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special report

MSM, HIV, and the Road to Universal Access — How Far Have We Come?



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AIDS RESEARCH

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The MSM Initiative

In an effort to significantly reduce HIV infection and transmission among MSM in resource-limited countries, amfAR, The Foundation for AIDS Research, has launched the MSM Initiative. The Initiative:

Supports and empowers grassroots MSM organizations—

Through small community awards, the MSM Initiative provides MSM groups with access to HIV information, education, and prevention services; conducts outreach and advocacy; and helps create and sustain safe spaces.

Builds understanding and awareness of HIV epidemics among MSM—

The MSM Initiative identifies and fills knowledge gaps about MSM and HIV; shares best practices; and uses research findings to build community and political support.

Advocates for effective policies and increased funding—

The MSM Initiative assists local, regional, and international efforts to combat discrimination and criminalization; increases access to healthcare; and makes HIV among MSM a global public health and funding priority.

www.amfar.org/msm

More than 20 years have elapsed since gay communities around the world began the fight for HIV treatment and prevention programs specifically for gay men and other men who have sex with men (MSM)(1). In far too many countries today, however, MSM continue to have little or no access to HIV services of any kind and as a result are plagued by high rates of infection. In an unfolding tragedy of epic proportions, the numbers tell the story. HIV prevalence among MSM in Mexico is 26%. In Thailand, it is 25%. In Bolivia, 22%. Globally, MSM are 19 times more likely to be infected with HIV than the general population.(2)

As this Special Report makes clear, this story is one of abject failure on the part of the institutions that have been charged with leading the response to HIV/AIDS at local, national, and international levels. For the first time, this report contrasts the most recent epidemiological data on HIV among MSM—data that show alarmingly high rates of infection—with reports from 128 countries that speak to an epidemic of denial, indifference, and inaction. Importantly, the report also outlines the crucial steps that must be taken to adequately address the HIV/AIDS epidemic among MSM. These evidence-based interventions have been proven effective in numerous settings, but lack of political will has impeded their adoption in regions where they are needed most.

At the first UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001, UN member states unanimously adopted a Declaration of Commitment on HIV/AIDS. This was followed in 2006 by an agreement to achieve universal access to HIV/AIDS programs by 2010. Now, two years from the target date, the question arises: on the road to universal access, how far have we come and how distant is that goal? This is especially relevant for MSM—one of the most marginalized and neglected populations in the context of HIV/AIDS.

MSM-targeted HIV programs comprise less than 1% of total HIV spending in Latin America.

The Current Crisis

It is well documented that MSM face a significantly higher risk of HIV infection than the general population in every region of the world. A 2007 analysis of data from 38

(1) The term *men who have sex with men* (MSM) is used to encompass all who engage in male-male sexual behavior. It includes gay men, bisexual men, MSM who do not identify as gay or bisexual, male sex workers, transgendered people, and a range of culture- and country-specific populations of MSM.

(2) Baral S, Sifakis F, Cleghorn F, et al. "Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: A systematic review." *PLoS Med.* 2007 December 1;4(12):e339.

low- and middle-income countries found an overall HIV prevalence among MSM of 12.8%. At the furthest end of the spectrum, MSM in Bolivia are 179 times more likely to be infected with HIV than the general population.

In spite of the evidence that the HIV epidemic continues to grow among MSM populations, few countries have taken proactive steps to reverse this crisis. MSM-targeted HIV programs comprise less than 1% of total HIV spending in Latin America, despite the reality that a quarter of the people in Latin America living with HIV are MSM and sex between men is the most prominent HIV mode of HIV transmission.

Stigma, Criminalization, and Violence

In many countries, institutionalized homophobia and criminalization of homosexual activity facilitate the spread of HIV, severely hindering efforts to provide treatment and prevention for MSM. In 86 countries,

executive summary

consensual same-sex sexual activity is a criminal offence. In 21 countries, male-male sex is punishable by prison sentences of 10 years or more; in seven countries, it is punishable by death. Just this year in Egypt, police used

Top 10: Highest HIV prevalence among MSM*

	HIV Prevalence Among MSM	National HIV Prevalence	Criminalize MSM?
Kenya	43%	6.1%	Yes
Jamaica	25-30%	1.5%	Yes
Benin	25.5%	1.8%	Yes
Thailand	24.6%	1.4%	No
Ghana	25%	2.3%	Yes
Bolivia	21.5%	0.1%	No
Senegal	21.5%	0.9%	Yes
Guyana	21.3%	2.4%	Yes
Trinidad and Tobago	20%	2.6%	Yes
Ecuador	19.2%	0.3%	No

*Sources: UNGASS 2008 Country Progress Reports; 2006 AIDS Epidemic Update, UNAIDS; International Lesbian and Gay Association, "State-Sponsored Homophobia," Ottosson, 2007.

laws against homosexual activity to arrest and persecute men who were thought to be HIV positive. As one of the most highly vulnerable populations to HIV, MSM need focused attention and strategies to receive adequate prevention and treatment. And yet, in many countries throughout the world, stigma and criminalization prevent these populations from getting even a fraction of the services they need.

Even in countries without legal prohibitions against same-sex sexual behavior, widespread stigma and discrimination often lead to low testing rates, limited knowledge about HIV prevention, and increased likelihood of transmission. In many cases—particularly in countries where political leaders deny the existence of same sex sexuality—these essential HIV services for MSM are absent altogether.

In seven member states of the UN, same-sex sexual activity is punishable by death.

Perhaps most shocking is the extent to which violence against MSM in developing countries is linked to rising rates of HIV among those same populations. Over the past year, violence against men due to their gender identification and sexual orientation has raised international alarm. Gambian president Yahya Jammeh said he would “cut off the head” of any homosexual caught in his country. Police in Senegal conducted mass arrests of men thought to be gay, and in Jamaica, a mob broke into a private residence and severely beat a group of gay men having a dinner party. Violence against MSM is a human rights violation that should not be tolerated and that must be addressed as part of national efforts to expand access to HIV prevention, treatment, and care programs.

Lack of Data, Lack of Action

As part of the 2001 UNGASS Declaration of Commitment, member countries are required to measure their progress periodically against a series of specific indicators. Twenty-three UNGASS indicators were identified for the 2008 and 2010 reports, five of which were relevant to MSM. These indicators pertained to prevalence of HIV infection, rates

Many countries that do not report any data on MSM may be unaware of an epidemic in their midst.

of HIV testing, HIV knowledge, condom use, and access to prevention programming.

Almost half of the 128 countries reviewed failed to report any data whatsoever on HIV/AIDS among MSM. Fewer than one-third reported on more than three of the five UNGASS indicators. Seventy-nine countries (62%) did not report on HIV seroprevalence among MSM. In other words, almost two-thirds of the countries surveyed appear to have no information on the extent of HIV/AIDS among their MSM residents.

At the regional level, the dearth of information on efforts to combat HIV among MSM is most apparent in Africa, the epicenter of the global epidemic. Of the 52 countries reviewed, two-thirds did not report on any of the five indicators related to MSM. Asia and the Middle East fared marginally better. Of 33 countries reviewed in these regions, 12 did not report on any of the five indicators.

Percentage of countries that reported on UNGASS indicators relevant to MSM

	MSM infected with HIV	MSM who tested for HIV in last year and know their results	MSM with correct knowledge about HIV transmission and prevention	MSM who used a condom the last time they had sex	MSM reached with HIV prevention programs
Latin America	62%	57%	48%	57%	43%
Caribbean	58%	33%	25%	58%	25%
Eastern Europe	50%	90%	70%	90%	70%
Asia, the Pacific, and the Middle East	47%	57%	53%	63%	40%
Africa	19%	19%	6%	21%	12%

Though little is known about HIV rates among MSM populations throughout the world, a pattern has emerged indicating that when countries adequately measure MSM populations, they find greater than anticipated epidemics. Since MSM populations are highly vulnerable to HIV infection, many countries that do not report any data on MSM may be unaware of an epidemic in their midst.

Lack of data means lack of action. Without data on the HIV epidemic among MSM populations, governments cannot assess the need for prevention and treatment programs targeting these populations. Too many governments interpret the lack of information about HIV among MSM to

International HIV/AIDS funding and policies have largely ignored the growing crisis of HIV infections among MSM.

mean a lack of need for MSM-specific HIV programs. Lack of data then becomes a justification for little or no funding for HIV services for MSM.

But it is not only national governments that are guilty of ignoring MSM. International HIV/AIDS funding and policies have largely ignored the growing crisis of HIV infections among MSM. Because donor countries and other organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria primarily fund HIV/AIDS efforts through national governments, MSM programs rarely receive adequate resources, while governments without any MSM programs continue to be awarded substantial AIDS funding. Often MSM are grouped with other “vulnerable populations” such as injection drug users, sex workers, and orphans, despite the substantial differences among these most at-risk populations.

In a hopeful development, several donor countries have begun to take a stand against discrimination in the countries whose HIV programs they support. The Netherlands, for example, recently adopted a policy making it a priority to end criminalization of homosexuality in the developing countries receiving Dutch funding. It is imperative that other nations strongly encourage recipient countries to value the health and human rights of all of their citizens, regardless of sexual orientation.

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A Call to Action

These findings bear out conclusively that, more than 25 years into the HIV/AIDS epidemic, the AIDS crisis persists among MSM worldwide and continues to be fueled by homophobia and official indifference. International neglect of these populations will serve only to undermine the global effort to fight HIV/AIDS in any context and among all populations.

This Special Report closes with detailed recommendations and conclusions, which are summarized as follows:

amfAR urges all countries to:

- **Develop evidence-based plans and programs to scale up** access to specific, culturally appropriate HIV prevention, treatment, care, and support services for MSM.
- **Develop** indicators for reporting progress in HIV treatment, care, and support programs for MSM.
- **Identify** best practice models and approaches to ensuring universal access to HIV/AIDS prevention, care, treatment, and support programs with MSM.
- **Conduct** baseline and ongoing surveys to gather data and to monitor and evaluate the state of the HIV epidemic among MSM.
- **Decriminalize** same-sex sexual behavior and take the legislative steps necessary to eliminate stigma and discrimination against MSM.

amfAR calls on the international HIV/AIDS funding community to:

- **Fund** HIV/AIDS programs for MSM and allocate adequate human and financial resources to assist countries in their efforts to ensure universal access to HIV treatment, care, and support programs for MSM.
- **Organize** regional consultations on pathways to scaling up access for MSM to HIV/AIDS prevention, care, treatment, and support programs.
- **Encourage** recipient countries to review and reform legislation with the aim of decriminalizing MSM so that all populations have equal access to HIV services.

Around the world, men who have sex with men (MSM) (1) are facing an HIV/AIDS crisis of enormous proportions. Available epidemiological data depict rates of infection that are universally higher than the general population and in many cases substantially so. But how severe is the situation exactly and why is it that, more than 25 years into the epidemic, HIV infection rates among MSM remain shockingly high and may even be worsening?

The first UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001 culminated in the unanimous adoption by UN member states of a landmark Declaration of Commitment on HIV/AIDS. The Declaration paved the way for a subsequent commitment in 2006 to achieve universal access to HIV/AIDS programs by 2010. For MSM, universal access is a matter of the utmost urgency. The next question, then, is how far have we traveled? And how much further do we still have to go?

introduction

amfAR set out to address these questions by compiling in a single document the best available data on the extent of the global HIV/AIDS epidemic among MSM, on the human rights factors that influence and exacerbate the epidemic, and on worldwide progress toward preventing the further spread of HIV infection among MSM.

The UNGASS commitment of 2006 required member states to report periodically on their progress against a series of specific indicators. A total of 23 indicators were identified for the 2008 reports and five of them were directly relevant to MSM:

- What percentage of MSM are living with HIV?
- What percentage of MSM have taken an HIV test in the last year?
- What percentage of MSM know how to prevent HIV?
- What percentage of MSM used a condom the last time they had sex?
- What percentage of MSM are being reached by HIV prevention programs?

Countries made a heroic effort to generate and submit their country progress reports, in many cases through intense consultations and participatory workshops to ensure the inclusion of the most up-to-date and detailed information. In March 2008, 147 out of 192 countries submitted reports to the UN. This response represents the most concerted worldwide effort to document progress against HIV/AIDS to date: 100% of Caribbean nations, 95% of Eastern Europe and Central Asia, 95% of Latin America, and 94% of sub-Saharan African countries filed reports. Indeed, the UN Secretary General described the country reports as “the most comprehensive body of evidence ever assembled regarding the response to HIV in low-, middle- and high-income countries.”

But these reports reveal a disturbing lack of attention to MSM. To assess the extent of global progress on HIV/AIDS among MSM, amfAR reviewed the five indicators relevant to MSM for the 128 UNGASS country progress reports for Latin America, the Caribbean, Eastern Europe, Asia and the Pacific, the Middle East, and Africa. The review, detailed in this publication, shows that many countries have made little effort and minimal progress in preventing the spread of HIV among

MSM. Indeed, when paired with the epidemiological and human rights reports, the review of country progress reports paints a dismal picture of denial, indifference, and inaction.

But there are some reasons to be hopeful. Certain nations are beginning to take a stand against the rampant discrimination against MSM that prevails in many countries. And the solutions already exist. What is required is the foresight to understand that neglect of MSM will serve only to undermine the global effort to fight HIV/AIDS among all populations, and the political will to cast prejudice aside and scale up the HIV prevention, treatment, care, and support programs that are so urgently needed.

(1) The term men who have sex with men (MSM) is a cumbersome and somewhat contentious term that is used to encompass all who engage in male-male sexual behavior. It includes gay men, bisexual men, MSM who do not identify as gay or bisexual, male sex workers, transgendered people, and a range of culture- and country-specific populations of MSM.

The Epidemiology of HIV Among MSM in Low- and Middle-Income Countries: High Rates, Limited Responses

Stefan Baral, Frangiscos Sifakis, Farley Cleghorn, Chris Beyrer

In many regions of the world, HIV first emerged among populations of men who have sex with men (MSM) (1). More than a quarter-century later and in an increasingly broad range of countries, contexts, and development levels, male-to-male sexual contact remains an important route of HIV transmission. *Men who have sex with men* is a technical phrase intended to be less stigmatizing than culturally bound terms such as gay, bisexual, or homosexual. It describes same-sex behaviors between men rather than identities, orientations, or cultural categories. Therefore, the term MSM includes gay men, bisexuals, MSM who do not identify as gay or bisexual despite their behaviors, male sex workers, transgendered people, and a range of culture- and country-specific populations of MSM. MSM belonging to these diverse populations may have both individual and network-level risks and these groups may have diverging HIV epidemic dynamics.

It may be a long time before the differential risk status of these various populations can be accurately described, given the homophobia that is prevalent in many countries and the limited funding available for studies and programs targeting MSM. Nevertheless, recent data indicate that HIV prevalence among MSM is high and rising across these groups, and that these epidemics are no longer limited to the high-income countries in which they were initially described. These studies have demonstrated high HIV prevalence among MSM from a number of low- and middle-income country settings (2). In certain countries—such as Thailand, Cambodia, and Senegal—with relatively low and declining HIV prevalence among heterosexual populations but high prevalence among MSM, the data suggest concentrated HIV epidemics among MSM and a “dislinked” epidemic pattern (3-7). These men exhibit ongoing high HIV prevalence against a backdrop of declining general population epidemics. Despite these significant findings, this continues to be an understudied and underserved population.

