

Achieving an AIDS-Free Generation for Gay Men and Other MSM in Southern Africa

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Selected acronyms and abbreviations

CCM	country coordinating mechanism (of the Global Fund)
CDC	U.S. Centers for Disease Control and Prevention
COP	Country Operational Plan (of PEPFAR)
CSO	civil society organization
FSW	female sex worker
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMT	gay men, other men who have sex with men, and transgender individuals
LGBT	lesbian, gay, bisexual and transgender
M&E	monitoring and evaluation
MARP	most-at-risk population
MSM	men who have sex with men
NCPI	National Commitments and Policies Instrument
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SADC	Southern African Development Community
SOGI	sexual orientation and gender identities
STI	sexually transmitted infection
TRP	Technical Review Panel (of the Global Fund)
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development

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

Executive Summary

Introduction

The HIV epidemic among gay men and other men who have sex with men (MSM) is expanding. Prevention, treatment, and care programs funded to reverse the epidemic often neglect this population. Stigma and discrimination against MSM flourish with impunity in countries that receive significant donor funding for HIV. National planning documents and donor funding agreements mention MSM, but little programming actually exists. Epidemiological surveillance that would help inform programs serving MSM lags far behind strategic information collected on other populations. Little to no attention is paid to the needs of transgender people.

This is the current state of HIV among gay men, other MSM, and transgender individuals (GMT). While the global conversation focuses on novel approaches to HIV treatment and prevention, GMT struggle to obtain the most basic health services. They are isolated, criminalized, blackmailed, and beaten.

Despite this, GMT communities in Southern Africa have shown great resilience and determination. In each country studied, numerous community-led programs supported by both large and small donors are making substantial inroads against pervasive stigma and discrimination.

While the global conversation focuses on novel approaches to HIV treatment and prevention, GMT struggle to obtain the most basic health services.

These are the findings of the second report in this series: *Achieving an AIDS-Free Generation for Gay Men and Other MSM*. Focused specifically on six countries in Southern Africa (Botswana, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe), this report describes the financing and implementation of programs for GMT in a region at the heart of the HIV epidemic through a combination of desk research and in-country consultations conducted by civil society advocates with implementers, policy makers, academics, and people living with HIV.

These six countries have made significant progress in reducing the number of new HIV infections among their adult populations, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS). Over the past 10 years, the number of annual new infections has dropped substantially, with declines ranging from 25 percent in Swaziland to as much as 63 percent in Botswana. This is not a small accomplishment and comes as the result of persistent, concerted efforts by national governments, donor countries, program implementers, researchers, and civil society.

The same level of effort is required to change the trajectory of the HIV epidemic among GMT. Currently, national governments spend almost no public money on programs for GMT globally, according to UNAIDS. This leaves a patchwork of isolated interventions sponsored by international donors that is inadequate to prevent further expansion of the epidemic. As these donors transition towards increased country ownership, the little money that is dedicated to this population is under threat. If new resources were directed to a combination of behavioral, biomedical, and structural interventions, hundreds of thousands of lives would be saved.



Photo: Chris Vail

HIV prevention education is one of the services provided by the Center for the Development of People (CEDEP) in Malawi.

However, the true impact of these efforts can never take shape without addressing the realities of life for GMT in Southern Africa. Human rights violations permeate every facet of life for these men and women, and the lack of robust engagement by donors, implementers, and governments has only perpetuated further abuse. Real efforts to increase donor and national government engagement in preventing and treating HIV infection among GMT must include comprehensive human rights programming that addresses stigma and discrimination.

Donor Financing and Support

This report finds a striking incongruence between donor policy and funding patterns. The top two funders of HIV/AIDS programs globally—the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—have clear policy commitments to addressing the epidemic among GMT. PEPFAR’s Blueprint for an AIDS-Free Generation and the Global Fund’s strategy in relation to sexual orientation and gender identities (SOGI) make a concrete case for the need, type, and scope of investments in programs serving GMT. However, the research in this report shows that funding and implementation come nowhere close to upholding these policy commitments.

Though **PEPFAR** and other financing mechanisms under the U.S. Department of State have gone to great lengths in recent years to target new funding opportunities to programs that support GMT, resources allocated do not approach potential need. The six countries profiled in this report comprised 10 percent of total PEPFAR funding between 2007 and 2011, but four of the six annual budgets contained no programming for MSM. When included, budgeted amounts were difficult to decipher, frequently miniscule, and often shared among multiple populations, reducing the certainty that MSM were reached at all. There was no mention of transgender individuals.

The **Global Fund** has one of the most progressive donor policies in relation to GMT, delineating clear responsibilities for every actor within its financing model. However, of the \$1.5 billion in funding allocated to these six countries since 2001, only 0.07 percent was for programs specifically targeting GMT. Moreover, the majority of this support is concentrated in just one of these six countries (Namibia). This percentage may not reflect the full demand from targeted

An AIDS-free generation will never be achieved without Southern Africa and Southern Africa cannot achieve an AIDS-free generation without greater attention to the needs of GMT.

programs in these countries as some proposals containing strong programs for MSM and other key populations were not approved for reasons other than technical merit.

The Global AIDS Response Progress Reports from **UNAIDS** remain the only global measure of progress against HIV among this population. Civil society representatives reported that UNAIDS is an important advocate for the needs of GMT in country. However, inconsistencies in the reported data obscure these reports' usefulness in strategic planning, and the absence of an accountability mechanism tied to the reports leaves little incentive for countries to achieve real progress.

Country Implementation

Civil society advocates studying the implementation of programs for GMT in each of these countries found:



In **Botswana**, criminalization, stigma, and discrimination have impeded equity goals that are built in to the country's national strategic plan. Positive change is happening, though, as some government officials speak openly about the need to work with MSM. The country is currently poised to be one of the first on the continent to finance HIV programs for MSM with public money.



A highly publicized trial of two men in **Malawi** arrested for attempting to marry brought considerable attention to the needs of GMT in 2010. Currently, the U.S. government and UNAIDS provide vital technical assistance and resource support to community-based service providers. Violence and discrimination within and outside of the healthcare setting remain major impediments despite high-level government commitments to change.



As an upper middle-income country, **Namibia** is seeing its share of donor resources dwindle. However, it is these donors, primarily the U.S. government, that have played a key role in maintaining MSM in national strategic frameworks and implementation plans. There is concern that the transition to full country ownership will happen without regard to the needs of this population.



In **Swaziland**, governmental denial of the existence of GMT creates an environment in which it is difficult to know whether or not programs for GMT actually exist. It appears some condom and lubricant distribution programs exist, but are available in limited coverage areas in urban centers. Other reports indicate that programs designed for multiple key populations focus primarily on serving female sex workers. Governmental resistance to programs for GMT remains strong.



LeGaBiBo (Lesbians, Gays and Bisexuals of Botswana) is the oldest LGBT organization in Botswana.



A coalition of nongovernmental organizations (NGOs) in **Zambia** struggles to deliver services and advocate in a legal environment that cripples the country's national HIV response. Harshly critical statements from religious leaders and respected clinicians further alienate and stigmatize GMT, limiting their willingness and ability to access prevention and treatment programs. Government corruption forced the transfer of donor money from public to private, religious implementers in 2010. That change has had significant, negative consequences for Zambian GMT.



Police in **Zimbabwe** actively pursue and arrest those suspected of being GMT or working on their behalf. As in other settings, strategic documents with commitments to GMT are drafted with no real intent to carry them out. The deliberate effort by national authorities to associate same-sex sexual practices with Western culture has only further politicized this issue in Zimbabwe.

Conclusion

Where programs for GMT exist in Southern Africa, they attempt to address the urgent needs of the population living in the region. However, there are too few programs that have a transformative effect on the epidemic overall. Funding by donors and national governments is not sufficient to achieve real public health impact or evaluate outcomes. Attention must shift from global and national strategy documents to actual implementation—developing robust, achievable indicators for programs serving GMT, and building the evidence base around high-impact interventions.

Being strategic on HIV requires greater attention to implementing programs for GMT and other key populations in Southern Africa. An AIDS-free generation will never be achieved without Southern Africa and Southern Africa cannot achieve an AIDS-free generation without greater attention to the needs of GMT.



Recommendations

National Governments

- National governments should decriminalize same-sex sexual practices and support programs that reduce stigma and discrimination against marginalized groups. Donors should actively support such efforts through diplomatic channels and funding for civil society groups working on these issues.
- National governments should be encouraged to develop implementation plans that operationalize national strategic frameworks, a step that would increase the likelihood that the commitments to GMT in those documents are actualized.

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

- PEPFAR should institute clearer budgeting and reporting practices that make the implementation of national strategic plans and the allocation of resources more transparent.
- PEPFAR should develop benchmarks that guide the transition to country ownership and the inclusion of key populations, especially GMT.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

- The Global Fund should implement the SOGI strategy in Southern Africa by helping countries reprogram existing grants to address the needs of GMT in the region and by instituting stronger accountability mechanisms to ensure that approved programs are actually implemented.
- The Global Fund should ensure that GMT are appropriately represented on country coordinating mechanisms (CCMs) and provide those bodies with any technical support required to address the needs of GMT.

The Joint United Nations Programme on HIV/AIDS (UNAIDS)

- UNAIDS should reform the Global AIDS Progress Reporting process to make it more relevant to the needs of implementers, policy makers, and civil society.
- UNAIDS should improve the quality and scope of the technical assistance it provides countries by increasing the number of staff with expert knowledge of issues related to key populations, particularly GMT.

Strategic Information

- All countries receiving international assistance for HIV should conduct biennial epidemiological surveillance that includes key populations, especially GMT.
- All donors should fund implementation science and operations research that will build the evidence base for effective delivery of combination prevention and treatment services to GMT.

Additional funding for this report was provided by
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Background

This report represents more than a year’s worth of in-country consultations and desk research undertaken to describe the financing and implementation of HIV programs for gay men, other men who have sex with men, and transgender individuals (GMT) in six countries in Southern Africa: Botswana, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe. Unlike the previous report in this series, which took a global view of programs serving GMT,¹ this analysis sought to describe the response to HIV in one region at the heart of the epidemic.

The countries selected for this analysis represent the diverse economic and epidemiological contexts of the Southern Africa region. Table 1 below summarizes the income status, general adult (15–49 years old) HIV prevalence, and HIV prevalence among men who have sex with men (MSM) in these six countries

Table 1. Economic classification and HIV prevalence by country

Country	World Bank income group ²	Number of people living with HIV ³	Adult population ³ HIV prevalence	MSM ⁴ HIV prevalence
Botswana	Upper middle income	910,000	23.4	No data reported
Malawi	Low income	300,000	10.0	21.4 ⁵
Namibia	Upper middle income	190,000	13.4	12.6 ⁵
Swaziland	Lower middle income	190,000	26.0	16.7 ⁶
Zambia	Lower middle income	970,000	12.5	No data reported
Zimbabwe	Low income	1,200,000	14.9	No data reported

The heart of this analysis is the individual country chapters. Civil society members in each country were contracted for a period of six to eight months to conduct consultations with key stakeholders in the national HIV response, review funding agreements and national strategies, and report on their findings.⁷ These reports were edited and revised as necessary but maintain the authors’ perspectives and writing. They remain the most current perspective on how national programs serve GMT in each country.

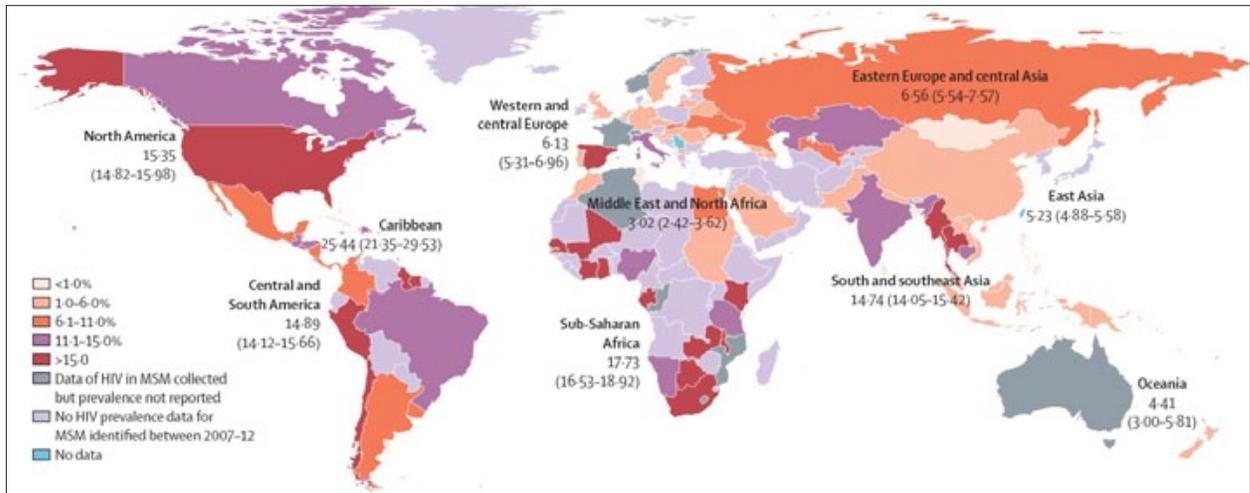
To complement this work, a group of consultants at amfAR and CPHHR conducted a systematic review of the literature and desk research on financing from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). These two donors comprised nearly 80 percent of development assistance for health dedicated to HIV in 2010.⁸ While desk research was limited to these two funders, in-country consultations were not—and thus should reflect the work of other funders where applicable.

An additional group of amfAR and CPHHR consultants analyzed the biennial Global AIDS Response Progress Reports (previously Progress Reports) submitted to UNAIDS by each country. There was a special emphasis on the National Commitments and Policies Instrument, which includes a qualitative assessment of the country’s national AIDS response from government and civil society respondents. Combined with the desk research on donor funding, this analysis was able to note multi-year trends in country attitudes towards GMT and funding for HIV programs meant to reach them. The methodologies used to describe these donor mechanisms and the Global AIDS Response Progress Reports are outlined in the relevant chapters.

GMT and HIV

The HIV epidemics in MSM are expanding in countries of all incomes (Figure 1). Infection rates among this population are substantially higher than those of adult males in the general population in every epidemic assessed. This disproportionate disease burden is explained largely by the high per-act and per-partner transmission possibility in receptive anal sex. Modeling suggests that if the transmission probability of receptive anal sex was similar to that associated with unprotected vaginal sex, five-year cumulative HIV incidence in MSM would be reduced by 80 to 90 percent.⁹

Figure 1: Global HIV prevalence in MSM, from studies published 2007-2011



Beyrer, C et al (2012). "Global epidemiology of HIV infection in men who have sex with men". *The Lancet*, Vol. 380:367-77 (reprinted with permission).

Large gaps in epidemiological surveillance of MSM persist. By the end of 2011, more than 47 percent of countries had not reported on HIV prevalence in MSM in the previous five years.^{9,10} For this analysis, data were only available for three countries (Malawi, Namibia, and Swaziland).^{11,12,13}

Lack of data is only part of the problem. The information used to characterize the epidemiology of HIV comes from demographic and health surveys in each of these countries. These surveys assess several risk factors for HIV (among other health issues) but do not assess same-sex practices or include a meaningful assessment of sex work or drug use. Such omissions have likely contributed to risk misclassification of HIV among men and a limited understanding of the actual drivers of the epidemic across Sub-Saharan Africa.

Also problematic is comparing general adult and MSM HIV prevalence. The former is age-standardized to model the average prevalence of HIV among those between the ages of 15 and 49, but the majority of MSM sampled are under 30. When small samples of MSM over 30 have been analyzed as part of broader studies of MSM in Botswana, Malawi, and Namibia, the prevalence has been measured to be as high as 50 percent.¹⁴

As will be observed throughout this report, stigma and discrimination (both perceived and experienced) are major barriers to data collection. The least is known about MSM where the greatest stigma exists; transgender individuals are rarely considered.

Criminalization

All six countries selected for this analysis criminalize same-sex sexual practices, but the acts that are criminalized and the allowable punishment associated with them vary. Table 2 contains a

summary overview of criminalization in each country and the punitive measures associated with each offense.

Table 2. Criminalization of same-sex sexual practices and associated punitive measures¹⁵

Country	What is criminalized?	What are the punitive measures?
Botswana	Any person seeking or consenting to anal sex	Offense charges,* punishable by up to seven years in prison for consenting or five years for seeking
	Any person—whether in public or in private—seeking or engaging in any same-sex sexual practices	
Malawi	Any person seeking or engaging in anal sex; seeking or engaging in any same-sex sexual practices	Felony charges,** punishable by up to 14 years in prison, with corporal punishment allowed
	In public or in private, seeking or engaging in any same-sex sexual practices. The law specifically prohibits both practices between men and between women.	For men: felony charges, punishable by up to five years, with corporal punishment allowed For women: offense charges, punishable by up to five years in prison
Namibia	Anal sex between men is criminalized under common law.*** Protections against employment discrimination based on sexual orientation were repealed in 2004.	No specific punishment has been identified.
Swaziland	Anal sex between men is criminalized under common law	No specific punishment
Zambia	Any person consenting to anal sex	Felony charges, punishable by 25 years to life in prison
	Any person attempting to commit anal sex	Felony charges, punishable by 7 to 14 years in prison
Zimbabwe	All consensual same-sex practices between men	Sodomy charges, punishable by a fine and/or up to one year in prison

* Offense is “a violation of the law... Often used when describing lesser crimes.”¹⁶

** Felony cases are those criminal cases involving “an offense punishable by incarceration for a year or more.”¹⁷

*** Common law is “Law that is derived from judicial decisions instead of from statute.”¹⁶

The extent to which these laws are enforced varies substantially among the countries examined. Enforcement notwithstanding, documented cases of harassment, discrimination, or violence against sexual minorities are found in nearly every country examined. In Namibia, Swaziland, Zambia, and Zimbabwe, for example, discrimination against and stigmatization of MSM and lesbian, gay, bisexual and transgender (LGBT) individuals are routinely practiced by law enforcement personnel and more broadly throughout society.^{5,18,19,20,21,22,23,24} Therefore, even in cases where enforcement is inconsistent, ordinary citizens, in effect, enforce the ban on same-sex practices.

Terminology

For the purposes of clarity, this report uses acronyms and other terms as precisely as possible. Our preferred acronym is GMT, which includes men who identify as gay, other men who have sex with men, and transgender individuals. However, the acronym MSM (men who have sex with men) is applied frequently. It is used only when that population was specified in the consultations, literature, and desk research without also including transgender individuals.

Other acronyms including SOGI (sexual orientation and gender identities), MARPs (most-at-risk populations), and LGBT (lesbian, gay, bisexual, and transgender individuals), as well as terms such as “key populations” and “vulnerable populations” are used only to replicate the language used by donors or other groups.

Similarly, when relevant, we prefer the term “people who use drugs” or “people who inject drugs.” However, a more common term is “injecting drug users (IDUs).” This term is applied only when it was specifically used within documents referenced in this research.

Other Populations

Lesbians and other women who have sex with women (WSW) have not been included in this analysis since HIV acquisition and transmission rates during sexual activity between women are quite low. However, in Southern Africa, high rates of sexual violence, including rape, are common throughout the region.²⁵ Of even more importance, lesbian and other WSW are often targets for “corrective rape” (e.g., rape with the intent of “correcting” sexual orientation or intimidating the victim to conform with perceived gender norms), which increases their HIV vulnerabilities.²⁵ Also of note is that some lesbian and other WSW choose to engage in sexual activity with men for various reasons, including heteronormative behavior (e.g., passing as a heterosexual) or desire for procreation, among other reasons. Investment in additional research and community-led programming is needed to address HIV vulnerabilities among these women at risk.

Donor Reporting and Financing

The Global AIDS Response Progress Reports

Introduction

The biennial reports submitted to UNAIDS known as the Global AIDS Response Progress Reports (formerly “UNGASS reports”) track member nations’ progress against 30 indicators related to HIV funding, prevention, treatment, and care. These reports provide a standardized format for countries to report on the status of their epidemics, including both the latest epidemiology and data on national response (e.g., testing, treatment, etc.). The reports are voluntarily submitted by national governments and all questions are optional. Although UNAIDS reconciles the data with information collected by large HIV financing initiatives (e.g., PEPFAR), the reports are not directly linked to any donor funding. Individual country progress reports are publicly available on the UNAIDS website.²⁶

The National Commitments and Policies Instrument (NCPI) is one of the 30 indicators that UNAIDS member states report on biennially (see box). Unlike other indicators, the NCPI is itself an extensive, multi-question survey focused on a country’s “progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws.”²⁷ The instrument is also the only component of the Global AIDS Response Progress Report (Progress Reports) that solicits input from civil society: half of the NCPI survey is filled out by representatives from government and half by representatives from the civil society sector.

GMT and Progress Reports

Global AIDS Response Progress Report indicators pertaining to MSM (excluding the NCPI) remained largely unchanged from 2008 to 2012. Between the 2010 and 2012 reporting cycles, the number of indicators related to MSM decreased from five to four, as summarized in Table 3. More importantly, the wording of the four remaining indicators was altered slightly to refer specifically to MSM; previously, the indicators had used the broader term “most-at-risk populations.” This change was initiated as part of an effort to prompt more countries to include information and data directly related to MSM.

Table 3. Quantitative Progress Report indicators relevant to MSM

Indicator	Years included
Percentage of MSM* reached with HIV prevention programs	2008, 2010, 2012
Percentage of men reporting use of a condom the last time they had anal sex with a male partner	2008, 2010, 2012
Percentage of MSM* that have received an HIV test in the past 12 months and know their results	2008, 2010, 2012
Percentage of MSM* who are living with HIV	2008, 2010, 2012
Percentage of MSM* who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2008, 2010

*In the 2008 and 2010 surveys, MSM were not specifically mentioned in the indicator stem. “Most-at-risk populations” was used instead. When results were reported, in some cases countries disaggregated data by specific key population group. In 2012, the indicators specifically asked about MSM.

National Commitments and Policies Instrument (NCPI)²⁸

Unlike the other indicators in a country's Progress Report, which only involve one question, the NCPI is a survey containing numerous questions and sub-parts. For this reason, UNAIDS cautions that the NCPI should not be viewed as a typical indicator, instead advising that its value derives from a unique data-gathering process that engages multiple stakeholders. As a result, the NCPI is often examined and discussed independently of countries' larger reports. NCPI reports may be accessed on countries' own UNAIDS sites.²⁹

Format

The NCPI is a multi-question survey covering HIV prevention, treatment, care, and support; human rights; civil society involvement; gender; workplace programs; stigma and discrimination; and monitoring and evaluation (M&E). In 2012, the NCPI included 66 questions, many of which contained multiple sub-parts. All questions are asked in a standardized format that requires "yes" or "no" responses or the selection of one answer from a given set of choices. Some are open questions in which respondents may provide more detailed narrative information to explain their standardized answers. Like all of the indicators, the questions in the NCPI are voluntary—questions may be skipped, omitted, or marked as "not applicable." The surveys are available in English, French, Russian, and Spanish.

The NCPI survey consists of two parts: Part A, which is completed by government officials, and Part B, which is completed by representatives from civil society, bilateral organizations, and United Nations agencies. UNAIDS

recommends that individuals who complete the government portion of the NCPI include representatives from the National AIDS Council, provincial- or district-level HIV programs, the Ministry of Health, national technical working groups, the Ministry of Justice, and agencies implementing HIV programs. For civil society, UNAIDS recommends that NCPI participants include representatives from human rights groups, implementing organizations, networks of people living with HIV, and key populations. The NCPI is the only component of the Progress Reports that requests direct action from civil society.

Several identical questions are asked in both Part A and Part B, which allows comparison of government and civil society perspectives on aspects of a country's HIV response. While some wording and formatting changes have occurred, questions asked in the 2008, 2010, and 2012 NCPI surveys (those examined in this report) are largely similar.

Part A (Government Response)

- I. Strategic plan
- II. Political support and leadership
- III. Human rights
- IV. Prevention
- V. Treatment, care, and support
- VI. Monitoring and evaluation

Part B (Civil Society Response)

- I. Civil society involvement
 - II. Political support and leadership
 - III. Human rights
 - IV. Prevention
 - V. Treatment, care, and support
-

Process

UNAIDS advises that countries adopt the following procedures for completing their NCPI reports: Two technical coordinators, one representing government and one representing civil society, should be responsible for ensuring that the NCPI is completed and submitted as part of a country's larger Progress Report submission to UNAIDS. The technical coordinators should perform desk reviews of relevant literature; identify and bring together relevant stakeholders for interviews or surveys; validate, analyze, and interpret collected data; and host a final workshop to review findings from both parts of the NCPI with all stakeholders involved before submitting the final

report to the country's National AIDS Council or equivalent body. Stakeholders should provide views indicative of their constituencies or sectors overall, not their personal views, and technical coordinators are encouraged to engage stakeholders with expertise in key populations in the data review and validation process. Once both parts of the NCPI are complete and consolidated, it is the responsibility of a country's national government to submit the report to UNAIDS. Submitted reports are validated by UNAIDS and countries are contacted if substantial data are missing from reports or if they were submitted improperly.

