The AIDS Accountability Scorecard on LGBT 2011

Element 3: An analysis of global data on HIV Knowledge

for Lesbian, Gay, Bisexual and Transgender people

Holding leaders accountable

AIDS Accountability International

About AIDS Accountability International

AAI is an independent non-profit organization established to increase accountability and inspire bolder leadership in the response to the AIDS epidemic. It does so by rating and comparing the degree to which state and non-state actors are fulfilling the commitments they have made to respond to the epidemic. AAI aims to build bridges between actors and institutions that collect and analyze primary data in the field of HIV/AIDS and those who make use of this data in different contexts, such as policy makers and advocates. AAI provides these actors with a compass that points to new policy and programmatic directions and helps stimulate debate on the need for greater accountability and leadership.

AAI's efforts are made possible through the support of Ford Foundation, Swedish International Development Cooperation Agency (Sida), Norwegian Ministry of Foreign Affairs and Open Society Foundation for South Africa as well as leading experts and civil society organizations in the field of HIV/AIDS.

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AAI would appreciate your feedback. Please send comments and/or corrections to:phillipa@aidsaccountability.org or phone Phillipa on +27 (0)21 466-8074, and these will be included in future revised editions of the report.

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Acknowledgments

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

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

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

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

List of Acronyms

AAI	AIDS Accountability International
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community based organization
CSO	Civil Society Organization
DHS	Demographic and Health Survey
FHI	Family Health International
FSW	Female sex worker
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
ICPD	International Conference on Population and Development
IDU	Injecting drug user
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
IPPF	International Planned Parenthood Federation
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and queer
M&E	Monitoring and Evaluation
MARP	Most at risk population
MDGs	Millennium Development Goals
MSM	Men who have sex with men
MSW	Male sex workers
NCPI	National Composite Policy Index
ND	No data
NGO	Non-Governmental Organization
SOGI	Sexual Orientation and Gender Identity
STD	Sexually transmitted disease
SW	Sex worker
TB	Tuberculosis
TG	Transgender
UA	Universal Access (to HIV prevention, treatment, care and support)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WSW	Women who have sex with women

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Introduction

In 2010, AIDS Accountability initiated research to analyze the degree to which countries are fulfilling commitments to lesbian, gay, bisexual and transgender (LGBT) people in the response to HIV and AIDS: the *AIDS Accountability Scorecard on LGBT*. This scorecard analysis follows on the *AIDS Accountability Country Scorecard* (2008) and the *AIDS Accountability Women Scorecard* (2009). The *Scorecard on LGBT* will be launched in a sequence of ten brief reports from March to November 2011, each covering a key element of the AIDS response.

This third element assesses country performance in terms of the reported coverage of HIV knowledge, specifically focusing on the value of comparing data across 2008 and 2010.

The *Scorecard on LGBT Framework Report* discusses some methodological and other concerns with the data used in this report. It is important to state here that AAI makes no independent claims for the veracity of the data. For the purposes of this scorecard analysis, AAI relies on the screening UNAIDS conducts of the data. The fact that, of all sexually diverse LGBT people, only MSM are covered in the UNGASS set of core indicators is a shortcoming that will be discussed further in the concluding synthesis report.

A concluding synthesis report will be launched in December 2011.

Why a focus on sexual diversity?

Lesbian women, gay men, bisexual people, transgender men and women, intersex and queer people face discrimination and marginalization in many social and economic areas. This is reflected in the response to HIV and AIDS. For instance, the exclusion of LGBT people, with the exception of men who have sex with men (MSM), from the global monitoring and evaluation (M&E) framework can in part explain why their role and behavior in the HIV epidemic is not well understood. This report will show the lack of monitoring and research even on an issue as basic as HIV Knowledge. The focus on LGBT people in this project is thus motivated and shaped by concerns relating to both epidemiology and human rights.

All women are vulnerable due to gender inequalities resulting in reduced employment opportunities (and the related financial constraints), freedom of movement, and exposure to domestic and other violence, among various other societal factors. This situation is exacerbated for lesbian and transgender women, as stigma and discrimination worsen barriers to accessing quality health care. Moreover, these women and transgender men are more vulnerable to homophobic rape and other forms of physical violence that put them at increased risk of HIV infection. Discrimination and violence represent violations of human rights that must stop. Irrespective of the level of exposure to HIV, LGBT people across the world face stigma and discrimination that deny them universal access.