Research among MSM in low- and middle-income countries has been limited by the criminalization and social stigmatization of their behavior, safety considerations for study participants, the hidden nature of this population, and lack of targeted funding. Thus, most available data evaluating determinants of HIV risk among MSM are derived from high-income countries. Available evidence from these countries suggests that structural risks—social, economic, political, or legal factors—are important in defining HIV risk for any one man. Individual-level acquisition risks have focused on the highest probability exposure: unprotected anal intercourse, and specifically on receptive anal intercourse (8). Use of “party” or “club” drugs has been associated with heightened sexual exposure risk among MSM, and, as with men who only report sex with women, HIV transmission in MSM is associated with genitourinary disease. However, high frequency of male partners and a high lifetime number of male partners are also relevant (7-9).

epidemiology

There are strong data supporting the preventive efficacy of circumcision among heterosexual men, but among MSM there exist only limited observational data regarding the possible protective effect of adult circumcision on HIV acquisition (9-18). Being a black or minority ethnic man who has sex with men in high-income country settings is associated with a higher risk of HIV compared to white MSM (19). A critical review of the evidence examining the racial differential seen in the HIV epidemic among MSM suggested that the increased HIV prevalence seen among black MSM is most likely due to the fact that a lower proportion of them have been tested and know their HIV status, as well as to higher rates of sexually transmitted infections (STIs), which facilitate HIV transmission (20). These individual risk factors likely transcend geography, whereas the higher-level structural risk factors vary significantly between countries and continents. In particular, high-risk behaviors such as those common among male sex workers, transgendered people, and MSM who inject drugs, likely put all the members of a sexual network at increased risk of infection (7). A high prevalence of STIs increases the probability of HIV transmission within a network. At the community level, access to prevention services, voluntary counseling and testing, and antiretroviral treatment (ART) can help diminish risk

within MSM communities. Finally, the more advanced an HIV epidemic is, the greater the risk to lower-order determinants of HIV infection.

In countries such as the U.S., HIV prevention and treatment efforts have been mainstreamed to target the general population. However, as of 2005, 72% of all HIV infections among men in the U.S. were related to MSM (21). MSM are the only vulnerable group with no significant decrease in transmission rates in the U.S. from 2001 to 2004 (22). Active surveillance in Baltimore has demonstrated HIV prevalence as high as 46% among African-American MSM, 67% of whom were unaware of their status. HIV prevalence was 21% among white MSM, 18% of whom were unaware of their status. These data suggest that HIV continues to have a disproportionate impact on MSM in the U.S., and that these epidemics continue to grow.

The regional average probability of being infected with HIV is 33.3 for MSM in Latin America, and 18.7 for MSM in Asia. In both cases, the HIV infection risk for MSM is much greater than for the general population.

To see if this disproportionate HIV burden also affected MSM in lower-income settings, in 2006 we examined a random sample of low- and middle-income countries and found some notable trends. First, it was difficult even to find studies of the prevalence of male-male sexual contact in lower-income settings, and second, where HIV data were available, prevalence was consistently high. To be able to draw more concrete conclusions, we completed a systematic review and meta-analysis of this topic in 2007. This review confirmed that HIV has spread widely in Asia, Africa, and Latin America, and that MSM are at increased risk of HIV infection compared to the general population of reproductive age adults, even in settings with high HIV prevalence.

The review evaluated 63,538 men from 38 countries and demonstrated an overall HIV prevalence among MSM of 12.8%. Studies from the 16 Latin American countries included 38,013 MSM with an overall HIV prevalence of 16.1%, compared to a general regional population HIV prevalence of 0.5%. Studies from 10 Asian countries included 19,142 men with an HIV prevalence of 11.4%, compared to a general regional prevalence of 0.1–0.3%. Though there were no published studies from the former

Soviet Union and Eastern Europe, data were available from 12 countries in this region and demonstrated an HIV prevalence among 8,609 MSM of 1.2%, compared to a general regional prevalence of 0.9%. Limited data were also available from Africa, where studies from four countries included 2,353 MSM with an HIV prevalence of 13.0%, compared to a general regional prevalence of 5.0%.

Looking at the more widely available data from Latin America, there have been significant differences within the region in the responses to HIV epidemics among MSM, which have likely resulted in different epidemic dynamics, even between neighboring countries. For example, in Peru, MSM are included in national HIV surveillance programs, and targeted HIV prevention expenditures match the relative burden of disease among MSM. HIV prevalence among MSM sampled was 12.2% with an odds ratio (the probability of being HIV positive relative to the general population) of 22.6 times greater than the general population (23). This can be contrasted to Bolivia, where programming and spending on MSM as a proportion of total HIV prevention expenditures are less than one half of the proportion that MSM contribute to the country's HIV epidemic. In Bolivia, HIV prevalence among MSM was 21.5%, with an odds ratio of 178.8 above the baseline general population prevalence. These differences between countries are likely related to structural risk factors for HIV infection among MSM, rather than individual level risk factors. With some exceptions, Latin American countries have included indicators on MSM in their national AIDS strategies, but the high HIV prevalence speaks to the continued need for expansion within these programs to be in line with the relative HIV burden among MSM.

Similar to Latin America, HIV in Asia tends to be highly concentrated among subpopulations, including MSM. Many of these epidemics seem to be occurring separately from what is happening in the general population. Consequently, the regional average probability of being infected with HIV is 33.3 for MSM in Latin America, and 18.7 for MSM in Asia. In both cases, the HIV infection risk for MSM is much greater than for the general population. Given that Asia makes up the majority of the global population, it is surprising that, as of 2007, data were only available from 19,142 men from seven countries in the region. The vast and diverse Asian continent contains very different HIV epidemics, as can be seen by comparing countries such as Thailand and China. In Thailand, HIV prevalence among 3,236 MSM sampled was 24.6%, compared to a prevalence rate of 3.8% among 6,270 MSM in China. However, while the absolute risk among MSM of being infected with HIV was higher in Thailand, MSM in

China were at higher risk of HIV infection compared to the general population. Specifically, while MSM in Thailand were approximately 20 times more likely than the general population to have HIV, MSM in China were more than 45 times more likely than the general population to be HIV positive. Thus, while programming has tended to focus on the absolute risk of HIV infection, it is also key to consider the relative risk of HIV infection among MSM in these settings. In Asia, prevention expenditures targeting MSM range from barely more than zero in parts of China to a high of 4% of all prevention expenditures in Thailand, highlighting the ongoing disparity between the burden of disease among MSM and the level of spending on prevention programs for this population (23).

The high prevalence of HIV infection and high odds ratios among MSM are quite consistent across most individual countries and geographic regions, as well as all epidemic states (low-level, concentrated, and generalized). Eastern Europe appears to be an exception: data on MSM are scarce, and the region's HIV epidemics are primarily driven by injection drug use. Since an unknown but potentially significant number of MSM in this region may also be injection drug users, it may be difficult to estimate the attributable risk fraction—the portion of the total burden of the epidemic that can be attributed to a particular cause—for these differing behaviors. What is clear is the need for better characterization of the risks for MSM in this region and for the development of effective prevention programs to curb these epidemics.

Data regarding MSM in Africa are the sparsest in the world, but are beginning to emerge. One of the earliest studies was published in 2005 in Senegal, where 463 MSM from Dakar and four other urban communities demonstrated an HIV prevalence of 21.5%. STI prevalence among MSM was 4.8% for active syphilis, 22.3% for herpes simplex virus 2, 4.1% for chlamydia, and 5.4% for gonorrhea. A 2005 study of 713 receptive MSM from Khartoum, Sudan, revealed a mostly Muslim population with an HIV prevalence of 9.3%. The best-developed data have been generated in Kenya, with the support of the Kenyan National AIDS Council. Groups throughout the country have shown HIV prevalence as high as 43% among MSM (24-26). In Nigeria, a recent study hosted by the Ministry of Health characterized the risk of MSM across the country and found that their overall HIV prevalence was 13.5%, though prevalence varied significantly between sites of study (27). Specifically, HIV prevalence among MSM in Cross River was 2.8%, 11.7% in Kano, and 25.4% in Lagos. The combination of these studies suggests that even in the generalized HIV epidemics of sub-Saharan Africa, MSM are nearly four times more likely to be infected with HIV than the general population.

Data on HIV prevalence among MSM are currently being generated or analyzed in Botswana, Ghana, Ivory Coast, Malawi, Namibia, South Africa, and Zambia, among other countries. While these data are preliminary, they clearly demonstrate that MSM not only exist in Africa, they are also at risk for HIV infection and in need of targeted prevention programming.

Decreasing the relative burden of disease among MSM will require a concerted effort and a strategic approach. We suggest that any such strategy should include at least three main components: increased surveillance, enhanced research, and targeted prevention programs.

Surveillance is the ongoing collection, collation, and analysis of data and the timely dissemination of information to those who need it. Surveillance of MSM in low- and middle-income countries to date has been largely carried out through research, and only a few countries have included MSM in national surveillance programs. However, where available, prevalence data have demonstrated a consistent and disproportionately high burden of HIV among MSM. National surveillance systems should consider this high burden of disease and include MSM in countries where they are currently excluded. Methodologically sound surveillance can help determine and demonstrate the need for targeted HIV prevention expenditures from regional, national, and international funding agencies.

Prevention expenditures should be allocated according to evidence-based need. To this end, it is important to use research to generate data proving that HIV epidemics in

Even in the generalized HIV epidemics of sub-Saharan Africa, MSM are nearly four times more likely to be infected with HIV than the general population.

low- and middle-income countries are real. Enhanced research can also inform the design of prevention strategies, and eventually serve to evaluate these prevention programs after their initiation.

Given documented high HIV prevalence among MSM, it is also vital to enact targeted and evidence-based prevention programs for these men. The goal of these programs is to decrease HIV transmission among men by increasing condom use during anal sex and employing other evidence-based biomedical interventions. We already know that these prevention strategies can work.

A recent systematic review and meta-analysis including 16,224 men in 38 experimental and observational studies demonstrated that compared to controls with no interventions, study groups reduced unprotected anal intercourse by 27% (28;29). In an additional 16 studies where MSM were given targeted prevention strategies, study groups decreased unprotected anal intercourse by 17%, compared to MSM who received standard HIV prevention measures.

Prevention strategies tend to work better when community-level rather than individual risks are targeted. These strategies functioned equally well independent of the proportion of minorities included. Globally, only 5–10% of MSM have access to programs such as these, with the majority taking place in high-income countries (30;31). However, studies of interventions targeting MSM in low- and middle-income settings have consistently demonstrated both the need for and effectiveness of these programs (32-35). Although prevention strategies targeting MSM have been shown to be effective across country income levels, the benefit of these interventions has been subject to decay over time, indicating that pro-

grams should be ongoing to preserve increased condom usage.

Effective arguments for improved HIV programming for MSM can be made both from public health and human rights perspectives. The data presented here make a clear case that MSM exist and are at risk for HIV infection throughout the world. Moreover, ignoring and stigmatizing high-risk population groups has never proven to be an effective tool in curbing HIV epidemics. From a human rights perspective, discrimination on the basis of sex, which includes sexual orientation, is prohibited by the International Covenant on Civil and Political Rights signed in 1966, of which most states, including all African countries, are signatories. In 1994, the United Nations held that sexual orientation was a status protected under this covenant from discrimination, with “sex” including “sexual orientation.” Whether one gives more weight to the public health or the human rights argument, the conclusion is the same: It is time to comprehensively address the AIDS pandemic, and to do so effectively, all vulnerable populations—including MSM—should be included in HIV prevention programs.

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Rights at the Root: Opportunities for State Leadership on Gender, Sexual Orientation, and Gender Identity*

Joanne Csete

I offer these brief remarks in honor of those courageous colleagues who work to eliminate human rights violations based on sexual orientation and gender identity but who could not be here today because they live in countries where governments do not approve of them, their lovers, their organizations, or their participation in international meetings.

A statement of good intentions about human rights will surely figure in the report from the upcoming high-level session as it has in statements from other General Assembly meetings on HIV/AIDS. Previous declarations from this body have recognized, as in the words of the 2001 UNGASS Declaration of Commitment on HIV/AIDS, that “the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic.”

Unfortunately, when it comes to human rights and HIV, somewhere between the declarations and the practice, many governments fall into a hole. Nothing makes that hole wider or deeper than when sex and sexuality are introduced into policy debates because that so often means the inclusion also of every irrational taboo, moralistic finger-pointing, and cultural stereotype that society can muster.

But we must find our way to rational policy debates on these questions, because we face nothing short of a human rights catastrophe caused by heinous and widespread abuses based on sex, gender, sexual orientation, gender identity, and sex as livelihood. Hatred, ignorance and moral judgmentalism are fueling a horrific war against men who have sex with men (MSM), whether they identify as gay or not; lesbians, bisexual, and transgender people; women facing social, economic and legal subordination; and people in sex work; and all of these people can find common cause in the struggle for sex- and gender-related rights. This is a war with far too many fronts, waged through violence—even murder—torture,

social exclusion, discrimination of all kinds, and hate speech. It is waged too often with impunity and with the active collaboration of the law and agents of the state. Abuses of people on the grounds of their sexual orientation and gender identity should by now be seen as shameful, and it is disturbing that this body of nations has brought so little leadership to stopping them. And it is not just stopping abuses that must be the concern of UN member states, but also safeguarding the sex- and gender-related human rights of all people to a degree that is manifest in their physical and mental health, their full participation in all aspects of life, and the assurance of their inherent dignity. Whether it is the man who has sex with another man but cannot love openly or live openly with that man, the already hyper-criminalized sex worker arrested for the high crime of possessing condoms, the woman in a violent heterosexual union who does not have the right by law to initiate divorce, the transgender person who even in the best of circumstances has to fight for the correct notation of his or her gender on a passport and in the worst of circumstances faces violence and

human rights

disdain (and probably no passport)—the reality of all of these and many more terrible abuses must finally figure in national and multilateral AIDS responses and in social and economic policy more broadly.

The opportunities for leadership and action by states in this regard are many:

First, in the reform of unjust laws: From the recent report from the International Lesbian and Gay Alliance, we know that some 86 UN member states criminalize consensual same-sex acts among adults; in 21 of those countries, people convicted of this ostensible crime can serve prison sentences of more than 10 years; and in seven of those countries, they may be sentenced to death. In any country with such unjust statutes, we can count on arbitrary persecution of lesbians, gay men, bisexual, and transgender people, including by the police.

If anyone is at a loss on how to reform such laws, much of the homework has been done for legislators in the form of the Yogyakarta Principles, the outstanding consensus

*This text is taken from an address by Joanne Csete, director of programs at the Firelight Foundation, at a side event titled *Full Enjoyment of Human Rights by All: Vulnerable Groups, Social Exclusion, and Progress Towards Universal Access*, which was held during the UN General Assembly High-Level Meeting on HIV/AIDS, June 9, 2008. The side event was cosponsored by aids2031, amfAR, the Global Forum on MSM & HIV, UNAIDS, and UNDP.

statement of a year ago now endorsed by many nations and welcomed by the high commissioner for human rights. Changing laws, of course, is only one step, as we heard from the Brazil case, but it is an essential one. Secondly, there are important opportunities for leadership obviously through national AIDS responses and also around the table at the Country Coordinating Mechanism (CCM). The Country Coordinating Mechanism, though created for other things, is still a potential platform for human rights leadership, including in respecting the Global Fund rule that NGO representatives to the CCM should be those that legitimately represent affected communities, chosen by those communities without state interference—and not just those NGOs that are inoffensive to government. If expressions of gender identity and sexual orientation are criminalized, it will be difficult to ensure this kind of representation in the CCM, but the effort can and must be made.