The NCPI in 2012 included a total of six standardized questions specifically addressing MSM. Three of these questions were asked of both government and civil society respondents, two were asked only of government, and one was asked only of civil society. In 2008 and 2010, many of the same questions were asked with slight variations in wording. Table 4 shows the NCPI standardized response questions related to MSM, using the wording found in the 2012 instrument. The numbering scheme used in the table does not reflect the organization or numbering of the NCPI instrument itself.

Table 4. NCPI standardized response indicators pertaining to MSM

Number	Indicator	Asked of government?	Asked of civil society?
1	Does the country have nondiscrimination laws or regulations which specify protections for key populations and other vulnerable groups?*	Yes (2010, 2012)	Yes (2008, 2010, 2012)
2	Does the country have laws, regulations or policies that present obstacles to effective treatment, care, and support for key populations and vulnerable groups?*	Yes (2010, 2012)	Yes (2008, 2010, 2012)
3	To what extent has HIV prevention been implemented?*	Yes (2008, 2010, 2012)	Yes (2008, 2010, 2012)
4	What percentage of prevention for key populations is estimated to be provided by civil society?*	No	Yes (2008, 2010, 2012)
5	Does the multisectoral HIV strategy address the following key populations/ other vulnerable populations, settings and cross-cutting issues?*	Yes (2008, 2010, 2012)	No
6	Which populations* and what elements of HIV prevention*** does the [information, education, communication and other preventive health interventions] policy strategy address?	Yes (2008, 2010, 2012)	No

* These questions list specific key population groups that require a unique response for each population. "MSM" was specifically listed for these questions in 2008, 2010, and 2012. "Transgender" was specified in questions 1, 2, 4, and 5 in 2012.

** The subpart of this question pertaining to MSM reads: "The majority of people have access to risk reduction for MSM."

*** A list of interventions followed each key population group. In 2012 these interventions were: condom promotion; drug substitution therapy; HIV testing and counseling; needle and syringe exchange; reproductive health, including prevention and treatment of sexually transmitted infections (STIs); stigma and discrimination reduction; targeted information on risk reduction and HIV education; and vulnerability reduction (e.g., income generation).

The questions require different types of answers:

- Questions one, two, and five required "yes" or "no" responses.
- Options for answering question three changed over time. In 2008, respondents were asked to indicate if risk reduction for MSM was available in "all," "most," or "some" districts in need. In 2010, respondents were asked to respond with "agree" or "don't agree" to the statement "the majority of people in need have access to risk reduction for MSM." In 2012, respondents were given the options "strongly agree," "agree," "disagree," and "strongly disagree" to respond to the same statement.
- Question four required respondents to estimate the percentage of services for MSM provided by civil society by selecting from a series of ranges.
- Question six required respondents to indicate which HIV prevention interventions for specific populations were addressed in their country's HIV policies. This question was disaggregated by population and by intervention. "Vulnerability reduction," "needle and syringe exchange," and "drug substitution therapy" for MSM were not included in NCPIs prior to 2012.

Methodology

The 2008, 2010, and 2012 Global AIDS Response Progress Reports for each of the six target countries were obtained directly from the UNAIDS website.³⁰ The numerical values for the MSM indicators listed in Table 3 were recorded. Through this analysis, the narratives of each country report were reviewed with special attention to the mention of MSM. Keyword search terms used to highlight discussion of MSM included “men who have sex with men,” “men having sex with men,” “same-sex,” “homosexual,” “gay,” “most at risk,” and “criminalization.”

NCPI reports from 2008, 2010, and 2012 were retrieved for the six target countries from the UNAIDS website.³¹ Responses to standardized questions pertaining to MSM and key populations listed in Table 4 were recorded. Narrative responses that followed several of the standardized response questions listed in Table 4 were systemically reviewed for additional information on MSM. Keyword searches of all narrative responses were performed using terms including “MSM,” “men having sex,” “men who have sex,” “homosexual,” and “sodomy.”

Limitations

There are several limitations involved in interpreting Progress Reports that directly relate to their content and reporting process:³²

- Limited data quality and limited consistency in country approaches to surveillance, monitoring, and reporting
- Concerns regarding the ability of Progress Reports indicators to reflect actual progress against HIV on a national level (e.g., often focused on major cities) as well as the validity of reported data to reflect on-the-ground realities (e.g., small sample sizes, indicators not programmatic or outcome driven)

There are limitations specific to the NCPI as well:

- Concern that in some countries civil society involvement is “minimal or tokenistic”³³
- Concern about the representativeness of civil society respondents^{34,35}
- Difficulty gathering information on key populations in some countries where these groups exist outside the legal framework³⁶
- Critiques from country respondents that the NCPI instrument itself does not adequately capture policy progress made towards HIV goals, is too focused on Ministry of Health actions at the expense of other government organizations, and is too lengthy overall^{36,37}
- Inconsistencies in how the NCPI is administered, which raises concerns about data validity
- Different interpretations of who represents “government” and “civil society” across countries
- The independence of technical coordinators contracted to conduct the survey

Results

Non-NCPI Progress Report indicators

Little data were available on MSM-relevant indicators for these six countries. HIV prevalence among MSM was included in Zambia’s and Malawi’s 2010 report, and Malawi’s, Namibia’s, and Swaziland’s 2012 report. Provisional data were reported by Swaziland in 2012 for all MSM indicators in the narrative portion of its Progress Reports, and by Malawi on condom use among MSM in 2010.

Much of these data were limited to results from older, independent studies with small sample sizes—except in the case of Swaziland, which conducted behavioral surveillance of most-at-risk populations in time for provisional data to be included on all relevant indicators in 2012. While there were limited data provided on MSM, reporting on unrelated indicators was often quite robust in all countries reviewed.

In all six countries, stigma and discrimination were cited as a significant human rights issue.

Across all three reporting periods for all countries reviewed, the narrative portions of the UNGASS country reports indicate that stigmatization and criminalization of same-sex practices i) impede health officials' ability to gather data on MSM, and ii) limit opportunities to connect MSM to prevention, testing, and care services. In all six countries, stigma and discrimination were cited as a significant human rights issue and/or as a barrier to developing a complete understanding of each country's epidemic in at least one of the three reports reviewed.

By 2012, half of the countries reviewed (Botswana, Namibia, and Swaziland) had described specific plans to increase surveillance of and reporting on MSM and other key populations; however, none of their reports mentioned potential or likely repeal of laws criminalizing same-sex practices.

NCPI responses

Across all countries and years examined, civil society addressed MSM, homosexuality, and sodomy more often than did government in the NCPI. In 2008, civil society responded to more MSM indicators than government: that year, all MSM-related standardized indicators were either omitted by government respondents or marked "not applicable" to their countries' epidemics. The same year, none of the government narrative responses directly mentioned MSM, sodomy, or homosexuality, while these terms were mentioned nine times across all civil society responses examined from that year.³⁸ Both government and civil society reported on most MSM indicators in 2010 and 2012; however, across all reports reviewed for these years, government did not provide responses for MSM-related standardized indicators in 10 instances,³⁹ while civil society did not respond in five.⁴⁰ In general, civil society narrative responses contained more details about the specific effects of criminalization on HIV service provision for MSM than government responses. However, over the three reporting cycles examined, government narrative responses included more detailed information regarding MSM each successive reporting cycle.

Government and civil society respondents most frequently recorded discordant standardized answers in 2010 and 2012 on question two, which asked whether the country had laws, regulations, or policies that presented obstacles to HIV service provision for MSM. In the five instances where this occurred (Namibia and Swaziland in 2012; Botswana, Namibia, and Swaziland in 2010), civil society respondents indicated that legal or regulatory barriers did exist while their government counterparts said they did not. In the narrative follow-up to this question, civil society representatives always cited the criminalization of same-sex practices and specified the barriers such policies created even as government responses (with one exception) did not acknowledge any such legal barriers existed. (The exception is Swaziland in 2012. In that report, the government's narrative response mentioned that criminalization prevents MSM from accessing HIV services, even as its standardized response indicated no legal or policy barriers existed for MSM.)

The largest number of discordant standardized answers between sectors in a single country in a given year was three (Namibia, 2012). Zimbabwe also had three standardized answers

that differed between government and civil society in 2012, but in each of those cases one respondent left an answer blank while the other did not.

Civil society responses as a whole became more unanimous on the existence of laws or policies that impede access to HIV services for MSM after 2008. In 2010 and 2012 in all cases where civil society representatives provided responses, they indicated that legal barriers existed while non-discrimination protections did not.

In 2012, government representatives also unanimously noted the absence of specific non-discrimination protections for MSM in standardized responses.

In five instances in 2012 (Botswana, Malawi, and Swaziland in Part A; Malawi and Namibia in Part B), and twice in 2010 (Malawi in Part A; Namibia in Part B), representatives from a given sector described in their narrative responses how the illegality of same-sex practices creates an obstacle to MSM receiving HIV services and, sometimes, reinforces stigma and discrimination towards this group. Such responses were provided even though in the same report representatives cited a country's constitution or Bill of Rights as providing human rights or non-discrimination protections for all citizens. Government narrative responses mentioned policy or legal obstacles to MSM receiving HIV services as well as broad non-discrimination protections in four different NCPI reports,⁴¹ and civil society responses did so in three different NCPI reports.⁴²

Inconsistencies sometimes existed between standardized and narrative responses. There were three instances (Namibia and Zimbabwe in 2008; Swaziland in 2012) in which government or civil society respondents reported one answer for a question's standardized response and then described a contradictory situation in that question's narrative response. For example, Swaziland's government respondents in 2012 stated "no" when asked if the country had laws, regulations, or policies that presented obstacles to effective HIV service provision to key populations. Yet in its free response, the government indicated that laws criminalize activities practiced by key populations, including MSM, and that "these groups cannot access specialized services as a result of the criminalization of their activities."⁴³

Country-specific results



Botswana

Unlike in previous years, government officials acknowledged in the 2012 NCPI that Botswana's laws and policies created barriers to HIV service provision for MSM, and that most MSM did not have access to HIV risk reduction services. However, in 2012, government respondents also indicated for the first time that the country's HIV policy addressed stigma and discrimination reduction for MSM.

While government respondents acknowledged legal barriers creating obstacles for MSM only in 2012, civil society respondents consistently reported legal or procedural obstacles to HIV service provision for MSM in their standardized NCPI responses for all years reviewed.

In NCPI narrative responses, government respondents acknowledged MSM specifically only in 2012, when they noted that Botswana's sodomy law "fuels negative public attitude/stigma and discrimination" and thus is responsible for low service uptake by MSM and other groups.⁴⁴ Commentary in Botswana's Progress Report further indicated that criminalization and stigmatization discouraged MSM from seeking services and limited the ability of health officials to determine the size and needs of the population. The 2010 Progress Report stated that a needs assessment of key populations was conducted in 2009 and that this assessment would inform an operational plan for and further mapping of key populations, including MSM. In 2012, these activities were described as ongoing. No new data were reported.



Malawi

In its 2010 Progress Report, Malawi cited a small study that found 35 percent of MSM surveyed (N=200) reported consistent condom use, while 10 percent reported they never used condoms. A small 2007 study was also cited in the 2010 report that found 21.4 percent of MSM sampled were living with HIV. The report stated that a larger study was needed, but that criminalization of same-sex practices impeded this research. No new data were provided in the 2012 report.

In their 2012 NCPI narrative responses, government respondents noted the existence of “discrimination, prosecution, and punishment of people solely for their sexual orientation or gender identity;” “hostility and resentment for lesbian, gay, bisexual and transgender people;” and “low MSM access to health care and HIV related information.”⁴⁵ Yet government officials in 2012 described the Malawi constitution as “broadly protect[ing] citizens of Malawi, including PLHIV [people living with HIV] and key populations, against human rights violations.”⁴⁵

Civil society’s narrative responses on the NCPI noted, in 2010 and 2012, that criminalization has driven MSM underground, thereby making it difficult to reach them with HIV interventions. Of note, in 2012, civil society representatives cited an instance where the “Malawi government through the Ministry of Information and Civic Education issued a press release condemning homosexuality and organizations fighting for the rights of MSM.”⁴⁵ Respondents in 2012 also explicitly stated that “[...] the criminal code criminalizing same-sex activities violates the constitution, which guaranteed the right to liberty, dignity, and security and prohibited discrimination on all grounds [...]”^{45,46}



Namibia

Namibia’s 2012 Progress Report cited a small (N=218) 2009 study that found HIV prevalence of 12.6 percent among MSM.

Government responses to the NCPI’s standardized questions in 2010 asserted that non-discrimination protections existed for MSM and that the country’s HIV policy addressed a wide range of preventive services for MSM. In contrast, however, the sector’s response in 2012 indicated that there were no non-discrimination protections for MSM and that condom promotion was the only preventive service for MSM addressed in the country’s HIV policy.

In 2008 and 2010, civil society respondents agreed with the statement that risk reduction was available for MSM, but in 2012 they “strongly disagree[d].” This 2012 response differed from that of government, which indicated that risk reduction was widely available for MSM.

While MSM were mentioned just twice in government narrative responses in all of Namibia’s NCPIs that were examined,⁴⁷ they were mentioned in the narrative portion of every larger Progress Report reviewed. The 2012 Progress Report stated that studies of MSM are currently occurring, with a survey of key populations approved and steps toward obtaining prevalence data already completed, though criminalization was acknowledged as creating a barrier to gathering data about this population. The 2010 Progress Report stated that lack of data made it difficult to know the extent of key populations’ roles as drivers of the epidemic, and acknowledged that efforts have focused more on areas “where funding is readily available and not necessarily on what drives the epidemic.”⁴⁸

Civil society’s narrative responses on the NCPI provided examples of the consequences of Namibia’s current legal regime for MSM, including the lack of condom distribution in prisons, stigmatization from healthcare workers, and impeded access to services.



Swaziland

In 2012, Swaziland reported provisional data for all UNGASS indicators on MSM. Data were gathered via recent surveillance of most-at-risk populations and showed that MSM have good access to condoms and report their consistent use; testing rates among MSM are similar to testing rates among heterosexual males in Swaziland; and prevalence among MSM sampled was 16.7 percent.

In 2012, civil society's responses to NCPI standardized questions indicated that a greater estimated share (25 to 50 percent) of service provision for MSM came from civil society than in 2010 or 2008 (less than 25 percent). Civil society and government respondents disagreed in 2010 and 2012 about the existence of legal barriers to HIV service provision for MSM, with the former affirming their existence and the latter denying it.

In government narrative responses on the NCPI, criminalization was acknowledged as hindering access to specialized and preventive services and as limiting the ability of service providers to offer effective care for MSM in 2012. At the same time, government's standardized responses the same year stated that no legal barriers to HIV service provision existed for MSM.

Civil society narrative responses in the 2010 NCPI described how criminalization caused MSM to be "left out in [...] campaigns for HIV prevention" and remain "underground."⁴⁹ Limited representation of MSM and other key populations in government and civil society was cited as another challenge in 2008 and 2012.



Zambia

For Progress Report indicators pertaining to MSM, Zambia only reported in 2010 that HIV prevalence among MSM sampled in an independent study from 2006 was 33 percent (N=641).

Though Zambia submitted a Progress Report in 2012, no NCPI-related data were available on the UNAIDS website when desk research for this report was conducted (December 2012).⁵⁰

In their 2010 NCPI narrative responses, government respondents acknowledged the sodomy law, which "describes homosexuality as unnatural and [...] mak[es] it punishable," while at the same time noting that the *National Strategy for Prevention of STI/HIV-2009* "comprehensively covered" topics on MSM.⁵¹ Respondents further stated that a policy review board had advocated "[...] the revision of laws on MSM and IDU to allow provision of HIV and AIDS related services [to these groups]."⁵¹ The 2012 Progress Report noted that the newest National AIDS Strategic Framework intends to address the needs of MSM and other key populations, although specific steps were not outlined.

The narrative response submitted by civil society in the 2010 NCPI about the sodomy law used exactly the same wording as that submitted by the government. When asked if the country's HIV response utilized different approaches for engaging different key populations, civil society noted the difference was that for "some at-risk populations there is nothing available."^{52,53}



Zimbabwe

In 2012, unlike in 2010, government respondents to standardized NCPI questions stated that MSM were not included in the country's multisectoral HIV strategic plan. In both years, government acknowledged that legal barriers to HIV services existed for MSM.

Civil society responses to NCPI standardized questions indicated that, in 2008, less than 25 percent of services for MSM were estimated to come from civil society. In 2010 that number was greater than 75 percent, and in 2012 no response was given for this question. In 2008, civil society representatives said that non-discrimination protections existed for MSM, but in both 2010 and 2012 representatives stated that these protections did not exist.

When government officials were asked to list key populations in their NCPI narrative responses, MSM were mentioned in 2010 but not in 2012. When MSM were mentioned in Progress Reports, the language used was nearly identical from year to year and pertained to the barrier that criminalization creates in gathering data from and offering services to MSM. These reports asserted, however, that criminalization does not bar MSM from accessing health services.

In the narrative responses in all three NCPIs examined, civil society respondents mentioned the effects of Zimbabwe's criminalizing legal regime, including promoting "fear of accessing treatment, care, and support, and testing," the inability to access information on "proper protective methods," as well as "stigma and discrimination."⁵³ In spite of the barriers posed by criminalization, civil society respondents noted in 2012 that "all population sub groups are entitled to HIV and AIDS services without discrimination."⁵⁴

Conclusion

Civil society representatives play a key role in monitoring the national response to HIV in each of these six countries. Nowhere is that more apparent than in the NCPI portion of the Global AIDS Response Progress Reports (formerly known as UNGASS reports). The analysis above shows that while many governments began to recognize the needs and vulnerabilities of MSM by 2012, most ignored these issues in 2008. In contrast, civil society respondents to the NCPI were detailing obstacles to health access, problems with HIV prevention and treatment programs, and the consequences of stigma and discrimination from the very beginning of the period of analysis. The conditions described by civil society were often validated by governments in later reports, with both sets of respondents recognizing the impediments raised by stigma and discrimination.

Criminalization is a different matter, though. In several settings, civil society and government respondents saw the impact of punitive legal frameworks differently, with the former noting its role in reducing access to HIV prevention, treatment and care services, and the latter claiming no such legal impediments existed.

It is possible that some of this dissonance derives from the format of the NCPI or the process involved in completing it, but this duality is also reflected in the on-the-ground reports featured later in this report. In many settings, criminalization is not seen as an inhibitor of health access by those responsible for enacting and enforcing those laws.

The Progress Reports are flawed but important mechanisms for tracking the global response to HIV. Prior to their establishment, there was no mechanism that required national governments to collect and report on indicators evaluating progress on HIV, including any related to MSM.⁴⁶ However, for these reports to remain relevant, two issues must be addressed. First, there are legitimate concerns about the quality of data reported. UNAIDS has a responsibility to help observers understand exactly what the data mean, and how that might be different than what the numbers reported by countries suggest.⁴⁶ Second, the extensive amount of effort involved in collecting and reporting data remains disconnected from any accountability around this information. Civil society advocates, donors, and governments need to be trained on how to understand and use the important data to guide their work.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund has undergone significant change since its inception in 2001. In the past three years alone, the financing institution has restructured or revised a majority of its processes for financing programs for the three diseases. Many of these changes have been implemented to make access to funding easier for countries, apply that funding to the most effective programs, and ensure national governments remain accountable to those most in need.

While it is still too early to tell if these new policies and structures have had any of those intended outcomes, there are many lessons that can be learned from earlier Global Fund financing that should inform these changes.

This analysis sought to examine the previous decade of Global Fund grant making to determine the institution's role in funding programs serving MSM in six countries (Botswana, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe). It builds off of previous efforts conducted by amfAR and CPHHR and other reports that have highlighted several internal and external impediments to financing programs for MSM.^{1,55,56}

GMT and the Global Fund

In May 2009, the Global Fund's Board of Directors approved the sexual orientation and gender identities (SOGI) strategy.⁵⁷ It outlined concrete actions that all actors involved in Global Fund grants are required to take to better understand and respond to the health needs and rights of sexual minorities. It also directed the Secretariat to provide appropriate guidance, resources, and technical support to country coordinating mechanisms (CCMs) and other national structures to strengthen their ability to meet those responsibilities.

Approximately one year later, the Global Fund established a targeted funding pool for key populations as part of Round 10 HIV funding applications. This dedicated funding was meant to incentivize country demand for programs for key populations. It was a modest success. Twenty-five of 78 HIV/AIDS proposals requested funding from the MARPs-dedicated funding stream and nearly half (12) of those were approved for a total of \$47 million over two years (5.8 percent of all approved HIV/AIDS grants for Round 10).⁵⁸

In November 2011, the Global Fund adopted a new five-year strategy that permanently embedded programs for GMT and other key populations in its organizational mandate. The strategy recognizes the extent to which discrimination, criminalization, and human rights violations impede the effectiveness of programs supported by the Fund and therefore prioritizes support for programs that address legal and policy barriers, especially those managed by civil society.⁵⁹

Fully implementing the strategy has necessitated considerable changes to the processes that guide how the Global Fund finances programs. The development of a new funding model (NFM) began shortly after the strategy's passage and is ongoing. A transition to the NFM was launched in February 2013 with the goal of full implementation in 2014 (see box).

Methodology

All approved Global Fund proposals for funding from Rounds 1 through 10 and the TFM were analyzed to determine what, if any, programs for GMT were being supported in these six countries. Both public and non-public documents provided by the Global Fund were analyzed to identify programs supporting GMT. Any associated budget or narrative details were recorded. Budget analysis particularly focused on the initial proposal budget; the budget approved

Transitional funding and the new funding model

The Global Fund established a transitional funding mechanism (TFM) in November 2011 after the cancellation of Round 11.⁶¹ It was meant to sustain Global Fund-supported programs until a more formal funding opportunity could be established.

The TFM was highly controversial when it was announced and remains so currently. Applicants to the funding stream were limited to applying for funding for the continuation of “essential programs.” Although some examples were provided, the term “essential programs” was not defined.⁶² In August 2012, 56 proposals were awarded \$511 million in two-year funding. Of these, 24 totaling \$179.3 million were specifically for HIV programs. This was approximately half the size of the previous Round 10 funding.⁶³

The Technical Review Panel (TRP), which evaluates the technical merit of all Global Fund proposals and make recommendations to the Board, recognized in its review that the structure of the TFM disadvantaged HIV prevention programs and those meant to serve key populations.⁶⁴ The panel also noted that civil society interventions and programs were almost entirely funded by the Global Fund, with little to no co-financing from national governments.

The new funding model (NFM) replaces both the TFM and the previous Rounds-based system. There are a significant number of parts to the NFM, but only three that are relevant to this report:

Iterative development – The Global Fund mandates the use of what it calls a “country dialogue” to facilitate the grant making process. This is supposed to be a series of meetings involving all relevant stakeholders to begin an iterative process in which countries and the Global Fund work together to develop a successful proposal. The TRP will technically evaluate proposals when they are deemed ready. Those the TRP assesses as in need of additional work will be returned for revisions and resubmission. This is in contrast to the Rounds-based system where proposals that were not approved by the TRP were rejected entirely.

Upfront funding allocation – The Global Fund will indicate to countries at the beginning of the grant making process how much funding they can expect to receive from the Fund. This is a departure from previous processes where no set limit was expressly stated upfront. The Global Fund will encourage countries to apply for their full need, regardless of this indicative amount.

Key populations – Funding for what the Global Fund terms “most-at-risk populations” (MARPs) will continue under the NFM but not as a set aside mechanism as seen in Round 10. The transition to the NFM in 2013 is expected to focus all upper middle-income countries on targeted programs for MARPs.

Of the six countries in this report, only Zimbabwe was chosen as an early applicant during the transition phase. Malawi is eligible for additional funding through grant renewal and reprogramming processes. Botswana, Namibia, Swaziland, and Zambia will not be able to obtain new Global Fund funding for HIV until at least 2014.

by the Board of Directors; and the final, negotiated budget that formally initiated the grant. Budget changes did not accompany changes to the narrative proposal; therefore, any activities discussed come directly from the original proposal.

Desk researchers also reviewed unapproved proposals for Rounds 7 through 10 to identify any programs for GMT that remained unfunded. Where possible, comments from the TRP were reviewed to understand why certain proposals were not funded.