Unsafe sex between men is a key driver in many concentrated HIV epidemics. In some of these countries, effective political advocacy by stakeholders has secured universal access to prevention, treatment, and care and support services. Such levels of coverage must be extended to all who need it. In addition, there is a need to better understand the role, the needs and the vulnerabilities of MSM in countries with generalized epidemics and hyper-endemic HIV.

The overall aim of the *AIDS Accountability Scorecard on LGBT* is to motivate greater emphasis in the AIDS response on the particular needs of all sexually diverse people. The full scorecard, that will be available at the end of 2011, will highlight a lack of data from many countries and poor performance from some, but also point to strong performances and a progressive approach in others. The scorecard analysis is designed to provide an evidence-base for a constructive dialogue between government and stakeholders on the strengths and weaknesses in countries' responses to HIV and AIDS. The scorecard is not intended as a final statement that apportions blame, but rather as a catalyst for an inclusive dialogue that will result in constructive change. It is our hope that the *AIDS Accountability Scorecard on LGBT* will empower stakeholders with new information and analysis that will increase the leverage of their advocacy for stronger responses to AIDS from their respective governments.

Language

The International Planned Parenthood Federation (IPPF) describes sexual diversity as a "term [that] refers to the full range of sexuality which includes all aspects of sexual attraction, behavior, identity, expression, orientation, relationships and response. It refers to all aspects of humans as sexual beings."[i]

The concept of sexual diversity does not position some groups as 'normal' and others as 'abnormal' or 'other', but rather reflects the reality that people have a variety of different kinds of sex, thus challenging the idea of heteronormativity.

For this reason, this report, whilst acknowledging that the research cannot statistically always speak to all sexually diverse individuals due to lack of data, prefers to use the term sexual diversity as an all encompassing term. As an international evaluation of government responses to HIV and AIDS this more global term seems fitting. This report therefore refers to LGBT, sexually diverse and same-sex inter-changeably. This discussion is continued in the Framework Report.

Government Commitment

In the *Millennium Declaration* (2000) and the *Declaration of Commitment on HIV/AIDS* (2001) all United Nations (UN) Member States made far-reaching political commitments for an effective response to HIV and AIDS. The 2001 declaration set targets for the AIDS response against which governments should be held accountable. To measure progress, the Joint United Nations Programme on HIV/AIDS (UNAIDS) developed a monitoring and evaluation framework that, by 2010, had collected four rounds of data on 25 indicators of the response. Further details can be found in the Framework report available on the AAI website

Indicator 14: Knowledge about HIV Transmission

The basis for this report is the data countries submitted to UNAIDS in the 2010 round of the United Nations General Assembly Special Session (UNGASS) reporting on indicator 14. The Guidelines on Construction of Core Indicators (United Nations General Assembly Special Session on HIV/AIDS) stipulates the following with regard to this indicator:

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

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

Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Purpose: To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations.

Applicability: Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemic within a generalized epidemic.

Data collection frequency: Every two years.

Measurement tool: Special behavioral surveys such as the Family Health International Behavioral Surveillance Survey for most-at-risk populations.

Method of measurement:

Respondents are asked the following five questions.
1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

Numerator: Number of most-at-risk population respondents who gave the correct answers to all five questions.

Denominator: Number of most-at-risk population respondents who gave answers, including "don't know", to all five questions.

Indicator scores are required for all respondents and should be disaggregated by sex and age (<25; 25+).

The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the country. Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.

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

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.[ii]

Interpretation

This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained. Surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

The purpose of the indicator is to measure progress amongst most-at-risk populations in terms of knowledge about HIV transmission. UNAIDS requires that all countries with low-prevalence epidemics or concentrated epidemics report on the indicator and collect data on men who have sex with men, sex workers and injecting drug users. However, UNAIDS points out that also countries with generalized epidemics should collect this data in case of concentrated sub-epidemics in these groups. However, the large majority of countries with generalized epidemics fail to conduct such monitoring and/or report whatever data they may have collected. A subsequent LGBT Scorecard element will highlight data that suggest that concentrated sub-epidemics are in fact present among MSM and other sexually diverse populations in many of these countries. While general resource constraints may be the reason for this lack of monitoring it may also, arguably, reflect prevailing discrimination against MSM in those countries.