Hatred, ignorance and moral judgmentalism are fueling a horrific war against men who have sex with men.

Similarly, with respect to national AIDS commissions—and beyond. Governments should find ethical and humane ways to generate the kind of data Professor Chris Beyrer presented and must understand that in many cases human rights violations are the other side of the coin of this epidemiologic situation. Ministries of health, of education, of labor, of the interior should all be concerned about the corrosive effect on society of repressing people's right to be who they are sexually and of forcing people to endure secrecy, exclusion, and abuse on these grounds. And organizations that bring to civic life the legitimate assertion of LGBT rights, the rights of women, and the rights of sex workers must be able to flourish; if governments cannot welcome them, they must at least get out of their way.

And in the UN, we may be at a crucial moment of opportunity, with increased consideration of sexual orientation and gender identity in the Human Rights Council and, one hopes, a chance for the General Assembly to show that an expansive vision of justice and human dignity is indeed a central pillar of its work. Precedents are there from other multilateral bodies. Just 10 days ago, the Organization of American States adopted an important resolution highlighting its concern about acts of violence and other human rights violations committed against people because

of their sexual orientation and gender identity, a most welcome step.

The government of France recently announced that it plans later this year to lead the General Assembly toward an assertion of human rights of all people regardless of sexual orientation or gender identity. And so we may learn, finally, what it takes to hear clearly from the General Assembly that whom people love and their private expressions of sexuality are not crimes; and that whether enshrined in the law or not, human rights abuse against people because of their sexual orientation or gender identity can never be acceptable. In the meantime, we thirst for an outcry from the UN when heads of member states make outrageous public threats to homosexuals and transgender people, or when national leaders who are lauded for their work in the fight against AIDS themselves commit hate speech against gays and lesbians—an unacceptable incongruity—or when gays, lesbians and transgender people are murdered brutally because of who they are. The UN must shine a global spotlight on these atrocities and call them by their name. As the secretary-general considers the appointment of a new high commissioner of human rights, he should choose someone who will bring leadership to this struggle. And UN mechanisms throughout the system must do more to make it easier for LGBT rights groups, sex worker rights groups, and women's rights organizations to participate fully in UN processes.

We have heard the case made here for refocusing HIV services on MSM, and every country should have a plan and a budget to pursue that goal. Our concern about human rights leads to two important conclusions about how that goal should be pursued.

First, if the refocusing of AIDS responses on MSM has the effect of facilitating or sharpening the focus of stigma and other abuse against LGBT people, then that refocusing will serve neither public health nor human rights ends. In any country, an AIDS response that is not explicit in its support of human rights without regard to sexuality and gender can easily become complicit in human rights abuses. And there are far too many documented cases in which knowing one's HIV status or attending an HIV conference has opened the door for persecution or prosecution of people because of their sexual orientation.

Governments have some choices here. They can do as they please but be sure to call it "a rights-based approach"—this is a popular strategy, as you know—or they can work to give real meaning to the notion of rights-based action. They can ensure that MSM, lesbians,

transgender people, women subordinated in society and law, and people in sex work have a real voice in decision-making at all levels. They can not just allow, but support, organizations working in this area to bring leadership to program and policy design, implementation, and evaluation. They can ensure that significant resources are invested in working with judges, prosecutors, police, and private sector leaders in respect for the rights of people outside the sexual and gender mainstream. In places where criminalization remains a barrier, political leaders can distinguish themselves by denouncing unjust laws. And, if the approach is really rights-based, it will be remembered that those who suffer the greatest abuses based on sex, gender and sexuality are those who also live in poverty or face racial, ethnic or disability-based discrimination or live with addictions that criminalize them further. Program strategies must be mindful of these compound abuses.

Secondly, it would be a missed opportunity if the refocusing of HIV/AIDS responses on MSM would mean a focus only on issues related directly to HIV or on the human rights only of those people judged to be at the highest clinical risk of HIV. We have a chance to go beyond AIDS and contribute to a larger movement for promotion, protection, and fulfillment of human rights in this sphere.

We have a chance to go beyond AIDS and contribute to a larger movement for promotion, protection, and fulfillment of human rights.

At this moment in history, there is a growing awareness in many societies of the dangers of allowing fundamentalism and moralizing to trump tolerance and scientific evidence in the policy arena. In spite of the actions of repressive states, this is a moment of promising and productive advances in the mobilization of well-informed and courageous civil society groups, ready in any forum to assert and defend the rights of all. I hope that the political leaders who will grace these chambers in the coming days will show by their words and actions that the time of intolerance and moral judgmentalism in AIDS policy—in all policy—is over. Millions of people persecuted for their sex, gender, gender identity, sexual orientation, or status as sex workers are reclaiming their rights and their lives. The high-level meeting is an occasion for government and civil society leaders to be loudly and clearly on the record as supporters of this movement toward justice for all.

Global and Regional Review of 2008 UNGASS Country Progress Reports

In the 2001 Declaration of Commitment, adopted unanimously at the UN General Assembly Special Session on HIV/AIDS (UNGASS), member states agreed by 2003 to “establish national prevention targets...to reduce HIV incidence for those identifiable groups...which currently have high or increasing rates of HIV infection.” In the follow-up Political Declaration of 2006, members agreed to “Commit ourselves to...scale up significantly towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.” They further agreed to a goal of “setting up and maintaining sound and rigorous monitoring and evaluation frameworks within their HIV/AIDS strategies.”

MSM and HIV/AIDS in 2008

The most recent step down the road to universal access came in January 2008 when 147 countries submitted reports to UNAIDS analyzing the concrete progress they have made toward implementing HIV/AIDS programs. Progress was charted by reporting on 23 key questions, or UNGASS indicators, five of which pertain specifically to MSM. These five UNGASS indicators seek to answer the following questions:

- What percentage of MSM are living with HIV?
- What percentage of MSM have taken an HIV test in the last year?
- What percentage of MSM know how to prevent HIV?
- What percentage of MSM used a condom the last time they had sex?
- What percentage of MSM are being reached by HIV prevention programs?

In order to isolate these five indicators and analyze them in detail for this report, amfAR and its research associates downloaded the 2008 UNGASS country reports from the UNAIDS website and reviewed 128 of them, including those from Latin America, the Caribbean, Eastern Europe, the Middle East, Asia, and Africa. The data from this review was compiled into the maps and spreadsheets that appear in this report, and full details from this compilation can be found in Annexes 1, 2, and 4.

A detailed review of the UNGASS MSM indicators is presented in the following pages, beginning with a global overview that summarizes and graphs the reported progress on MSM and HIV. The remainder of this section presents regional breakdowns of the five UNGASS indicators, focusing on middle- and low-income countries.

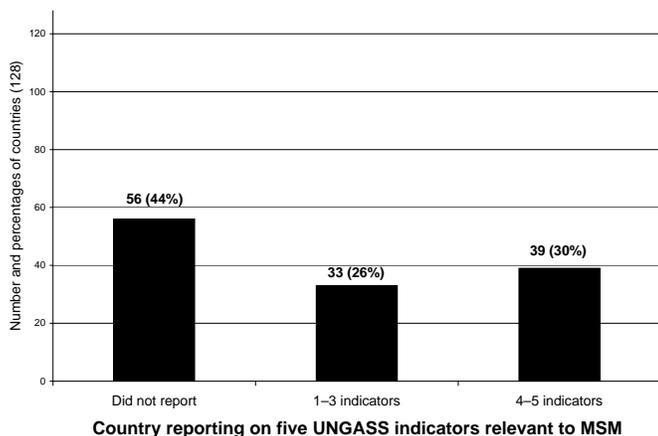
In addition to reviewing the 2008 UNGASS country progress reports, amfAR research associates spoke directly with leaders around the world who work with MSM

populations—people who see the epidemic and its impact up close every day. Eighteen detailed interviews were conducted with leaders at the local, regional, and international level from major NGOs, governments, and civil society organizations. Information gathered from these interviews augments the picture of MSM and HIV found in the UNGASS country reports and appears in the form of the case studies that can be found in the regional sections of this presentation.

global overview

1. Country Reporting: How many countries reported on MSM?

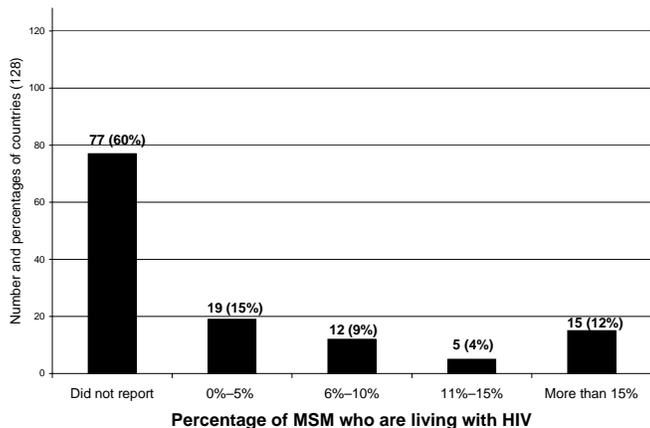
Country reporting of five UNGASS indicators relevant to MSM



Summary: Of the 128 countries reviewed, 56 (44%) did not report on any of the five indicators; 33 countries (26%) reported on 1-3 indicators; and 39 countries (30%) reported on 4-5 indicators.

2. Seroprevalence: What percentage of MSM are living with HIV?

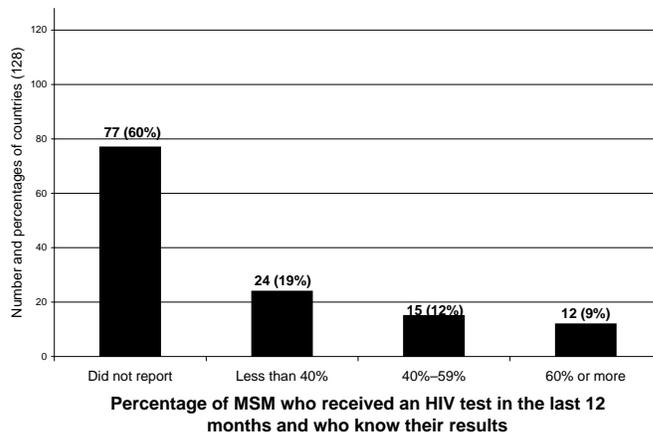
UNGASS Indicator: Percentage of MSM who are living with HIV



Summary: Seventy-seven countries (60%) did not report on HIV seroprevalence among MSM; 19 countries (15%) reported seroprevalence of 5% or less; 12 countries (9%) reported seroprevalence of 6-10%; 5 countries (4%) reported seroprevalence of 11-15%; and 15 countries (12%) reported seroprevalence of more than 15%.

3. Testing: What percentage of MSM have taken an HIV test in the last year?

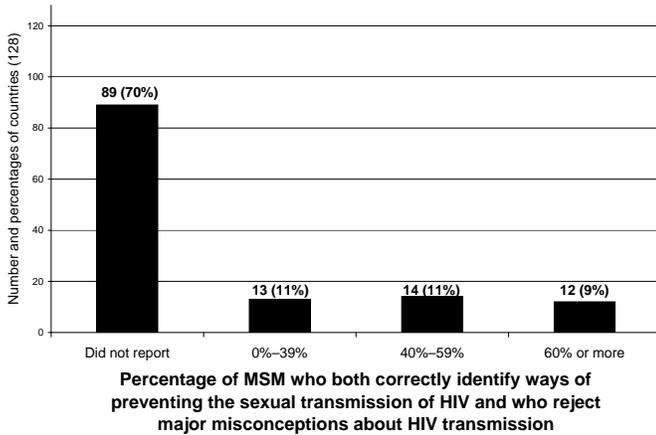
UNGASS Indicator: Percentage of MSM who received an HIV test in the last 12 months and who know their results



Summary: Seventy-seven countries (60%) did not report on HIV testing among MSM; 24 countries (19%) reported testing rates of less than 40%; 15 countries (12%) reported testing rates of 40-59%; and only 12 countries (9%) reported testing rates of 60% or higher.

4. Knowledge: What percentage of MSM know how to prevent HIV?

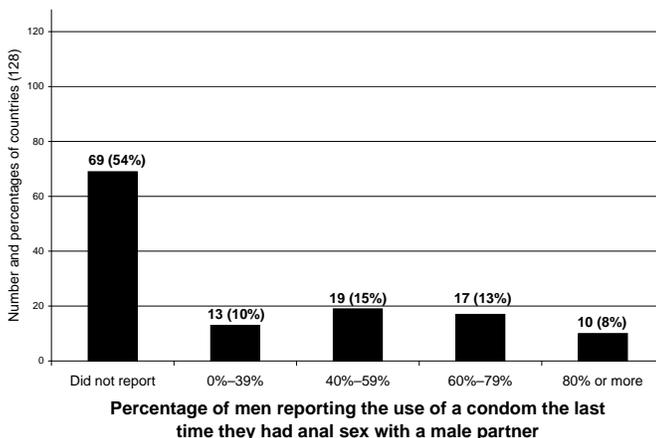
UNGASS Indicator: Percentage of MSM who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission



Summary: Eighty-nine countries (70%) did not report on the level of understanding among MSM of HIV prevention; 13 countries (11%) reported that 0–39% of MSM demonstrate correct knowledge of HIV transmission; 14 countries (11%) reported rates of 40–59%; and only 12 countries (9%) reported rates of 60% or more.

5. Behavior: What percentage of MSM used a condom the last time they had sex?

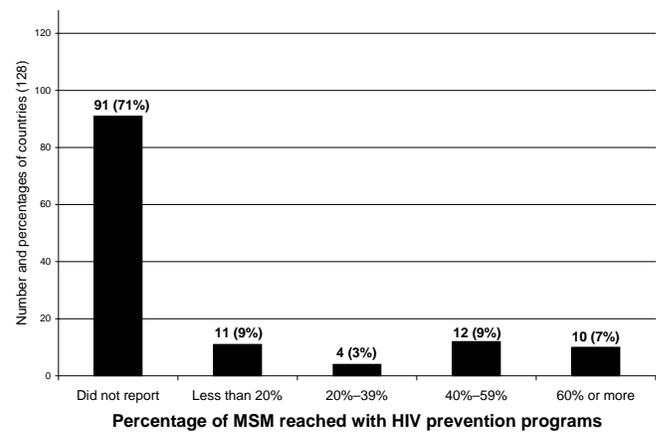
UNGASS Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner



Summary: Sixty-nine countries (54%) did not report on condom use among MSM; 13 countries (10%) reported condom use rates among MSM of 0–39%; 19 countries (15%) reported rates of 40–59%; 17 countries (13%) reported rates of 60–79%; and 10 countries (8%) reported condom use rates among MSM of 80% or more.

6. Coverage: What percentage of MSM are being reached by HIV prevention programs?

UNGASS Indicator: Percentage of MSM reached with HIV prevention programs



Summary: Ninety-one countries (71%) do not know how many MSM are being reached by HIV prevention programs; 11 countries (9%) reported reaching fewer than 20% of MSM; 4 countries (3%) reported reaching 20–39%; and another 12 countries (9%) reported reaching 40–59%. Only 10 out of a total of 128 countries (7%) reported reaching 60% or more MSM with HIV prevention programs.

Latin America had an estimated 100,000 new HIV infections in 2007, for a total of 1.6 million people living with HIV/AIDS in the region. Approximately 58,000 people died of AIDS in 2007. MSM account for at least 25% of HIV infections in Latin America.

