changes stem largely from efforts by international and local organizations advocating for improved, accessible, and friendly services for MSM and transgender individuals. In Ho Chi Minh City, for example, the provincial AIDS center has annual trainings for service providers on reduction of stigma and discrimination at city and district levels. In Hanoi, an STI clinic exclusively for MSM is run by the Binh Thanh District Health Department with the involvement of MSM staff as care givers; informants agreed that it and all general VCT centers are well prepared for MSM clients.

However, respondents from USAID maintained that service providers often do not pay attention to the special needs of MSM or transgender individuals and therefore do not ask specific questions or conduct medical procedures to identify health and social concerns they might face. A majority of interviewees said that the environment in which services in PEPFAR provinces are provided has become more favorable to MSM—as staff are friendly and medically skilled, and privacy and confidentiality are guaranteed. However, some interviewees shared concerns that even in the highest quality places there remains a lack of in-depth understanding about complex issues of importance to many LGBT, such as sex-reassignment operations and same-sex legal support services.

Study informants indicated that except for a few health and HIV service providers who had been trained by NGOs, particularly through PEPFAR-supported initiatives, most public health personnel in non-PEFAR provinces maintain discriminatory attitudes. Manifestation of the discrimination ranges from lack of dedicated essential services to negative attitudes to the exclusion of MSM and transgender people from existing services.

Respondents from VICOMC and UNAIDS said that except for the nine provinces (out of 64 total) where the MSM networks are highly active and health personnel receive anti-stigma and anti-discrimination training, comprehensive and friendly services for MSM are nearly absent. One main reason is that service providers, including the heads of clinics and other facilities, in those areas are rarely trained in issues associated with same-sex sexual practices and thus are mostly ignorant of them. As a result, many MSM are reluctant to discuss their sexuality and sexual practices when seeking services because they fear being stigmatized. One common judgment on the part of service providers is that only male sex workers engage in male-to-male anal sex. Informants also agreed that transgender people are among the most discriminated populations because of their appearance.

Respondents noted that there are no strong policies in place in the public health system to protect client confidentiality, or to reprimand or punish violators of confidentiality. Partly as a result, there have been many reports of rights violations such as clients' sexuality being discussed outside the office by health staff. Such breaches of privacy have often led to widespread knowledge in the community of a client's sexuality, and that individual rarely if ever returns for services even if in need.

Discriminatory practices of this sort often have a wider impact across communities of vulnerable individuals. For example, after an MSM client told his peers that he had been treated poorly at a Hanoi VCT clinic, they said they did not want to visit or revisit that facility.

Other challenges associated with MSM-specific programming

Some respondents added that media outlets have directly contributed to anti-gay attitudes among the general public. For example, in the wake of a number of cases in which gay men were robbed and murdered, stories in print media focused on "immoral" gay lifestyles and allegedly common behaviors such as multiple sexual contacts and older men abusing younger ones. Most of the stories blamed the murders on such lifestyles and urged the general public to avoid such "deviant" individuals. Study participants, especially those who are implementing projects, said there is a strong link between crackdowns on project activities and criminal cases involving gays, even when the gay individuals are the victims. The causal evidence, they claim, stems from the fact that projects are more likely to be shut down or forced to curtail services after stories about gays appear in media outlets.

Police harassment is a major ongoing challenge faced by providers of services for street-based male and/or transgender sex workers. In 2011, for example, a number of street-based outreach workers in Ho Chi Minh City were questioned by the police or not allowed to work during the evening or in areas where sex work is common. They were accused of violating public order and safety. As a result, many male sex workers do not always have access to counseling and supplies (condoms, lubricant, clean needles, etc.) when they need them.

Most non-government informants remain concerned that there is a serious lack of financial commitment from the national government to HIV/AIDS in general and more specifically to MSM and transgender populations. A participant from VAAC contended that the annual national budget for AIDS—VND 100 billion (\$4.8 million)—is insufficient and that there is no specific allocation for MSM. Of that amount, it is estimated that the equivalent of approximately \$20,000 is allocated for AIDS research and none for MSM-specific programming.

Respondents from some non-governmental stakeholders also maintained that the lack of in-depth analysis of same-sex sexual practices in the national HIV epidemic could limit the development of improved programming for MSM. They were particularly concerned that HIV epidemic reports continue to state that heterosexual contact is the key transmission mode yet do not discuss the major risk factor of men (including married ones) who have sex with both men and women. Most of them hide their same-sex sexual practices and are particularly difficult to reach with prevention and treatment support.

4.8.4 Government response and engagement

The most active division within the Ministry of Health (MoH) in the response to HIV among MSM is the Viet Nam Administration of HIV/AIDS Control (VAAC). VAAC led the development of the nine national programs of action and collaborated with UNAIDS and other agencies to develop the national guidelines for prevention, care, and support for MSM in Viet Nam. It also provides policy and technical support for provincial AIDS centers in a number of HIV areas, including MSM programming.

However, there is no exclusive program for MSM within VAAC. Instead, MSM responses are developed within its harm reduction program and IEC and community mobilization department. Because VAAC does not have an exclusive program for MSM, it does not have a dedicated budget for MSM responses. As a result, its responses are ad hoc in nature, including when it allocates human resources to work on MSM programming and other initiatives such as behavioral surveillance.

Another MoH division actively involved in MSM research is the National Institute of Hygiene and Epidemiology (NIHE). It provided technical oversight for the inclusion of MSM in Integrated Biological and Behavioral Surveillance Survey (IBBSS) reports in selected provinces (including Ho Chi Minh City and Hai Phong).