In addition to data on indicator 14, this report will highlight any relevant information on knowledge on HIV transmission for same-sex people that countries included in the narrative reports.

Knowledge on HIV transmission

If knowledge is power then Indicator 14 is perhaps one of the more important measures of a countries response to HIV.

Knowing how one can reduce their risk of exposure to HIV, and equally importantly reduce the risk of passing on HIV to partners and children is a vital part of a person's basic human right to bodily integrity. Just as obvious is the fact that knowledge reduces stigma and discrimination and creates a more open and caring space for all people in a society.

Many misconceptions abound on how HIV can be contracted (and cured) and having accurate information that is based on science rather than misinformation or myths is fundamental to responsible and respectful behavior. This said, it cannot be taken for granted that having knowledge leads to changes in behavior. However, there is evidence that it significantly contributes to more sensible decision making processes, especially in lowering risk of exposure, in accessing pre and/or post-exposure prophylaxis, or in interactions with PLHIV.

HIV education can happen through many different mediums: lessons (in schools, workplaces, and community meetings), literature (books, pamphlets, comic strips, newspapers, and posters), theatre, music, radio and TV, and modern social information and communication technology (ICT) such as Facebook, Twitter and Mxit Mobile Chat. A variety of people share their knowledge from medical doctors to nurses, business leaders, people living with HIV, children affected by HIV, famous performers and the ordinary citizen. The form that education takes might be spectatorial or participative, it may be scientific or education entertainment driven, what is important is that it effectively caters to the target audience.

Relevant target audiences

Although in the earlier years of the epidemic HIV education campaigns or behavior change communication largely focused on staying HIV negative, over time education campaigns on how to live positively, supporting people affected and infected, accessing HIV counseling and testing (HCT), and treatment have all been key areas of education campaigns. Increasingly there is an awareness and implementation of positive prevention too.

LGBT

As discussed in previous element reports and the Framework Report attached to the AAI Scorecard on LGBT (available on our website) LGBT people face particular barriers in accessing all healthcare as well as adequate quality healthcare and prevention for HIV and AIDS. Elevated levels of risk make these individuals more vulnerable and targeted education campaigns are necessary to inform them of what they can do to protect themselves, their loved ones, and in the case of nosocomial infections their colleagues. Addressing relevant barriers, issues and identifying particular solutions and routes specific to LGBT should obviously form part of any targeted LGBT education programme.

General population

All too often campaigns only target the victims and not the perpetrators. Education campaigns that increase the knowledge of the general population are also necessary to supply them with the knowledge so as to reduce homo-prejudice, reduce stigma and discrimination, and allow many in this group to be able to do their jobs in conjunction with LGBT in an open, caring and effective manner. In some countries, same sex activities or identities are criminalized and this creates in the general population an overt fear, hatred and other negative and unhelpful behaviors and attitudes. Knowledge plays a key role in reducing this destructive behavior and creates more inclusionary and constructive environment for all.

PLHIV

Positive prevention, now also called positive health, dignity and prevention, "highlights and links issues of HIV treatment, prevention, support and care within a human rights framework. Positive Health, Dignity and Prevention highlight the importance of placing the person living with HIV at the centre of managing their health and well-being."[iii]