Stigma and discrimination are important factors in the continued spread of HIV in the region. They have often impeded dialogue about MSM and hindered attempts to promote safer sexual relations. They can also negatively impact self-esteem and drive sexual behavior and vulnerable groups underground, complicating efforts to contact communities and educate them about risk behavior.

Unprotected sex among MSM contributes significantly to AIDS epidemics in many countries in Latin America, including Bolivia, Chile, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, and Peru (1).

latin america

Review of Country Progress Reports

Latin American countries reviewed: Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, Venezuela.

1. Country Reporting: How many countries reported on MSM?

Country reporting of five UNGASS indicators relevant to MSM

Summary: Of the 20 countries reviewed, five (Belize, Nicaragua, Paraguay, Uruguay, and Venezuela) did not report on any of the five indicators. Three countries (Argentina, Chile, and Suriname) reported on 1–3 indicators. Twelve countries (Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Panama, and Peru) reported on 4–5 indicators.

2. Seroprevalence: What percentage of MSM are living with HIV?

UNGASS Indicator: Percentage of MSM who are living with HIV

Summary: Seven countries (Belize, Chile, Costa Rica, Nicaragua, Paraguay, Uruguay, and Venezuela) did not report on HIV seroprevalence among MSM. Of the countries that did, none reported prevalence of 5% or less. Seven countries (Brazil, Colombia, Honduras, Mexico, Panama, Peru, and Suriname) reported seroprevalence among MSM of 6–10%. Two countries (Argentina and Guatemala) reported HIV seroprevalence of 11–15%. Four countries (Bolivia, Ecuador, El Salvador, and Guyana) reported HIV seroprevalence among MSM of more than 15%.

3. Testing: What percentage of MSM have taken an HIV test in the last year?

UNGASS Indicator: Percentage of MSM who received an HIV test in the last 12 months and who know their result.

Summary: Seven of the countries in the region—more than a third—did not report on HIV testing among MSM (Argentina, Belize, Nicaragua, Paraguay, Suriname, Uruguay, and Venezuela). Two countries (Chile and Peru) have MSM testing rates below 40%. Five countries (Costa Rica, Ecuador, El Salvador, Honduras, and Mexico) have testing rates of 40–59%. Six countries (Bolivia, Brazil, Colombia, Guatemala, Guyana, and Panama) have testing rates of 60% or higher.

4. Knowledge: What percentage of MSM know how to prevent HIV?

UNGASS Indicator: Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Summary: Half of the countries in the region (Argentina, Belize, Bolivia, Chile, Nicaragua, Panama, Paraguay, Suriname, Uruguay, and Venezuela) did not report on the level of understanding of HIV prevention among MSM. Three countries (El Salvador, Guatemala, and Honduras) reported that 0–39% of MSM demonstrate correct knowledge of HIV transmission. Two countries (Ecuador and Peru) reported rates between 40% and 59%, and only five (Brazil, Colombia, Costa Rica, Guyana, and Mexico) reported rates of more than 60%.

5. Behavior: What percentage of MSM used a condom the last time they had sex?

UNGASS Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Summary: Seven of the countries in the region (Argentina, Belize, Guyana, Nicaragua, Paraguay, Uruguay, and Venezuela) did not report on condom use among MSM. Two countries (Chile and Ecuador) reported condom use rates among MSM of 0–39%. Three countries (Brazil, Honduras, and Peru) reported condom use rates of 40–59%. Three countries (Bolivia, Costa Rica, and Mexico) reported rates of 60–79%. Five countries (Colombia, El Salvador, Guatemala, Panama, and Suriname) reported condom use rates among MSM of 80% or higher.

6. Coverage: What percentage of MSM are being reached by HIV prevention programs?

UNGASS Indicator: Percentage of MSM reached with HIV prevention programs

Summary: One-half of the countries in Latin America (Argentina, Belize, Brazil, Chile, Colombia, Nicaragua, Paraguay, Suriname, Uruguay, and Venezuela) do not know how many MSM are being reached by HIV prevention programs. Three countries (Bolivia, Guyana, and Mexico) are reaching less than 20%, two countries (Costa Rica and Honduras) are reaching 20–39%, and another two (Ecuador and Peru) are reaching 40–59%. Three countries (El Salvador, Guatemala, and Panama) report reaching 60% or more MSM with HIV prevention programs.

Case Study: Peru

In Peru, HIV prevalence among males aged 15–24 is estimated at approximately 0.26%, while HIV prevalence among MSM is believed to be 10.8% (2). In recent years, public policy in Peru has gone from being largely unsupportive of MSM programs to incorporating a multitude of prevention programs and other measures that have led to the formation of a vibrant gay community. The country now produces epidemiological data on high-risk populations and is working actively to improve the situation of these groups.

This was not always the case. Peru did not begin to address the HIV epidemic consistently until the country's political situation stabilized after 1995. Early studies indicating the disproportionately high prevalence of HIV infection among MSM versus other groups in the country forced the government to address this population.

It is necessary to address MSM in Peru both through organizations working specifically within the gay community and through organizations that address the HIV epidemic among the general population.

The gay community in Peru has grown considerably over the past decade, becoming a much more central, vibrant part of city life. Some MSM are openly gay and active in gay community life while others identify as heterosexuals

**Peru 2008 Country Progress Report:
UNGASS Indicators Relevant to MSM**

Percentage of MSM who received an HIV test in the last 12 months and who know their results	20.6%
Percentage of MSM reached with HIV prevention programmes	44.5%
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	40.2%
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	47.2%
Percentage of MSM who are HIV infected	10.8% (downward trend since 1996)
Prevalence among males aged 15–24	0.26%

who sometimes have sex with other men. For this reason, it is necessary to address MSM in Peru both through organizations working specifically within the gay community and through organizations that address the HIV epidemic among the general population.

Peru is a poor country and inevitably faces problems procuring funding to subsidize its programs. According to some observers, one of the challenges preventing individual MSM programs from receiving sufficient funds—and MSM from being able to access services—is the multitude of gay rights groups. There are currently some 75 organizations that focus on HIV in MSM populations. On the one hand, this is a positive development, reflecting a supportive civil society that is eager to address the epidemic among MSM. But the confusion arising from a lack of coordination between different groups that have formed to support gay men and other MSM makes it challenging for the government to effectively distribute funds. Some civil society leaders have suggested that many of these organizations should merge in order to achieve their common goal of reducing HIV prevalence among MSM in Peru (3).

In 2007, some 230,000 people were living with HIV/AIDS in the countries of the Caribbean, where adult HIV prevalence is estimated at 1%, and AIDS is a leading cause of death among people aged 25–44 years. Haiti has the highest HIV prevalence in the region, with 2.2% of those aged 15–49 living with the virus, a total of about 170,000 countrywide. But numbers are difficult to determine because in many countries HIV surveillance systems are inadequate, complicating efforts to track epidemic patterns.

HIV transmission in the Caribbean is mainly due to unprotected heterosexual intercourse, including unprotected sex between sex workers and their clients. To a lesser degree, injection drug use also contributes to the spread of HIV, notably in Bermuda and Puerto Rico. Unprotected sex among MSM is also an important contributor to AIDS epidemics in the Caribbean, with stigma impeding relevant education and prevention efforts. Some estimates suggest that up to one in 10 reported HIV infections result from transmission among MSM.

caribbean

Review of Country Progress Reports

Caribbean countries reviewed: Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago.

1. Country Reporting: How many countries reported on MSM?

Country reporting of five UNGASS indicators relevant to MSM

Summary: Out of the 13 countries reviewed, three (Antigua and Barbuda, Dominica, and St. Vincent and the Grenadines) did not report on any of the five UNGASS indicators. Eight countries (Barbados, Dominican Republic, Grenada, Haiti, Jamaica, St. Kitts and Nevis, St. Lucia, and Trinidad and Tobago) reported on 1–3 indicators. Two countries (Cuba and Bahamas) reported on 4–5 indicators.

2. Seroprevalence: What percentage of MSM are living with HIV?

UNGASS Indicator: Percentage of MSM who are living with HIV

Summary: Six countries (Antigua and Barbuda, Barbados, Dominica, Haiti, St. Lucia, St. Vincent and the Grenadines) did not report on HIV seroprevalence among MSM. Of the countries that did, three (Cuba, Grenada, and St. Kitts and Nevis) reported prevalence below 6%, one (Bahamas) reported a rate of 6–10%, one (Dominican Republic) reported a rate of 11–15%, and two (Jamaica and Trinidad and Tobago) reported HIV seroprevalence rates among MSM of over 15%.

3. Testing: What percentage of MSM have taken an HIV test in the last year?

UNGASS Indicator: Percentage of MSM who received an HIV test in the last 12 months and who know their result.

Summary: Approximately two-thirds (nine) of the countries in the region did not report on HIV testing among MSM (Antigua and Barbuda, Dominica, Dominican Republic, Grenada, Jamaica, St. Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, and Trinidad and Tobago). One country (Cuba) reported a testing rate of below 40%. One country (Haiti) reported a rate of 40–59% and two countries (Bahamas and Barbados) reported rates of 60% or higher.

4. Knowledge: What percentage of MSM know how to prevent HIV?

UNGASS Indicator: Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Summary: Over three-quarters of the countries in the Caribbean (Antigua and Barbuda, Barbados, Dominica, Dominican Republic, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago) did not report on the level of understanding of HIV prevention among MSM. One country (Haiti) reported 0–39% of MSM demonstrate correct knowledge of HIV transmission. Two countries (Bahamas and Cuba) reported rates of 40–59%. None reported rates of more than 60%.

5. Behavior: What percentage of MSM used a condom the last time they had sex?

UNGASS Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Summary: Six countries in the region (Antigua and Barbuda, Dominica, Grenada, Jamaica, St. Kitts and Nevis, and St. Vincent and the Grenadines) did not report on condom use among MSM. Two countries (Cuba and Trinidad and Tobago) reported condom use rates of 40–59%. Five countries (Bahamas, Barbados, Dominican Republic, Haiti, and St. Lucia) reported condom use rates among MSM of 60–79%.

6. Coverage: What percentage of MSM are being reached by HIV prevention programs?

UNGASS Indicator: Percentage of MSM reached with HIV prevention programs

Summary: Over three-quarters of countries in the Caribbean (Antigua and Barbuda, Barbados, Dominica, Haiti, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago) do not know how many MSM are being reached by HIV prevention programs. One country (Dominican Republic) reported reaching less than 20% of MSM. Two countries (Bahamas and Cuba) reported reaching 40–59% of MSM. No countries reported reaching 60% or more.

Case Study: Jamaica

According to Jamaica's 2008 UNGASS progress report, 25,000 people, or 1.3% of the adult population, are currently living with HIV, with two thirds of infected people unaware of their HIV status. Among MSM, HIV prevalence is estimated between 25 and 30% (4).

Jamaica is notorious for its rampant and violent homophobia. There have been accounts of mobs beating, burning, stabbing, and drowning men who are believed to be gay, while the police, who are also infamous for abusing LGBT populations, arrive late on the scene and make no effort to disband the mobs (5). In 2007, men suspected of being gay were stoned at a funeral, held hostage by a mob of 200 people demanding their deaths, and told that they had two weeks to leave East Kingston before they would be subject to community action. Health workers are also at risk: In 2005, HIV/AIDS activist Steve Harvey was murdered (6). Recent articles in Time and The New York Times have painted a bleak picture of the country, where LGBT people live in constant fear for their lives. Time's article was entitled "The Most Homophobic Place on Earth?"

In the face of crippling stigma and discrimination, local and international actors have somehow managed to begin to implement HIV/AIDS programming for Jamaica's MSM population.

In the face of this crippling stigma and discrimination, however, local and international actors have somehow managed to begin to implement HIV/AIDS programming for Jamaica's MSM population. "It's not all darkness," says a senior UNAIDS official in Jamaica. "There has been huge movement in this region around

**Jamaica 2008 Country Progress Report:
UNGASS Indicators Relevant to MSM**

Percentage of MSM who received an HIV test in the last 12 months and who know their results	Did not report
Percentage of MSM reached with HIV prevention programmes	Did not report
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Did not report
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Did not report
Percentage of MSM who are HIV infected	25-30% (estimate)
National HIV Prevalence	1.3%

addressing issues of stigma and discrimination, especially on a programming level for MSM, [and] there has been clear progress”(7). One example of an effective program in Jamaica is called PLACE—Priority for Local AIDS Control Efforts. PLACE involves delivering services in an area where a particularly vulnerable group such as MSM is known to be concentrated—but without specifically targeting that group. By avoiding mention of its focus, PLACE avoids generating stigma toward the people who access its services. Evaluations of PLACE show that it has a broad outreach in its coverage and is very effective (8).

Further mobilization has taken place among local, national, and international stakeholders who established the Pan Caribbean Partnership on HIV/AIDS (PANCAP) in 2001 (9). And in November 2006, the Caribbean Vulnerable Communities Coalition and Caribbean Treatment Action Group agreed on a set of declarations calling on Caribbean governments to remedy their inadequate response to the needs of all groups in their populations with regards to HIV/AIDS.

The success of some interventions in Jamaica, and the beginnings of community mobilization in the face of deep and violent stigma, demonstrate the power of stakeholders to operate within a vehemently homophobic society in order to combat HIV/AIDS among MSM. Legal reforms and social change are obviously desirable, but in their absence, the potential to save lives still exists.

In Eastern Europe and Central Asia, there were 1.6 million PLWHAs in 2007, a 150% increase over 2001, when 630,000 cases were reported. Injection drug use and heterosexual transmission are largely responsible for this increase, but MSM also account for a growing number of infections. Women currently represent 26% of adults living with HIV/AIDS in the region. The Russian Federation and Ukraine account for the largest number of newly reported HIV infections.

eastern europe

Review of Country Progress Reports

Eastern European countries reviewed: Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Estonia, Latvia, Lithuania, Moldova, Romania, Russia.

1. Country Reporting: How many countries reported on MSM?

Country reporting of five UNGASS indicators relevant to MSM

Summary: Out of the 10 countries reviewed, one (Latvia) did not report on any of the five indicators. Two countries (Bosnia and Herzegovina, and Estonia) reported on 1–3 indicators. Seven countries (Belarus, Bulgaria, Croatia, Lithuania, Moldova, Romania, and Russia) reported on 4–5 indicators.

2. Seroprevalence: What percentage of MSM are living with HIV?

UNGASS Indicator: Percentage of MSM who are living with HIV.

Summary: Five countries (Bosnia and Herzegovina, Bulgaria, Estonia, Latvia, and Romania) did not report on HIV seroprevalence among MSM. Of the countries that reported on HIV seroprevalence among MSM, two (Belarus and Russia) reported prevalence below 1%. One country (Lithuania) reported an HIV seroprevalence of 1–2%. Two countries (Croatia and Moldova) reported HIV seroprevalence among MSM of 3–5%.

3. Testing: What percentage of MSM have taken an HIV test in the last year?

UNGASS Indicator: Percentage of MSM who received an HIV test in the last 12 months and who know their result

Summary: One country in the region (Latvia) did not report on HIV testing among MSM. Five countries (Bosnia and Herzegovina, Bulgaria, Lithuania, Moldova, and Russia) reported HIV testing rates among MSM below 40%. Four countries (Belarus, Croatia, Estonia, and Romania) reported testing rates of 40–59% among MSM.

4. Knowledge: What percentage of MSM know how to prevent HIV?

UNGASS Indicator: Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Summary: Three countries in the region (Bosnia and Herzegovina, Croatia, and Latvia) did not report on the level of understanding among MSM of HIV prevention. Three countries (Estonia, Lithuania, and Russia) reported that 0–39% of MSM demonstrate accurate knowledge of HIV transmission. Four countries (Belarus, Bulgaria, Moldova, and Romania) reported rates of 40–59%.