The strategy recognizes the extent to which discrimination, criminalization, and human rights violations impede the effectiveness of programs supported by the Fund.⁵⁹

The search terms deemed relevant and used were “MSM,” “men who have sex with men,” “sexual minorities,” “most at risk,” “MARP,” “transgender,” and “vulnerable populations.” Relevant text was recorded for qualitative and quantitative analysis.

When any of these terms were identified, the associated narrative and budget data were analyzed to determine if and to what extent programs serving GMT were included as part of funded activities. Distinctions were drawn between proposals that excluded any mention of GMT, mentioned but contained no budget or activity-level data on this population, or included activity-level data specifying programs for GMT.

Frequently, MSM were mentioned as part of a larger group of key populations. In line with the methodology from the previous report in this series, the amount allocated to MSM was determined by dividing the full budget amount for that activity by the number of populations described in the text.

Transgender individuals were mentioned in only one proposal: Botswana Round 10.

Limitations

- This report examines much of the most up-to-date information available from the Global Fund; however, even the most timely data in some cases are nearly three years old. The uncertainty surrounding Global Fund financing since November 2011 has had consequences for country programs that are not reflected in these results.
- Changes to grant management at the Global Fund have made budget tracking particularly cumbersome. Single-stream funding adopted in 2009 has made it difficult to determine the difference between new and existing funding in countries that have adopted this grant management process.
- Available information on unapproved Global Fund proposals varies greatly from that for approved grants. Proposals that were not approved were only available for Rounds 7 through 10, thus limiting the depth of analysis.
- The results below should be interpreted as case studies of opportunities and challenges for funding GMT programs through the Global Fund and not as representative of all Global Fund financing.

Results

General results

Overall investment

Table 5 below provides basic information about Global Fund financing to the six target countries and one region. The check marks signify approved Global Fund HIV/AIDS proposals. Cells marked with an X signify unapproved proposals. Cells shaded in gray indicate proposals that included programs for MSM or transgender individuals.

The TFM [transitional funding mechanism] is described in the box above. Also, the RCC [Rolling Continuation Channel] is a special financing mechanism at the Global Fund that extends a grant award for an additional six years—in this case, Namibia’s Round 2 award.)⁶⁴

Table 5. Global Fund investments in the six target countries (in \$ millions)⁶⁵

Country	Round												Approved HIV funding (in millions)	Approved MSM funding	
	1	2	3	4	5	6	7	8	9	10	RCC	TFM			
Botswana		✓					X		X	X				\$18.6	\$0
Malawi	✓				✓		✓		X	X				\$386.2	\$0
Namibia		✓						X		X	✓			\$161.9	\$1.029 [§]
Swaziland		✓		✓			✓	✓		X		✓		\$155.1	\$0
Zambia	✓			✓				✓	X	✓				\$475.7	\$.085*
Zimbabwe	✓				✓			✓		X				\$278.3	\$0
SADC**									✓					\$13.2	\$0

§ Only the proposed budget was available.

*Changes to the principal recipient (PR) in Zambia led to an unclear approved budget

** Refers to multi-country grant in the region. SADC stands for the Southern African Development Community.

Among the six countries, there were 29 proposals submitted and 19 approved (66 percent) including one regional proposal awarded to the Southern African Development Community (SADC). The total approved funding for HIV programs was approximately \$1.5 billion.

Round 10 was the only funding round in which all six countries surveyed submitted an HIV/AIDS proposal for consideration and all of those proposals at least mentioned MSM.

Of the 29 total proposals, 41 percent did not mention MSM at all (12 proposals), 31 percent (nine proposals) mentioned MSM but did not state any specific activities, and 28 percent (eight proposals) contained activity-level data.

Of the 19 approved proposals, 58 percent (eleven proposals) made no mention of MSM, 32 percent (six proposals) mentioned MSM but did not state any specific activities; and 11 percent (two proposals, one each from Namibia and Zambia) contained activity-level data.

Of the ten proposals not approved, 10 percent (one proposal) did not mention MSM, 30 percent (three proposals) mentioned MSM but did not state any specific activities, and 60 percent (six proposals) mentioned MSM and specific activities with links to specific budget items. Only Botswana's Round 10 proposal included transgender populations.

Round 10 was the only funding round in which all six countries surveyed for this report submitted an HIV/AIDS proposal for consideration and all of those proposals at least mentioned MSM. Namibia, Swaziland, Zambia, and Zimbabwe merely mentioned the population, while Botswana's and Malawi's proposals detailed MSM-targeted activities and included specific budget information. Only Zambia's was approved and only Botswana's included transgender individuals.

Country-specific results



Botswana

Botswana received HIV/AIDS funding from the Global Fund in Round 2. Its proposal made no mention of MSM. It did, however, mention funding for “vulnerable groups,” which were defined as “youth, PLWHA, commercial sex workers, women, etc.”⁶⁶

Botswana submitted HIV/AIDS grant proposals in Rounds 7, 9, and 10, but none were approved. The Round 7 proposal mentioned vulnerable groups including “sex workers, MSM, farm workers, etc.” and explained that there was not a sufficient amount of data to show how large these groups were or how they were being reached.⁶⁷ The proposal intended to collect surveillance data in the first year that would lead to other interventions in later years. Approximately \$264,296 was proposed for MSM programs, including applied research and behavior change interventions. This represented about 0.7 percent of the entire budget.

The ultimately unsuccessful Round 9 proposal included less detail about MARPs, noting instead that “the proposal targets the poor; vulnerable groups such as young people, women, people living with disability and sexual minorities.”⁶⁸ The latter were defined as men who have sex with men and women who have sex with women. Approximately \$648,973 was proposed for programs for MSM, including community outreach and mobilization, plus a needs assessment. This represented 0.9 percent of the entire proposed budget.

Botswana's Round 10 proposal was more explicit as it stated its “emphasis on key affected populations including: most at risk populations (MARPS), including men having sex with men (MSM) and commercial sex workers (CSW); along with women, PLHIV [people living with HIV], youth, people with disabilities, other vulnerable populations such as pregnant women, children, prisoners, and those away from home for extended periods of time (i.e., drivers and farm workers).”⁶⁹ Although MSM were mentioned in that definition, MARPS were defined in other parts of the proposal as including different groups (and without always specifying MSM).

The estimated total amount Botswana was seeking for MSM-specific programming was \$1,634,056 over the five-year funding period. This represented about 1.2 percent of the total budget.⁶⁹ Though not approved, the Round 10 proposal exhibited significant improvements in discussing and asking for funding for MARPs-related activities, especially for MSM, in comparison with the earlier proposals.

It is also notable as being the only single-country proposal among the six target countries to include transgender populations. The Round 10 proposal listed “transgender groups” as a population targeted for epidemiological surveillance; however, the specific budget was difficult to disaggregate.



Malawi

Malawi received funding for HIV/AIDS from the Global Fund in Rounds 1, 5, and 7. There was no mention of MSM in the Round 1 or Round 5 proposals, but the population was referenced in the Round 7 proposal as one whose size had not been estimated. The proposal reasoned that MSM were excluded because “high-risk practices such as injecting drug use and men having sex with men are not common in Malawi.”⁶⁹

Malawi applied for but did not receive HIV/AIDS funding in Rounds 9 and 10. There was no mention of MSM in the Round 9 application, but the Round 10 proposal discussed in detail the importance of making programs relevant to sexual minorities. Moreover, it proposed activities designed not only to estimate the population size and needs of MSM, but also to empower MSM and challenge HIV-related stigma and discrimination. Activities included behavior change communication (BCC) programs, lubricant and condom distribution, testing and counseling, and behavioral surveillance including size estimation. The total amount Malawi asked for these specific MSM activities was \$2,610,623 over the five-year funding period.⁶⁹

Although the inclusion of such activities appeared to mark an important positive change toward meeting the population’s needs, it is worth noting that the amount was still less than 1 percent of the total funding requested in the proposal.

The TRP’s comments for the Malawi Round 10 proposal provided insight as to why it was not approved. Even though the TRP acknowledged the inclusion of identified risk groups in the scale-up of HIV prevention and control interventions as a progressive step forward, one of the major reasons for not recommending this proposal was that it did not “provide context-specific evidence that underpins the feasibility of the expansive approach...”⁷⁰ The applicant was encouraged to take the panel’s recommendations into consideration and resubmit during the next round of funding. That opportunity has not occurred as of this writing.



Namibia

Namibia received HIV/AIDS funding from the Global Fund in Round 2. Its proposal made no mention of MSM, though it targeted money for “high-risk groups” designated as “truck drivers, migrant workers, and sex workers.”⁷¹

Namibia applied for but did not receive HIV/AIDS funding in Rounds 8 and 10. The Round 8 proposal described key affected populations as “men who have sex with men (MSM), sex workers, mobile populations, and youth” and further outlined activities to prevent HIV transmission among these groups including “the strengthening of mass media campaigns, increasing access to counseling and testing via mobile services, and promoting male circumcision.”⁷² Namibia requested \$2,702,877 for programs for MSM, representing 1.7 percent of the total requested budget.

The Round 10 proposal included more groups in the definition of MARPs—“SWs [sex workers], MSM, fisherman, uniformed services, mobile and migrant populations and prisoners”—and discussed the need for size estimation and behavioral surveillance.⁷³ However there is no evidence in the proposal of any potential programs or funding for MSM.

Although the Rounds 8 and 10 proposals were not successful, MSM in Namibia benefited from the extension of the Round 2 grant through the Global Fund’s Rolling Continuation Channel (RCC). The RCC agreement, approved in 2009, outlined interventions to reduce HIV among difficult-to-reach populations. A total of \$1,029,227 was allocated for activities for MSM,

including behavior change communication and STI diagnosis and treatment, representing 0.6 percent of the proposed budget. It was not possible to track this allocation in the final budget.



Swaziland

Swaziland received funding for HIV/AIDS from the Global Fund in Rounds 2, 4, 7, and 8. The Round 7 proposal focused on “vulnerable” populations, defining them primarily as youth, people living with HIV, orphans and the elderly. For MSM, the proposal mentioned that “a country workshop identified that the HIV epidemic in Swaziland is not being driven by drug users, sex workers or men who have sex with men, but is instead driven primarily through heterosexual relationships. As such, data for the above mentioned groups is not gathered.”⁷⁴ The Rounds 2, 4, and 8 proposals made no mention of MSM (Round 8 was a health systems strengthening grant).

Swaziland submitted an HIV/AIDS proposal in Round 10 that was not successful. The proposal defined MARPs as “commercial sex workers, prisoners, and migrant/mobile populations,” then further stated that “evidence of men having sex with men is insufficient in Swaziland.”⁷⁵ The proposal discussed the need to undertake a size estimation study to determine the impact of HIV on those groups. It also noted that plans were under way to conduct a behavioral surveillance survey in 2010, although support for that activity was not reflected in the proposed grant budget. There was no evidence of any potential programs or funding for MSM in the Round 10 proposal.

Swaziland was the only country of the six reviewed in this study that successfully applied for the transitional funding mechanism (TFM) support in 2012. MSM were included in the definition of key population groups along with “women and girls, transgender persons, people who inject drugs, male and female transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern.”⁷⁶ However, the proposal did not describe activities that would target any of those groups.



Zambia

Zambia received funding for HIV/AIDS from the Global Fund in Rounds 1, 4, 8, and 10. There was no mention of MSM in the Round 1 or Round 4 HIV/AIDS proposals. The Round 8 proposal called for increased behavioral surveillance and size estimation. A total of \$85,213 was allocated for monitoring and evaluation (M&E) for MSM, specifically a population size estimate. This represented 0.03 percent of the entire budget. The proposal also mentioned sexual minorities as a group for whom civil society funding should be increased, but did not include MSM in a definition of sexual minorities anywhere in the proposal; instead, the proposal specifically focused on other groups such as sex workers. The final budget for M&E in Phase 1 of the Round 8 grant appeared to be greater than the Phase 1 proposed budget for M&E, but no Phase 2 final budget was available.⁷⁷

The Round 10 proposal also noted the need for increased M&E for MSM. The proposal explicitly listed lack of funding for or evidence about HIV among MSM as a weakness of Zambia’s HIV program. It stated that MSM have largely been ignored in HIV/AIDS planning, adding that attempts would be made to include MSM in “inclusive planning.”⁷⁸ There was no evidence of actual programs or funding for MSM in the Round 10 proposal.

The main principle recipients for many of Zambia’s Global Fund grants came under heavy scrutiny in 2010 when charges of fraud and abuse were levied by the Global Fund’s Office of the Inspector General. A new principle recipient took over the Rounds 8 and 10 grants in 2011.^{79,80} The upheaval

to grant management combined with efforts to consolidate Zambia's grants into a single-stream greatly obfuscated the country's budgeted activities. It was difficult to determine the extent to which (if any) funding has been or will be allocated specifically for MSM programming.

Zambia applied for but did not receive funding in Round 9. The Round 9 proposal mentioned MSM as a high-risk group that should be targeted for population size estimates, other special studies, and M&E framework, but those activities were not specifically outlined in the proposal's budget. M&E strengthening was not included in this proposal because the focus was on treatment.⁸¹



Zimbabwe

Zimbabwe received HIV/AIDS funding from the Global Fund in Rounds 1, 5, and 8. In Rounds 1 and 5 there was no mention of MSM. In Round 8, Zimbabwe's proposal mentioned that improved programming must be developed for MSM, but there was no mention of MSM-specific activities in the final budget.⁸²

Zimbabwe applied for but did not receive HIV/AIDS funding in Round 10. The Round 10 proposal defined key HIV-affected populations as "sex workers, cross-border traders, young people, men who have sex with men, mobile populations, truckers, internally displaced people, members of uniformed forces, the physically challenged, and survivors of rape and sexual abuse." However, there were no activities outlined specifically for targeting MSM.⁸²

Multi-country grant

In Round 9, the Southern African Development Community (SADC) successfully applied as a regional organization for an HIV/AIDS grant focused on 14 countries (including the six in this report). The proposal included "men who have sex with men as a key affected population," and recognized the stigma experienced by sexual minorities.⁸³ It went further by acknowledging i) the need for programs and M&E targeting all vulnerable populations (including MSM), and ii) the importance of advocacy to end stigma and discrimination among sexual minorities and other groups. Although the proposal included MSM-specific activities, the amount that would be reserved solely for the MSM population was not clear in the budget. The Global Fund responded to a request for clarification to state that there were no components specifically targeting MSM. The performance framework also showed no sign of working with MSM, and there were no budget items for MSM.

In Round 10, the Dutch NGO Hivos applied for a multi-country grant focused on GMT and women who have sex with women (WSW). The application was for \$36,066,771 for programs in Lesotho, Mauritius, Namibia, South Africa, and Swaziland. It was not approved.⁸⁴

Conclusion

Despite the Global Fund's progressive policies on the inclusion of GMT, programs supporting this population make up just 0.07 percent of total HIV/AIDS financing in these six countries. Desk researchers could only identify two approved programs (Namibia's RCC and Zambia's Round 8) that potentially included MSM. There was no approved programming for transgender individuals

The analysis presented above underscores previous concerns raised about the limitations of Global Fund programming for GMT. Since at least Round 9, the TRP has noted the exclusion of GMT in submitted proposals.⁸⁵ The panel, which is responsible for technically assessing all proposals and making recommendations for approval to the Global Fund Board, strengthened

its critique in Round 10 by urging the Global Fund to address criminalization, stigma, and discrimination.⁸⁶ Perhaps the strongest criticism came from the report on the transitional funding mechanism (TFM), the bridge funding that replaced Round 11. The TRP noted the following in that report:⁸⁷

...[A]ctivities for most-at-risk populations (MARPs) were often reduced in scale or removed altogether under TFM.... [T]here were reductions in targets associated with MARPs, which for the most part are poorly monitored and absent from performance frameworks. In some cases, activities mentioned in the proposal were not included in the budget even though listed as a priority.... [O]verall there is a lack of knowledge among applicants regarding most-at-risk-populations.

The timing of Round 11's cancellation and the installation of the TFM is troubling given the poor history of approved funding for these six countries. Of the 29 total proposals, 19 were submitted in Round 7 or later and only seven of those were approved. Half of the proposals that were not approved contained activities for GMT, but Global Fund policy prevented them from applying through the TFM to support these programs. This meant that only Namibia and Zambia were eligible to apply for additional funding for programs for GMT and neither did.⁸⁸

An independent evaluation of the implementation of the SOGI strategy commissioned by the Global Fund in 2011 raised similar concerns, noting in particular how lackluster the operationalization of the strategy was to date.⁸⁹

The lack of prioritization of the SOGI strategy at the Global Fund Secretariat is contributing to a tokenistic approach to the inclusion of GMT in proposals. There are three steps the Secretariat could take to begin moving forward.

Despite the Global Fund's progressive policies on the inclusion of GMT, programs supporting this population make up just 0.07 percent of total HIV/AIDS financing in these six countries..

First, the Global Fund should aggressively pursue reprogramming grants while the new funding model is being established. Countries are operating under grant agreements that are outdated and there is currently no clear guidance on how they can reprogram or who is responsible for doing that. The Global Fund needs to address this lack of process and the outdated nature of many current grant agreements immediately.

Second, the Secretariat needs to move from policy and strategy to guidance and operationalization. Since 2009, the Global Fund has instituted progressive policies that have deeply influenced the work of partner organizations such as PEPFAR; however, little has resulted in terms of real resources and programs. The SOGI strategy needs a work plan, staffing, money, and priority.

Finally, the needs of GMT should be embedded in the new funding model. It is unclear how GMT or other key populations fit into the model, which began via a transitional period in early 2013. There have been early indications that when the new model is fully launched, which is expected in late 2013 or early 2014, certain middle-income countries will have their eligibility limited to programs intending to serve these populations. That step may have useful, though limited, impact. Epidemiology has long proven that GMT exist and are at risk for the acquisition and transmission

of HIV in all economic contexts. It is time for the Global Fund to recognize the needs of GMT through increased funding for programs serving them in all parts of the organization's portfolio.

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

December 6, 2011 was a historic day for the U.S. government's response to the public health and human rights vulnerabilities of GMT and other sexual minorities. Secretary of State Hillary Clinton delivered remarks in recognition of Human Rights Day that cemented in policy her department's proactive support for the health and wellbeing of lesbian, gay, bisexual, and transgender people. "Gay rights are human rights," she said. "It is a violation of human rights when life-saving care is withheld from people because they are gay."⁹⁰

The Secretary's words were the culmination of years of policy changes across a wide array of government agencies, including the Office of the Global AIDS Coordinator (OGAC)—the government agency responsible for managing PEPFAR funding. Prior to PEPFAR's reauthorization in 2008, it was unclear how directly the U.S. government's bilateral aid program for HIV, the largest of its kind in history, included GMT in its programming. The new legislation "recognized the need for PEPFAR to support countries... 'to prevent the transmission of HIV among men who have sex with men'... [and] call[ed] on PEPFAR to work with partner countries to 'gather epidemiological and social science data on HIV' and 'evaluate the effectiveness of prevention efforts among men who have sex with men.'"⁹¹ The legislation did not address transgender individuals.

More than two years after the passage of this legislation, OGAC issued direct guidance to countries on how to include MSM in PEPFAR Country Operational Plans (COPs).⁹¹ The recommended core package of services includes:

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

The Southern African region has always retained prominence in PEPFAR due to its relatively high disease burden and the large number of low-income countries it includes. The 15 countries that make up the Southern African Development Community (SADC) account for 31 percent (\$8.0 billion)⁹² of total PEPFAR funding from 2007 through 2011. Seven SADC countries were part of the original 15 PEPFAR focus countries that received increased investment during the program's first phase.⁹³ Three of the six countries included in this desk research were original PEPFAR focus countries (Botswana, Namibia, and Zambia).

Though investments have been robust, it is unclear to what extent MSM programming has been a priority in this region. This desk research sought to address that.

Methodology

This analysis intended to examine PEPFAR COPs for six countries (Botswana, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe) between U.S. fiscal years 2007 (October 2006 to September 2007) and 2011 (October 2010 to September 2011)—the years available on PEPFAR’s website.

Given changes in PEPFAR reporting policy over this time period, documentation was not available for all years and countries. Of the six countries included in this analysis, COPs were available for only Botswana, Namibia, and Zambia in fiscal year (FY) 2007 because they were the only PEPFAR focus countries included in this analysis.^{93,98}

In FY 2011, PEPFAR adapted its reporting process for countries. Under the new policy, countries submit “short” and “full” COPs in alternating years.⁹⁹ These “short” COPs only require data on new programs proposed for that fiscal year rather than the entirety of a country’s programming.

Targeted funding opportunities from the U.S. government for programs serving sexual minorities

Between December 2011 and July 2012, the U.S. State Department launched and announced support for several funding opportunities for programs serving GMT and other sexual minorities, including the following:

Key Populations Challenge Fund – a \$20 million challenge fund intended to incentivize accelerated programming for key populations (e.g., GMT, people who inject drugs, and sex workers) in PEPFAR countries. Countries must match challenge fund awards with resources from existing PEPFAR country budgets (a minimum \$100,000).⁹⁵ Applications for this funding occurred in line with the 2013 COP process.

Key Populations Implementation Science Fund – a \$15 million pool of funding intended to build the evidence base around the most effective interventions for key populations. As of when this report was released, the program was still being developed by OGAC.

The Robert Carr Civil Society Networks Fund – a civil society support mechanism established in 2012 as a tribute to the civil society advocate for whom it was named. It is a multi-donor funding mechanism managed by the Aids Fonds Netherlands and UNAIDS. The U.S. government played a critical role in its establishment and provided \$2 million in support. Awards are meant to address HIV among “inadequately served populations,” including people living with HIV, GMT, people who inject drugs, sex workers, and prisoners.⁹⁶ The Fund awarded \$5.4 million in 2012 to 24 global and regional civil society networks including several groups focused on GMT and HIV.⁹⁶

The Global Equality Fund – established in 2011 and managed by the Bureau of Democracy, Human Rights and Labor at the State Department, the program’s approximately \$3 million in annual funding is intended to support civil society groups working to advance the rights of lesbian, gay, bisexual, and transgender persons. Funding is distributed via small grants awarded by U.S. embassies to local civil society organizations. Grants support short-term projects; longer-term capacity-building and technical assistance programs for local and national civil society groups; and rapid-response emergency assistance for LGBT groups under serious physical threat or experiencing extreme harassment.^{97,98}

All FY 2011 COPs were “short” and only Namibia’s and Zimbabwe’s provided detail sufficient to include in this analysis.

Available COPs were searched for key GMT-related terms, including “MSM,” “men who,” “homosexual,” “most at risk,” “MARP,” “transgender,” and “key population.” Relevant hits were recorded for qualitative and quantitative analysis.

When any of these terms were identified, the narrative and budget data connected with specific funding mechanisms were analyzed to determine if and to what extent programs serving GMT were included as part of the funded activities.

Budget analysis was limited to portions that could reasonably include GMT program activity given PEPFAR budget coding—i.e., budget codes related to prevention of mother-to-child treatment (PMTCT) and antiretroviral treatment, among other categories, were excluded. For the sake of clarity, the portion of a COP’s budget that could include programs serving GMT is referenced as “eligible COP.”

To determine the total eligible COP budget, budget areas were recorded for all activities that contained specific descriptions of GMT activities or that included GMT as one of many target populations in this analysis and in the previous report in this series.¹ This yielded a total of nine relevant budget areas that contained at least one GMT activity from FY 2007 to FY 2011.¹⁰⁰ For each target country and year of interest, the total funding for each of the GMT-relevant budget codes was retrieved from the country’s COP and recorded. Therefore, the eligible COP budget was the sum total of funding from each of these nine budget areas.

Total appropriated PEPFAR funding was also collected for reference from the U.S. government’s Foreign Assistance Dashboard.¹⁰¹

Limitations

The following are limitations associated with this analysis:

- There were numerous examples of GMT programming that was proposed in COPs but was undetectable during in-country consultations conducted for this report. This finding indicates that there is a fair amount of overestimation in a COP-only analysis.
- OGAC redacts budget data to protect proprietary information. The level of redaction across different COPs is inconsistent, thereby limiting comparison between countries and years.
- When GMT are specifically mentioned in program descriptions in COPs, activities focused on this population are usually just one among many supported by a single funding mechanism. As such, it is difficult or impossible to accurately disaggregate what portion of each mechanism’s funding was intended to specifically target GMT. In these instances, total funding for the mechanism was counted towards GMT programming, though it is unlikely that this amount in its entirety contributed to programs serving GMT.
- When GMT are *not* specifically mentioned in activity descriptions for a mechanism, they are sometimes included among a list of target populations for the mechanism following its description. In these instances, lists of target populations in which GMT were included contained six or more other target groups, including “general population” groups of all ages. It was therefore impossible to accurately disaggregate what portion of the mechanism’s funding reached each group. The funding for these mechanisms was not counted towards the total funding for GMT programming, though it is possible that some of the activities funded by these mechanisms reached GMT.