Despite the lack of MSM-targeted funding from the national government, most study participants indicated that Viet Nam has progressed well with national strategic planning that builds the foundation for more funding for MSM and transgender individuals. Currently, the MoH is leading the development of the “National Strategy for the Prevention and Control of HIV/AIDS for the period of 2011 to 2020 with the vision to 2030.” This yet-to-be-approved strategy is expected to include greater governmental commitment in the areas of MSM research, program, and policy responses.

Several research participants stated that there are more initiatives occurring at the local level that demonstrate the improved investment of local governments in responses for MSM, even though the respondents also acknowledge that such efforts are not currently sufficient to reach most in need. The most significant investment is the inclusion of MSM in provincial sentinel surveillance systems, which measure HIV prevalence and risk behavior biannually. Informants from the Ho Chi Minh City provincial AIDS center and its AIDS association also said that by allocating resources such as government staff, experts, service providers, and condoms to international donors and INGOs, the provincial AIDS center will have contributed greatly to MSM responses. However, those respondents acknowledged that such efforts are not currently sufficient.

Study participants said that local authorities, especially in the health sector, have positively supported HIV prevention programming (including for MSM). This is manifested by the fact that an increased number of grassroots groups and local NGOs have been supported to implement projects and initiatives for MSM and transgender individuals. Informants provided examples ranging from small, dedicated websites providing information for LGBT to projects operated by larger organizations such as LIFE and VICOMC. Participants noted that most of those projects

have established relationships with local governments: In Ho Chi Minh City, for example, the MSM-focused CBO Blue Sky Club has been established for many years, enjoys a good reputation among MSM, and is accepted by local authorities and the community. Newer initiatives in that city are also receiving positive responses, according to informants.

FHI 360 and provincial AIDS centers from selected PEPFAR provinces also have achieved some success when seeking to work with local authorities, including People's Committees and law enforcement entities, to allow MSM projects to be implemented. These projects nevertheless have faced a number of challenges.

4.8.5 Global Fund support and engagement

From July 2011, for the first time in the history of the Global Fund in Viet Nam, local NGOs are being allocated funding to implement HIV projects (through the Round 9 HIV/AIDS grant). The MoH is the Principal Recipient for that grant; among the Viet Nameese NGO sub-recipients are LIFE, VICOMC, the Center for Community Health and Development (COHED), and the Center for Supporting Community Development Initiatives (SCDI).

As this grant has only recently been initiated, there is little information on specific budget allocations for MSM programming.

4.8.6 U.S. government support and engagement

PEPFAR supports a significant share of HIV prevention programming among MSM and transgender individuals in Viet Nam. Among its partners and sub-contractors are Pact, PSI, FHI 360, and the U.S. Centers for Disease Control and Prevention (CDC). Most PEPFAR-supported projects are budgeted annually, although some of FHI 360's projects are of longer duration and have multi-year budgets—including its structured intervention programs with entertainment establishments and services associated with preventing and treating STIs in Hanoi and Ho Chi Minh City.

As noted elsewhere in this country report, the PEPFAR-supported MSM-specific projects operate in five of the nine PEPFAR focus provinces: Ho Chi Minh City, Hanoi, Hai Phong, An Giang, and Can Tho. Those are the provinces believed to have the highest number of MSM, although no official estimates of the MSM population in Viet Nam had been released at the time this report was researched. Some study informants maintained that several non-PEPFAR provinces also have relatively high numbers of MSM and transgender individuals, including Da Nang, Nha Trang, Ba Ria-Vung Tau, and Dong Nai. Their reasoning (admittedly untested) is that those provinces are economically and socially developed and attract many migrants and tourists—including, it is believed, MSM. Recognizing the gaps of the PEPFAR program, UNAIDS has facilitated the development of a national network of MSM, and MSM-targeted projects in some of these other provinces have been supported through the Global Fund Round 9 grant.

4.8.7 Recommendations

Recommendations regarding research

- There should be more research on MSM and transgender populations in Viet Nam. Research should not only focus on HIV risk behaviors but also on:
 - better understanding the public perception of and attitudes toward same-sex sexual practices and behaviors;

- how to reach not only urban-based MSM but also those living in rural areas;
 - obtaining reliable, thorough estimates of the size of the MSM population and epidemic trends, with the goal of increasing government policy makers' awareness of the need to prioritize comprehensive interventions among the population;
 - understanding the social networks of MSM and transgender individuals and their relationships in society; and
 - recognizing the forms, extent, and impact of violence, abuse, and harassment directed toward MSM, as well as the reasons behind them.
- Research should be led by reliable independent institutions such as the Hanoi School of Medicine, the Pasteur Institute or an equivalent institute. This approach would ensure that proper, rigorous methods are applied and that the research is not influenced by inappropriate political or social considerations. For this research to be effective and comprehensive, however, the institutions should first receive training and support on issues regarding MSM. Expertise from abroad is likely to be needed.
 - The role of MSM in research should be increased. Representatives from MSM groups should be trained in research methodologies so they can be more active members of ongoing research projects or conduct research themselves in the future. Training for them could be provided at the same time that such expertise is provided to the independent research institutions mentioned immediately above.
 - Increased national research could be initiated by tapping into VAAC's existing research budget.