5. Behavior: What percentage of MSM used a condom the last time they had sex?

UNGASS Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Summary: One of the countries (Latvia) did not report on condom use among MSM. One country (Bosnia and Herzegovina) reported a condom use rate of 0–19% among MSM. Six countries (Bulgaria, Croatia, Estonia, Lithuania, Moldova, Russia) reported condom use rates of 40–59%. Two countries (Belarus and Romania) reported condom use rates of 60–79% among MSM.

6. Coverage: What percentage of MSM are being reached by HIV prevention programs?

UNGASS Indicator: Percentage of MSM reached with HIV prevention programs

Summary: Three countries in Eastern Europe (Bosnia and Herzegovina, Estonia, and Latvia) did not know how many MSM are being reached by HIV prevention programs. One country (Russia) reported reaching less than 20% of MSM. One country (Bulgaria) reported reaching 20–39% of MSM. Three countries (Croatia, Lithuania, and Romania) reported reaching 40–59% of MSM. Two countries (Belarus and Moldova) reported reaching 60% of MSM or more.

There were more than 5 million people living with HIV/AIDS in Asia, the Pacific, and the Middle East in 2007. In many countries in these regions, injection drug use and unprotected sex (especially commercial sex) are largely responsible for the spread of HIV. Asia is home to some of the most populous countries in the world, resulting in large numbers of people living with HIV/AIDS, even when national HIV prevalence is relatively low. For example, in India 0.36% of those aged 15–49 were living with the virus in 2007, for a total of approximately 2.5 million people. China’s epidemic is largely fueled by injection drug use, but MSM account for a growing number of infections.

Indonesia harbors the fastest-growing epidemic in Southeast Asia, due to injection drug use, commercial sex, and sex between men. Thailand has registered some success in slowing the spread of HIV, but 30–50% of injection drug users are believed to be HIV positive, and HIV prevalence among MSM is rising rapidly.

asia, the pacific, and the middle east

Review of Country Progress Reports

Asian, the Pacific, and Middle Eastern countries reviewed:

Armenia, Azerbaijan, Bangladesh, Cambodia, China, Fiji, Georgia, India, Indonesia, Japan, Jordan, Kazakhstan, Kyrgyzstan, Lao People’s Democratic Republic, Lebanon, Malaysia, Marshall Islands, Mongolia, Nepal, Pakistan, Palau, Papua New Guinea, Philippines, Qatar, Republic of Korea, Seychelles, Singapore, Sri Lanka, Tajikistan, Thailand, Turkey, Tuvalu, Vietnam.

1. Country Reporting: How many countries reported on MSM?

Country reporting of five UNGASS indicators relevant to MSM

Summary: Out of the 33 countries reviewed, 12 (Azerbaijan, Fiji, Japan, Jordan, Marshall Islands, Palau, Qatar, Republic of Korea, Seychelles, Singapore, Tajikistan, and Tuvalu) did not report on any of the

five indicators. Nine countries (Armenia, Cambodia, China, Georgia, Kazakhstan, Malaysia, Pakistan, Sri Lanka, and Turkey) reported on 1–3 indicators. Twelve countries (Bangladesh, India, Indonesia, Kyrgyzstan, Lao People’s Democratic Republic, Lebanon, Mongolia, Nepal, Papua New Guinea, Philippines, Thailand, and Vietnam) reported on 4–5 indicators.

2. Seroprevalence: What percentage of MSM are living with HIV?

UNGASS Indicator: Percentage of MSM who are living with HIV

Summary: Twenty countries (Azerbaijan, China, Fiji, Japan, Jordan, Kazakhstan, Kyrgyzstan, Lebanon, Marshall Islands, Mongolia, Pakistan, Palau, Papua New Guinea, and Qatar, Republic of Korea, Seychelles, Singapore, Sri Lanka, Tajikistan, and Tuvalu) did not report on HIV seroprevalence among MSM. Of the countries that reported on HIV seroprevalence

among MSM, nine (Armenia, Bangladesh, Cambodia, Georgia, Indonesia, Lao People's Democratic Republic, Nepal, Philippines, and Turkey) reported prevalence of 0–5%. Three countries (India, Malaysia, and Vietnam) reported HIV seroprevalence among MSM of 6–10%. One country (Thailand) reported HIV seroprevalence among MSM of more than 15%.

3. Testing: What percentage of MSM have taken an HIV test in the last year?

UNGASS Indicator: Percentage of MSM who received an HIV test in the last 12 months and who know their result

Summary: Sixteen countries in the regions (Armenia, Azerbaijan, China, Fiji, Japan, Jordan, Marshall Islands, Pakistan, Palau, Qatar, Republic of Korea, Seychelles, Singapore, Tajikistan, Turkey, and Tuvalu) did not report on HIV testing among MSM. Twelve countries (Bangladesh, Georgia, India, Indonesia, Kazakhstan, Lao People's Democratic Republic, Lebanon, Nepal, Philippines, Sri Lanka, Thailand, and Vietnam) reported HIV testing rates among MSM of below 40%. Two countries (Cambodia and Papua New Guinea) reported rates of 40–59% and three countries (Kyrgyzstan, Malaysia, and Mongolia) reported HIV testing rates among MSM of 60% or higher.

4. Knowledge: What percentage of MSM know how to prevent HIV?

UNGASS Indicator: Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Summary: Seventeen countries in the region (Azerbaijan, Cambodia, China, Fiji, Georgia, Japan, Jordan, Malaysia, Marshall Islands, Pakistan, Palau, Qatar, Republic of Korea, Seychelles, Singapore, Tajikistan, and Tuvalu) did not report on the level of understanding among MSM about HIV prevention. Six countries (Bangladesh, Lao People's Democratic Republic, Mongolia, Philippines, Sri Lanka, and Thailand) reported that 0–39% of MSM demonstrate accurate knowledge of HIV transmission. Four countries (India, Indonesia, Nepal, and Vietnam) reported that 40–59% of MSM know how HIV is transmitted. Six countries (Armenia, Kazakhstan, Kyrgyzstan, Lebanon, Papua New Guinea, and Turkey) reported rates of 60% or more.

5. Behavior: What percentage of MSM used a condom the last time they had sex?

UNGASS Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Summary: Fourteen countries in Asia, the Pacific, and the Middle East did not report on condom use among MSM (Azerbaijan, Fiji, Georgia, Japan, Jordan, Malaysia, Marshall Islands, Palau, Qatar, Republic of Korea, Seychelles, Singapore, Tajikistan, and Tuvalu). Eight countries (Bangladesh, China, Indonesia, Lao People's Democratic Republic, Lebanon, Pakistan, Philippines, and Turkey) reported condom use rates of 20–39% among MSM. One country (India) reported a condom use rate of 40–59%. Five countries (Kazakhstan, Mongolia, Nepal, Sri Lanka and Vietnam) reported condom use rates of 60–79%. Five countries (Armenia, Cambodia, Kyrgyzstan, Papua New Guinea, and Thailand) reported condom use rates among MSM of 80% or higher.

6. Coverage: What percentage of MSM are being reached by HIV prevention programs?

UNGASS Indicator: Percentage of MSM reached with HIV-prevention programs

Summary: Twenty-one countries in the regions (Armenia, Azerbaijan, Cambodia, Fiji, Japan, Jordan, Kazakhstan, Lao People's Democratic Republic, Malaysia, Marshall Islands, Pakistan, Palau, Qatar, Republic of Korea, Seychelles, Singapore, Sri Lanka, Tajikistan, Thailand, Turkey, and Tuvalu) did not know how many MSM are being reached by HIV prevention programs. Five countries (Bangladesh, China, Lebanon, Papua New Guinea, and Philippines) reported reaching less than 20% of MSM. One country (Vietnam) reported reaching 20–39% of MSM. Three countries (India, Indonesia, and Nepal) reported reaching 40–59% of MSM. Three countries (Georgia, Kyrgyzstan, and Mongolia) reported reaching 60% of MSM or more.

Case Study: India

In India, 0.36% of those aged 15 to 49 are estimated to be living with HIV, representing a total of approximately 2.5 million people. About 6.4% of the country's estimated two million MSM are believed to be infected with the virus (10). These numbers are disputed, however, among people who work with MSM populations because of the difficulty of identifying and counting MSM in India.

Although the Indian government in its UNGASS progress report acknowledges the need to focus on MSM, many civil society leaders claim that current efforts to slow the spread of HIV among MSM are inadequate and inappropriate. One difficulty cited is the view among some that HIV/AIDS among MSM is a problem to solve quickly rather than a community issue to address. For example, one respondent interviewed for this case study maintained that the government funds religious groups that try to "solve" the problem by "converting" homosexual men into heterosexuals.

While respondents noted that the social and legal environment in India has changed considerably and that testing and prevention services are more widely available now than in the past, all respondents noted that current HIV testing, prevention, and treatment efforts are still highly inadequate. Reaching non-feminized MSM—men who often do not consider themselves homosexual—presents another difficulty in providing health services to MSM. Targeted interventions often miss these MSM groups because they are not visibly identifiable, often do not consider their actions as homosexual, are more often married, and consider feminized MSM as social inferiors with whom they don't wish to be categorized. MSM in India face considerable discrimination from medical service providers and this serves as a barrier for treatment access. Respondents noted the need for awareness of MSM issues among healthcare providers,

sensitivity training for the medical community, and MSM-specific care. Including MSM-specific information in HIV education programs for the general public would be an effective means of reaching MSM without forcing them to reveal their sexual behavior and face continued discrimination.

Although the Indian government has made progress in addressing the HIV-prevention and care needs of MSM, section 377 of the country's penal code prohibits homosexual relations and abetting such relations. Repealing the law might not make much difference in terms of decreasing the social stigma that MSM currently face, but it could serve to provide immunity to MSM community workers and allow communities to challenge police extortion and harassment.

Case Study: Nepal

The Nepal UNGASS report estimates that about 0.48% of the adult population is living with HIV, a total of about 70,000 people. Among MSM, HIV prevalence is estimated at 3.3% (11).

Homophobia is deep-seated in Nepal, particularly toward *meti* (feminized men). The Nepali civil code forbids "unnatural sex" but does not define the act. In July 2004, a lawyer filed a case in the Supreme Court of Nepal accusing the government of failing to control the openly homosexual activities of the Blue Diamond Society, a Nepali NGO that works on issues of sexual health and advocacy for LGBT populations. The lawsuit also demanded that the Blue Diamond Society be dissolved (12). In August of the same year, 39 members of the Blue Diamond Society were jailed for 13 days without any charges, before eventually being charged with public nuisance. As the right of the Blue Diamond Society to exist was debated at the Supreme Court and the Home Ministry, community mobilization began to occur, and when a more progressive government came to power, the Society decided to take its own case to the Supreme Court in 2007. On December 21 of that year, the Nepali Supreme Court ruled that the government must recognize LGBT as "natural" people and protect their rights. The conservative nation's recognition of MSM represents a major step forward in the battle against discrimination and HIV/AIDS.

Nepal's victory is by no means the final step in the inclusion of MSM and transgender people in mainstream society; according to a Human Rights Watch advocate, "Things are [still] pretty horrific for a lot of people in Nepal" (13). The new protective rulings, however,

**India 2008 Country Progress Report:
UNGASS Indicators Relevant to MSM**

Percentage of MSM who received an HIV test in the last 12 months and who know their results	3-67%
Percentage of MSM reached with HIV prevention programmes	17-97%
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	16-75%
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	13-87%
Percentage of MSM who are HIV infected	6.4%
National HIV Prevalence	0.36%

**Nepal 2008 Country Progress Report:
UNGASS Indicators Relevant to MSM**

Percentage of MSM who received an HIV test in the last 12 months and who know their results	30%
Percentage of MSM reached with HIV prevention programmes	46.7%
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	44.5%
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	73.5%
Percentage of MSM who are HIV infected	3.2%
National HIV Prevalence	0.48%

provide ammunition for advocates who can now demand that MSM be included in the national HIV/AIDS plan. In the opinion of the director of the Blue Diamond Society, who was also recently elected as Nepal's first openly gay member of Parliament, "People are talking more openly and becoming more friendly, but we also need to work for the next few years." Although he acknowledges that reducing stigma towards MSM, particularly meti, and increasing resources for HIV/AIDS prevention and treatment of MSM is "a huge, huge task," the country's new laws provide a platform from which Nepali advocates can begin to reshape their society.

More than two out of three HIV-positive adults and nearly 90% of all HIV-positive children live in sub-Saharan Africa, where national HIV prevalence rates range from less than 2% to more than 26% of adult populations. In total, some 22.5 million people were living with HIV/AIDS in the region in 2007, including the 1.7 million who were newly infected during that year. Also in 2007, 1.6 million sub-Saharan Africans died of AIDS. And more than half of all PLWHAs in sub-Saharan Africa (61%) are women.

africa

Southern Africa is the area of the world most affected by HIV/AIDS, with nearly one third of all new HIV infections and AIDS deaths in 2007, and 35% of all PLWHAs. In East Africa, where AIDS first emerged on the continent, most countries are experiencing either a stabilization or a decline in adult HIV prevalence, although it remains high in many places. In West and Central Africa, HIV prevalence is either stable or declining, though conflict has increased the risk for HIV transmission in a number of countries.

(14) Unprotected heterosexual sex is responsible for the largest number of HIV infections in sub-Saharan Africa. But there is growing evidence of high rates of HIV transmission among MSM in the region.

In North Africa (and the Middle East, represented by a few countries included in the above section on Asia), epidemiological surveillance has been minimal. Available information, however, suggests that some 380,000 people are living with HIV/AIDS in the region. While few HIV/AIDS cases are being reported, men in urban areas account for the majority of infections. In some countries, commercial sex and injection drug use are also important factors in HIV transmission. In most countries, there is little knowledge of HIV/AIDS and few prevention efforts, even among the most vulnerable populations.

Review of Country Progress Reports

African countries reviewed: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zanzibar, Zimbabwe.

1. Country Reporting: How many countries reported on MSM?

Country reporting of five UNGASS indicators relevant to MSM

Summary: Out of the 52 countries reviewed, 35 did not report on any of the five indicators (Algeria, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea,

Ethiopia, Gabon, Gambia, Guinea, Guinea Bissau, Lesotho, Liberia, Libya, Madagascar, Malawi, Morocco, Mozambique, Namibia, Rwanda, Sierra Leone, Somalia, South Africa, Tanzania, Togo, Uganda, Zimbabwe). Twelve countries (Angola, Benin, Ghana, Kenya, Mali, Mauritania, Niger, Senegal, Swaziland, Tunisia, Zambia, and Zanzibar) reported on 1–3 indicators. Five countries (Ivory Coast, Mauritius, Nigeria, Sao Tome and Principe, and Sudan) reported on 4–5 indicators.

2. Seroprevalence: What percentage of MSM are living with HIV?

UNGASS Indicator: Percentage of MSM who are living with HIV

Summary: Forty-two countries did not report on HIV seroprevalence among MSM (Algeria, Angola, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea Bissau, Lesotho, Liberia, Libya, Madagascar, Malawi, Mauritius, Morocco, Mozambique, Namibia, Rwanda, Sao Tome and Principe, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, and Zimbabwe.) Of the countries that reported on HIV seroprevalence rates among MSM, none reported prevalence of 0–10%. Two countries (Ivory Coast and Zanzibar) reported HIV seroprevalence of 11–15%. Eight countries (Benin, Ghana, Kenya, Mali, Mauritania, Niger, Nigeria, and Senegal) reported an HIV seroprevalence rate among MSM exceeding 15%.