Results

General results

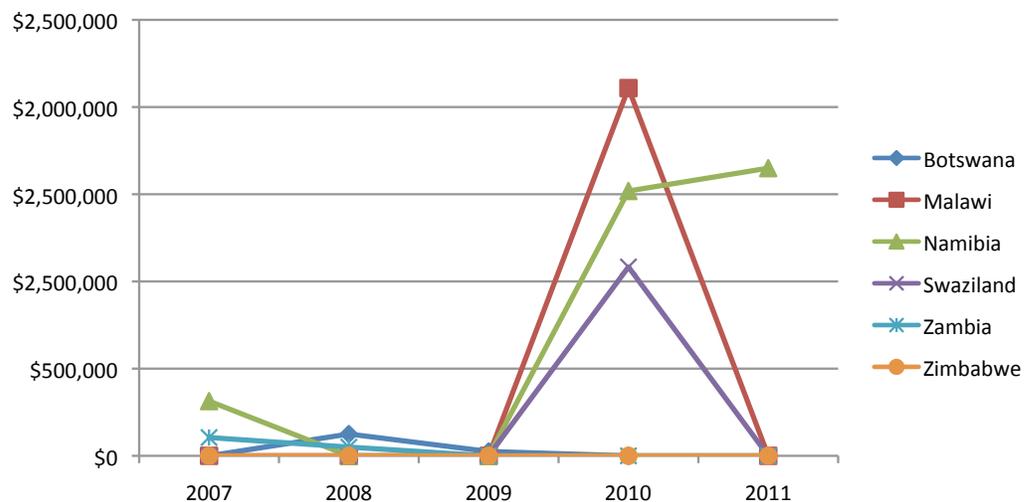
Transgender individuals were never mentioned in any of the COPs; therefore, this analysis is limited to MSM only.

PEPFAR COPs, FY 2007–2011

Programs serving MSM were present at least once over the period of review in all countries except Zimbabwe. Where investments were made, total possible funding ranged from \$25,000 in Botswana’s FY 2009 COP to approximately \$2.1 million in Malawi’s FY 2010 COP. The qualifier “possible” is used to indicate that these were ceiling amounts based on the methodology, not actual allocations. Only once (in 2007) did more than half of the countries for which full COP data were available in a given year include programs serving MSM. Much more frequently, countries made no investments in programs serving MSM in a given fiscal year.

As seen in Figure 2, there was a noticeable increase in funding for programs serving MSM in FY 2010. The cumulative investment in these programs in FY 2010 (\$4,710,441) was approximately 7.5 times greater than it was cumulatively in the three previous years (\$618,807).

Figure 2. Total possible funding for MSM-specific activities by country by year



As a percentage of the total eligible COP budget, funding for MSM-specific activities was minimal (see Table 6). Programs serving MSM represented the lowest proportion of funding in Zambia’s FY 2009 COP (0.04 percent). Swaziland’s FY 2010 COP had largest proportion of budget dedicated to these programs (9.1 percent).

Across all years, Namibia’s total funding for MSM-relevant mechanisms was highest at nearly \$3.5 million—although it is important to note that relevant data for Namibia were available in FY 2011 and FY 2007, both of which were years that had limited COP data for other target countries. When only years for which detailed COP data were available for all countries were examined (FY 2008, FY 2009, and FY 2010), Malawi’s cumulative MSM-relevant funding was greatest at about \$2.1 million, followed by Namibia (\$1.5 million) and Swaziland (\$1.1 million). In both Botswana and Zambia, cumulative funding for mechanisms containing MSM activities was around \$150,000 across all years in which detailed COPs were available for these countries. Zimbabwe provided no funding data for MSM-relevant activities in the years examined.

Table 6. Proposed funding for programs including MSM in COPs by year (in \$)

	2007		2008		2009		2010		2011	
Country	MSM-specific activities	% of eligible COP								
Botswana	0	0	125,000	0.2%	25,000	0.05%	0	0	0	0
Malawi			0	0	0	0	2,108,741	7.3%	0	0
Namibia	313,807	0.7%	0	0	0	0	1,518,700	3.4%	1,649,531	3.5%
Swaziland			0	0	0	0	1,083,000	9.1%	0	0
Zambia	105,000	0.1%	50,000	0.04%	0	0	0	0	0	0
Zimbabwe			0	0	0	0	0	0	0	0
Total	\$418,807		\$175,000		\$25,000		\$4,710,441		\$1,649,531	

Country-specific results



Botswana

The 2007 COP proposed a prevention services needs assessment among MSM to fill knowledge gaps created by the “illegality and low acceptance of homosexual behaviors and identity” that kept the population largely hidden.¹⁰² However, no specific activities or funding allocations for MSM were described later in the COP. In 2008, MSM and injecting drug users were explicitly characterized as “not priority” target populations in Botswana.¹⁰² The same year, disseminating “the results of a situational analysis on vulnerable groups,” including MSM, was mentioned in the activity description of a \$125,000 program focused on a variety of human rights and legislative issues.¹⁰² The same exact description was used in the 2009 COP as well, in which the activity received \$25,000 in continued funding.¹⁰² In 2009, MSM were again omitted in the country’s definition of target, most-at-risk populations.¹⁰² The 2010 COP represented a shift when it indicated that a needs assessment would be conducted among MSM to address the “urgent need to ensure that services are provided to this high-risk group” that was described in literature from the region.¹⁰² However, no specific funding or implementing agency was described for this activity. The 2011 COP did not mention MSM.



Malawi

In Malawi’s 2008 and 2009 COPs, MSM were mentioned just once—as one of 13 target populations for a counseling and testing activity in 2008, though no description was included of how the activity would impact or engage MSM. The 2010 COP marked a major contrast. MSM were included among at-risk populations “who are often overlooked” as a target for increased focus in sexual prevention programs.¹⁰³ Two activities specifically targeting MSM were described as part of a prevention funding mechanism implemented by Population Services International (PSI). Promotion of safer-sex practices and partner reduction for MSM were included as part of an \$836,000 activity. The activity description estimated that 67 percent of Malawian MSM were married and cited multiple concurrent partnerships among MSM, both within and outside the MSM network, as a major concern.¹⁰³ As part of a \$1.27 million activity, MSM were included in activities that would identify the size of the population, engage with the group’s networks, and provide information on risks faced by MSM as well as safer-sex practices.¹⁰³ The possibility of implementing peer education activities for MSM and developing MSM-specific counseling and testing services was also proposed in the description of this activity. The 2011 COP did not mention MSM.



Namibia

In 2007, surveillance of MSM was described as one of five activities for a \$313,000 mechanism implemented by the University of Washington.¹⁰⁴ In the rest of the 2007 and 2008 Namibia COPs, MSM were never specifically mentioned in other program descriptions, though they were listed as one among many target populations for one mechanism in 2007 and six in 2008. MSM were not mentioned in the 2009 COP.

The 2010 COP specifically named MSM as a most-at-risk population that needed to be addressed in the country's HIV response.¹⁰⁴ Lack of epidemiological knowledge about MSM was cited in five instances, and "rapid assessment, population size estimation, and bio-behavioral survey of MARPS," including MSM, was one of four activities comprising a \$1.5 million mechanism implemented by the U.S. Centers for Disease Control and Prevention (CDC).¹⁰⁴ The 2010 COP also described a new mechanism, "TBD MARP"—whose planned funding was redacted and whose implementer was yet to be determined—to enact a number of activities targeting MSM and female sex workers and their clients.¹⁰⁴ Program activities included targeted condom and lubricant promotion, peer education and outreach, HIV counseling and testing, risk reduction activities and counseling, utilization of data for evidence-based programming, advocacy efforts to reduce barriers to service delivery, and capacity building for organizations providing services to these groups.

In 2011, the same wording for the "TBD MARP" mechanism was included in Namibia's COP.¹⁰⁴ Funding levels for this mechanism remained redacted and an implementer was still unnamed. The COP also included a second activity, with a redacted funding amount, to complete population size estimates and behavioral surveillance survey MSM and female sex workers (FSWs).¹⁰⁴ Population size estimation and bio-behavioral survey of FSWs and MSM was also included as one of three programs in a \$200,000 activity implemented by CDC.¹⁰⁴ Finally, MSM were included as part of a \$1.4 million activity to procure and distribute HIV testing kits and supplies as follows: "test kits will be used for behavioral surveillance surveys for HIV prevalence studies amongst MARPS (sex workers and men who have sex with men)."¹⁰⁴

It is important to note that the in-country analysis conducted for this report was not able to uncover much of this work.



Swaziland

MSM were not included in Swaziland's COPs from 2008, 2009, or 2011. Three activities in 2010 specifically addressed MSM. HIV counseling and testing for MSM, FSWs, and mobile populations was one of 13 activities for an \$833,000 mechanism implemented by Population Services International (PSI).¹⁰⁵ PSI also implemented a \$50,000 mechanism in which scale-up of HIV counseling and testing for MSM, FSWs, seasonal workers, and mobile populations was included as one of the mechanism's two activities.¹⁰⁵ Finally, \$200,000 was allocated to a mechanism implemented by The Johns Hopkins University to develop and launch a prevention program for MSM, FSWs, mobile populations and other MARPs.¹⁰⁵



Zambia

Two mechanisms in Zambia's 2007 COP addressed MSM. A \$32,000 mechanism implemented by CDC funded efforts to estimate population size and HIV prevalence by gathering biological and behavioral data from at least 100 MSM in three provinces. The activity description noted a

dearth of data regarding this group because “homosexuality is illegal” and “due to fear of being stigmatized or publicly persecuted [MSM] appear to be predominantly underground.”¹⁰⁶ A similar project, to estimate MSM population size and access to prevention services, was undertaken by PSI through a \$73,000 mechanism.¹⁰⁶ In 2008, \$50,000 was also allocated to CDC to undertake a population size and HIV prevalence estimation project among 433 MSM in Lusaka, Zambia.¹⁰⁶ MSM were also specifically mentioned as one of the population groups that comprised MARPs in the country. Additionally in 2008, MSM were included as one of six target populations for a \$200,000 mechanism related to prevention, though MSM were never mentioned in the program description itself. In the 2009 COP, there were no specific activities or funding allocations for MSM-related activities, though it was noted that results from MSM HIV prevalence and behavioral studies would be finalized and disseminated that year, and that forging partnerships with the private sector to “learn more about the risk behaviors that predispose high-risk populations such as men who have sex with men to HIV infection” would be a priority.¹⁰⁶

While the 2009 COP indicated that MSM HIV prevalence data would be released, the 2010 COP makes no mention of this data and instead reports “...sex between men remains illegal and taboo...the hidden nature of th[is] sub-group increases the difficulty in reaching them for surveillance purposes or prevention activities.”¹⁰⁶ Prevention activities for MSM were included as a priority in 2010, and population size estimates for MARPs were included in 2011. In neither the 2010 nor 2011 COPs were specific activities or funding allocations made for MSM.



Zimbabwe

MSM were not mentioned in Zimbabwe’s 2008 and 2009 COPs. In 2010 and 2011, MSM were included as a target population for an antiretroviral treatment (ART) outcomes evaluation project in its implementation stage, but no funding data or details were provided in either COP.¹⁰⁷

Conclusion

After almost 10 years of PEPFAR investment in the HIV epidemic in these six countries, there is little progress to show against the disease among GMT. While recent policy shifts should not be understated or undervalued, they come incredibly late in the response to the disease in the region. The need for programs serving MSM as stated by epidemiological surveillance and in legislation guiding PEPFAR remains unrealized.^{108,109,110}

After almost 10 years of PEPFAR investment in the HIV epidemic in these six countries, there is little progress to show against the disease among GMT.

These six countries comprise 10 percent of all of PEPFAR investments over the period examined, and yet investments in programs meant to serve MSM were negligible in COPs. Recent trends in Malawi, Namibia, and Swaziland are encouraging, but data in this analysis show that year-to-year funding for activities supporting MSM is volatile. It is unclear whether FY 2012 COPs will show similar levels of support.

The COPs reviewed in this analysis also point to important issues around transparency and accountability. Researching and identifying programs for MSM and other key populations is

extremely difficult. As early as 2007, MSM are mentioned in overall program summaries but disappear in activity and budget level narratives in many countries. Redactions further obscure the ability to understand even the most general details of a program.

As with the previous report in this series, there continue to be instances in which data collection supersedes or replaces actual programming. Even as late as 2010, when independent studies had already proven the burden of disease among MSM in the region,^{110,111} programming extended no further than surveillance—thus making it appear as if strategic information was the real impediment to investment for MSM.

There are some encouraging signs, however. The sudden increase in investment in Malawi in FY 2010 demonstrates how quickly underinvestment can begin to turn around. As a result, Malawi remains a promising case study for how PEPFAR can begin to change its history of neglecting the MSM part of the HIV epidemic. The Malawi country chapter below elaborates on important developments there.

Country Reporting



Botswana

With national HIV prevalence of 23.4 percent,³ Botswana has one of the world's most severe HIV epidemics. The epidemic has long been generalized, with heterosexual and vertical transmission presumed to be the main modes of transmission.

Little is known about HIV among GMT in the country. The Botswana AIDS Impact Surveillance of 2008 (BAIS III) did not collect data on GMT, but prevalence among the population appears to be broadly similar to the population overall.¹¹² According to the UNAIDS 2010 global HIV report,¹¹³ an estimated 20 percent of MSM in Botswana are living with HIV; another study, from 2009, estimated 19.7 percent HIV prevalence among MSM in Botswana.¹¹⁴

A relatively comprehensive 2009 study found substantial differences in HIV prevalence by age, with the highest being among men over the age of 30 years (46.7 percent).¹¹⁴ According to estimates in the Botswana UNGASS Country Report from 2010, MSM were likely to contribute 6 percent of projected new infections in 2011.¹¹⁵

The first analysis to explore bisexual concurrency among MSM in several countries, including Botswana, found overall rates of HIV infection nearly twice as high as national prevalence estimates for all men of reproductive age. Of 117 men, 43.6 percent self-reported being bisexual and 56.9 percent had used the internet to find a male sexual partner in the last six months.¹¹⁶ Other studies have had similar findings.¹¹⁷

Landscape

In the government sector, the National AIDS Coordinating Agency (NACA) coordinates the implementation of the multisectoral national response against HIV, in addition to providing policy guidance to other sectors. District and sub-district multisectoral AIDS committees mainly coordinate and promote response programs at the local level.

The Botswana Business Coalition on AIDS coordinates HIV interventions in the private sector. Civil society organizations have formed several networks—such as the Botswana Network of AIDS Service Organizations, the Botswana Network of People Living with HIV and AIDS, the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) and the Botswana Christian AIDS Intervention Programme—to support and promote coordination, networking, and collaboration among them.

BONELA and Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) are the two main NGOs that advocate for the rights of GMT. Both receive funding and support from international organizations and donor governments to further their efforts. In their advocacy work, BONELA and LeGaBiBo seek to inform the public about LGBT issues; put pressure on policy makers and service providers to be accountable for providing services to GMT; reduce stigma and discrimination against sexual minorities; and reform the current discriminatory legal regime in regards to LGBT. Both groups use media as an advocacy tool.

Challenges and obstacles to adequate services for GMT

Stigma, discrimination, and the legal environment

Same-sex practices are criminalized under two sections of the Botswana Penal Code. Section 164 states that “any person who has carnal knowledge of any person against the order of nature...or permits carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable for imprisonment for a term not exceeding seven years.” Section 167 states that individuals who commit acts of “gross indecency” with another person are “guilty of an offence.”¹¹⁸

These two sections of the Penal Code are rarely enforced. Yet both were upheld by the High Court of Botswana in 2002.¹¹⁹ The court held that the State may enact legislation that overrides the freedoms of association and conscience, and the right of privacy, in order to defend “public morality.” Therefore, laws prohibiting same-sex practices under the labels of “unnatural carnal knowledge” and “gross indecency” do not violate constitutional rights.

Many advocates believe the court’s decision was improper because the Constitution of Botswana provides for the protection of fundamental human rights and basic freedoms for individuals. In 2011 LeGaBiBo initiated a lawsuit, *Youngman v Attorney-General*, seeking a declaration that Section 164 is unconstitutional as it is discriminatory both in itself and in effect against persons on the basis of sexual orientation—and that as such it should be repealed. This action came after the government again denied LeGaBiBo’s application to be registered, a decision that the organization and its supporters argue is a violation of the constitutional right to freedom of association. The organization and its lead plaintiff, Caine Youngman (a member of LeGaBiBo), subsequently withdrew the case in order to collect additional information and support to more successfully present its claims in court. LeGaBiBo has vowed to re-file the case after additional supporting evidence has been collected.

Many influential individuals and organizations oppose any change in the current legal code. For example, the Evangelical Fellowship of Botswana (EFB) strongly objects to the decriminalization of same-sex practices in Botswana and has urged the government and the general public to disregard and block efforts aimed at achieving that goal by BONELA, LeGaBiBo, and other organizations. EFB rejects advocates’ arguments for decriminalization by arguing that such practices contravene the cultural traditions and religious beliefs of most people in Botswana.¹²⁰

The advocates’ efforts have also been hampered by the lack of nondiscrimination laws or regulations that specify protections for specific key populations and other vulnerable groups such as people living with HIV, MSM, and other sexual minorities. Moreover, the government uses the Penal Code’s provisions as basis for repeatedly denying official registration of groups that focus on issues related to the LGBT community.

The existence of laws forbidding same-sex sexual conduct has also given legitimacy to political leaders in Botswana to make undisguised anti-homosexuality statements as well as fuel stigma and discrimination against those engaged in same-sex practices. In 2011, Pono Moatlhodi, deputy speaker of Parliament, was quoted as saying the following during a meeting organized by BONELA and the Parliament AIDS Committee to discuss the provision of condoms in prison:¹²¹ “On this point I would agree with Zimbabwean President Robert Mugabe, who once described that behavior as that of western dogs; I don’t like those gay people and will never tolerate them. They are demonic and evil.”

Other politicians currently in office have been a bit more open-minded, but they rarely show political will to make substantial legal and policy changes to benefit GMT. For example, when asked his opinion about current laws and policies, the MP for Serowe North East, Ramadeluka

Seretse, said the following in 2011:¹²² “I am a Christian and a Motswana. I can tell you the majority of Botswana will not accept LeGaBiBo’s views. But contemporary politics allows that minority rights should also be recognized, even though the laws of Botswana do not recognize some of them. I am one of the people who need to be educated about that [homosexuality]. Because of my Christian beliefs, it is difficult to say I support that, but I am [also] a politician.”

Botswana does not have specific legislative provisions to criminalize the transmission of HIV. However, Section 184 of the Penal Code states that a person who “unlawfully or negligently does any act which is...likely to spread the infection of any disease dangerous to life, is guilty of an offence.” Based on that language, people living with HIV could be prosecuted for transmitting HIV, although as of August 2012 no one had ever been charged with that specific offence in Botswana.

Botswana is one of the few African countries where politicians have talked openly about homosexuality in positive ways. For instance, in 2000, then-President Festus Mogae urged the nation “not to be judgmental” towards groups vulnerable to HIV, including MSM, prisoners, and sex workers.¹²³ Mogae, who currently chairs the Botswana National AIDS Council (NAC), continues to speak openly about decriminalization. In a 2011 interview with BBC, he called for the legalization of same-sex practices and prostitution, arguing that such changes are critical to help address the HIV epidemic.¹²⁴ In particular, he has said that the current laws and associated HIV-related discrimination effectively exclude a whole community of people from participating in HIV prevention programs.

The relatively progressive environment in Botswana compared with most of the rest of region is underscored by some important policies and laws intended to shield GMT and people living with HIV from discrimination. The Botswana Employment Act provides for nondiscrimination of people based on their health status or sexual orientation in the work place. Sexual orientation has since been recognized as a principle for nondiscrimination in several government instruments, for example Section 24 (d) of the Employment Act (CAP 47:01). The introduction of the Public Service Act of 2008 gave protection to employees from discriminatory treatment or prejudice because of their HIV status. As such, employees cannot be denied promotions or opportunities for further education because they are living

In addition, the *National Strategic Framework 2011–2016 (NSF II)* states that the national HIV response upholds individual and human rights by promoting the dignity, nondiscrimination, and welfare of all people, whether infected or affected by HIV. The framework further prioritizes equal access to health and social support services regardless of race, creed, religious or political affiliation, sexual orientation, or socio-economic status.¹²⁵

Other key policy documents have been less welcoming from the perspective of GMT and other sexual minorities. The 2010 draft National Policy on HIV and AIDS was not presented to Parliament for approval in 2011 because of pressure from BONELA, which objected that the policy was not based on the human rights approach because it excluded MARPs such as sex workers, gays, lesbians, bisexuals, and transgendered and intersexed persons. The draft policy was later reviewed to consider BONELA’s recommendations and, as of August 2012, was expected to go through Parliament within the following couple of months. Advocates were optimistic given assurances that all the recommendations were accepted. However, it is worth noting that the final draft was not shared with BONELA to verify that all its demands were included before finally being sent to Parliament.

The existence of some important laws and policies supporting the rights of MSM and people living with HIV is undoubtedly beneficial. But the overall impact of such steps forward is muted by the unreformed Penal Code. The government’s use of Section 164 to deny LeGaBiBo’s registration highlights the negative and discriminatory effects of the current legal regime despite hints of progress.

Access to and quality of health services

Discriminatory laws against GMT help perpetuate stigma against them, thereby limiting their ability to access essential health services. One study in Botswana found that less than 15 percent of LGBT respondents shared information about their sexual orientation with their doctors¹²⁶ and another found that, for those who did share, disclosure was highly associated with denial of health services.¹¹⁷

The HIV and broader healthcare needs of GMT are rarely noted or addressed in public-sector facilities, which provide most health services. There are no social workers, doctors, or nurses with training to provide competent services to address the specific health needs of the population.

The government recently appeared to recognize the importance of bridging such gaps. HIV prevention has been identified as priority number one in the Botswana national response, and key populations are identified as needing special attention if the country is to achieve zero new infections by 2016. Therefore, as noted elsewhere in this country chapter, the government has supported a MARPs situation analysis to better understand the size of key populations, the specific behaviors associated with them, where they are based, etc.

One study in Botswana found that less than 15 percent of LGBT respondents shared information about their sexual orientation.

Although HIV knowledge was found to be high among MSM, risk behaviors such as multiple partners (both male and female), inconsistent or no condom use, and alcohol and drug use reportedly are common. In addition, among MSM who reported using lubricant, only 50 percent reported using water-based products—with the remainder using petroleum-based products, which can weaken condoms and cause them to break.¹²⁷

In 2009, BONELA's Prevention Research Initiative for Sexual Minorities (PRISM) program launched a needs assessment report on the LGBT community in Botswana. The report highlighted some of the key barriers preventing GMT from accessing HIV prevention and care services. Among the obstacles were i) lack of knowledge about existing services and their rights to access them, and ii) the discriminatory practices of the government healthcare facilities providing those services.

The failings of the health facilities include not providing specific and targeted information on the health needs of GMT. The lack of a conducive environment for GMT effectively excludes them from adequate and comprehensive access to the services they need. Most members of the population are unwilling to disclose their sexual orientation out of fear of being stigmatized, denied services, or even reported to the police.

Government response and engagement

The national HIV response in Botswana is funded primarily by the public budget. The government currently spends more than \$200 million per year to address the epidemic, and it is regularly cited as having developed one of the best responses on the African continent. Yet, although the government is considered a model for public-sector engagement in HIV prevention, treatment, care, and support interventions, GMT and members of other criminalized populations rarely benefit.

The government has never initiated targeted HIV information and education programs for GMT, for example. It also has refused to provide or allow the provision of condoms and lubricant to prisoners. That lack of support represents a major concern as same-sex practices in prisons generally occur among men who do not necessarily identify as gay, and once released they often have sexual activity with women who are not likely to consider themselves at risk.

Recent government-supported initiatives offer hope that such targeted programming will eventually come. The Botswana National Strategic Framework (NSF II 2010–2016) states that “... more research is also needed on the negative impact of stigma and discrimination against most-at-risk populations since they seem to erect and reinforce social barriers that inhibit health seeking behaviours.”¹²⁸ The National Operational Plan (NOP) further notes that the framework has prioritized prevention, care, and support for MARPs, including MSM, as one of the critical areas for the national prevention response. The NOP has mainstreamed interventions that will promote and strengthen human rights strategies; among those interventions are ones that address issues of stigma, discrimination, and universal access to HIV services by all people, including MARPs. The plan calls for having adequate mobilization of communities and specific interventions designed and implemented that target MARPS.