Recommendations regarding programs

- The scope and coverage of service provision targeting "hidden" MSM and transgender individuals (e.g., those living in rural areas) should be increased. In consultation with representatives from MSM NGOs, the MoH should take the lead in this priority area. In particular:
 - there should be strategies, plans, and budgets for MSM programming in provinces other than those covered by PEPFAR. All programs should include distribution of condoms, lubricant, and information as well as referrals and access to VCT and STI services; and
 - there should be active social marketing and assistance for rural and poor MSM to access these services.
- Additional new services should be introduced in PEPFAR-covered provinces as well as nationwide. Among the most important are psychological support and family/community education on MSM issues. One potentially effective option would be for PEPFAR to introduce such services in its priority provinces as a pilot project; based on evaluation, such efforts could then be implemented elsewhere.
- In an effort to make health services more accommodating and friendly to MSM, government health authorities should ensure that more training and education are provided for health service providers at all levels regarding same-sex sexual practices, the specific health and social needs of transgender individuals, and how and why stigma and discrimination negatively impact public health in general. Authorities should also implement mechanisms to monitor and enforce anti-discrimination efforts.
- INGOs and donors that support MSM-specific programming should work with the MoH to develop operational protocol and policies to ensure confidentiality and protect the privacy of all healthcare consumers, including MSM and transgender individuals.

- NGOs and government agencies that create and distribute IEC materials should ensure that MSM and transgender individuals are clearly represented in such materials, as part of an effort to raise public visibility. Such efforts could include, for example, using two men in a condom-promoting public billboard (not just the man-woman images used currently).
- NGOs and government agencies that have harm reduction interventions for injecting drug users and males incarcerated in prisons and camps should include MSM-related messages.

Policy recommendations

- The National Assembly and VAAC should review all provisions of the Law on Prevention and Control of HIV/AIDS to identify where potential amendments and reforms should be proposed to benefit MSM and transgender individuals. Among the objectives should be the proposal of amendments that specifically recognize the rights of all sexual minorities. Members of NGOs working with and for MSM should be partners in this endeavor.
- The MoH should quickly approve the proposed national guidelines for the HIV response among MSM so that provinces and local partners can use them.

Recommendations on reduction of stigma and discrimination

- Government entities and NGOs engaged in MSM programming should build on the ongoing work of the Institute for Social and Development Studies, UNAIDS, and other NGOs by providing extensive anti-stigma and anti-discrimination training to editors of local newspapers and heads of other media outlets. This training should include education about same-sex sexual practices and key public health principles.
- National NGOs should collaborate with local NGOs to conduct awareness campaigns targeting local authorities and Women's Unions. The study respondents believed that by changing the views of the Women's Union and local authorities so that they are more open with regard to same-sex sexual practices, family and community attitudes toward MSM would improve as well.

Recommendations regarding resource allocations from national and international sources

- The MoH should work with the Ministry of Finance to ensure that government funding for targeted programming for MSM and transgender individuals is increased significantly. This would include increased advocacy aimed at having the MoH's HIV prevention, care, and support program be classified as the 15th national program,²⁵⁹ which would ensure more financial resources are allocated.
- INGOs and multilateral agencies working on HIV/AIDS issues in Viet Nam should conduct a "return on investment" analysis and use international examples to advocate for the government to increase its investment in safer-sex interventions and other health and social services targeting MSM and transgender individuals.
- Donors such as PEPFAR and the World Bank should channel funding and support to civil society to build the sector's capacity and accountability for sustainable programming for MSM and transgender individuals.
- Although there is no expectation that funding from the World Bank or PEPFAR will be increased in the near future, study participants recommended that those donors provide more capacity-building support for local LGBT groups. Such investment, they believe, would be more worthwhile and cost-effective than services delivered solely or primarily through INGOs or the government.

5. Policy Analysis and Recommendations

Over the past year considerable attention has been paid to aligning international investments and national AIDS plans more closely with epidemiology and impact modeling. In particular, major AIDS funders, implementers, and researchers have coalesced around the principle of an “investment framework.” A principle of such a framework is the centrality of programs for key populations, including MSM, and the “critical enablers” that remove contextual barriers “stifling the adoption of evidence-based policies and best practices.”²⁶⁰

In parallel, we have seen increasing violence against MSM in many settings, including those examined in this report.²⁶¹ Global attacks on MSM range from intimidation and threats to violence, persecution, and murder.²⁶² As a recent study in Senegal has shown,²⁶³ state-sponsored persecution in the form of punitive laws has a direct negative effect on the ability of HIV programs to reach MSM with needed prevention, care, and treatment services.

This report adds to growing evidence about the gap that needs to be filled to reach MSM most effectively. The findings and observations discussed throughout present a stark picture of the obstacles encountered by MSM seeking HIV prevention, treatment, and care services from programs funded by international donors and national governments. This section considers the findings and recommendations from the country-specific reports (Section 4), as well as those gleaned from the review of major international initiatives and programs (Section 3) to craft a broader set of recommendations for international donors and national governments.

Three main conclusions can be drawn from the research and analysis in this report:

1. Decriminalization is only the first step. Effectively reaching MSM requires addressing stigma and discrimination more broadly while providing the right programs in the right places.
2. International financing and reporting, without real measurement and accountability mechanisms, enable discrimination through simple neglect.
3. New donor trends may be undercutting simultaneous efforts to expand effective HIV programs for MSM.

Stigma, discrimination, and delivery

The individual country reports provide a nuanced assessment of the impact of punitive policies on MSM and HIV. Among the eight countries are those that punish same-sex sexual practices with death (Nigeria), retain ambiguous or unenforced laws (Mozambique), and provide clear, protective legal frameworks (Viet Nam). Not all countries that have been classified as criminalizing neglect the human rights of MSM entirely, and not all that have decriminalized are entirely (or even mostly) supportive.

These examples typify the complex environments in which many MSM live and reinforce the need to carefully consider how to categorize country responses to MSM epidemics to avoid over-simplification. They also underscore the importance of community-based research and the value of having experienced civil society advocates directly responsible for data collection and reporting. The researchers involved in this report—all from civil society—have been able to describe in detail the extent to which national governments engage or neglect the needs of MSM in-country while also commenting on the effectiveness of international AIDS financing mechanisms. That work has helped illustrate and inform much of the global-level data.