3. Testing: What percentage of MSM have taken an HIV test in the last year?

UNGASS Indicator: Percentage of MSM who received an HIV test in the last 12 months and who know their result.

Summary: Forty-two countries in the region did not report on HIV testing among MSM (Algeria, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Morocco, Mozambique, Namibia, Niger, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, Zanzibar, and Zimbabwe). Six countries (Benin, Mauritania, Mauritius, Nigeria, Sudan, and Tunisia) reported HIV testing rates among

MSM of less than 40%. Three countries (Angola, Ivory Coast, and Kenya) reported testing rates of 40–59% and one country (Sao Tome and Principe) reported a rate of 60% or higher.

4. Knowledge: What percentage of MSM know how to prevent HIV?

UNGASS Indicator: Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Summary: Forty-nine countries in the region did not report on the level of understanding among MSM of HIV prevention (Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Morocco, Mozambique, Namibia, Niger, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zanzibar, and Zimbabwe). Two countries (Mauritius and Nigeria) reported rates of 40–59% and one country (Sao Tome and Principe) reported a rate of 60% or more.

5. Behavior: What percentage of MSM used a condom the last time they had sex?

UNGASS Indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Summary: Forty-one of the 52 African countries did not report on condom use among MSM (Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea Bissau, Lesotho, Liberia, Libya, Madagascar, Malawi, Mauritania, Morocco, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Togo, Uganda, and Zimbabwe). Two countries (Tunisia and Zanzibar) reported condom use among MSM of 20–39%. Seven countries (Ivory Coast, Ghana, Mali, Mauritius, Nigeria, Senegal, and Tanzania) reported rates of 40–59%. Two countries (Kenya and Zambia) reported rates of 60–79%. No country reported condom use rates among MSM of 80% or higher.

6. Coverage: What percentage of MSM are being reached by HIV prevention programs?

UNGASS Indicator: Percentage of MSM reached with HIV prevention programs

Summary: Forty-six countries in Africa do not know how many MSM are being reached by HIV prevention programs (Algeria, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comores, Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Morocco, Mozambique, Namibia, Niger, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zanzibar, and Zimbabwe). One country (Angola) reported reaching less than 20% of MSM. No countries reported reaching 20–39% of MSM. Two countries (Mauritius and Nigeria) reported reaching 40–59% of MSM. Three countries (Benin, Ivory Coast, Sao Tome and Principe) reported reaching 60% or more of MSM.

Case Study: Nigeria

As Africa’s most populous country, with 140 million inhabitants, Nigeria has a relatively low national HIV prevalence—4.4% of people aged 15 to 49. However, the West African country is home to the third largest number of people living with HIV in the world (3.86 million) (15). The first HIV/STI Integrated Biological and Behavioural Surveillance Survey, conducted in 2007, revealed that HIV prevalence among MSM in Nigeria was 13.5% and concluded that “while Nigeria’s HIV epidemic may be classified as ‘generalized’, the unequal distribution of HIV among different sub-population groups means that the Nigerian epidemic shares characteristics with ‘concentrated’ epidemics of other countries.” (16) The survey also stated that only 20–30% of MSM receive HIV outreach in the form of free condoms and safe sex education. Low condom use among MSM increases the risk of exposure to HIV, as does common use of condom-damaging oil-based lubricant.

Homosexuality in Nigeria is a criminal activity that is punishable by death in certain parts of the country. The International Gay and Lesbian Human Rights Commission recently released a report entitled “Voices from Nigeria: Gays, Lesbians, Bisexuals, and Transgenders Speak Out About the Same-Sex Bill,” in which anonymous gay Nigerians expressed their opinions on the criminalization

**Nigeria 2008 Country Progress Report:
UNGASS Indicators Relevant to MSM**

Percentage of MSM who received an HIV test in the last 12 months and who know their results	30.1%
Percentage of MSM reached with HIV prevention programmes	54.3%
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	44%
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	52.7%
Percentage of MSM who are HIV infected	13.5%
National HIV Prevalence	4.4%

of homosexuality in Nigeria and its impact on the HIV epidemic. One man described his situation: “I am a 21-year-old gay man. In June this year I found out I was HIV positive....I have learnt that I am not allowed to express myself [about this] at all. I do not tell my family or my work. Being gay, I have to be as discreet as I can. I have to keep it away from the community. I am also scared about what would happen to me if I came out. I know of a man in a college boarding school who was beaten to death in 2001. These issues in society force gay life underground and contribute to the spread of HIV/AIDS.”

Another Nigerian gay man remarked, “I am HIV positive. I run an organization that seeks to defend the human rights and well-being of LGBT persons in Nigeria. We do a lot of work in HIV/AIDS prevention. A few months ago my organization, in partnership with other organizations, completed research on HIV/AIDS prevalence among men who have sex with men. We carried out HIV tests on 1,300 men who have sex with men. The results of this study are not finalized but the problem is very great. The worst thing is that many of the people who tested have not come back to get their results.” (17)

According to Dr. Oliver Ezechi, a chief research fellow at the Nigerian Institute of Medical Research, “People don’t want to be identified as MSM. Some are married....[and] they don’t categorize themselves because it is derogatory.” On the subject of the government’s lack of intervention programs for MSM, he added, “The problem is that the church and the Muslim groups have a strong influence, so even when you advise the government they are not likely to make policy recommendations because they are afraid of backlash from the church groups. The government is not likely to do anything now because politicians want to remain in power.” Dr. Ezechi stresses the need for more social science research on MSM to make it difficult for the government to ignore the issue of MSM and their link to the HIV epidemic (18).

Case Study: Cameroon

In Cameroon, 5.5% of the population aged 15 to 49 is living with HIV (19). Cameroon's 2007 UNGASS report does not mention MSM, but section 347 of the Cameroonian Penal Code states, "sexual relations with a person of the same sex" are punishable by up to five years in prison and a fine (20). Often, Cameroonian MSM are detained under more general moral laws as well (21). In May 2005, 17 people were arrested on charges of homosexuality; 11 spent more than a year in prison before seven were actually convicted of a crime (22). There is also a significant threat of public outing in Cameroon, as some newspapers in the past few years have taken to printing the names of prominent citizens suspected of being gay (23).

Cameroon 2008 Country Progress Report: UNGASS Indicators Relevant to MSM

Percentage of MSM who received an HIV test in the last 12 months and who know their results	Did not report
Percentage of MSM reached with HIV prevention programmes	Did not report
Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Did not report
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Did not report
Percentage of MSM who are HIV infected	Did not report
National HIV Prevalence	5.5%

The legal and social ramifications of being gay in Cameroon represent a huge barrier to the prevention and care of MSM. According to the director of Alternatives-Cameroon, a human rights organization, HIV-positive MSM are so afraid of being open about their status that some do not access antiretrovirals, even though treatment is free. Alternatives-Cameroon is currently working on collecting data on MSM and HIV/AIDS, in the hopes that facts will force the government to acknowledge the presence of an MSM population; the group is also working to unite civil societies to present a more unified front in demands for HIV/AIDS programs. Although it is unusual for countries to enforce their anti-homosexuality legislation to the degree that this occurs in Cameroon, the country is one of many in which society does not acknowledge the existence of MSM. As a result, prevention efforts ignore MSM, who are even more susceptible to contracting HIV/AIDS and unable to access treatment safely.

References

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- (18) Interview with Dr. Oliver Ezechi, Nigerian Institute of Medical Research, May 22, 2008.
- (19) Cameroon National AIDS Control Committee: *Cameroon 2007 UNGASS Country Progress Report* (2008)
- (20) Cary Alan Johnson: *Off the Map: How HIV/AIDS Programming Is Failing Same-Sex Practicing People in Africa* (IGLHRC, 2007).
- (21) Interview with Steave Nemande, director of Alternatives-Cameroon, May 23, 2008.
- (22) "Human Rights Activists Protest Continued Arrests of Gay Men in Cameroon: Demonstrations in Paris, Pretoria and Washington, D.C." (IGLHRC, 2007).
- (23) Johnson.
- (24) Nemande.
- (25) Ibid.

Universal Access for MSM to HIV Prevention, Treatment, Care, and Support Programs

Ninety-one countries (71%) did not report on access for MSM to HIV prevention programs. Only 10 of 128 countries (7%) were able to report that at least 60% of MSM have access to HIV prevention programs. Some MSM experts note that the calculations of coverage of HIV prevention programs are often overestimated, based either on estimations of MSM population size not performed with scientific rigor or on research studies of time-limited projects as opposed to sustained programmatic interventions.

While these findings on HIV prevention programs for MSM are incomplete, no reporting whatsoever is required in the areas of treat-

ment, care, and support programs for MSM. This absence of data is compounded by a lack of experience in successfully scaling up these programs to ensure universal access to HIV/AIDS prevention, treatment, care, and support programs for men who have sex with men.

Recommendations for Action

- Countries should urgently scale up access to culturally appropriate, evidence-based HIV prevention, treatment, care, and support programs in consultation with affected populations using proven assessment, response, and monitoring and evaluation tools such as:
 - *Rapid Assessment and Response Adaptation Guide on HIV and Men Who Have Sex with Men (WHO)*
 - *Practical Guidelines for Intensifying HIV Prevention (UNAIDS)*
 - *Framework for Monitoring and Evaluating HIV Prevention Programs with Most at Risk Populations (UNAIDS)*

conclusions and recommendations

- Countries should urgently develop indicators for reporting progress in HIV treatment, care, and support programs for MSM and should develop costed work plans for scaling up these programs
- Best practice models and approaches to ensuring universal access to HIV/AIDS prevention, care, treatment and support programs with MSM should be identified, and should include relevant regional, national and local planning, costing, resource mobilization, implementation, monitoring and evaluation strategies.
- International and bilateral donor and technical cooperation agencies should develop strategies and commit adequate human and financial resources to assist countries in their efforts to ensure universal access to HIV treatment, care, and support programs for MSM including adequate technical assistance and support to MSM organizations.
- UNAIDS, in collaboration with key stakeholders, should organize regional consultations on pathways to scaling up access for MSM to HIV/AIDS prevention, care, treatment, and support programs.

MSM and Human Rights

Criminalization of consensual same-sex sexual activity, along with pervasive stigma and discrimination, continue to heavily constrain efforts to ensure or expand access to HIV prevention, treatment, care, and support services for MSM.

Recommendation for Action

- Countries should take steps to decriminalize same-sex sexual behavior and to eliminate the stigma surrounding MSM. They should adopt international human rights guidelines such as:
- International Guidelines on HIV/AIDS and Human Rights, Office of the United Nations High Commissioner for Human Rights and UNAIDS
- Yogyakarta Principles: Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity

Country Reporting on MSM and HIV

Almost half (44%) of the countries reviewed failed to submit data on any of the five UNGASS indicators pertaining to HIV/AIDS among MSM. It is safe to assume that in the majority of countries that did not submit data, HIV/AIDS interventions targeting MSM are scant or nonexistent. Among those countries that did supply data, almost half (45%) reported on three or less of the five indicators relevant to MSM.

Recommendation for Action

- Countries should immediately take steps necessary to address the issue of MSM and HIV/AIDS in consultation with affected populations using proven monitoring and evaluation tools such as UNAIDS Framework for Monitoring and Evaluating HIV Prevention Programs with Most at Risk Populations

HIV Testing and Seroprevalence among MSM

Seventy-seven countries (70%) did not report on HIV testing among MSM. In less than a quarter of the countries that submitted UNGASS reports (21%) did at least 40% of MSM have access to HIV testing. 79 countries (62%) did not report on HIV seroprevalence among MSM. Where information has been gathered and reported, MSM are in all instances disproportionately affected by HIV relative to the general population, in most cases by a wide margin.

Recommendations for Action

- Countries should urgently scale up access for MSM to culturally appropriate voluntary counseling and testing services that are nondiscriminatory and respect confidentiality.
- Countries should take the necessary steps to measure HIV prevalence among MSM in close consultation with affected populations and respecting ethical research practices and confidentiality by applying tools such as the Bio-Behavioral Assessment Surveys (FHI).

Knowledge About HIV and Condom Use Among MSM

Eighty-nine countries (70%) did not report on knowledge of HIV among MSM. Only 20% of the countries that submitted UNGASS reports reported adequate levels of knowledge about HIV among at least 40% of MSM. Sixty-nine countries (54%) did not report on condom use among MSM during their last anal intercourse. Only 27 countries (21%) reported the use of a condom by at least 60% of MSM the last time they had anal intercourse.

Recommendation for Action

- Countries should urgently scale up access for MSM to culturally appropriate information, education and communication activities on condom use. Additionally, much greater efforts should be made to ensure access to condoms and water-based lubricants.

Annex 1

Data from 2008 UNGASS Country Reports on MSM and HIV/AIDS

	Percentage of MSM who received an HIV test in the last 12 months and who know their results	Percentage of MSM reached with HIV prevention programmes	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Percentage of MSM who are HIV infected	Number of UNGASS Indicators reported by country
Algeria						0
Angola	42	16				2
Antigua and Barbuda						0
Argentina					13	1
Armenia			73	83	2	3
Azerbaijan						0
Bahamas	60	47	44	68	8	5
Bangladesh	6	12	27	24	0.2	5
Barbados	85			64		2
Belarus	53	89	56	66	0.1	5
Belize						0
Benin	39	60			25	3
Bolivia	99	2		69	21	4
Bosnia and Herzegovina	10			6		2
Botswana						0
Brazil	62		66	43	10	4
Bulgaria	28	29	46	46		4
Burkina Faso						0
Burundi						0
Cambodia	58			86	4	3
Cameroon						0
Cape Verde						0
Central African Republic						0
Chad						0
Chile	36			29		2
China		8		30		2
Colombia	61		77	80	10	4
Comores						0
Costa Rica	43	26	85	78		4
Cote d'Ivoire	57	100		46	18	4
Croatia	51	49		53	3	4
Cuba	33	55	54	55	0.8	5
Democratic Republic of the Congo						0
Djibouti						0
Dominica						0
Dominican Republic		15		79	11	3
Ecuador	49	48	58	22	19	5
Egypt						0

	Percentage of MSM who received an HIV test in the last 12 months and who know their results	Percentage of MSM reached with HIV prevention programmes	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Percentage of MSM who are HIV infected	Number of UNGASS Indicators reported by country
El Salvador	55	62	25	83	17	5
Equatorial Guinea						0
Eritrea						0
Estonia	41		29	45		3
Ethiopia						0
Fiji						0
Gabon						0
Gambia						0
Georgia	30	71			4	3
Ghana				48	25	2
Grenada					7	1
Guatemala	63	72	30	80	14	5
Guinea						0
Guinea Bissau						0
Guyana	87	17	67		21	4
Haiti	48		36	73		3
Honduras	40	24	20	48	6	5
India	35	57	45	50	6	5
Indonesia	31	40	41	39	5	5
Jamaica					27	1
Japan						0
Jordan						0
Kazakhstan	38		65	66		3
Kenya	40			75	43	3
Kyrgyzstan	70	77	89	81	1	5
Lao PDR	4		30	24	5	4
Latvia						0
Lebanon	13	14	63	39		4
Lesotho						0
Liberia						0
Libya						0
Lithuania	27	40	38	58	1	5
Madagascar						0
Malawi						0
Malaysia	100				7	2
Mali				53	17	2
Marshall Islands						0
Mauritania	15				19	2
Mauritius	16	40	48	52		4
Mexico	53	18	65	79	9	5
Moldova	38	68	46	48	4	5
Mongolia	60	66	22	66		4
Morocco						0
Mozambique						0