Also of note is the National Condom Marketing Strategy and Implementation Plan 2012–2016, which is intended to increase the accessibility and availability of condoms by removing barriers, especially for MARPs. The strategy takes into account the specific needs of MARPs and was drafted to ensure that those specific needs are considered in all accessibility planning... MSM have been identified as a focus of the marketing plan’s efforts, but currently there is no mention of condom-compatible lubricant in the document.¹²⁹ LeGaBiBo and BONELA are strategic and implementation partners.

The initiatives and strategies mentioned in the two paragraphs above represent a major shift by the government to provide targeted services for GMT. They are being developed at the same time as the Ministry of Health has begun to implement a nationwide mapping exercise of the MSM population, with particular focus on HIV prevalence and risks. The results of that survey are expected to prod the development of a minimum health service package for MSM. Most of these efforts are in the preliminary stage, so it is not clear whether the hopes and expectations of MSM and other MARPs will be realized in the near future, let alone by 2016 (the final year of the National Strategic Framework 2010–2016).

The government is also supporting some important research initiatives that will ideally inform future programming for MSM. The Botswana HIV and AIDS Research Agenda 2011 was developed by NACA and stakeholders with the goal of promoting evidence-based planning. Two research projects that included MSM were planned in 2012, one by the University of Botswana, sponsored by the Southern African Development Community (SADC), and another jointly undertaken by the Ministry of Health and FHI 360. The university’s study, for example, was designed to measure the extent to which sexual minorities are being reached with services and identify facilitating and inhibiting factors for effective HIV prevention. The short-term objective was to provide information that will lead to changes in the legal and policy framework and create an enabling environment for inclusive HIV prevention interventions. Results from the study had not been released by the time this report was finalized.

Global Fund support and engagement

BONELA has represented the needs of GMT on the country coordinating mechanism (CCM). The Botswana CCM has a task force that conducts consultations with several sectors when they develop country proposals and design programs. LeGaBiBo was consulted during proposal-writing stages for the Round 10 and 11 proposals. The country’s Round 10 proposal, which was

not approved, included GMT in epidemiological surveillance along with several other populations. Botswana, in that proposal, was the only country of the six in our research to include transgender individuals in any Global Fund proposal.

There are no Global Fund-supported programs serving GMT in Botswana.

U.S. government support and engagement

The U.S. government, through PEPFAR, has invested in infrastructure development, the healthcare workforce, technical assistance, and procurement. In 2009, PEPFAR contributed \$92 million to support the HIV response in Botswana. According to the Botswana Partnership Framework for HIV and AIDS 2010–2014, the annual level of support is likely to slowly decline each year over the next five years.¹²⁸

PEPFAR funding supported research on MARPs, including MSM, in 2012. The goal was to generate baseline information regarding the incidence and prevalence of HIV, the prevalence of other sexually transmitted infections, and the risk factors for HIV (including among MSM).

This study reportedly is the first such HIV surveillance survey of these sub-populations conducted in Botswana. It is also unusual in that it has sought out partnerships with civil society by establishing collaborative arrangements with LeGaBiBo, BONELA, and some community-based organizations (CBOs) to assist with the organization of field research activities, the pilot-testing and adaptation of data collection instruments, and the identification and recruitment of potential participants.

Recommendations

The following recommendations are advanced to improve the delivery of and access to comprehensive HIV services for GMT in Botswana:

- The government of Botswana should decriminalize same-sex practices between consenting adults, as well as promote other equitable policies related to full access to public and private services.
- The Global Fund, PEPFAR, and the U.S. Agency for International Development (USAID) should fund GMT programs and work with the Ministry of Health to create GMT health-related services.
- PEPFAR and the Global Fund should provide direct funding to the main LGBT organizations—BONELA, LeGaBiBo, and Rainbow Identity. This is necessary for them to build and sustain greater capacity to lead a strong movement advocating for equitable access to public and private services, as well as decriminalization of consensual same-sex practices.
- The Global Fund should provide targeted technical assistance to Botswana stakeholders, including those on the CCM, to develop proposals that adequately reflect epidemiological surveillance, the latest science, and best practice in HIV services for GMT.
- Civil society organizations should develop a collaborative agenda that promotes accountability and the mainstreaming of the healthcare needs of GMT in the national HIV response.



Malawi

According to UNAIDS, current adult HIV prevalence in Malawi is estimated at 10 percent.³ Transmission is presumed to occur primarily through heterosexual and vertical transmission from mother to child. Fortunately, through intense efforts to scale up access to HIV testing and linkage to treatment for those living with HIV to prevent heterosexual and vertical transmission, the rate of new infections has significantly slowed over the last eight years. Little information is known about the size of the GMT population in Malawi or the specific HIV risks and prevalence associated with it. One reason is that the HIV surveillance system has traditionally excluded populations such as GMT and female sex workers who in other settings have long been known to be at high risk for HIV.

Recently, studies have been completed among both of these populations demonstrating consistently high prevalence of HIV, thereby challenging the traditional assessment of the drivers of the HIV epidemic in Malawi. The most recent UNAIDS report (2012) cited prior estimates by the Centre for the Development of People (CEDEP), the Malawi College of Medicine, and The Johns Hopkins University indicating 21.4 percent HIV prevalence among MSM compared with 8 percent among the general adult male population. In addition, 95 percent of those men who were found to be living with HIV were previously unaware of their status and thus not linked into HIV care; as such, they are at high risk for transmitting HIV to sexual partners.¹¹⁶ The increased prevalence is consistent with data from other settings in Southern Africa.

Landscape

Funding for HIV activities in Malawi has increased over the years from \$29.1 million in 2002–2003 to \$107.43 million in 2007–2008, largely due to the commitment of development partners.¹³⁰ However, the amount of funding for HIV projects specifically targeting MSM remains low, though the actual total is unclear.

The government has never budgeted funding specifically for GMT projects. What money is available comes largely from PEPFAR and USAID. UNAIDS has played a major role in providing technical support, including capacity building, as well as to purchase and dispense condoms and water-based lubricant.

Those agencies work closely with local organizations—such as CEDEP, the Malawi Network of Religious Leaders Living or Personally affected by HIV/AIDS (MANERELA+), the Malawi College of Medicine—and international organizations—such as PACT and Population Services International (PSI). The Malawi Centre for Human Rights and Rehabilitation has also provided advocacy support on behalf of GMT. Targeted funding has also been provided for GMT-related activities in Malawi by AIDS Fondet in Denmark, Hivos, and amfAR.

CEDEP is known to be the most active civil society organization (CSO) defining the needs of and designing programs for GMT. Since 2005, CEDEP has completed several research projects focused on GMT in partnership with the Malawi College of Medicine and The Johns Hopkins School of Public Health. These studies have included characterizing the prevalence of HIV among MSM, the size of the population, and the impact of stigma. More recently a prospective cohort of MSM has been followed since 2011 to estimate the rate of new infections among MSM in Malawi.

In general, however, there is limited support for GMT-specific HIV projects. CSOs working on such issues have limited scope to design and implement tangible programs specifically for GMT. Outreach efforts, often undertaken through a “peer approach,” tend to focus on raising awareness on HIV preventive measures and distribution of condoms and lubricant.

Challenges and obstacles to adequate services for GMT

Stigma, discrimination, and the legal environment

Same-sex practices are illegal in Malawi. Authorities enforce the law, as seen in a highly publicized case from 2010 when two people, Steven Monjeza and Tiwonge Chimbalanga, were sentenced to 14 years in prison on three charges of “unnatural practices” between males and “gross indecency.” International pressure is thought to be one reason the country’s then-president, Bingu wa Mutharika, freed them on “humanitarian grounds” shortly thereafter—though it was clear he and most other Malawian officials supported the conviction.¹³¹

The repressive legal environment both reflects and perpetuates stigma and discrimination against GMT throughout Malawian society. Most GMT remain underground, unwilling to disclose their sexual practices for fear of harassment, abuse, or even arrest.

There are signs of possible improvement after Joyce Banda became president following Mutharika’s death in April 2012. President Banda has said she wants to overturn the country’s legal ban on same-sex practices. Most notably, in her first state of the nation address to Parliament in May 2012, she said, “Some laws which were duly passed by the august house... will be repealed as a matter of urgency... these include the provisions regarding indecent practices and unnatural acts.”¹³² Repeal is only possible with the approval of Parliament, however, and it is not clear if there is sufficient support. Most Malawians also appear to oppose decriminalization as the country is culturally and religiously conservative in general. As of September 2012, no specific action had been taken toward reducing the punitive legal contexts for GMT.

The repressive legal environment both reflects and perpetuates stigma and discrimination against GMT throughout Malawian society. Most GMT remain underground, unwilling to disclose their sexual practices for fear of harassment, abuse, or even arrest. Their concerns are validated by reports of men being fired from their jobs or blocked from renting a house if identified as (or accused of) having engaged in same-sex practices.

Although organizations working with GMT support the repeal of the discriminatory laws, many say their immediate priority is the health needs of the community. High levels of stigma limit both the provision and uptake of comprehensive and effective healthcare access for many individuals. A 2009 U.S. Department of State Human Rights Report on Malawi found that “societal violence and discrimination based on sexual orientation occurred” and stated that “approximately 34 percent of gay men in the country had been blackmailed or denied services such as housing or health care due to their sexual orientation.”¹³³

Access to and quality of healthcare services

The negative attitudes of healthcare personnel greatly limit the ability of most GMT to be open about their sexual practices when seeking care. Many reportedly fear being rejected and lack trust in the healthcare system in general. As a result, they may not seek out health care and information even when in need. Those who do visit health facilities often do not receive comprehensive care because they are unwilling to reveal their sexual orientation or

other important information. In both cases, the individual's vulnerability to the acquisition and transmission of HIV and STIs increases.

The vulnerability is underscored by the low level of knowledge about HIV and the lack of adequate information or resources regarding sexual health and sexuality. The 2007 CEDEP survey¹³³ and desk research for this report indicate that consistent condom use among MSM remains low in sex with other men as well as with their female partners.

GMT in the urban areas have better access to HIV-related healthcare services, condoms, and lubricant compared with their counterparts in rural areas. The main reason appears to be the availability in urban areas of clinics run by nongovernmental institutions such as Johns Hopkins Malawi and Banja La Mtsogolo (both in Blantyre), many of which uphold confidentiality to a greater extent and employ staff who tend to be more welcoming of GMT. However, some of the nongovernmental clinics charge user fees for those accessing care and treatment, thus hindering access for GMT with limited disposable income. Participants reported that some GMT are forced to seek free services at government-operated health facilities that are often not welcoming or accommodating to them or their needs. To address these difficult contexts, in 2011 amfAR supported Fenway Health, The Johns Hopkins Bloomberg School of Public Health, and CEDEP to complete intensive training for health service providers to increase the cultural and clinical competence in addressing the needs of MSM in Blantyre. In addition, MSM peer educators from CEDEP—supported by USAID, amfAR, the Open Society Foundations (OSF), and AIDS Fondet—act as health system navigators to guide their peers towards seeking care at providers who participated in the training.

Respondents provided anecdotes reinforcing the negative impact of discrimination in healthcare access, noting that some MSM are “not accepted” in many hospitals if their sexual practices are disclosed. The attitudes of healthcare workers can range from dismissive to punitive. According to one interviewee, an individual from the GMT community seeking treatment for an STI returned with a man and was told by a healthcare provider: “I told you to bring your female partner, not another man.” The potential client was denied care and nothing further was done at that clinic, despite the fact that a partner-notification process is supposed to be initiated at all STI clinics for all clients.

Another respondent said the following, “Once we mention our sexual orientation in the consultation room, the medical personnel would immediately call the police. We have to bribe the police [in order to be] treated; otherwise the police are highly empowered by the law to arrest us.”

Government response and engagement

To date, there are no government programs that support the needs of GMT in Malawi, including in regards to HIV. The government's refusal to provide such support seems to constitute a decision to contradict its own 2009–2013 National HIV Prevention Strategy. Released by NAC in June 2009, the comprehensive document includes Strategic Approach 6.1.5: “Improve access to HIV prevention services and products to vulnerable populations.”¹³⁴ The “broad activities” specified for this approach were as follows: “Develop tailored interventions for populations who are vulnerable to HIV infection because of their behaviors or environments (sex workers, MSM, prisoners, etc.).”

The government's inaction regarding GMT is mirrored in its refusal (to date) to focus on the incarcerated. This persists despite clear evidence of higher rates of risk in penitentiaries. For example, a study conducted in Thyolo district over two years through December 2001 found that 4.2 percent of 4,229 inmates covered by the study were diagnosed with an STI—and that of those, one third had acquired their infection within the prison setting.¹³⁵

Global Fund support and engagement

Malawi has received three HIV/AIDS grants from the Global Fund, for Rounds 1, 5, and 7. The issues and needs of GMT are not addressed in any of them. The most recent grant, for Round 7, would seem to have direct relevance for GMT because of its title: “Intensifying HIV/AIDS Behavioral Change Communication (BCC) for all and Scaling up of HIV Prevention Services for Young People in Malawi.” Two of the specified program areas also appear relevant to GMT: i) strengthening of civil society and institutional capacity building, plus stigma reduction in all settings; and ii) condom distribution, behavioral change communication, and community outreach.

Yet neither the original proposal nor the program agreement discusses GMT, including the potential development of targeted programming for them. Similarly, GMT are not mentioned in the proposal for the Rolling Continuation Channel (RCC) grant that followed the Round 1 grant. The oversight here is especially remarkable because Malawi was awarded more than \$300 million in its successful RCC application.

Respondents to this research from NAC, the principal recipient (PR) of all Malawi Global Fund HIV/AIDS grants, confirmed that no money has ever been allocated for GMT-specific activities. They said, however, that MSM are likely to benefit because the population is among those included in a broader “high-risk” pool. As such, they added, funds allocated for that broader pool may have reached MSM and groups working with and for them.

U.S. government support and engagement

Through PEPFAR, the U.S. government is an important donor for Malawi’s HIV/AIDS response. Malawi received \$155.4 million to support comprehensive HIV prevention, treatment, and care programs from FY 2004 to FY 2009.¹³⁶ PEPFAR funds a broader “high-risk” pool that includes MSM. Some of the programs in this category have been implemented by CEDEP, PSI, and PACT and focused on training of peer educators and condom distribution with more recent support for the distribution of condom-compatible lubricant.

However, to date the support has been limited and seems unlikely to change based on the five-year Partnership Framework signed by the U.S. government and Malawi in 2009.¹³⁷ The document does not mention MSM at all, including in regards to a key prevention goal (“To reduce new HIV infections.”) or in regards to the goal on treatment, care, and support (“To improve the quality of treatment and care for Malawians impacted by HIV.”) Given the needs and vulnerability of MSM in the country, it would seem as though the population would be an important priority. But nothing about them is noted.

PEPFAR’s FY 2010 planning for Malawi seems to offer some optimism to GMT. For that period, PEPFAR agreed to allocate a total of \$55.28 million to Malawi, of which \$32.89 million flows through USAID.¹³⁸ PEPFAR’s website states the following about its Malawi support in FY 2010: “PEPFAR will support the key priorities of the National Prevention Strategy, including PMTCT, prevention of sexual transmission of HIV, and prevention of transmission through medical procedures. PEPFAR will also support the [government] with behavior change interventions directed at partner reduction, targeted condom social marketing in high-risk populations and for discordant couples, positive prevention and support for expansion of HCT [HIV counseling and treatment], timely initiation of ART, and increasing access to [voluntary medical male circumcision]...”

GMT would appear to be a logical and important recipient of funding for “targeted condom social marketing in high-risk populations.” Yet it was not clear at the time field consultations for this report concluded whether any GMT-specific funding would be provided through PEPFAR for this period.

Recommendations

- Civil society organizations should develop a unified strategy to prod and support the government to reform the existing legal regime to promote equal access to social services and decriminalize same-sex practices. This effort should focus specifically on repealing the discriminatory laws and statutes, a step the new president supports. The most effective strategy is likely to decouple such a specific goal from other issues, such as same-sex marriage, which have received negative press and attention in the past several months. The focus on discriminatory laws is likely to be the most effective initial strategy to remove barriers to GMT's access to improved HIV services.
- All healthcare services, including throughout the public sector and all other sectors, should be nondiscriminatory and thus user-friendly to GMT. Therefore, the Ministry of Health should initiate training and awareness-raising programs among all health personnel on GMT-related issues so that the services are more accommodating to GMT. The training should include information on HIV risk and transmission as well as a strong focus on reducing GMT-related stigma and discrimination.
- Effective programming is difficult to develop due to the limited data available regarding the GMT population in Malawi. The Ministry of Health, the National Health Sciences Research Committee, and NAC should therefore provide technical support to organizations already focusing directly on GMT issues, such as CEDEP, to conduct a comprehensive assessment of the GMT population. The results of this assessment should provide better estimates of the size of the population, the key HIV risk factors, and overall health needs. Such information is essential for the development of GMT-specific programming and activities in the future. It is also needed to attract donors, most of which will only provide funding and technical support when reliable statistics are available.

Also important to note in this regard: In order to ensure accuracy and transparency, GMT should be included in the design and implementation of programs specifically targeting the population.

- The government should allocate a specific share of its HIV/AIDS budget to GMT-targeted activities, including in the areas of prevention, treatment, and care. At the same time, it should seek to ensure that an evidence-based allocation of Global Fund and PEPFAR money is also targeted to GMT-specific activities. Such a step is necessary to ensure that the population is no longer ignored and to promote the development of truly comprehensive HIV programming in the country.
- In order to ensure that such specific funding is used effectively and efficiently, the government should recognize the value of supporting civil society groups with experience working with and among GMT populations. Organizations such as CEDEP, PSI Malawi, and MANERELA+ should have priority access to funding intended to provide HIV prevention, treatment and care—including scale-up of distribution of commodities such as condoms and lubricant—among GMT. They are trusted by the population and are far more likely to understand how and where support should be provided.



Recent data estimate adult HIV prevalence in Namibia to be 13.4 percent,³ though rates are significantly higher among pregnant women attending antenatal care (ANC) clinics (18.8 percent).¹³⁹ The HIV epidemic in Namibia is assumed to be driven mainly by heterosexual sex and vertical transmission. A 2008 study commissioned by the Ministry of Health and Social Services (MoHSS) identified the drivers of the HIV epidemic in the country as follows: multiple and concurrent partnerships, intergenerational sex, transactional sex, low and inconsistent condom use, low perceptions of HIV infection risk, low levels of medical male circumcision, alcohol abuse, mobility and migration in and outside the country, gender inequality, income inequality, and early sex debut, among others.¹⁴⁰

Little is known about HIV prevalence or incidence among key populations (including GMT). A small-scale study among 218 MSM in 2008 estimated HIV prevalence to be 12.4 percent (including 31.4 percent among men older than 30 years).¹¹¹ Bisexual concurrency was also found to be significant, with 50.4 percent of respondents reporting to have had both male and female sexual partners in the past six months.¹¹¹ Currently, epidemiological surveillance for MSM and FSWs is being undertaken by the MoHSS. It is assumed that the results of this survey, expected to be released in 2013, will provide evidence for policy, programming and advocacy for MSM and other key populations.

According to the MoHSS, the main achievements in the HIV response for Namibia have been an increase in the coverage of HIV counseling and testing, an increase in coverage for prevention of mother-to-child transmission (PMTCT) services, a decline in STI prevalence, an increase in condom distribution, an increase in antiretroviral treatment (ART) coverage, and an increase in HIV/TB diagnosis and treatment.¹⁴¹

Landscape

No domestic (i.e., government) funding is currently allocated to GMT-specific programming. Funding that is available is provided instead by international donors, notably the Global Fund and PEPFAR (through USAID and CDC). The government's main contribution is through the provision of healthcare services, although such support is not targeted specifically for GMT as it is available for all Namibians in need.

Other key stakeholders include civil society and United Nations agencies. The HIV response for GMT in Namibia is mainly spearheaded by civil society organizations (CSOs), including Out-Right Namibia (ORN), an LGBT-led organization. Society for Family Health (SFH) and the Legal Assistance Centre (LAC) have been implementing prevention projects for GMT, including the distribution of lubricant. As part of its efforts, ORN engages community-based facilitators as regional resource hubs to implement its programs in order to expand reach outside the capital, Windhoek, in a sustainable manner.

In the United Nations family, UNAIDS has been working on issues of participation and inclusion of GMT in national planning, research, and programming over the last few years. Although it does not fund any actual programs dealing with GMT, UNAIDS has established and leads a technical working group (TWG) on the removal of punitive and discriminatory policies, laws, and practices. It also regularly invites organizations led by key populations to national workshops, planning meetings, and advocacy forums to ensure their participation in the national response to HIV. More broadly, UNAIDS works closely with the United Nations Development Programme (UNDP) and other agencies in the United Nations system to advance the human rights approach to the HIV epidemic, including in regards to members of key populations.

The United Nations Office on Drugs and Crime (UNODC) has been working with incarcerated persons to ensure that HIV prevention, treatment, and care services are available and accessible for prison inmates. It is currently undertaking a study to determine HIV prevalence and risk behaviors in prisons. Although the study had been completed at the time desk research for this report was conducted, a public release was waiting for the endorsement of the Ministry of Prisons and Correctional Services. In addition, UNODC is financing a prisons program focused on providing prison staff and inmates with knowledge about HIV as well as human rights. The project is implemented by LAC's AIDS Law Unit.

GMT-specific HIV programming

Current programs for GMT in the national HIV response are mostly limited to small group behavior change interventions. With few exceptions, they have been implemented by NGOs at the community level, with members of the LGBT community often involved. It is notable that Namibia has an active civil society engaged on issues related specifically to the transgender community.

Targeted and tailored services for GMT in HIV care and treatment programs do not currently exist. To some extent that may be because the Namibian government has not defined a minimum service package for GMT and instead maintains general services for the public overall. The outcomes of the current study, which will determine the size and needs of members of the MSM population, may determine whether specifically tailored services for MSM should be developed. More work will need to be done to determine the needs of Namibia's transgender community.

The Out-Right Namibia (ORN) program distributes packaged condoms, lubricant, and information brochures at GMT-frequented venues and offers "safe" sites of distribution. Community facilitators also act as referral points to care and treatment for HIV, STIs, and other clinical health challenges as well as to social services for substance abuse and sexual and gender-based violence. They also serve as local advocacy agents on behalf of MSM and other sexual minorities. In doing this, they engage with local hospitals and clinics, the police, and local councils and municipalities when MSM and other sexual minorities are unable to access public services.

Another important ORN activity is its human rights documentation project—funded by amfAR and the Open Society Foundations (OSF). Community facilitators are collecting and documenting incidences of human rights violations with a view to contributing to the publication of the first human rights report for LGBT persons in Namibia. Through this project, the organization engages stakeholders in media and policy making and will use the report as an advocacy tool for policy and legal reform.

Challenges and obstacles to services for GMT

Stigma, discrimination, and the legal environment

Same-sex practices are criminalized as a common law offence under anti-sodomy provisions in the Penal Code. This legal regime makes it difficult for HIV service organizations to reach and provide services to GMT, especially as many remain underground and maintain secret sexual lives. Sex work in Namibia also remains illegal, a situation that increases sex workers' vulnerability to human rights abuses even by agents of the state who are supposed to protect them as citizens.

Efforts are currently under way, as proposed in the 2010/11-2015/16 National Strategic Framework for HIV and AIDS Response (NSF), to review laws that impede the HIV response. A joint working group involving United Nations agencies (UNAIDS and UNDP), CSOs, and academia are working towards engaging the government to remove the discriminatory and punitive laws.

Another major legal challenge stems from the fact that distribution of condoms to incarcerated persons is not allowed. The lack of such an essential HIV prevention commodity greatly increases transmission risks among this particularly vulnerable population.

Access to and quality of health services

Most respondents agreed that targeted programming and tailored health services for GMT were not available in Namibia. Yet while acknowledging that much needs to be done for GMT in terms of the national HIV response, government interviewees stressed that services were available to all Namibians regardless of their sexual orientation or gender identity. Others noted, however, that access to adequate services remains a problem due to high levels of stigma, including self-stigma, and resulting fear of discrimination and violation of rights. Some pointed to the absence of clinical services that are friendly to sexual minorities and key populations while also being sensitive and aware of their HIV and sexual health concerns. As a result, many GMT do not seek out and utilize services they may need.

Donor resources are dwindling and international partners are urging the Namibian government to take fiscal responsibility for the national HIV response. However, the government has not signaled its interest in funding programs related to HIV prevention, treatment, care, and support for GMT.

Anecdotal evidence from GMT seeking and engaged in health care indicates that members of the population experience discrimination, especially when personnel are aware of (or suspect) that they engage in same-sex practices. Some, for example, say they have been treated poorly and in a dismissive manner. It is expected that the forthcoming epidemiological survey report will provide extensive information and data on instances of human rights violations—including in regards to access to services—among MSM and other sexual minorities. The findings will help determine the priority strategies needed to overcome the challenges.