Perhaps the most important conclusion from the country research is the oppressive nature of stigma and discrimination targeting sexuality, sexual orientation, and sexual practices.

Consultants working independently in eight countries each cited stigma as a major obstacle to service delivery, either due to fear on the part of MSM or discrimination on the part of providers (or both, in some instances). Stigma undercuts confidentiality and creates significant vulnerabilities for all MSM everywhere. Criminalization is both a cause and consequence of stigma; it only serves to reinforce discrimination in society. In the absence of enforced legal protection, decriminalization is only a first step. Stigma must be addressed systematically across all sectors.

Several reports discuss how police and the media often reflect stigma, with the former acting as either oppressor or enabler and the latter providing a voice for fear and discrimination. In these situations, it can often appear that MSM are provided equal access to services only inasmuch as they are seen as vectors of disease or targets for research, and, outside the public health arena, all bets are off. This is reinforced by the perception that stigma and discrimination tend to be stronger and more oppressive regarding sexuality than HIV status. Although in some contexts HIV-related stigma has been aggressively addressed, stigma related to sexuality or sexual practice has not.

The reports also discuss basic quality issues with service delivery for MSM. Most notable is the consistent inaccessibility of condom-compatible lubricants. Five of the eight reports cited this as a significant problem for MSM seeking HIV prevention services. Others also noted the “low-hanging fruit” approach of national AIDS programs that only address MSM in capital cities or major metropolitan areas, while neglecting rural and peri-urban populations. Several reports mentioned misaligned targeting either due to geography, as described above, or due to outdated concepts of how MSM interact. The days of finding MSM solely in bars, clubs, and other meeting places are gone. Effective outreach has to appropriately identify how MSM meet. Where appropriate, programs should leverage the internet and the large online communities that flourish there.

Money without measure

The analyses of global financing and reporting mechanisms present a dichotomous view of criminalization and its impact on MSM. The differences in the quantity and quality of reporting on MSM and the amount of funding dedicated to programs serving them are glaring. Countries that criminalize report less data, less consistently; budget for less programming; and have higher attrition rates between proposed and funded programs. In these analyses, Viet Nam is a clear leader in MSM programming while Nigeria, Ethiopia, and Guyana all fall far behind.

There is a sizeable difference in the total amount of Global Fund HIV funding directed to countries with punitive polices versus those without (\$891 million versus \$296 million across Rounds 5 through 9) that is explained by the reality that the burden of HIV is highest in these settings. However, that disparity is proportionally larger and inverse when examining only MSM-specific activities (\$2.08 million versus \$14.84 million). Consistent with the observation that MSM are sidelined in generalized epidemics, countries with punitive policies have much less funding directed toward MSM-specific activities compared to their counterparts. PEPFAR totals for the three years of analysis also demonstrate significant disparity associated with punitive policies in overall HIV funding (\$2.85 billion versus \$386 million); however, much of that gap can be attributed to an early emphasis on, and deeper investment in, 15 focus countries—only five of which were included in this report (and of which four fall in the criminalization category).

Equally striking is the lack of impact global tracking mechanisms have on programs for vulnerable populations. Though the analysis focused specifically on MSM, there is nothing in the report that suggests that the UNGASS process assists MARPs. Improvement in reporting has not led to a commensurate improvement in funding or an increase in program implementation in

these eight countries. For example, although Guyana doubled the number of MSM indicators it reported on between the 2006 and 2010 reporting periods, MSM funding dropped more than 50 percent between 2007 and 2009 through PEPFAR. There may be a reasonable explanation for this decline, but it could not be identified in the thousands of pages of documents reviewed for this report.

The paucity of funding for MSM-targeted programming underscores that the global systems that track and report on expenditures lack three vital characteristics: accessibility, accountability, and quality. Useful data are difficult to find and interpret; epidemiological surveillance is often fragmented and applied to financing mechanisms capriciously; and data quality is limited. The type of analysis conducted for this report should be occurring in all donor and recipient nations, and yet data collection, reporting, and surveillance systems are far from optimal after billions of dollars in AIDS investments. In nearly every country in the world, HIV prevalence among MSM is higher—often several times higher—than among the general population, yet far too little is known about this population in most countries. It is not a coincidence that the best surveillance systems for MSM are in places where men feel most comfortable disclosing their sexuality.

Troubling trends

To their credit, the Global Fund and PEPFAR are actively addressing these issues. They are keenly aware of the need to improve data collection and monitoring at both global and national levels. PEPFAR's most recent guidance to countries stresses the need to apply U.S. government funding to establish effective surveillance and monitoring systems.²⁶⁴ The Global Fund has begun a process to strengthen its data reporting and analysis²⁶⁵ and is likely to change its award process to limit the likelihood that attrition would occur after technical evaluations of proposals have occurred. However, there are four trends that undercut these efforts.

First, country ownership remains one of the most complicated issues facing both the Global Fund and PEPFAR as well as the UNGASS process overseen by UNAIDS. Each grapples with applying the term in such a way that allows national governments and in-country stakeholders to have real, sustainable buy-in to HIV planning, implementation, and monitoring while also ensuring that those initiatives align with global targets and intended goals. The Global Fund and UNAIDS approach country ownership in a similar manner, relying on national capacity for the bulk of management and stewardship. PEPFAR uses a hybrid model; it includes national governments and stakeholders in operational planning and monitoring but leaves the day-to-day management to U.S. government agencies. None of the research findings for this report point to a specific model as preferable, but it is notable that in-country authors of seven of the eight country reports credited PEPFAR and USAID with the progress made on MSM service delivery in their country.