	Percentage of MSM who received an HIV test in the last 12 months and who know their results	Percentage of MSM reached with HIV prevention programmes	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Percentage of MSM who are HIV infected	Number of UNGASS Indicators reported by country
Namibia						0
Nepal	30	46	44	73	3	5
Nicaragua						0
Niger					38	1
Nigeria	30	54	44	52	13	5
Pakistan				24		1
Palau						0
Panama	76	96		86	10	4
Papua New Guinea	41	10	70	88		4
Paraguay						0
Peru	20	44	40	47	10	5
Philippines	16	19	10	32	0.2	5
Qatar						0
Republic of Korea						0
Romania	46	58	45	72		4
Russia	31	16	26	59	0.9	5
Rwanda						0
Saint Lucia				73		1
Sao Tome and Principe	72	80	92			3
Senegal				55	21	2
Seychelles						0
Sierra Leone						0
Singapore						0
Somalia						0
South Africa						0
Sri Lanka	13		19	60		3
St. Kitts and Nevis					5	1
St. Vincent and the Grenadines						0
Sudan	20					1
Suriname				89	6	2
Swaziland						0
Tajikistan						0
Tanzania				58		1
Thailand	34		25	89	24	4
Togo						0
Trinidad and Tobago				47	20	2
Tunisia	34			37		2
Turkey			72	36	1	3
Tuvalu						0
Uganda						0
Uruguay						0
Venezuela						0
Vietnam	16	25	54	61	9	5
Zambia				71		1
Zanzibar				28	12	2
Zimbabwe						0

Annex 2

Summary of Data from 2008 UNGASS Country Reports on MSM and HIV/AIDS

	Latin America	Caribbean	Eastern Europe	Asia	Africa	Global Total	Global Percentage
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Number of Countries That Reported							
Did Not Report	5	3	1	12	35	56	44%
1–3 Indicators	3	7	2	9	12	33	26%
4–5 Indicators	12	3	7	12	5	39	30%
Total	20	13	10	33	52	128	100%

What Percentage of MSM Are Living with HIV?							
Did Not Report	6	5	5	19	42	77	60%
0%–5%	1	3	5	10	0	19	15%
6%–10%	7	2	0	3	0	12	9%
11%–15%	2	1	0	0	2	5	4%
16%–20%	2	0	0	0	3	5	4%
21%–50%	2	2	0	1	5	10	8%
Total	20	13	10	33	52	128	100%

What Percentage of MSM Have Taken an HIV Test in the Last Year?							
Did Not Report	7	9	3	16	42	77	60%
0%–19%	0	0	0	6	2	8	6%
20%–39%	2	1	3	6	4	16	13%
40%–59%	5	1	4	2	3	15	12%
60%–79%	3	1	0	2	1	7	5%
80%–100%	3	1	0	1	0	5	4%
Total	20	13	10	33	52	128	100%

What Percentage of MSM Know How to Prevent HIV?							
Did Not Report	10	10	3	17	49	89	70%
0%–19%	0	0	0	2	0	2	2%
20%–39%	3	1	3	4	0	11	9%
40%–59%	2	2	4	4	2	14	11%
60%–79%	4	0	0	5	0	9	7%
80%–100%	1	0	0	1	1	3	2%
Total	20	13	10	33	52	128	100%

What Percentage of MSM Used a Condom the Last Time They Had Sex?							
Did Not Report	7	6	1	14	41	69	54%
0%–19%	0	0	1	0	0	1	1%
20%–39%	2	0	0	8	2	12	9%
40%–59%	3	2	6	1	7	19	15%
60%–79%	3	5	2	5	2	17	13%
80%–100%	5	0	0	5	0	10	8%
Total	20	13	10	33	52	128	100%

What Percentage of MSM Are Being Reached by HIV Prevention Programs?							
Did Not Report	12	9	3	21	46	91	71%
0%–19%	3	1	1	5	1	11	9%
20%–39%	2	0	1	1	0	4	3%
40%–59%	2	2	3	3	2	12	9%
60%–79%	2	0	0	3	2	7	5%
80%–100%	1	0	1	0	1	3	2%
Total	22	12	9	33	52	128	100%

Annex 3

Technical Details of UNGASS Indicators Relevant to MSM and HIV/AIDS

Reprinted, *Guidelines on Construction of Core Indicators* (2008 Reporting), UNAIDS, 2007.

Most-at-risk Populations: Reduction in HIV Prevalence

Most-at-risk populations typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among most-at-risk populations is a critical measure of a national-level response to HIV. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users, men who have sex with men.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk population. If so, it would be valuable for them to calculate and report on this indicator for those populations.

Percentage of most-at-risk populations who are HIV-infected

PURPOSE	To assess progress on reducing HIV prevalence among most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, where routine surveillance among pregnant women is not recommended; also includes countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	UNAIDS/WHO <i>Second Generation Surveillance Guidelines</i> ; Family Health International guidelines on sampling in population groups
METHOD OF MEASUREMENT	This indicator is calculated using data from HIV tests conducted among members of most-at-risk population groups in the capital city
Numerator:	Number of members of the most-at-risk population who test positive for HIV.
Denominator:	Number of members of the most-at-risk population tested for HIV. Prevalence estimates should be disaggregated by sex and age (<25/25+). To avoid biases in trends over time, this indicator should be reported for the capital city only. In recent years, many countries have expanded the number of sentinel sites to include more rural ones, leading to biased trends resulting from aggregation of data from these sites.

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available. In analyzing prevalence data of most-at-risk-populations for the assessment of prevention

programme impact, it is desirable not to restrict analysis to young people but to report on those persons who are newly initiated to behaviours that put them at risk for infection (e.g. by restricting the analysis to people who have initiated injecting drug use within the last year or participated in sex work for less than one year, etc.) This type of restricted analysis will also have the advantage of not being affected by the effect of antiretroviral treatment in increasing survival and thereby increasing prevalence. In the Country Progress Report, it is imperative to indicate whether this type of analysis is used to allow for meaningful global analysis.

INTERPRETATION

Due to difficulties in accessing most-at-risk populations, biases in serosurveillance data are likely to be far more significant than in data from a more general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the interpretation.

An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.

Trends in HIV prevalence among most-at-risk populations in the capital city will provide a useful indication of HIV-prevention programme performance in that city. However, it will not be representative of the situation in the country as a whole.

FURTHER INFORMATION

For further information, please consult the following website:

- http://www.unaids.org/en/HIV_data/Methodology/default.asp

HIV Testing in Most-at-risk Populations

In order to protect themselves and to prevent infecting others, it is important for most-at-risk populations to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users and men who have sex with men.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, they should calculate and report this indicator for those populations.

Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results

PURPOSE

To assess progress in implementing HIV testing and counselling among most-at-risk populations

APPLICABILITY

Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic

DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Behavioural surveillance or other special surveys
METHOD OF MEASUREMENT	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Have you been tested for HIV in the last 12 months? <p>If yes:</p> <ol style="list-style-type: none"> 2. I don't want to know the results, but did you receive the results of that test?
Numerator:	Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results
Denominator:	<p>Number of most-at-risk population included in the sample</p> <p>Data for this indicator should be disaggregated by sex and age (<25/25+).</p> <p>Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

INTERPRETATION

Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

Tracking most-at-risk populations over time to measure progress may be difficult due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

Most-at-risk Populations: Knowledge about HIV Prevention

Concentrated epidemics are generally driven by sexual transmission or use of contaminated injecting equipment. Sound knowledge about HIV is an essential prerequisite if people are going to adopt behaviours that reduce their risk of infection. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users, men who have sex with men.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, it would be valuable for them to calculate and report on this indicator for those populations.

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

PURPOSE	To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special behavioural surveys such as the Family Health International Behavioural Surveillance Survey for most-at-risk populations
METHOD OF MEASUREMENT	<p>Respondents are asked the following five questions:</p> <ol style="list-style-type: none"> 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected?
Numerator:	Number of most-at-risk population respondents who gave the correct answers to all five questions
Denominator:	<p>Number of most-at-risk population respondents who gave answers, including “don’t know”, to all five questions</p> <p>Indicator scores are required for all respondents and should be disaggregated by sex and age (<25; 25+).</p> <p>The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the country.</p> <p>Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.</p>

Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator.

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

INTERPRETATION

The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Correct knowledge about false beliefs of possible modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behaviour, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.

This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained.

Surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

Men Who Have Sex with Men: Condom Use

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with their most recent male partner is considered a reliable indicator of longer-term behaviour.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among men who have sex with men. If so, it would be valuable for them to calculate and report on this indicator for this population.

Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

PURPOSE	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special surveys including the Family Health International Behavioural Surveillance Survey for men who have sex with men
METHOD OF MEASUREMENT	In a behavioural survey of a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex.
Numerator:	Number of respondents who reported that a condom was used the last time they had anal sex
Denominator:	Number of respondents who reported having had anal sex with a male partner in the last six months
	Data for this indicator should be disaggregated by age (<25/25+).
	Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field.
	Access to survey respondents as well as the data collected from them must remain confidential.

INTERPRETATION

For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. This indicator does not give any idea of risk behaviour in sex with women among men who have sex with both women and men. In countries where men in the sub-population surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for female and male partners.

Surveying men who have sex with men can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.

Most-at-risk Populations: Prevention Programmes

Most-at-risk populations are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV among these populations as well as into the general population, it is important that they access these services. This indicator should be calculated separately for each population that is considered most-at-risk in a given country: sex workers, injecting drug users, men who have sex with men.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, they should calculate and report this indicator for those populations.

Percentage of most-at-risk populations reached with HIV prevention programmes

PURPOSE	To assess progress in implementing HIV prevention programmes for most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Behavioural surveillance or other special surveys
METHOD OF MEASUREMENT	Respondents are asked the following questions: <ol style="list-style-type: none">1. Do you know where you can go if you wish to receive an HIV test?2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic) Injecting drug users (IDUs) should be asked the following additional question: <ol style="list-style-type: none">3. In the last twelve months, have you been given sterile needles and syringes? (e.g. by an outreach worker, a peer educator or from a needle exchange programme)
Numerator:	Number of most-at-risk population respondents who replied “yes” to both (all three for IDUs) questions
Denominator:	Total number of respondents surveyed

Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator.

Data collected for this indicator should be reported separately for each most-at-risk population and disaggregated by sex and age (<25/25+).

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

INTERPRETATION

Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

The inclusion of these indicators for reporting purposes should not be interpreted to mean that these services alone are sufficient for HIV prevention programmes for these populations. The set of key interventions described above should be part of a comprehensive HIV prevention programme, which also includes elements such as provision of HIV prevention messages (e.g. through outreach programmes and peer education), and opioid substitution therapy for injecting drug users.

Since the Global Progress Report in 2006, it has been recommended that the issue of quality and intensity of reported services among most-at-risk populations be addressed more explicitly in terms of criteria for the measurement of the components of provided services. Taking into account the complexity of this element of measurement, particularly within the context of most-at-risk populations, the development of such criteria requires an intensive process of information gathering, synthesis and recommendations formulation. This was difficult to address between the reporting processes of 2005 and 2007. However, the process has been initiated and is expected to have recommendations for the next reporting round. In the meantime, it is recommended that the guidelines mentioned below be referred to as reference documents that can facilitate interpretation of the collected data from a quality and intensity perspective.

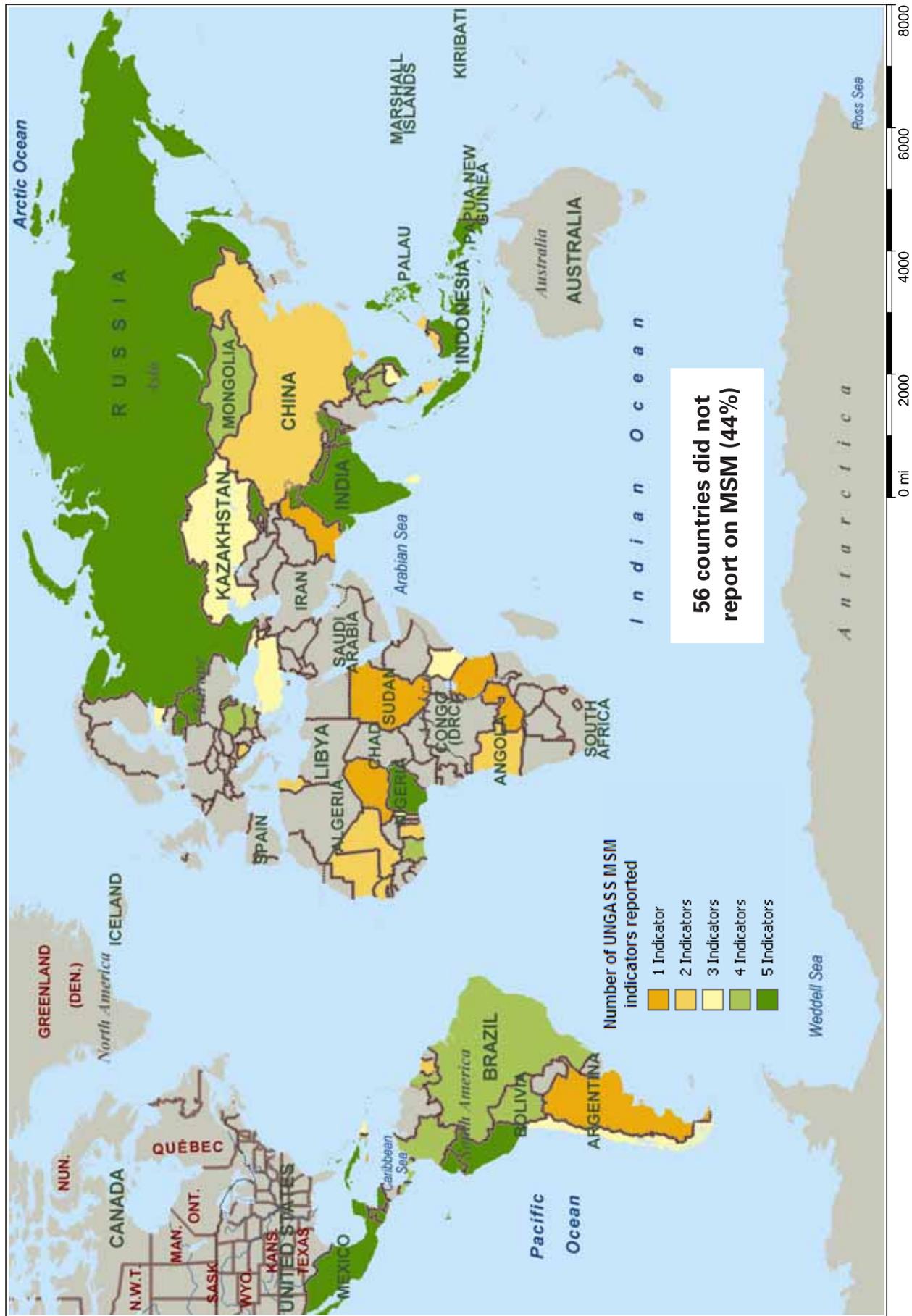
FURTHER INFORMATION

For further information, please consult the following references:

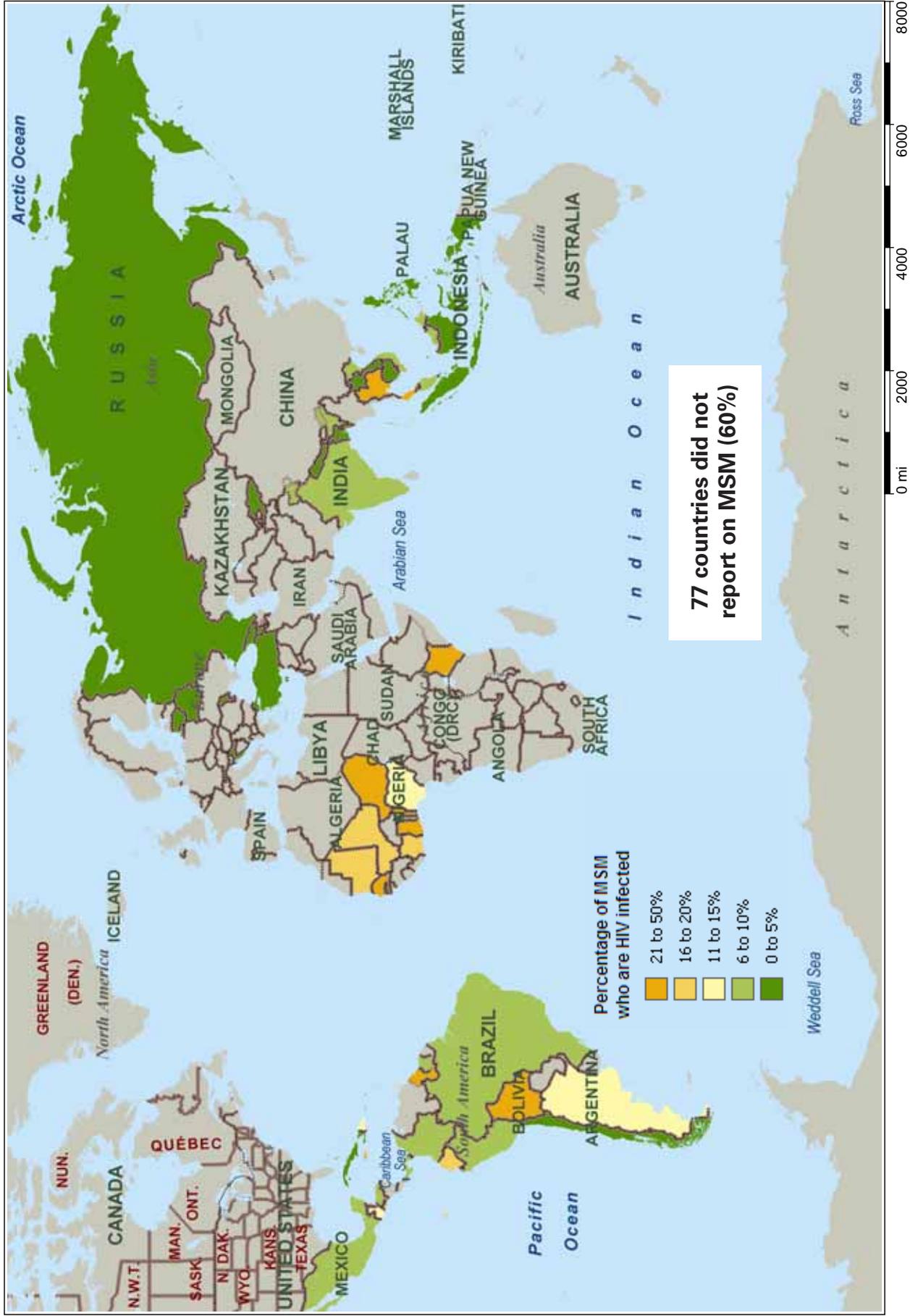
- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

Annex 4 Review of Global Country Progress Reports: Maps

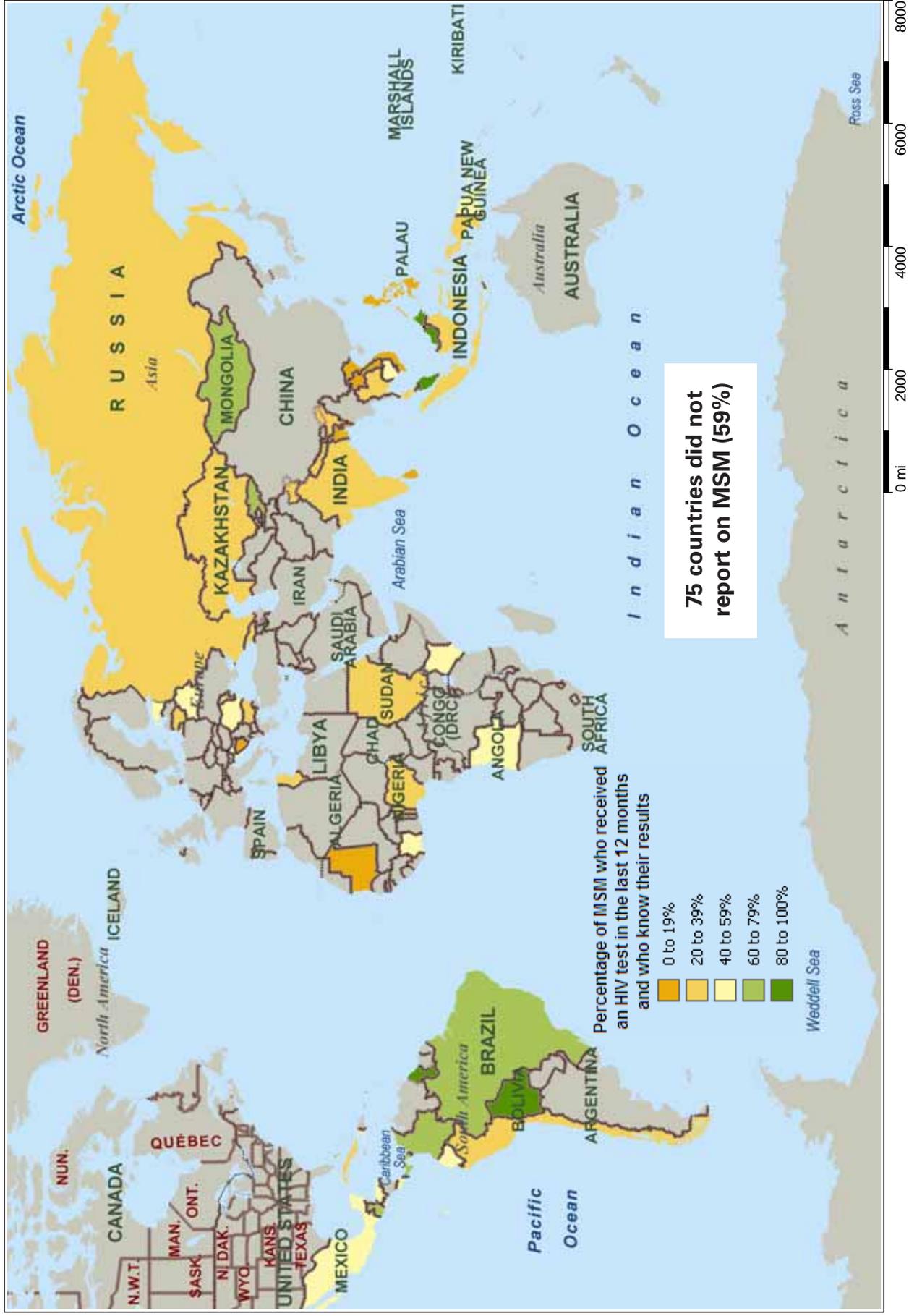
Which Countries Reported on MSM?



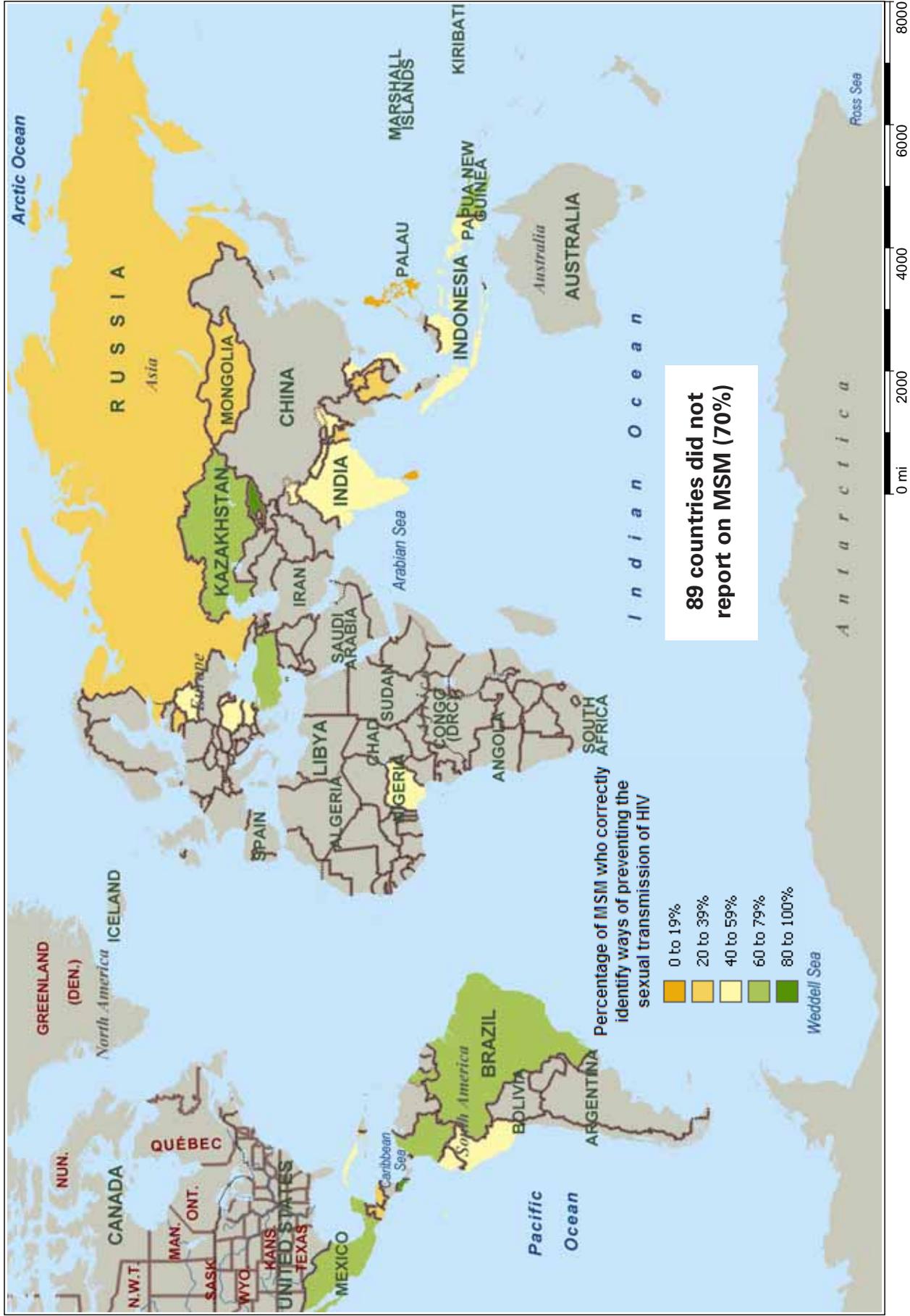
What Percentage of MSM are Living with HIV?



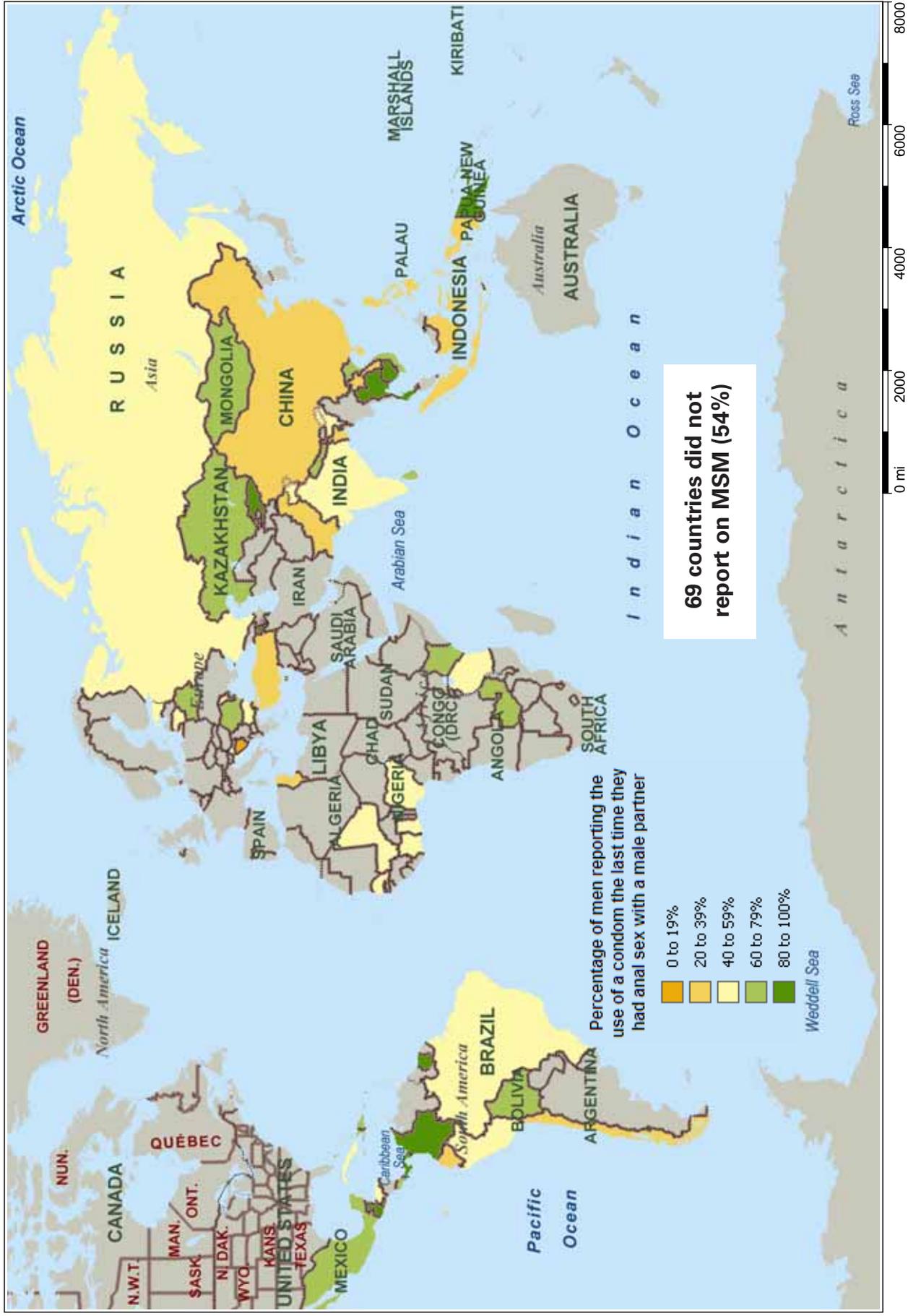
What Percentage of MSM Have Taken an HIV Test in the Last Year?



What Percentage of MSM Know How to Prevent HIV?



What Percentage of MSM Used a Condom the Last Time They Had Sex?



What Percentage of MSM are Being Reached by HIV Prevention Programs?



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