Lack of information about MSM

A notable factor hampering work with GMT from a public health perspective is the lack of strategic information on this population group. As a result, according to some respondents, neither policy makers nor healthcare personnel are aware of the size of the GMT population, the specific needs of GMT, and how those needs might be best addressed. Such data are also important for prioritizing, planning, and budgeting purposes.

Small organizational studies on MSM have been conducted in the past, but they have not sought to determine population size and HIV prevalence. As noted elsewhere in this report, the MoHSS is undertaking epidemiological surveillance among MSM and sex workers to address these questions as well as other issues such as risk behaviors. The results are expected at the end of 2013.

Other challenges associated with MSM-specific programming

- The 2010/11–2015/16 NSF specifically mentions MSM and sex workers and proposes targeted interventions for them. Their inclusion was flagged as problematic at the Cabinet level, which ultimately approves the NSF. Yet following several months of delay, the specific references to MARPs and targeted interventions remained in the final document. Pressure from U.S. government partners (including PEPFAR) and United Nations agencies in Namibia helped ensure that such information and priorities were not removed. The NSF is now being implemented by the government and civil society partners. One of its most important initial elements is the epidemiological surveillance currently being undertaken.
- The government's essential service package (ESP) is limited due to the lack of funding for targeted care and support services for key populations. As a result, programs are not implemented to address the social challenges that make members of the MSM community more vulnerable to HIV infection. Such programs might also be useful in retaining them in HIV treatment, care, and support.
- According to some respondents, quantitative requirements of current donors can hinder their work with GMT on sustained behavior change interventions. The requirements, they said, focus on numbers of GMT reached rather than on the impact (if any) of the interventions.
- Due to Namibia's World Bank status as an upper middle-income country, donor resources are dwindling and international partners are urging the Namibian government to take fiscal responsibility for the national HIV response. However, the government has not signaled its interest in funding programs related to HIV prevention, treatment, care, and support for GMT. A major risk therefore remains that programs currently implemented for GMT and other key populations may not be sustained as donors withdraw. Most of these programs are currently provided by CSOs with support from international donors.

Government response and engagement

The Namibian government has mostly refused to implement programs for GMT despite the inclusion of this population in the latest national strategic framework (NSF). The NSF provides specific indicators, strategies, and budget allocations for programs for GMT, raising the hopes of some that the government may eventually support appropriately targeted HIV services. However, some Cabinet members do not support the NSF precisely because it mentions and prioritizes these groups.

The following are among the important elements of the NSF in regards to MSM. Out-Right Namibia and other CSOs have pledged to work to help achieve the following indicators and targets:

- **Reach for MARPS at national level:** Between 2011 and 2015, a total of 17,000 sex workers, 5,000 prisoners, and 3,000 MSM have been reached with individual or small group HIV prevention interventions that address their needs.
- **More MSM use condoms when having sex with a male partner:** Percent of men reporting the use of a condom the last time they had anal sex with a male partner increases by 50 percent between 2011 and 2015.
- **More MARPs/key populations have correct prevention knowledge:** Percent of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission increases 20 percent between 2011 and 2013 and by 50 percent between 2011 and 2016.

- **Customized HIV prevention programs for MARPs/ key populations:** Percent of MSM who received an HIV test in the last 12 months and who know their results increases to 40 percent by 2013 and 80 percent by 2016.
- **Customized HIV prevention programs for MARPs/ key populations:** Percent of MSM reached with individual or small group HIV prevention interventions that address the drivers of the epidemic increases to 50 percent by 2013 and 80 percent by 2016.

Global Fund support and engagement

Global Fund support for GMT is limited to HIV prevention programming with little to no resources for capacity and skills development of community implementers who provide these services. Out-Right Namibia (ORN), a sub-sub recipient, has experienced capacity gaps in sustainable programming that have hindered its ability to reach MSM with quality behavior change communication interventions.

In the preparations for Rounds 10 and 11 grant applications, Namibia's CCM indicated its willingness to include interventions targeting key populations. However, the country was not successful in its Round 10 HIV/AIDS application and Round 11 was cancelled. Although it is clear there is a new willingness within national bodies to improve programming for GMT, it is not readily apparent what opportunities will be available from the Global Fund itself.

Namibia's CCM currently includes representatives of key populations: the director of ORN holds a seat on the CCM and the organization's LGBT coordinator is an alternate member.

U.S. government support and engagement

Through PEPFAR, the U.S. government has become one of the most important supporters of MSM programming in Namibia. According to PEPFAR, Namibia received \$432.2 million to support comprehensive HIV prevention, treatment, and care programs from FY 2004 to FY 2009.¹⁴² In 2009, a \$5.4 million grant was provided to work with key populations in HIV prevention, institutional strengthening, and advocacy for an enabling environment. This grant is being administered through Society for Family Health, a local CSO that engages a consortium of local NGOs (including Out-Right Namibia) to implement programming.

The Legal Assistance Centre's AIDS Law Unit is also involved in this project, specifically to deliver the human rights aspects. It is working with organizations led by key populations to roll out a Know-Your-Rights campaign with MSM in the country as well as provide legal advice and serve as a referral point. Another partner is the Namibia Planned Parenthood Association (NAPPA), the local chapter of the International Planned Parenthood Association, which is focusing on the provision of competent and friendly clinical services for MSM. NAPPA currently operates specialized clinics in Windhoek and Katima Mulilo, but plans to open an additional three (with USAID support) in 2012 in Walvis Bay, Oshikango, and Keetmanshoop.

USAID also has donated lubricant for MSM in the country; it is currently distributed by Out-Right Namibia's community facilitators as part of the organization's behavior change communications work among the population.

Another U.S. government entity, CDC, is working closely with the MoHSS to conduct the epidemiological survey underway among MSM and sex workers. The agency is funding the assessment and technical assistance is being provided by the University of California at San Francisco. In this study, CDC has sought to ensure community participation by working with

organizations led by key populations and including MSM and sex workers as interviewers, data collectors, and as community liaisons. Inclusion of this sort is also seen as an important way to reach MSM.

Consultations revealed potential changes in U.S. government engagement moving forward, with some of the likely changes to be of concern from the perspective of GMT in the country. The U.S. government reportedly has not earmarked further funding for Namibia apart from the grants being used for current programs, including those discussed above. Contributions are also expected to diminish over time, partly because U.S. government donor priorities emphasize countries categorized in less advantageous income categories, regardless of the realities behind such categorization. Reduction in support is likely to occur regardless of the Namibian government's ability or inclination to sustain programming for GMT in the future.

Recommendations

- The law reform and development commission under the Ministry of Justice should prioritize the review of the current anti-sodomy law and Out-Right Namibia should advocate for this process to be undertaken during the lifetime of the current National Strategic Framework for HIV and AIDS Response (NSF).
- A dialogue is encouraged among GMT-led organizations, the Namibian government, and donors to ensure that the HIV response for GMT is not endangered when donors withdraw. This dialogue should focus on ensuring that the government is able and willing to “own” and sustain the GMT programs currently being rolled out in Namibia. UNAIDS should take the lead in bringing partners together. Its role and engagement are important because it is one of the main sponsors of the strategic investment framework for HIV that is being proposed as a model for future global, national, and community engagement.¹⁴³
- There is a need to go beyond HIV and gather strategic information on and about GMT in other aspects of life. Civil society groups should work with the MoHSS and/or the National Planning Commission to undertake a review of issues other than health and sexual practice that make GMT more vulnerable to HIV. Such issues might include legal obstacles and lack of employment and social support. Many respondents to this research stated that such challenges must be better understood in order to craft the most effective strategies to support GMT overall.
- The MoHSS should, in partnership with UNAIDS, strengthen structural aspects of combination prevention at the national level in order to reach GMT with comprehensive services. For example, the MoHSS should offer a health provider sensitization course on GMT issues.
- With technical assistance from United Nations partners, the MoHSS should define and endorse a minimum service package for GMT.
- Through the ongoing epidemiological survey, the Namibian government has started the process of collecting data on GMT and other key populations in the country. It will be critical that the recommendations of the research are implemented by the MoHSS once they are available. In the meantime, the government should leverage existing epidemiologic and program data on GMT in Namibia (there is no data on transgender populations currently) to begin the process of planning for what will almost certainly be recommended in the survey, including i) an allocation for GMT in the national budget, ii) roll out of targeted GMT programs, and iii) regular monitoring of uptake and use of services by members of the population. All of these steps are critical to ensure that the HIV epidemic among GMT is arrested in the country.



Swaziland

Swaziland is burdened by one of the world's worst generalized HIV epidemics, with an estimated 26.1 percent of adults currently infected.³ That is the world's highest HIV prevalence rate. HIV prevention strategies and policies have been based on the notion that the primary transmission mode is only through heterosexual sexual activity, as was highlighted in the National Health Policy 2006. Despite a lack of data, evidence from similar sub-Saharan Africa countries suggests that MSM are at heightened risk for HIV infection in Swaziland.^{5,9}

The assumption that GMT do not contribute meaningfully to the transmission of HIV in Swaziland has resulted in their absence in policy and implementation strategies in country. The legal environment compounds that, but change is happening slowly. PEPFAR has recently extended their definition of MARPs to include MSM (but not transgender individuals) which has had a positive impact on major PEPFAR implementers such as Populations Services International (PSI). Similarly, the Global Fund country coordinating mechanism (CCM) and other policy making bodies in Swaziland have come to recognize the need to engage organizations serving GMT.

Landscape

The government continues to deny the existence of GMT and therefore has not invested any funding in GMT-specific HIV programming. Some civil society organizations have undertaken work of relevance to the greater LGBT community, including awareness raising and capacity building. The extent and impact of those efforts are limited, as indicated by the following comment from one discussant:¹⁴⁴

SWAPOL [Swaziland for Positive Living] initiated a program in 2010 with support from the Open Society Initiative for Southern Africa, which was more about creating awareness on LGBT issues. Among the outcomes was the establishment of a group called House of Our Pride, which is no longer functioning due to funding issues. Also, PSI Swaziland and Family Life Association of Swaziland are doing some work on their own [regarding the LGBT community]...but it is difficult to have details of what exactly is being done in terms of programming and the coverage as well.

PSI, with funding from PEPFAR, provides condoms and condom-compatible lubricant for distribution through peer networks among GMT in a limited number of settings. Family Life Association (FLAS) on the other hand has two clinics in Manzini and Mbabane that provide targeted treatment of STIs free of charge for MSM below the age of 24. SWAPOL, meanwhile, provides training on human rights and advocacy for MSM.

Challenges and obstacles to adequate services for GMT

Stigma, discrimination, and the legal environment

There are no laws in Swaziland that specifically prohibit same-sex practices, but such practices are understood to be illegal under the Sodomy Act. A person convicted of sodomy can be subject to imprisonment for not less than two years. Same-sex practices can also be charged as indecent acts or a public nuisance under common law.

There are no anti-discrimination laws protecting or even mentioning GMT in Swaziland and recently public officials have taken conflicting stances on issues related to this population. For example, the deputy prime minister defended a person who had apparently undergone a sex change while the prime minister was quoted recently as stating that there are no gays in Swaziland.^{145,146}

A study published by USAID's Research to Prevention task force found that more than one-third of MSM in Swaziland reported having been tortured due to their sexual orientation.¹⁴⁷

Access to and quality of health services

Awareness of how HIV is transmitted between partners of the same sex is low among Swaziland's GMT population. The same USAID study found that only 18.3 percent of Swazi MSM participants knew of the heightened risk of contracting HIV from receptive anal sex. In the same study, while three quarters of all participants reported having received HIV prevention information on sex between men and women in the last year, less than 21.4 percent had received prevention information relating to sex between men in the same time period. Moreover, more than half of the participants reported either no access or difficulty in gaining access to water-based lubricant.¹⁴⁷

In general, it is difficult to determine the quality of healthcare services available to GMT in Swaziland. According to respondents, no clinics that deal directly or specifically with GMT exist. FLAS has a MARPs wing in both its clinics providing treatment for STIs. These services have an urban skew, however, and there are none in the rural areas except for a FLAS outreach program. Some stakeholders noted a shortfall in the distribution of lubricant and condoms for GMT.

Clinicians who are not sensitized to GMT and their specific health risks are often unable to offer sufficient care for the population. The 2013 USAID study mentioned previously found that about one in five (19 percent) felt that they had received lower quality medical care due to their sexual orientation, only 33.3 percent of MSM living with HIV reported receiving HIV treatment, and only 51 percent of MSM who tested positive for HIV in the study were tested for HIV within the past year.¹⁴⁷

Respondents revealed that although the situation for MSM in urban areas has improved with more exposure to social media, the situation remains far worse in rural areas where stigma associated with same-sex practices and GMT is especially strong. Transgender populations remain unmentioned and underserved. This environment heightens fear of disclosure and further limits potential efforts to set up targeted interventions. The growing gap perpetuates an urban bias in the provision of healthcare services for MSM as none of the organizations providing such services have branches in rural areas.

Research on GMT has been minimal. It is believed that no research of direct relevance to the population had ever been undertaken prior to 2010. That year, a study focused on male and female sex workers was conducted but since it did not explicitly target MSM, only limited data on the population were obtained.¹⁴⁸ In 2011, an epidemiological survey of MSM was started.¹⁴⁹ The lack of sufficient information about the population is one of the main reasons few MSM-targeted interventions have been developed and introduced.

Funding for programs serving GMT has been affected by a restricted definition of MARPs that did not include MSM or transgender individuals. That definition, used by the U.S. government, was revised in 2011 to include MSM, but not transgender individuals. Programs include treatment for STIs, HIV testing, and condom provision at PSI through funding from PEPFAR.

Government response and engagement

As noted previously, the government has not invested any public funding in GMT-specific HIV programming. In some ways that is not surprising given that the National Health Policy states that HIV in Swaziland is mainly transmitted via heterosexual intercourse.¹⁵⁰ The National Strategic Framework (NSF) recognizes that there is a gap in providing services to MSM.¹⁵¹ It does not, however, propose any GMT-specific strategies; nevertheless, it offers hope for the population due to its all-inclusive strategy.

Many respondents took issue with the government's approach and argued that the national HIV research agenda needs to cover all target groups so the epidemic can be better understood and HIV services provided in a more effective way.

Global Fund support and engagement

There are no Global Fund supported programs for GMT in Swaziland. MSM were included in a draft application for Round 11, but once that funding opportunity was canceled, the programming opportunity was canceled as well. Swaziland was awarded funding through the transitional funding mechanism that replaced Round 11, but that did not include any programming for GMT.

U.S. government support and engagement

The U.S. government engages in Swaziland through PEPFAR, and this funding supports mainly the general population, except for the limited PSI programming noted above. Though PEPFAR funds MARPs, the majority of that funding is targeted to female sex workers.

The legal framework in Swaziland makes it difficult for these agencies to delve into the field of MSM as this is a legal grey area and PEPFAR cannot force its will in a sovereign country. Respondents from PEPFAR cited an incident where the Swazi government refused a donation of lubricant from the United Nations Population Fund (UNFPA). PEPFAR has, however, provided support for small scale lubricant distribution programs.

Recommendations

The following recommendations all aim to improve access to comprehensive HIV and other health services for GMT.

The current legal code should be reformed to specifically decriminalize same-sex practices. Ideally this would require repealing the Sodomy Act. An even better approach would be the passage of legislation clearly outlawing discrimination based on same-sex practices.

- A separate category in HIV surveillance and in behavioral surveillance surveys for GMT should be set up by all program implementers under the coordination of the CCM and the Ministry of Health. This should be followed by an in-depth situational analysis of the population. During the analysis, enforcement of laws prohibiting same-sex practices should be suspended to allow for ease of analysis and wider participation.
- The needs of GMT should be mainstreamed within the healthcare system. An important step in this regard would be the development of a curriculum addressing their specific health needs. The Ministry of Health should develop this curriculum through a thorough consultative process with a wide range of stakeholders. The curriculum should be introduced in pre-service training and provided to health workers already in the field.
- GMT should be involved in all decision making regarding their own health and lives, including the development of specific HIV prevention and treatment strategies and research. Participation in decision-making bodies, such as the Global Fund CCM, is vital to such success.
- More and improved research on GMT should be conducted in Swaziland. All such efforts should ensure that the GMT community is fully engaged from planning until completion.



Like many other countries in sub-Saharan Africa, Zambia has been hit hard by the HIV epidemic. Adult HIV prevalence is 12.5 percent according to recent estimates.³ The epidemic is considered generalized, but key populations have been identified that have a higher HIV prevalence and engage in practices that put them at greater risk of HIV infection. In Zambia, substantial evidence indicates that those populations include prisoners, sex workers, migrant workers, and members of the armed services.

Less evidence has been obtained regarding GMT and injecting drug users, though they are considered at heightened risk as well. Research among these populations, as well as those engaged in sex work, has been hampered by the fact that their main risk practices remain illegal. One of the few research efforts undertaken, an independent study of MSM done in the city of Ndola in 2006, found that one-third of study participants self-reported to be living with HIV.¹⁵² The study indicates that MSM are a high-risk group in Zambia even though the population remains poorly understood.

Respondents consulted for this report from both the government and civil society said that obtaining useful information about the MSM population and providing services targeting them is hampered by the fact that same-sex practices are illegal. Consequently, funding and programs in the country rarely target MSM and there continues to be a gap in essential HIV prevention programming. There is little to no discussion of issues facing transgender individuals.

Landscape

Key stakeholders involved in the HIV response regarding GMT include the government, United Nations agencies, and several CSOs. Summaries of current engagement are noted below:

Government

The government's primary engagement is through the Ministry of Health, which oversees healthcare provision through the public sector, and the National AIDS Council (NAC), whose main role is to coordinate efforts aimed at achieving universal access to HIV-related services. NAC has aimed to include activities targeting MARPs in the national strategic plan.

United Nations agencies

In particular, UNAIDS and the United Nations Development Programme (UNDP) are involved in the protection of GMT and/or promotion of their rights. UNAIDS is currently working with other stakeholders in developing research programs on GMT focusing on estimating the population's size and HIV prevalence.

Civil society

In Zambia, around 75 percent of CSOs working on HIV are local organizations and 22 percent have religious affiliations.¹⁵³ The following are among the key CSOs working on issues relating to HIV and MSM in the country (all of which were surveyed as part of this consultation):

- **Planned Parenthood Association of Zambia (PPAZ)** focuses on advancing the cause of sexual and reproductive health rights of women, men, and young people, especially the most vulnerable. Among other things, it aims to respond to unmet needs such as low condom use for HIV prevention and inadequate access to services by underprivileged and underserved

communities. In regards to MSM in particular, it provides LGBT-friendly services in the areas of voluntary counseling and testing (VCT) and psychosocial counseling. PPAZ is currently in the midst of a three-year plan, operated in collaboration with Friends of Rainka (see below), to train peer educators (including LGBT individuals) who will help sensitize its staff on providing nondiscriminatory service.

- **Society for Family Health (SFH)** mainly works in the area of HIV prevention; among other services, it provides VCT, condom distribution, and male circumcision. Although it aims to provide MSM-friendly counseling services, its VCT and male circumcision services do not specifically target MSM. Yet this may change: At the time consultations for this report were undertaken, the organization reportedly was planning to develop targeted services for the population.
- **Friends of Rainka (FoR)** is an NGO that champions the rights of sexual minorities in Zambia through advocacy, information dissemination, legal reform, research, and direct service provision. It is not yet registered and therefore cannot receive funds on its own; instead, it has a fiscal agent that manages its funds. The organization has not had much success when it comes to advocating for LGBT rights due to most organizations not being willing to work with it and the fear of its own members and staff of discrimination and arrest. However, some CSOs have been willing to work with FoR using an integrated approach. In 2010, FoR and PPAZ conducted two sensitization workshops for PPAZ staff on MSM issues. This resulted in raising those staff members' awareness and confronting myths they had about MSM.
- **Youth Vision Zambia** focuses on the sexual and reproductive health and rights of young people aged 10 to 35. Its programs do not discriminate on the basis of gender or sexual orientation. Peer educators sensitize their target audiences—including traditional leaders and churches—on MSM issues. Currently Youth Vision is in talks with FoR to identify more LGBT persons and train them as peer educators in addition to its own staff.
- **Panos Institute Southern Africa** focuses on HIV prevention through media. In 2011, Panos, in partnership with FoR and the National AIDS Council, designed and launched a study focusing on sexual minorities' association with HIV. The research aims to obtain more information on HIV-related knowledge among MSM and sex workers, among other sexual minority populations, as well as more reliable estimates as to the size of the populations and HIV prevalence. Another expected outcome is the identification of opportunities for interventions among those populations in Zambia.

Challenges and obstacles to adequate services for GMT

Stigma, discrimination, and the legal environment

Same-sex practices have long been criminalized in Zambia. In 2005, amendments to the Penal Code made the situation much harsher in terms of punishment, leaving the potential for lifelong incarceration.

The Zambia Penal Code criminalizes what it terms “unnatural offences” (Section 155). Specified in the list of such offences are “any person” who “permits a male person to have carnal knowledge of him or her against the order of nature” and where a person “permits a male person to have carnal knowledge of a male.” As amended in 2005, the section states that those convicted of such offences are liable to imprisonment for “not less than twenty-five years” and may be imprisoned for life. Section 156, also amended in 2005, goes further and states that any person who “*attempts* [emphasis added] to commit any of the offences specified” in Section 155 commits a felony and could be imprisoned for between seven and 14 years.¹⁵⁴ The amendment to

Section 156 is notable in that it opens the door for potential prosecutions based on the vaguely defined word “attempt.” Such wording could be interpreted expansively to include a wide range of comments, gestures, and actions that may have little or nothing to do with the supposed intent of Section 155.

Against this background, directly addressing the needs and rights of MSM in Zambia is difficult. Government agencies, even those that seek to improve HIV prevention and care services, are wary of acting in conflict with the law. Strong opposition to MSM from religious institutions also reduces the scope for effective action. Ignorance about the population therefore persists, including in regards to HIV infection risks and the need for targeted services.

One clear challenge GMT face is lack of access to condom-compatible lubricant, which is nonexistent in health centers.

The wariness and opposition continue even though relatively few people are prosecuted for same-sex practices; most cases reportedly are dismissed due to lack of evidence. On occasion, though, prosecutions take place, therefore reinforcing the precarious legal position and lack of rights among MSM. In one notable recent event, for example, three school-age boys were prosecuted and sentenced to prison for 12 months each for “having committed one count of indecent practice between persons of the same sex.”¹⁵⁵

UNAIDS is among the entities seeking to address the current situation. It has sought to sensitize key persons in the Ministry of Health about MSM and HIV despite the illegality of same-sex practices. Its efforts are based on the belief that even if existing legal regimes criminalize certain practices, that should never be a justification to block the provision of services to a population especially susceptible to the epidemic’s impact.

Most respondents agreed that stigma and discrimination against MSM are widespread across Zambian society. Same-sex sexual acts are perceived as abominations by the majority of Zambians. Most of those who engage in such practices worry about the consequences of disclosure, a concern that prevents many from even seeking to access relevant health services for fear of being identified as a member of the GMT population. As noted above, UNAIDS has been among the organizations seeking to address this challenge. Agency personnel have arranged meetings with officials from NAC and the Ministry of Home Affairs as well as traditional leaders to bring to their attention the personal and public impact of such widespread attitudes towards GMT. Among the key points they make is the need to reduce such stigma and discrimination to ensure a balanced and more effective approach to HIV prevention.

To date, the government has yet to take a stand against GMT-related stigma. There is a two-pronged justification for its inaction: one is legal, as the current Penal Code criminalizes same-sex practices; and the other is religious, as most Zambians are conservative Christians. Officials are concerned that the majority of the electorate would oppose any government efforts to combat such stigma. Moreover, most government officials appear to be disinclined to speak out because they themselves support the repressive legal regime and religious-based condemnation of same-sex practices.

The extent of GMT-related stigma and discrimination in the healthcare system is difficult to determine. On the one hand, none of the focus group participants from Friends of Rainka said they had experienced discrimination in this area. Yet they and other GMT acknowledge at the

same time that they often decide not to seek out services, even when in need, out of fear that healthcare workers may ask them personal questions that would expose their sexual practices. It therefore can be concluded that the perception of discrimination is as much of a concern to the population's health as experienced discrimination. Both are a major constraint to individuals' health and human rights.

One clear challenge GMT face is lack of access to condom-compatible lubricant, which is non-existent in health centers. GMT and others can only get it from supermarkets and chemists, but often the available products are expensive.