Regardless of model, it is clear from this report that countries remain underprepared to adopt and implement these mechanisms and structures fully, including to the extent envisioned by the donor entities themselves. Improved data and reporting will require more engaged donor involvement, which creates a tension with country ownership principles based on how they are currently conceptualized.

Second, each of the eight country reports noted a tokenistic approach to civil society engagement in planning, monitoring, and reporting on HIV programming for MSM. While PEPFAR was credited with making the greatest strides towards including reputable civil society organizations, all three structures lack the kind of transparent in-country mechanisms that allow for the type of civil society monitoring that can strengthen national data systems. Of course, civil society cannot act alone, and, in many contexts, key personnel in national governments are working behind the scenes to effect change as well. These individuals must be supported.

Third, the term MARPs seems to have become a problem that no one expected. As the term has become universally accepted, it has also lost its specificity. In some countries, MARPs specifically refers to MSM, FSWs, and people who inject drugs. However in many contexts, MARPs has become a broadly encompassing term to include any population at heightened risk for HIV. In generalized epidemics, such broader definitions are near useless but still commonly applied. National planners and implementers must be encouraged to move away from convenient abbreviations that hide a lack of understanding.

Finally, each of these mechanisms has taken steps in the last year to streamline processes in an effort to align the administrative and bureaucratic pieces of international financing with national strategic planning and accounting. This is a useful goal. However, the means by which each is attempting this raises significant issues.

The Global Fund has adopted several streamlined processes and will likely adopt expanded single-stream funding when new funding opportunities arise. Findings from this report indicate that single-stream funding will exacerbate the difficulties in tracking targeted Global Fund investments over time. Reducing the reporting burden on countries is a shared goal; thus, the Global Fund needs to prepare strong internal mechanisms to ensure financing reaches the right populations with the right interventions and make data on this available to the world.

UNAIDS has released a new template for reporting UNGASS indicators, expanding the total number from 25 to 30. The MSM indicators have been reduced by one (indicator 14 has been removed) and remain largely unspecific. Unlike the indicators for people who inject drugs, which specify particular prevention interventions, the UNGASS indicators for MSM remain broad and non-specific. A common recommendation of the country reports was the need to revise the UNGASS indicators to be more scientific, valid, and practical in characterizing the epidemics of HIV among MSM and national responses to address this. The latest indicator revisions do not do this.

PEPFAR has transitioned to a two-year COP cycle in which countries produce “long” COPs that include activity level detail and budget codes every two years, and short COPs, every other year, that do not. While this may solve the constant writing cycle countries find themselves in, without significantly stronger tracking and reporting mechanisms internally, this system will be counterproductive to PEPFAR’s commitment to accountability and transparency.

Case study

Ethiopia is a useful example for discussing these issues. The country has received approximately \$1.9 billion²⁶⁶ in HIV-directed aid from PEPFAR and the Global Fund, which has led to over 400,000 people on antiretroviral treatment and more than 6 million individuals tested for HIV. However, despite receiving over \$6 million from PEPFAR for MSM-specific services, Ethiopia has refused to conduct MSM surveillance, to report on MSM to UNGASS, to use any Global Fund money for MSM, or to include MSM civil society in national planning bodies. Ethiopia’s neglect extends beyond MSM as well. The country has one of the highest maternal mortality rates and one of the lowest PMTCT coverage rates. The UNAIDS country page on Ethiopia is completely devoid of data. Though top donors stress the need for country strategies to derive from strong data and reporting, Ethiopia, one of the top recipients, contradicts such assertions. This report’s analysis of U.S. government RFAs shows that Ethiopia received \$77 million for MARPs that covered sex workers, students, mobile populations, laborers, and others. In principle, these are all valid groups in need of HIV prevention, treatment, and care services; however, the lack of data on even the most basic aspects of Ethiopia’s epidemic calls into question the decision-making process and whether or not these investments will have a real impact on the epidemic.

Without donor involvement and engagement, the climate in Ethiopia, as in many of the countries in this report, will not change. Country ownership faces a test in Ethiopia and elsewhere. To be successful, a new model must appropriately balance evidence-based, strategy-driven country planning with national ownership and implementation, the most basic elements of which should include: providing countries analytic means to collect data and make informed choices, funding programs based on those data, and holding countries accountable for their commitments.

Recommendations

National governments

1. Decriminalize same-sex sexual practices and publicly support programs that reduce stigma and discrimination against marginalized groups.
2. Include MSM in epidemiological surveillance and make results publicly available.
3. Prioritize and fund HIV programs targeting MSM.
4. Include civil society in national planning, monitoring, evaluation, and accountability for health programming.

PEPFAR

5. Regularly collect and report on PEPFAR funding that targets marginalized populations and consistently make this data publicly available.
6. Provide financial and technical assistance to collect epidemiological data on MSM in all PEPFAR countries.
7. Forcefully implement PEPFAR MSM guidance, ensuring country plans adhere to best practice and are backed by epidemiological data.
8. Use Partnership Frameworks, official diplomatic channels, and other means to encourage rescission of laws criminalizing same-sex sexual practices.
9. Establish a unique funding mechanism for countries with a significant burden of HIV among MSM and other marginalized populations to intensify services available to these populations (as recommended by the PEPFAR Scientific Advisory Board).
10. Discontinue PEPFAR funding for non-governmental organizations that actively work against human rights for sexual minorities or appropriate health services for this population.
11. Fund operations research to build the evidence base for effective delivery of combination prevention and treatment services to MSM, including biomedical, behavioral, and structural interventions.

Global Fund

12. Create internal mechanisms that monitor and report on attrition of programs targeting marginalized populations, especially MSM.
13. Ensure that any programmatic changes occurring in proposals after technical review receive further technical validation before final grant approval.

14. Require community systems strengthening (CSS) components within existing and new health systems strengthening (HSS) grants, in line with the Sexual Orientation and Gender Identity (SOGI) strategy and the Five Year Global Fund Strategy.
15. Strengthen capacity of Secretariat staff—particularly members of Country Teams with direct involvement in grant management—in the areas of most-at-risk populations, human rights, and equity to enable effective and strategic management of grants in contexts where same-sex sexual practices are criminalized or stigmatized.
16. Accelerate resource mobilization efforts to continue future funding rounds, allowing for the operationalization of the new five-year strategy and an expansion of the MARPs targeted funding pool.

UNAIDS

17. Reform the UNGASS process to ensure that it more effectively serves as a global accountability mechanism for AIDS-related expenditures, including services and policies affecting MSM.
18. Fund civil society accountability efforts, including those regarding MSM services.
19. Provide targeted technical assistance to countries to develop Global Fund proposals that adequately reflect epidemiological surveillance, the latest science, and best practice in HIV prevention for MSM.
20. Monitor and report on the implementation of the Action Framework for MSM among donors.

Endnotes

- 1 Kaiser Family Foundation. "Global Fund to Fight AIDS, Tuberculosis and Malaria – Cumulative Disbursements for HIV/AIDS Grants (US\$) as of October 20, 2011." Available: <http://www.globalhealthfacts.org/data/topic/map.aspx?ind=61>. Date last accessed: Nov. 21, 2011.
- 2 PEPFAR (2011). Available online at www.pepfar.gov/press/80064.htm (date last accessed: November 21, 2011).
- 3 Although there are commonalities between the higher order risk factors faced by transgender women and MSM, including the criminalization of anal sex and other same-sex sexual practices, this report does not include a detailed analysis for data availability and HIV programmatic services for transgender individuals. One reason is that there are a host of risk factors and programmatic targets that are specific to transgender women, notably marginalization at all levels of the life experience including family and social, education, employment, and health. And, given the limited access to data for MSM more broadly, it was not deemed feasible to obtain access to or assess a critical mass of data on transgender-specific programs.
- 4 See http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/mozambique_2010_country_progress_report_en.pdf and http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/nigeria_2010_country_progress_report_en.pdf.
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- 9 Available online at www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html (date last accessed: November 21, 2011).
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- 77 As per approved budget. Available online at <http://portfolio.theglobalfund.org/en/Grant/List/CHN> (date last accessed: November 21, 2011).
- 78 The final budget provided by China to the Global Fund and by the Global Fund to the researchers is identical to the budget in the proposal. It is unclear whether these were the actual final negotiated amounts.
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- 80 The level of detail in the approved budget is not sufficient to determine the funding included for MSM.
- 81 Only Year 1 data were available in the final budget.
- 82 As per grant proposal (page 2). Available online at www.theglobalfund.org/grantDocuments/CHN-R06-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 83 As per grant performance report, budget period 4. (page 15) Available online at www.theglobalfund.org/grantDocuments/CHN-607-G10-H_GPR_0_en/ (date last accessed: November 21, 2011).
- 84 This entry is tagged "unclear" because the way funding for service delivery areas and other funding categories (e.g., equipment, human resources) were reported in the final budget makes the amount difficult to calculate.
- 85 As per grant proposal. (page 78) Available online at www.theglobalfund.org/grantDocuments/CHN-R06-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
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- 88 The approved budgets are not available in this level of detail.
- 89 As per grant proposal. (page 2) Available online at www.theglobalfund.org/grantDocuments/ETH-R07-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 90 $\$25,521,225 + \$41,666,516 + \$18,446,415 = \$85,634,156$ Available online at <http://portfolio.theglobalfund.org/en/Grant/List/ETH>. Date last accessed: November 21, 2011.
- 91 The final budgets do not contain data for all years, making the amount difficult to decipher.
- 92 As per grant proposal. (page 3) Year 1 \$2,372,104 + Year 2 \$2,265,387 = \$4,637,491. Available online at www.theglobalfund.org/grantDocuments/GYA-R08-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 93 Available online at <http://portfolio.theglobalfund.org/en/Grant/Index/GYA-809-G05-S> (date last accessed: November 21, 2011).
- 94 As part of MARPs funding, Summary Budget. $\$274,865$ divided by six = \$45,780.83. p. 87 Available online at www.theglobalfund.org/grantDocuments/GYA-R08-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 95 As part of MARPs funding, Summary Budget. (page 6) $\$275,000$ divided by six = \$45,833.33. Available online at www.theglobalfund.org/grantDocuments/GYA-809-G05-S_IL_2_en (date last accessed: November 21, 2011).
- 96 From the final budget. $\$11,250$ divided by six = \$1,875.
- 97 As per grant proposal. (page 2) Available online at www.theglobalfund.org/grantDocuments/IDA-R06-HA_Proposal_0_en/. Date last accessed: November 21, 2011.
- 98 $\$14,472,382 + \$95,132,020 + \$13,904,010 = \$123,508,412$ Available online at <http://portfolio.theglobalfund.org/en/Grant/List/IDA>. Date last accessed: November 21, 2011.
- 99 The final budget is unclear because multiple agencies received the grants and did not report on their budgets in the same format.