Other challenges associated with MSM-specific programming

- Media coverage on GMT issues is mostly negative. Most respondents said this is often because journalists seek to appeal to a public that is already predisposed to feel uncomfortable regarding people who engage in same-sex practices. Many journalists openly said they support harassment of GMT, including violence and abuse.
- A lack of adequate data regarding GMT, including the size of the population and its needs, greatly limits the ability to plan and implement programs for the population. Comprehensive data collection is hampered by the restrictive legal regime.
- GMT and groups working with and for them are relatively invisible and operate in an environment of insecurity. As such, they do not advocate effectively for services, including in regards to HIV, for the population.
- Even potentially open-minded government officials and agencies are reluctant to develop targeted programming for GMT out of concern that doing so might violate the law and result in personal harm. Some CSOs have expressed similar sentiments, and thus have refused to work with organizations such as Youth Vision on MSM-specific projects.
- Groups such as Friends of Rainka note the huge knowledge gap about HIV among GMT in Zambia. While the organization continues to do what it can to overcome this challenge, especially in Lusaka, the fact remains that most Zambian MSM are ignorant about the risk of HIV transmission from anal intercourse and have limited access to condoms and condom-compatible lubricant and continue to have unprotected sex.

Government response and engagement

The government established NAC in December 2002 to coordinate the response to its HIV epidemic. A National HIV/AIDS Policy was published in 2005 to provide the policy guidelines for the national multisectoral response. In order to effectively manage intervention efforts, the government works with several stakeholders ranging from donors, multilateral institutions, academia, and civil society organizations.

The Ministry of Health is the main government body engaged, both in terms of setting policy and guidelines and providing services through public-sector hospitals, clinics, and health centers. Other key government structures include a high-level Cabinet Committee of Ministers on HIV and AIDS, which provides policy direction and supervises and monitors the implementation of HIV programs, and a Partnership Forum that includes high-level representation of different stakeholders. Budgetary support for HIV programs is mostly donor driven; for instance, in 2009, around 80 percent of the national response was funded by donors, particularly the U.S. government, the Global Fund, the World Bank, and the UK Department for International Development (DFID).¹⁵⁶

Yet despite the National AIDS Strategic Framework 2011–2015 (NASF) identifying GMT as a high-risk population, there are no programs specifically designed for them. As noted previously, many Ministry of Health officials believe that attempts to design such programs would constitute breaking the laws criminalizing same-sex practices. However, healthcare personnel are bound by medical ethics to treat all patients. Whether that policy is adhered to consistently in regards to GMT is unknown and difficult to determine. There is some evidence that not all medical personnel feel they must abide by such basic ethical standards. For example, Dr. Francis Manda, a well-known urologist who hosts a popular radio talk show from Lusaka, reportedly has spoken on air against treating GMT who have STIs. He has said that he would have no qualms about turning in to the police any patient who had engaged in same-sex practices.

The reluctance to respond to the specific needs of GMT can also be seen in research and surveillance. NAC has been trying to conduct MARPs studies and surveillance activities over the past five years, but reportedly has been unable to do so because of the legal environment. The Ministry of Health's Research and Ethics Committee has echoed such concerns as a reason it cannot sanction a study on sexual minorities and has consistently declined approval for such research.

In addition to legal issues, the government's inclination to address specific GMT health needs appears to be constrained by two other important factors. First, as noted previously, churches have strong and influential voices in Zambia, and most religious leaders oppose decriminalizing same-sex practices. Secondly, and linked to that, the general population on which the government relies for support remains socially conservative about GMT, with an often-stressed undercurrent of deep hostility based on the belief that same-sex practices are "alien" and "un-African." The immediate past government was reflexively hostile to the LGBT community and its attitude turned particularly harsh when it claimed, during the 2011 presidential election campaign, that the main presidential candidate, Michael Sata, was gay-friendly. Sata won the election and is now the head of government, a development that has slightly relaxed the environment in which MSM work can be done. For example, as of the time research for this report was concluded, there was an approved MSM research study by NAC and Panos awaiting authorization from the Ministry of Health, and another one supported by CDC was in the protocol stage.

The general perception by GMT of the government is that it can and should do more. Members of the population feel that the government lets religious leaders and the general population trample on their rights. They are more hopeful with the new government; to date, it has not made any homophobic or discriminatory statements against GMT.

Global Fund support and engagement

Zambia is among the top countries worldwide in terms of total Global Fund support. It has been awarded HIV/AIDS grants in Rounds 1, 4, 8, and 10; of those four programs, the first two have closed. Principal recipients (PRs) for different parts of the grants have included UNDP, the Churches Health Association of Zambia (CHAZ), the Ministry of Finance and National Planning, the Ministry of Health, and the Zambia National AIDS Network.

The Global Fund's engagement in Zambia has experienced complications and difficulties at times. Most notably, in June 2010 the Global Fund announced that it had frozen funding to the Ministry of Health following revelations of fraud in the ministry. It resumed support two years later. (Funding continued to flow through the other PRs during the suspension period.)

CHAZ was selected as a civil society PR based on its important role as an inter-denominational umbrella organization for coordinating church-run health services in Zambia. Through its Global Fund projects, it supports programs providing services including sensitization, behavioral change

campaigns, HIV counseling and testing, treatment of STIs, condom distribution, voluntary medical male circumcision, post-exposure prophylaxis, and capacity building of service providers.

The funding CHAZ receives is for the general population, not specifically for MARPs or other marginalized groups. It has, however, used some of its funding to support initiatives for certain of those groups—but not directly for GMT. It will not work with that population because doing so would conflict with its religiously defined moral tenets. Though the other PRs are not religious-oriented entities like CHAZ, they too have not funded GMT-targeted work. The partial exception is UNDP, which has set aside some funding to raise awareness about MSM issues among country partners including the Ministry of Health. But the agency has not provided funds directly to MSM groups as part of its Global Fund work.

The Global Fund CCM currently has 24 members, of whom just five are from the civil society sector. No MSM groups are currently represented, an omission that appears to be at least partly deliberative and based on the legal regime. The CCM reportedly does not want to appear to be violating laws criminalizing same-sex practices. This is considered a concern because the CCM is largely government-controlled.

U.S. government support and engagement

Zambia is one of the original PEPFAR recipient countries. According to PEPFAR, the country received nearly \$1.12 billion to support comprehensive HIV/AIDS prevention, treatment, and care programs from FY 2004 to FY 2009.¹⁵⁷ In Zambia as elsewhere, PEPFAR money is coordinated by the U.S. ambassador's office but is distributed through a number of different government agencies including USAID, the U.S. Department of Health and Human Services (HHS), the U.S. Department of Defense, the U.S. Department of Labor, the Peace Corps, and the Census Bureau. USAID is the most substantially involved in Zambia. For the most recent U.S. fiscal year, running from October 2011 through October 2012, USAID's overall budget for its programs in Zambia totals \$306 million.

PEPFAR funding is distributed among NAC, the Ministry of Health, and some other government agencies as well as among both international and national NGOs (including faith-based organizations). One of the main approaches specified by USAID in Zambia is to reduce HIV transmission among the most-at-risk populations.¹⁵⁸ However, PEPFAR, through USAID, has not allocated direct funds for GMT programs, and U.S. government agencies have never established any direct linkages or programs with any MSM groups in Zambia.

Recent developments indicate beneficial change from the MSM perspective. CDC has submitted a study protocol for an MSM size estimation and biological surveillance survey to the Tropical Disease and Research Centre (TDRC). Unlike a study proposed earlier that would have focused on Lusaka city only, this project aims to cover 10 locations in the country: Lusaka, Ndola, Chipata, Kitwe, Livingstone, Mansa, Kapiri Mposhi, Solwezi, Kasama, and Mongu. The study will be done in partnership with the Population Council as principal investigators. Because neither CDC nor the Population Council has access to any MSM groups, it is expected they will most likely work with local organizations such as Friends of Rainka. Although the study is not solely focused on MSM—it also includes drug users, sex workers, and their clients—it is expected to provide valuable information and bring greater visibility of MSM to service providers and policy makers.

Recommendations

- Stronger and more effective coordination is needed between NAC and Ministry of Health in order to better link NAC's actions as a planning body and the Ministry of Health's as an

implementer. Currently, the NASF identifies gaps in treatment and prevention for MSM but measures and mechanism to address these gaps are not packaged into Ministry of Health healthcare services.

To achieve this recommendation, NAC should take responsibility by forming a prevention theme group for sexual minorities. It should then ensure that the recommendations of this theme group are made to the Ministry of Health to consider for programming.

- More attention and resources should be focused on male and adolescent sexual reproductive health. It is clear that most HIV programs that are being integrated at service delivery levels focus primarily or solely on women and children, with little or nothing done in the areas of male and adolescent reproductive health. The first step to overcome this gap would be to carry out a study to understand the needs and propose mechanisms for addressing them. Any resulting programming would be a significant entry point to more thoroughly integrated care and services for GMT, including in regards to HIV.

NAC as a planning body should take responsibility for moving this effort forward by engaging with GMT groups and identifying their specific needs. That way, there will be evidence for NAC to convince the Ministry of Health and ultimately the service providers as to the importance of incorporating the identified needs in their services.

- Organizations such as Planned Parenthood Association of Zambia (PPAZ), Youth Vision Zambia, and Society for Family Health (SFH) have in-house counseling training programs regarding HIV and other important health issues. These programs should be revised to take into account the needs of LGBT, and do so in a confidential and nondiscriminatory manner. Such revisions are necessary because, among other reasons, not every man who seeks such services is or has been sleeping with a woman only. PPAZ and Youth Vision reportedly have begun to discuss LGBT issues in their training; they and SFH should be as comprehensive and consistent as possible moving forward in regards to specific issues of importance to GMT.
- NAC should take the lead in seeking to amend or repeal the existing laws criminalizing same-sex practices. The agency is best placed to undertake this effort now as it is a government body, and thus more likely to be listened to and respected, and also because the current legal regime is a major obstacle to efforts by NAC and other bodies to conduct research studies on GMT and thereby promote better services targeting them. Lobbying to amend or repeal these laws should be directed at relevant parliamentary committees.
- Donors should demand that a share of their funding for HIV/AIDS be directed toward the needs of GMT. Part of this effort might be supporting civil society advocacy aimed at reducing discriminatory services in the health sector and the decriminalization of same-sex practices.
- The Zambian government, through its relevant agencies (the Ministry of Education and the Ministry of Health), should provide comprehensive sexuality education to high school pupils and college students. This effort should aim to provide them with a broader understanding of human sexuality and help clear away myths surrounding same-sex practices. The training should include members of the GMT community, and groups representing LGBT should be involved in developing the curricula and monitoring implementation.
- The Global Fund CCM should include a GMT group so that LGBT have a representative on a key body that influences national health priorities.
- The United Nations family should actively support local and national groups aiming to influence national policy and programs to advance the rights and address the needs of key populations. MSM groups in Zambia cannot work on their own toward these critical goals.

They can only do so by engaging with major stakeholders through the convening power of the United Nations.

- The Global Fund should insist on greater allocation of funds to address the specific needs of GMT. It should clearly state that it intends to reject any application that does not follow this policy. Further down the line, the Global Fund should ensure that provisions meeting this policy remain in grant agreements that are eventually signed by principal recipients.
- A civil society coalition should be created to promote the objective that GMT should be involved in all HIV-related program planning. Efforts to achieve this goal ideally would first focus on sensitizing and creating awareness among a range of NGOs on the need and importance of GMT engagement in all HIV-related issues. Such a step would not only make the GMT integration agenda prominent among civil society groups working on HIV, but would also begin to influence the allocation of resources in a manner that allows GMT-targeted programs to be developed and supported.



Adult HIV prevalence in Zimbabwe is approximately 14.9 percent, according to the most recent UNAIDS estimates.³ As in the rest of Southern Africa, data on GMT are scarce, and no reliable estimates are available of HIV prevalence among the population in Zimbabwe.

Some behavioral data from a small convenience sample of Zimbabwean MSM, conducted by Gays and Lesbians of Zimbabwe (GALZ), found that 19 of 34 men identified as single, while the rest identified as married, committed, or dating.¹⁵⁹ Most men reported being sexually active. Many gave inconsistent answers about condom use, suggesting that it was irregular. Most (79 percent) reported that they had received an HIV test at least once. Less than half said that if they had HIV they would disclose their status to a sexual partner before having sex, and a similar share refused to say they would not have sex without protection.

Methodology

Editor's note: The Zimbabwean consultants were targeted by police, harassed, and arrested for their work on HIV and GMT while this report was in development. As a result, they were unable to consult with a large number of stakeholders, but that limitation did not impede their ability to conduct thorough analysis.

This report is based primarily on interviews with five key stakeholders held in May 2012, including representatives from the Ministry of Health and Child Welfare's AIDS and TB Unit, the Zimbabwe Institute of Systemic Therapy (CONNECT ZIST), the Zimbabwe AIDS Network (ZAN), the International Network of Religious Leaders Living with or Personally Affected with HIV and AIDS (INERELA+), and GALZ. Additional information and observations were obtained through a review of documentation both online and in print.

Landscape

The government is heavily involved in the HIV response in general, especially in regards to setting overall policies and priorities and providing services through public-sector facilities. The agencies most engaged are the Ministry of Health and Child Welfare (MoHCW), the Ministry of Women, Gender and Community Development (MoWGCD), the Ministry of Education, and the National AIDS Council (NAC). Numerous academic institutions and CSOs are also involved, including Population Services International (PSI), the Zimbabwe AIDS Network (ZAN), the Zimbabwe

National Network of People Living with HIV and AIDS (ZNNP+), the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), and the Women and AIDS Support Network (WASN). Within the United Nations family, UNAIDS, the United Nations Development Programme (UNDP), and the United Nations Population Fund (UNFPA) also have major presences regarding the HIV response.

The major sources of funding for HIV in Zimbabwe include the Global Fund; the National AIDS Trust Fund (NATF), which is supported by a special tax in Zimbabwe; the U.S. and United Kingdom governments; and The Expanded Support Programme (ESP), which has recently been transformed into the Health Transition Fund (HTF).¹⁶⁰ (The ESP used to be specifically for HIV/AIDS. With the transformation into the HTF, however, the fund is meant to cover other health issues in addition to HIV/AIDS.)

Fewer stakeholders are directly engaged in GMT-specific programming. The government is largely absent, as confirmed by respondents from agencies including the MoHCW. UNAIDS has provided technical support aimed at raising awareness and increasing access to services for members of the population. Some civil society groups, including GALZ and the Sexual Rights Centre (SRC), are also involved, though respondents provided conflicting comments about the extent and impact of civil society engagement.

Programs available for GMT specifically are mainly those offered by GALZ and SRC; they include psychosocial support, advocacy, job-skills training, and addressing barriers to healthcare access. Also, CONNECT ZIST includes interventions to tackle taboo issues, while the Biomedical Research and Training Institute (BRTI), is currently collaborating with GALZ in carrying out research on LGBT. SAfAIDS also includes GMT in its information dissemination services, such as crafting, packaging, and distributing appropriate messages. From the government side, NAC maintains that its interventions are for all citizens even if GMT and/or distinct sexual minorities are not mentioned by name in the agency's responses and reporting. NAC respondents said that staff are, however, exploring ways to ensure effective outreach to MARPs and will initiate a dialogue with GALZ.

Challenges and obstacles to adequate services for GMT

Stigma, discrimination, and the legal environment

Same-sex practices and sex work are illegal in Zimbabwe; those who engage in such activities lack legal status and protection. There is little support among politicians and the general public to change the current legal regime. Several officials, including President Robert Mugabe, regularly make anti-gay statements. In May 2012, for example, Justice Minister Patrick Chinamasa told United Nations High Commissioner for Human Rights Navi Pillay that his government rejected calls for basic LGBT rights and would continue to arrest people for engaging in same-sex practices.¹⁶¹ Some respondents to this report noted that the police harass, arrest, and abuse people suspected of engaging in same-sex practices.

The impact is difficult to determine because most GMT do not disclose and remain underground. It is clear, though, that the legal regime and associated hostility limit the development and implementation of GMT-specific services of any kind, including in regards to HIV prevention, treatment, care, and support. Yet despite officials' aggressive words and behavior and the absence of laws protecting MSM and other sexual minorities, a 2011 United Nations-sponsored assessment concluded that "Zimbabwe has allowed the existence of informal lobby groups for these populations."¹⁶²

Of note is the existence of laws protecting people living with HIV from discrimination¹⁶³ and specific legal provisions offering protection for “non-consenting men” who engage in anal sex. These laws are not sufficient to overcome the opposition to distribution of condoms and condom-compatible lubricant in prisons, among other important areas regarding HIV prevention. Also, the HIV anti-discrimination law is considered weak by some respondents because no mechanisms exist to record, document, and address cases of discrimination experienced by people living with HIV, MARPs, or other vulnerable sub-populations.¹⁶²

The media is generally negative regarding GMT and same-sex practices, and tends to amplify the homophobic statements of the political and religious leadership.

The lack of social acceptance and negative attitudes towards GMT, which emanate in part from religious and cultural teachings, greatly contribute to stigma and discrimination directed at the population. The homophobic pronouncements made by political, religious, and community leaders at the highest level are intimidating and create a hostile, stigmatizing environment.

One respondent argued, though, that the homophobic utterances by political and religious leaders were also having a galvanizing effect on some GMT who no longer accepted being intimidated. According to that interviewee, there is increasing “open disclosure” (coming out), subtle acceptance of same-sex practices, and more sex work.

Stigma and discrimination toward GMT is considered extensive in healthcare facilities, and among all levels of staff. The consequences are major in terms of the health and well-being of members of the population who are reluctant to seek out care when needed. One example given during these consultations referred to when a member of GALZ presented at the biggest teaching hospital with an anal STI. He acknowledged to the nurse that he had engaged in anal sex. The nurse left the exam room as if to go and get something to do with the treatment. However, she had gone to call her colleagues, and they all trooped in to stare and lecture the patient over his “immorality” and how he was being “punished” for his waywardness. When he shared what had happened with other GMT, they said they would not go to government health facilities for treatment of STIs.

GALZ and SRC reportedly also provide referrals on a regular basis and seek to advocate for the health needs of GMT in Zimbabwe. As part of its efforts to improve the health of GMT, GALZ also undertakes outreach campaigns. Some respondents said they thought advocacy efforts were rather weak in general, but assumed the main obstacle is the repressive legal regime.

In terms of specific commodities, interviewees said that condom-compatible lubricant is not available in most public health facilities or from the majority of CSOs providing HIV prevention services.

Other challenges associated with MSM-specific programming

- The media is generally negative regarding GMT and same-sex practices, and tends to amplify the homophobic statements of the political and religious leadership. While reporters have been engaged and included in discussions and workshops by government and civil society, and profess receptiveness to positive media coverage from a human rights

perspective, they claim that editors generally refuse to publish positive stories. This may be because Zimbabwe's media industry is dominated by government-controlled print and electronic media, with the industry's leadership aligned to one political party.

- Limited information exists about GMT, including HIV prevalence data. Though the Zimbabwe National AIDS Strategic Plan (ZNASP I) 2006–2010 proposed size estimation and bio-behavioral surveillance for the population, no research took place. The lack of information greatly hampers opportunities to accurately model the potential contribution of GMT to new HIV infections or to develop evidence-based social and behavior change communication interventions targeting them.
- The Zimbabwe Demographic Health Survey (ZDHS) does not mention GMT or any other key populations or measure any indicators related to their health needs, thus indicating a lack of understanding of the populations' specific (and unmet) health needs.
- Availability and coverage of GMT-targeted services is perceived to be generally available in big cities, but far less so in rural and peri-urban areas and small towns.

Government response and engagement

The MoHCW and NAC are the main government bodies responsible for addressing HIV in Zimbabwe. Neither is specifically tasked with working with GMT. To date, the government has never earmarked any domestic funding for MSM-specific HIV programs or to conduct any research focused on GMT.

The government's lack of engagement is exemplified by the fact that the high-level government officials who have made public statements relating to same-sex sexual practices have not usually been from the health ministry. For example, in addition to comments mentioned earlier from the justice minister in 2012, both the prisons commissioner and the police commissioner have referred to the need to uphold and enforce laws prohibiting same-sex practices. Given such examples, it is unsurprising that most GMT in Zimbabwe view the government with suspicion, perceiving it as homophobic and intolerant.

Policy makers have at times signaled a willingness to engage on GMT-specific issues and programming vis-à-vis the HIV response. Yet the follow-up has been disappointing. For example, ZNASP I (2006–2010) recognized the importance of including MARPs in HIV prevention programming and interventions, noting that "specific programs will be developed targeting" MSM, sex workers, injecting drug users, prisoners, orphans, and street children, among others.¹⁶⁴ It explicitly outlined strategies for MSM and sex workers and stated that "an assessment of MSM patterns, meeting points and behaviors will...be carried out, and adequate public health interventions developed based on the findings." However, neither targeted programs for MSM nor the promised assessment were undertaken during that plan's period.

ZNASP II (2011–2015) appears to represent a step backward for GMT as it only vaguely mentions MSM in a list of populations that "will be targeted."¹⁶⁴

Global Fund support and engagement

Zimbabwe has been awarded three HIV/AIDS grants (Rounds 1, 5, and 8) from the Global Fund. Members of the population undoubtedly benefit from Global Fund support, but opportunities for more extensive and comprehensive support have not been made available. Despite the hundreds of millions of dollars flowing through this vital funding mechanism for the HIV response, no

Global Fund-supported programs or research have ever specifically targeted GMT, and no GMT community group has ever been funded through the Global Fund.

Moreover, no GMT groups or representatives have ever sat on the Global Fund CCM or been invited to participate. None of the principal recipients (PRs) of Global Fund grants—including UNDP, the PR for the Round 8 HIV/AIDS grant—have ever approached GMT groups about developing programs. Respondents indicated that GMT issues are never discussed by the CCM even when it considers HIV prevention, treatment, and care priorities.

U.S. government support and engagement

Most U.S. government support for Zimbabwe's HIV response flows through PEPFAR. According to PEPFAR's website, Zimbabwe received \$97.9 million to support comprehensive HIV prevention, treatment, and care programs from FY 2007 to FY 2009.¹⁶⁵ An additional \$47.5 million was approved for FY 2010, with the bulk of funding being used by USAID.

Respondents indicated that no U.S. government funds had ever been directed to GMT community groups or used for GMT-specific HIV programming. Those who commented also said they did not believe that U.S. government officials have consulted or engaged with GMT groups in planning processes. Such analysis seems relatively accurate given PEPFAR's stated focus in Zimbabwe, as noted on its website: "In the short term, PEPFAR is placing particular attention on two key systemic linkages: commodity supply and logistics systems, and laboratory systems."¹⁶⁶

Recommendations

- The government, with support from donors, should collect strategic information on GMT that clearly demonstrates the presence of these populations in Zimbabwe and their need for services. Funded efforts should use a public health approach that enables the collection of factual information on GMT populations in Zimbabwe, including size of the population, HIV prevalence, and understanding and awareness of HIV. The research should be adequately funded and findings should be publicized.
- The government should decriminalize not only same-sex sexual practices but also work to deliver services to GMT and advocate for their needs.
- The government should work with United Nations agencies that can partner with GALZ and SRC to design a nondiscriminatory policy for universal access to HIV services.
- Civil society should address human rights more universally, and engage peer organizations working on issues related to GMT including GALZ and SRC. UNAIDS should play a key role in bridging civil society organizations and battling the homophobia that exists within them.
- Global Fund and PEPFAR policy makers in Zimbabwe, including the Global Fund CCM, should specify that a certain percentage of available funds are to be used for services for GMT, including training of health personnel and civil society organizations. Such a step is needed to ensure the normalization of inclusion of GMT issues in national responses. As well, funding should be allocated to directly support GMT-led organizations to carry out HIV services.

Endnotes

1. amfAR (2012). Achieving an AIDS-free generation for gay men and other MSM. Available at www.amfar.org/uploadedFiles/_amfar.org/In_The_Community/Publications/MSM-GlobalRept2012.pdf.
2. World Bank. Available at http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Sub_Saharan_Africa.
3. UNAIDS (2011). AIDSInfo database. Available at www.unaids.org/en/dataanalysis/datatools/aidsinfo/.
4. UNAIDS. (2012). Country Progress Reports. Available at www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/.
5. Baral S et al (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*. 2009; 4(3): e4997.
6. Behavioral sentinel surveillance survey for MARPS (2011). Preliminary results, as reported in Swaziland's 2012 country progress report for 2012. Available at [www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report[1].pdf).
7. Consultations used a standardized instrument to guide their interviews, allowing for cross-country comparability. They did not include any questions focused on protected health information including past or current medical history, family medical history, sexual practices or orientation, or any socio-demographic characteristics. All consultations and associated discussion pertained to participants' general knowledge about GMT-specific expenditures, research, and/or programming rather than personal experiences with HIV or programs.
8. Institute for Health Metrics and Evaluation (2012). Financing global health 2012: the end of the golden age? Seattle, WA: IHME; 2012.
9. Beyrer C et al (2012). Global epidemiology of HIV infection in men who have sex with men. *The Lancet*. 2012; 380: 367-77.
10. Beyrer C et al (2011). The global HIV epidemics among men who have sex with men. Washington, DC: The World Bank; 2011.
11. World Bank. Available at http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Sub_Saharan_Africa.
12. Baral S et al (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*. 2009; 4(3): e4997.
13. Behavioral sentinel surveillance survey for MARPS (2011). Preliminary results, as reported in Swaziland's 2012 Country Progress Report for 2012. Available at [www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report[1].pdf).
14. Baral S et al (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*. 2009; 4(3): e4997.
15. Itaborahy L (2012). State-sponsored homophobia: A world survey on laws criminalizing same-sex sexual acts between consenting adults. International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA). Available at http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2012.pdf.
16. Cornell University Law School. Legal Information Institute. Available at <http://www.law.cornell.edu/wex/offense> (date last accessed: April 16, 2013).
17. American Bar Association (2011). Resolution adopted by the House of Delegates: August 8-9, 2011.
18. Gays and Lesbians of Zimbabwe (2011). GALZ LGBTI rights violations report 2011. Available at www.iglhrc.org/binary-data/ATTACHMENT/file/000/000/575-1.
19. Immigration and Refugee Board of Canada (2007). Namibia: treatment of homosexuals by society and government authorities; legal recourse and protection available to homosexuals who have been subjected to ill-treatment (2005 - February 2007). Available at www.unhcr.org/refworld/docid/469cd6ad17.htm.
20. U.S. State Department (2011). Country reports on human rights practices for 2011: Zimbabwe. Available at www.state.gov/documents/organization/186469.pdf.
21. International Gay and Lesbian Human Rights Commission (2007). Zambia: shadow report on the status of lesbian, gay, bisexual, and transgender individuals. Press release from July 11, 2007. Available at www.iglhrc.org/cgi-bin/iowa/article/publications/reportsandpublications/437.html.
22. Vilakazi F and Mbaru M (2010). Homophobia heightens in Swaziland. Press release from January 1, 2010. International Gay and Lesbian Human Rights Commission. Available at www.iglhrc.org/cgi-bin/iowa/article/pressroom/pressrelease/1063.html.
23. U.S. State Department (2012). 2011 Country reports on human rights practices: Swaziland. Available at www.unhcr.org/refworld/docid/4fc75a5c50.html.

24. Cowell F (2010). Colonial sodomy: homophobic threat within common law. *Consultancy Africa Intelligence*. Available at www.consultancyafrica.com/index.php?option=com_content&view=article&id=472:colonial-sodomy-homophobic-threat-within-common-law&catid=91:rights-in-focus&Itemid=296.
25. Sandfort T et al (2013). Forced sexual experiences as risk factor for self-reported HIV infection among Southern African lesbian and bisexual women. *PLoS ONE*. 8(1): e53552. doi:10.1371/journal.pone.0053552.
26. See www.unaids.org.
27. UNAIDS (2011). Global AIDS response reporting 2012 (page 82). Available at www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf.
28. UNAIDS (2012). Global AIDS response reporting: 2012 guidelines. Available at www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf.
29. UNAIDS (2011). Global AIDS response reporting 2012 (page 83). Available at www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf.
30. Information for all years is available at www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports.
31. UNAIDS (2012) "National Commitments and Policy Instrument (NCPI) – Countries" Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/.
32. amfAR (2012). Achieving an AIDS-free generation for gay men and other MSM. Available at www.amfar.org/uploadedFiles/_amfar.org/In_The_Community/Publications/MSM-GlobalRept2012.pdf.
33. Peersman G et al (2009). Increasing civil society participation in the national HIV response: the role of UNGASS reporting. *Journal of Acquired Immune Deficiency Syndrome (JAIDS)*. Available at www.ncbi.nlm.nih.gov/pubmed/19901632.
34. UNAIDS (2010). Swaziland NCPI 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/swaziland_2010_ncpi_en.pdf.
35. UNAIDS (2012). Namibia NCPI 2012. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Namibia%20NCPI%202012.pdf.
36. UNAIDS (2010). Zambia NCPI 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/zambia_2010_ncpi_en.pdf.
37. UNAIDS (2010). Namibia NCPI 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/ncpi_report_namibia_2010.pdf.
38. MSM were mentioned by civil society in 2008 NCPIs from Botswana, Namibia (three mentions), Swaziland (two mentions), Zambia, and Zimbabwe (two mentions).
39. Standardized answers were omitted by government respondents in 2010 NCPIs from Botswana, Namibia, and Zimbabwe (five instances) and in 2012 NCPIs from Malawi and Zimbabwe (two instances).
40. Standardized answers were omitted by civil society respondents in Botswana's 2010 NCPI and Zimbabwe's 2012 NCPI (four times).
41. In 2012 NCPIs from Botswana, Malawi, and Swaziland and the 2010 NCPI from Malawi.
42. In 2012 NCPIs from Malawi and Namibia and the 2010 NCPI from Namibia.
43. UNAIDS (2012). Swaziland NCPI 2012. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Swaziland%20NCPI%202012.pdf.
44. UNAIDS (2012). Botswana NCPI 2012. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Botswana%20NCPI%202012.pdf.
45. UNAIDS (2012). Malawi NCPI 2012. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Malawi%20NCPI%202012.pdf.
46. Adams, P et al (2009). Estimating levels of HIV testing, HIV prevention coverage, HIV knowledge, and condom use among men who have sex with men (MSM) in low-income and middle-income countries." *Journal of Acquired Immune Deficiency Syndrome (JAIDS)*. 2009 Dec;52 Suppl 2:S143-51.
47. Both mentions occurred in 2012.
48. Namibia Progress Report 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/namibia_2010_country_progress_report_en.pdf.
49. UNAIDS (2010). Swaziland NCPI 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/swaziland_2010_ncpi_en.pdf.
50. As of October 12, 2012.
51. UNAIDS (2010). Zambia NCPI 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/zambia_2010_ncpi_en.pdf.

52. UNAIDS (2008). Zambia NCPI 2008. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2008/zambia_2008_ncpi_en.pdf.
53. UNAIDS (2010). Zimbabwe NCPI 2010. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2010countries/zimbabwe_2010_ncpi_en.pdf.
54. UNAIDS (2012). Zimbabwe NCPI 2012. Available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2012countries/Zimbabwe%20NCPI%202012.pdf.
55. Ryan O, Macom J, Moses-Eisenstein M (2012). Demand for programs for key populations in Africa from countries receiving international donor assistance. *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 9 (3): 131-6.
56. Fried S, Kowalski-Morton S (2008). Sex and the Global Fund: how sex workers, lesbians, gays, bisexuals, transgender people, and men who have sex with men are benefiting from the Global Fund, or not. *Health and Human Rights* 10(2):127-136.
57. Global Fund (2012). The Global Fund strategy in relation to sexual orientation and gender identities. Available at www.theglobalfund.org/documents/core/strategies/Core_SexualOrientationAndGenderIdentities_Strategy_en/.
58. Rivers B (2010). Global Fund Board approves Round 10 proposals. *Global Fund Observer*, Issue 135 (December 10, 2010). Available at www.aidspace.org/gfo_article/global-fund-board-approves-round-10-proposals.
59. The Global Fund Strategy 2012-2016: Investing for Impact. Available at www.theglobalfund.org/en/about/strategy/.
60. Global Fund (2011). The Global Fund Board establishes a transitional funding mechanism to replace Round 11 and revise the application and approval process for renewals. Available at www.theglobalfund.org/en/mediacenter/announcements/2011-12-01_Global_Fund_Board_establishes_a_Transitional_Funding_Mechanism/.
61. Global Fund (2011). Transitional funding mechanism (TFM) information note. Available at https://www.google.com/url?q=http://www.theglobalfund.org/documents/tfm/TFM_Request_InfoNote_en/&sa=U&ei=-vleUcaSO_LU0gHa1ICABQ&ved=0CAcQFjAA&client=internal-uds-cse&usg=AFQjCNEKFJLDqUQV5QilG8amLL2GHkdG2g.
62. Garmaise D (2012). TFM funding decisions announced. *Global Fund Observer*. Available at www.aidspace.org/gfo_article/tfm-funding-decisions-announced.
63. The review is available at www.theglobalfund.org/en/trp/reports/#TFM.
64. Global Fund (2012). The Office of the Inspector General: audit of Global Fund grants to the Republic of Namibia. GF-OIG-11-006. Available at www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/5/.
65. U.S. Global Health Policy (2012). Global Fund to Fight AIDS, Tuberculosis, and Malaria—cumulative distribution for HIV/AIDS grants (US\$) as of November 7, 2012. Kaiser Family Foundation. Available at www.globalhealthfacts.org/data/topic/map.aspx?ind=61.
66. Global Fund (2002). Botswana proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/grantDocuments/BOT-R02-HA_Proposal_0_en.
67. Global Fund (2007). Botswana Round 7 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/7/notapproved/7BOTH_1477_0_full/.
68. Global Fund (2009). Botswana Round 9 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/9/notapproved/9BOTH_1804_0_full/.
69. Global Fund (2010). Botswana Round 10 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/10/notapproved/10BOTH_2016_0_full/.
70. Technical Review Panel comments from Malawi Round 10 proposal.
71. Global Fund. Namibia Section IV detailed information on HIV/AIDS [Goal 1]. Available at www.theglobalfund.org/grantDocuments/NMB-R02-HA_Proposal_0_en.
72. Global Fund (2009). Namibia Round 8 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/8/notapproved/8NMBH_1726_0_full/.
73. Global Fund (2010). Namibia Round 10 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/10/notapproved/10NMBH_2094_0_full/.
74. Government of Swaziland (2007). Global Fund to Fight AIDS, Tuberculosis, and Malaria 7th call for proposals: HIV/AIDS. Available at www.theglobalfund.org/grantDocuments/SWZ-R07-HA_Proposal_0_en.
75. Global Fund (2010). Swaziland Round 10 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/10/notapproved/10SWZH_2124_0_full/.
76. Global Fund (2012). Swaziland transitional funding mechanism single country applicant. Available at www.theglobalfund.org/grantdocuments/SWZ_TFM_HA_Proposal_0_en/.

77. Global Fund (2009). Zambia Round 8 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/grantDocuments/ZAM-R08-HA_Proposal_0_en.
78. Global Fund (2010). Zambia Round 10 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/grantDocuments/ZAM-R10-HA_Proposal_0_en.
79. Garmaise D (2010). OIG finds serious deficiencies in performance of all four PRs in Zambia. *Global Fund Observer*. Available at www.aidspace.org/gfo_article/oig-finds-serious-deficiencies-performance-all-four-prs-zambia.
80. Garmaise D (2011). CHAZ to replace ZNAN as PR for HIV grants in Zambia; ZNAN no longer solvent. *Global Fund Observer*. Available at www.aidspace.org/gfo_article/chaz-replace-znan-pr-hiv-grants-zambia-znan-no-longer-solvent.
81. Global Fund (2009). Zambia Round 9 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/9/notapproved/9ZAMH_1944_0_full/.
82. Global Fund (2010). Zimbabwe Round 10 proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/10/notapproved/10ZIMH_2149_0_full/.
83. Global Fund (2009). SADC Round 9 multi-country proposal form to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/grantDocuments/MAS-R09-HA_Proposal_0_en.
84. Global Fund (2010). Hivos Round 10 multi-country proposal to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at www.theglobalfund.org/documents/rounds/10/notapproved/10HIVOS-SAH_2081_0_full/.
85. Global Fund (2009). Report of the TRP and Secretariat on Round 9 proposals. Available at www.theglobalfund.org/documents/board/20/BM20_09TRPBoardReport_Annexes_en/.
86. Global Fund (2010). Report of the TRP and Secretariat on Round 10 proposals." Available at www.theglobalfund.org/documents/board/22/BM22_13TRPRound10_Report_en/.
87. Global Fund (2012). Report of the TRP and Secretariat on the transitional funding mechanism. Available at www.theglobalfund.org/documents/board/26/BM26_ER11TRP_Report_en/.
88. See Zambia country chapter in this report.
89. Pangaea Global AIDS Foundation (2011). Formative evaluations of the gender equality and sexual orientation and gender identities strategies of The Global Fund to Fight AIDS, Tuberculosis, and Malaria. Available at https://www.google.com/url?q=http://www.theglobalfund.org/documents/core/strategies/Core_GenderAndSOGIEvaluation2011_Report_en/&sa=U&ei=HA1fUdekK4HF0gHVulGoCw&ved=0CAgQFjAA&client=internal-uds-cse&usq=AFQjCNGoPEMSqyNTvw-pZGGnNYEkK7zP8w.
90. Clinton H (2011). Remarks in recognition of International Human Rights Day. U.S. Department of State. Available at www.state.gov/secretary/rm/2011/12/178368.htm.
91. PEPFAR (2011). Technical guidance on combination HIV prevention. Available at www.pepfar.gov/documents/organization/164010.pdf.
92. Appropriated country-by-country data from <http://foreignassistance.gov/DataView.aspx>.
93. PEPFAR (2009). Focus countries. Available at <http://2006-2009.pepfar.gov/countries/c19418.htm>.
94. Office of the Global AIDS Coordinator (2012). FY 2013 country operational plan (COP) guidance [version 2]. Available at www.pepfar.gov/documents/organization/198960.pdf.
95. AidsFonds (2013). Setting priorities for the Robert Carr Civil Society Networks Fund 2013 and 2014. Available at www.aidsfonds.nl/rc-nf/robertcarrfund.htm.
96. U.S. Department of State (2013). About the Fund. Available at www.state.gov/globalequality/about/index.htm.
97. U.S. Department of State. Bureau of Democracy, Human Rights and Labor (2011). Fact sheet: the Department of State's accomplishments promoting the human rights of lesbian, gay, bisexual and transgender people. Available at www.state.gov/r/pa/prs/ps/2011/12/178341.htm.
98. Prior to FY 2008, only 15 countries were required to submit a full COP.
99. PEPFAR (2010). Country Operational Plan guidance. Available at www.pepfar.gov/documents/organization/148826.pdf.
100. These areas were represented by the COP budget codes HVAP, HVOP, HBHC, HVTB, HVCT, HLAB, HVSI, OHPS (FY 2007, FY2008)/OHSS (FY 2009-2011), and IDUP (FY 2009-2011).
101. Appropriated country-by-country data are available at www.foreignassistance.gov/DataView.aspx.
102. PEPFAR (2007). Botswana 2007 COP. Available at www.pepfar.gov/about/82468.htm.
103. PEPFAR (2010). Malawi 2010 COP. Available at www.pepfar.gov/documents/organization/145727.pdf.
104. PEPFAR (2007). Namibia 2007 COP. Available at www.pepfar.gov/about/82446.htm.
105. PEPFAR (2010). Swaziland 2010 COP. Available at www.pepfar.gov/documents/organization/145735.pdf.
106. PEPFAR (2007). Zambia 2007 COP. Available at www.pepfar.gov/documents/organization/103946.pdf.

107. PEPFAR (2010). Zimbabwe 2010 COP. Available at www.pepfar.gov/documents/organization/145742.pdf.
108. De Cock K, Jaffe H, and Curran J. The evolving epidemiology of HIV/AIDS. *AIDS* 26 (10): 1205-13.
109. Smith A, et al (2009). Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *The Lancet* 374(9687): 416-22.
110. National Research Council (2007). PEPFAR implementation: progress and promise. Washington, DC: The National Academies Press.
111. Baral S et al (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*. 2009; 4(3): e4997.
112. Estimates from 2008 were the most recent at the time this publication was being finalized. The follow-up to the 2008 BAIS report, to be known as BAIS IV, had not been completed.
113. UNAIDS (2010). Report on the Global epidemic 2010. Available at www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf.
114. Beyrer C et al (2009). Sexual concurrency and bisexual practices among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. Abstract W-172, Conference on Retroviruses and Opportunistic Infections 2009. Information obtained from the following presentation: www.jhsph.edu/humanrights/_pdf/Baral_GlobalArcOfJustice_AfricaMSM_Mar09.pdf.
115. UNAIDS (2010). 2010 Botswana UNGASS country report. Available at http://data.unaids.org/pub/Report/2010/botswana_2010_country_progress_report_en.pdf.
116. Beyrer C et al (2010). Bisexual concurrency, bisexual partnerships, and HIV among Southern African men who have sex with men. *Sexually transmitted infections* 86.4 (2010): 323-327.
117. Baral S et al (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*. 2009; 4(3): e4997.
118. The full text of the Botswana Penal Code is available at www.wipo.int/wipolex/en/text.jsp?file_id=238601.
119. As cited on the website of the Botswana Centre for Human Rights (Ditschwanelo) at www.ditshwanelo.org.bw/gay.html.
120. As per a letter from Pastor Biggie Butale, EFB president, in Mmegionline on 2 February 2011. Available at www.mmegi.bw/index.php?sid=2&aid=616&dir=2011/February/Wednesday2.
121. Kenosi D (2011). Just like Mugabe I hate gays – MP Moatlhodi. *Botswana Gazette*. 9 February 2011. Available at www.gazettebw.com/index.php?option=com_content&view=article&id=8678:just-like-mugabe-i-hate-gays-mp-moatlhodi&catid=18:headlines&Itemid=2.
122. Keoring E (2011). Seretse goes on tour with gays. Mmegionline, 8 April 2011. Available at www.mmegi.bw/index.php?sid=1&aid=134&dir=2011/April/Friday8.
123. UNDP (2000). Botswana Human Development Report 2000. Available at http://hdr.undp.org/en/reports/national/africa/botswana/botswana_2000_en.pdf.
124. BBC News Africa (2011). Botswana HIV: Mogae in call to legalize homosexuality. 19 October 2011. Available at www.bbc.co.uk/news/world-africa-15368752.
125. Botswana National Strategic Framework for HIV and AIDS (2010-2016). Available at www.bbca.org.bw/Botswana%20Nat%20Strat%20Fram%202010.pdf.
126. Open Society of Southern Africa (OSISA). Rights not rescue: female, male, and trans sex workers' human rights in Botswana, Namibia and South Africa. OSISA. 2008.
127. Baral S et al (2009). HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS ONE*. 2009; 4(3): e4997.
128. Botswana National Strategic Framework for HIV and AIDS (2010-2016). Available at www.bbca.org.bw/Botswana%20Nat%20Strat%20Fram%202010.pdf.
129. Government of Botswana (2010). Botswana national condom marketing strategy and implementation plan 2012-2016. Available at www.bbca.org.bw/Botswana%20Nat%20Strat%20Fram%202010.pdf.
130. UNAIDS (2010). UNGASS 2010 Malawi country report. Available at http://data.unaids.org/pub/Report/2010/malawi_2010_country_progress_report_en.pdf.
131. Mapondera G (2010). Love fails to conquer all as Malawi gay couple separate. *The Guardian*. Available at www.guardian.co.uk/world/2010/jun/08/malawi-steven-monjeza-tiwonge-chimbalanga.
132. BBC News Africa (2012). Malawi to overturn homosexual ban, Joyce Banda says. Available at www.bbc.co.uk/news/world-africa-18118350.
133. CEDEP. Research. Available at www.cedepmalawi.org/programmes.html.
134. The full text of the strategy is available at http://hivaidsclearinghouse.unesco.org/search/resources/iiep_hiv_prevention_strategy_june_2009_malawi.pdf.

135. Zachariah R, et al (2002). Sexually transmitted infections among prison inmates in a rural district of Malawi. *Transactions of the Royal Society of Tropical Medicine* 96 (6): 617-619. Abstract available at www.journals.elsevierhealth.com/periodicals/trstmh/article/PIIS0035920302903305/abstract.
136. PEPFAR. Partnership to fight HIV/AIDS in Malawi. Available at www.pepfar.gov/countries/malawi/index.htm.
137. PEPFAR (2009). Malawi partnership framework. Available at www.pepfar.gov/countries/frameworks/malawi/index.htm.
138. PEPFAR. Malawi – FY 2010 approved funding by program area, agency and funding source. Available www.pepfar.gov/about/2010/africa/150619.htm.
139. Ministry of Health and Social Services (2011). The 2010 national antenatal sentinel HIV and syphilis prevalence report, Department of Special Programmes. Available at www.doh.gov.za/docs/reports/2011/hiv_aids_survey.pdf.
140. De la Torre C et al. (2009). HIV and AIDS in Namibia: behavioural and contextual factors driving the epidemic. Ministry of Health and Social Services. Available at www.saf aids.net/files/HIVAIDS%20Behavioural%20Report%20Nam_May2009.pdf.
141. Ministry of Health and Social Services (2010). National strategic framework for HIV and AIDS response in Namibia. Available at aidsmap.com.
142. PEPFAR. Partnership to Fight HIV/AIDS in Namibia. Available at www.pepfar.gov/countries/namibia/index.htm.
143. A summary of the strategic investment framework is available at www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2244_InvestmentFramework_en.pdf.
144. As cited in an interview for this consultation with Cebile Dlamini, coordinator of SWAPOL.
145. As cited in the *Times of Swaziland*, July 28, 2010.
146. As cited in the *Times of Swaziland*, June 15, 2012.
147. Baral S et al (2013). Examining prevalence of HIV infection and risk factors among female sex workers and men who have sex with men in Swaziland. USAID Project SEARCH (page 10). Available at www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/Swazi-Quantitative-final.pdf.
148. Chipamaunga S, Muula A, Mayata R (2010). An assessment of sex work in Swaziland: barriers to and opportunities for HIV prevention among sex workers. *SAHARA* 7(3): 44-50.
149. UNAIDS (2012). Swaziland country report on monitoring the political declaration on HIV and AIDS. Available at [www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/ce_SZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/ce_SZ_Narrative_Report[1].pdf).
150. Government of Swaziland (2006). Available at www.gov.sz.
151. Government of Swaziland (2009). The national multi-sectoral strategic framework for HIV and AIDS 2009-2014. Available at www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174723.pdf.
152. Zulu K, et al (2006). Understanding HIV risk behavior among men who have sex with men in Zambia. XVI International AIDS Conference (Toronto, Canada): Abstract no. WEPE0719. Available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/MoTZAMsynthesisFINAL.pdf>.
153. Government of Zambia (2010). National AIDS strategic framework 2011-2015. Available at www.aidstar-one.com/sites/default/files/prevention/resources/national_strategic_plans/Zambia%20NASF%202011-2015.pdf.
154. The text of the Penal Code is available at www.parliament.gov.zm/downloads/VOLUME%207.pdf.
155. Zambia Watchdog (2011). Three Zambian school boys found guilty of practicing homosexuality. Available at www.zambianwatchdog.com/2011/04/06/three-zambian-school-boys-found-guilty-of-practicing-homosexuality/.
156. Government of Zambia (2006). NAC's joint midterm review of the national AIDS strategic framework 2006-2010 technical report. Available at www.nac.org.zm.
157. PEPFAR (2010). Partnership to fight HIV/AIDS in Zambia. Available at www.pepfar.gov/countries/zambia/index.htm.
158. USAID (2009). Fact sheet: multisectoral response to HIV/AIDS in Zambia. Available at <http://zambia.usaid.gov/program-areas/hiv-aids/factsheet/>.
159. Goddard K, Makosa C (2009). Synergy project needs assessment report "issues of HIV and AIDS amongst members of GALZ." GALZ. Available at www.galz.co.zw.
160. The ESP was designed to scale up the national HIV and AIDS response in line with ZNASP I (2006-2010). It was financed by a common fund supported by five bilateral donors, with the majority of funding coming from the UK Department for International Development.

161. The Advocate.com (2012). Zimbabwe rejects calls for LGBT rights. Available at www.advocate.com/news/daily-news/2012/05/21/zimbabwe-rejects-calls-lgbt-rights.
162. Zimbabwe National AIDS Council (2011). Zimbabwe: analysis of HIV epidemic, response and modes of transmission. Available at <http://ms-hiv-gdc.org/wp-content/uploads/group-documents/1/1314808832-Zimbabwesynthesisreport.pdf>.
163. Discrimination of HIV-positive people is prohibited by the Zimbabwean government under the National HIV and AIDS Policy of 2000 and the Statutory Instrument (SI 202) of 1998.
164. Zimbabwe National AIDS Council (2006). Zimbabwe national HIV and AIDS strategic plan (ZNASP) 2006-2010. Available at www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_125613.pdf.
165. PEPFAR. Partnership to fight HIV/AIDS in Zimbabwe. Available at www.pepfar.gov/countries/zimbabwe/index.htm.
166. PEPFAR. Zimbabwe – FY 2010 approved funding by program area, agency, and funding source. Available at www.pepfar.gov/about/2010/africa/150630.htm.

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