- 100 As per grant proposal. (page 2) Available online at www.theglobalfund.org/grantDocuments/IDA-R07-HA_Proposal_0_en/. Date last accessed: November 21, 2011.
- 101 As per grant proposal. For Phase 1, Year 1 \$12,941,828 + Year 2 \$18,095,269 = \$31,037,097. (page 2) Available online at www.theglobalfund.org/grantDocuments/IDA-R07-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 102 Grant IDA-708-G13-H \$8,330,619 + Grant IDA-708-G14-H \$23,924,839 + Grant IDA-708-G15-H \$12,748,818 = \$45,004,276. Available online at <http://portfolio.theglobalfund.org/en/Grant/List/IDA> (date last accessed: November 21, 2011).
- 103 Grant IDA-708-G13-H \$8,330,619 + Grant IDA-708-G14-H \$15,798,995 + Grant IDA-708-G15-H \$8,464,365 = \$32,593,979. Available online at <http://portfolio.theglobalfund.org/en/Grant/Index/IDA-708-G13-H>; <http://portfolio.theglobalfund.org/en/Grant/Index/IDA-708-G14-H>; and <http://portfolio.theglobalfund.org/en/Grant/Index/IDA-708-G15-H> (date last accessed for all: November 21, 2011).
- 104 The final budget is unclear because multiple agencies received the grants and did not report on their budgets in the same format.
- 105 As part of MARPs funding. Objective 3, Service Delivery Area 2, Activity 2: Community Outreach, BCC for MSM, injecting drug users and sex workers. Year 1 \$178,125 + Year 2 \$106,500 = \$284,625 divided by three groups (including MSM, sex workers and injecting drug users) = \$94,975. Available online at www.theglobalfund.org/grantDocuments/IDA-R07-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 106 The approved budgets are not available in this level of detail.
- 107 As part of MARPs funding. According to the final budget for Phase 1, \$231,563 divided by three groups = \$77,187.67.
- 108 As per grant proposal. (page 7) Year 1 \$ 6,941,647 + Year 2 \$14,058,559 = \$21,000,206. Available online at www.theglobalfund.org/grantDocuments/IDA-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 109 On the website, the signed amount for grant IDA-910-G20-H is \$5,500,938, and the approved amount for grant IDA-910-G21-H is \$4,700,873. Available online at <http://portfolio.theglobalfund.org/en/Grant/List/IDA> (date last accessed: November 21, 2011). However, grant IDA-910-G24-H is not listed on the website but is in the final budgets with an awarded amount of \$7,417,421. According to the final budgets, \$5,223,193 was awarded for grant IDA-910-G21-H, and \$6,112,153 was awarded for grant IDA-910-G20-H. Since the website seems not to be up to date as of mid-September 2011, the amounts from the final budgets for all three grants are added together and used here: \$6,112,153 + \$5,223,193 + \$7,417,421 = \$18,752,767.
- 110 As per grant proposal. (page 110) Objective 2: Strengthening community systems that benefit MSM, hijra and transgender communities. Year 1 \$2,107,940 + Year 2 \$4670732 = \$6,778,672. Available online at www.theglobalfund.org/grantDocuments/IDA-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 111 According to the final budgets. Grant IDA-910-G20-H is MSM-specific.
- 112 As per grant proposals. (pages 3-4) Round 6 \$76,044,549 + Round 8 Year 1: 9,207,981 + Round 8 Year 2: \$29,865,150 + Round 9 Year 1: \$17,148,728 + Round 9 Year 2: \$52,229,251 = \$184,495,659. Available online at www.theglobalfund.org/grantDocuments/MOZ-R06-ML_Proposal_0_en/ www.theglobalfund.org/grantDocuments/MOZ-R08-HA_Proposal_0_en/ and www.theglobalfund.org/grantDocuments/MOZ-R09-ML_Proposal_0_en/ (date last accessed: November 21, 2011).
- 113 Round 6: \$61,305,300 + Round 8: \$11,823,414 + Round 9: \$41,140,895 + \$14,384,504 = \$128,654,113 Available online at <http://portfolio.theglobalfund.org/en/Grant/List/MOZ> (date last accessed: November 21, 2011).
- 114 Unclear because final budgets are not available for all years.
- 115 As per grant proposals. (pages 3) Round 5 \$180,642,512 + Round 8 Year 1 \$45,315,004 + Round 8 Year 2 \$29,740,359 = \$255,697,875. Available online at www.theglobalfund.org/grantDocuments/NGA-R08-HA_Proposal_0_en (date last accessed: November 21, 2011).
- 116 NGA-506-G07-H \$74,170,883 + NGA-506-G08-H \$15,324,677 + NGA-506-G09-H \$18,242,871 + NGA-809-G12-S \$55,379,935 = \$163,300,366. Available online at <http://portfolio.theglobalfund.org/en/Grant/List/NGA> (date last accessed: November 21, 2011).
- 117 Unclear because final budgets are not available for all years.
- 118 As per grant proposal. (page 4) Available online at www.theglobalfund.org/grantDocuments/NGA-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 119 Due to the nature of the single-stream funding mechanism, which aims in part to streamline and consolidate grants, it is unclear how much new money was awarded in Round 9 and how much was previously awarded.
- 120 The final budgets are not available for all of the PRs for this Round.
- 121 As part of MARPs funding (pages 18-20 and 62) Objective 1 SDA 4 Request = \$24,256,940 divided by four programs divided by three groups in the one program including MSM (MSM, injecting drug users, female sex workers) = \$2,021,411. Available online at www.theglobalfund.org/grantDocuments/NGA-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 122 Due to the nature of the single-stream funding mechanism, which aims in part to streamline and consolidate grants, it is unclear how much new money was awarded in Round 9 and how much was previously awarded.
- 123 MSM were included in Objective 1 Service Delivery Area 4 (BCC-community outreach). The PR for that area was Civil Society for HIV/AIDS in Nigeria; however, no final budget was provided to the researchers for that PR.
- 124 As per grant proposal. (page 2) Available online at www.theglobalfund.org/grantDocuments/UKR-R06-HA_Proposal_0_en/ (date last accessed: November 21, 2011).

- 125 Grant UKR-607-G05-H \$79,222,821+ Grant UKR-607-G06-H \$52,314,214= \$131,537,035. Available online at <http://portfolio.theglobalfund.org/en/Grant/List/UKR> (date last accessed: November 21, 2011).
- 126 From the Global Fund provided final budget documents. This budget represents real dollars rather than nominal dollars.
- 127 As per grant proposal. (page 127) Objective 1, SDA 4 Community Outreach for MSM. Year 1 \$333,768 + Year 2 \$543,620 + Year 3 \$906,428 + Year 4 \$1,088,199 + Year 5 \$1,345,071 = \$4,217,086. Available online at www.theglobalfund.org/grantDocuments/UKR-R06-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 128 The approved budgets are not available in this level of detail.
- 129 From the Global Fund provided final budget documents. This budget represents real dollars rather than nominal dollars.
- 130 As per Round 6 proposal (page 10) Available online at www.theglobalfund.org/grantDocuments/VTN-R06-HA_Proposal_0_en/ (date last accessed: November 21, 2011). Year 1 \$4,782,250 + Year 2 \$5,436,930 = \$10,219,180. Round 8 proposal (page 3) Available online at www.theglobalfund.org/grantDocuments/VTN-R08-HA_Proposal_0_en/ (date last accessed: November 21, 2011). Year 1 \$ 6,883,882 + Year 2 \$ 7,693,322 = \$14,577,204. Round 6 \$10,219,180 + Round 8 \$14,577,204 = \$24,796,384.
- 131 Round 6: \$10,695,906 + Round 8: \$8,163,008 = \$18,858,914. Available online at <http://portfolio.theglobalfund.org/en/Grant/List/VTN> (date last accessed: November 21, 2011).
- 132 The final budgets combined equaled about \$30 million. It is unlikely that more money was in the final budget than in the proposal.
- 133 As per grant proposal. (page 4) Available online at www.theglobalfund.org/grantDocuments/VTN-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 134 Due to the nature of the single-stream funding mechanism, which aims in part to streamline and consolidate grants, it is unclear how much new money was awarded in Round 9 and how much was previously awarded.
- 135 The final budget for this Round was not provided to the researchers.
- 136 Due to the format of the proposed budget, it is difficult to break out the amount(s) proposed for MSM specifically.
- 137 As per grant proposal. (page 4) Year 1 \$6,136,969 + Year 2 \$8,321,927 = \$14,458,896. Available online at www.theglobalfund.org/grantDocuments/MAC-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
- 138 Available online at <http://portfolio.theglobalfund.org/en/Grant/Index/MAC-910-G02-H> (date last accessed: November 21, 2011).
- 139 The final budget was not provided to the researchers.
- 140 As per grant proposal. (pages 33 and 76) Available online at www.theglobalfund.org/grantDocuments/MAC-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011). SDA 2.1 "Behavioral Change Communication – Community Outreach and Schools" has three activities. One of these three activities includes MSM and four other MARPs groups. Year 1 funding for SDA 2.2 \$509,716 + Year 2 \$429,309=\$939,025 divided by three activities = \$346,321 divided by five groups = \$ 62,601 for MSM.
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- 143 As per grant proposal. (page 3) Phase 1 = Year 1 \$8,553,295 + Year 2 \$10,107,480 = \$18,660,775 Available online at www.theglobalfund.org/grantDocuments/MSA-R09-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
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- 146 Available online at <http://portfolio.theglobalfund.org/en/Grant/List/MAW> (date last accessed: November 21, 2011).
- 147 As per grant proposal. (page 111) Year 1 \$1,780,000 + Year 2 \$3,374,000 + Year 3 \$2,720,000 + Year 4 \$2,240,000 + Year 5 \$934,500 = \$11,048,500 divided by nine (different groups specified) = \$1,227,611.11. Available online at www.theglobalfund.org/grantDocuments/MAW-R06-HA_Proposal_0_en/ (date last accessed: November 21, 2011).
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- 175 The FY 2010 COPs did not contain the same level of detail and some funding figures were redacted or marked to-be-determined. Thus, FY 2010 COPs were excluded from the analysis. ROPs were not examined since each of the eight target countries produced its own COPs during this time frame.
- 176 See www.pepfar.gov.
- 177 See www.grants.gov.
- 178 Only the original 15 focus countries (which included Ethiopia, Guyana, Mozambique, Nigeria, and Viet Nam) submitted full COPs during this time period, FY 2007 through FY 2009. China and Ukraine originally submitted shorter COPs which did not describe programs at the activity level, and India only started submitting full COPs in FY 2008.

- 179 For the purpose of counting the number of MSM-related activities by program area, data was collected from each individual MSM-related activity, including program area and code. For China and Ukraine, only program area narratives were given (not details on individual activities); therefore, if “MSM” was mentioned in the program area narrative, then it counted as one activity under that program area.
- 180 MSM-related activities are defined as those activities proposed in the COPs that included MSM in the activity narrative or as a target population. The term “MARPs” alone did not sufficiently qualify an activity as MSM-related, unless “MSM” or “men who have sex with men” were specifically mentioned.
- 181 For comparison, Guyana’s total PEPFAR budget fell by 27.8 percent during this same time period.
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