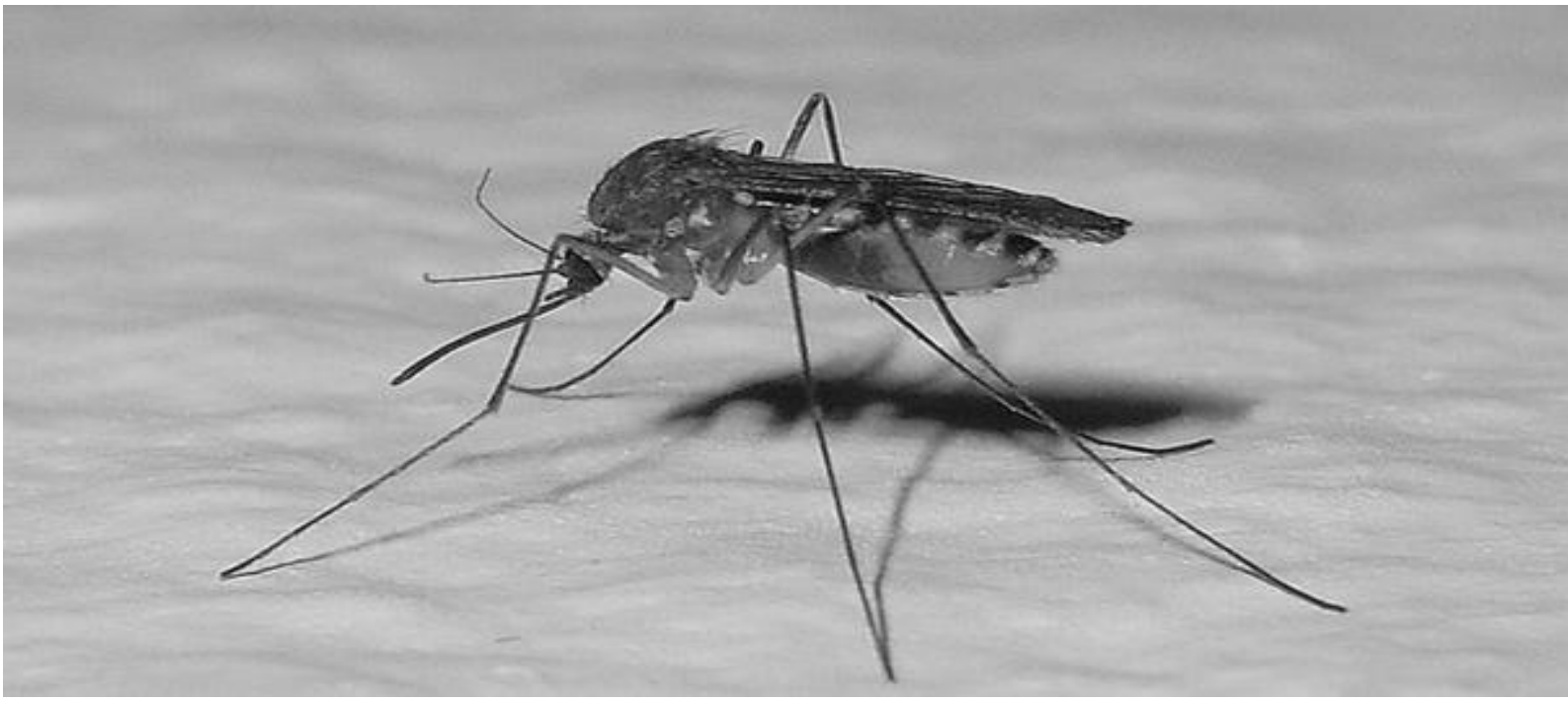
Children

Education campaigns that are aimed at children often cause controversy. Sexuality and gender identity however are issues that many children face. HIV and AIDS also affects or infects many children. An open, sensitive, age-targeted education campaign that addresses not just HIV but gender identity and sexual orientation can go far in assisting young children in dealing with relevant issues. Increasingly, campaigns aimed at adolescents and children are being developed as they often form a captive audience in the school environment, and catches them before they become sexually active thus ensuring that at sexual debut they are already starting off on the right foot.

Prisoners

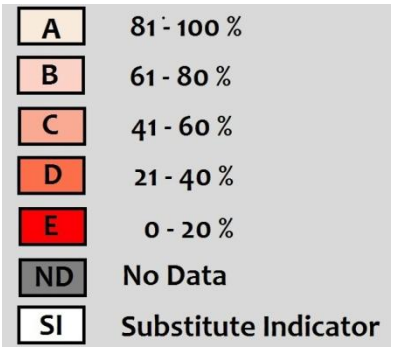
Prisoners are also particularly vulnerable, not only to HIV and other sexually transmitted infections, but also for Tuberculosis. Both consensual sex and rape pose situations in which protection are not often enough provided against transmission. High rates of injecting, and the reduced access to clean paraphernalia also pose increased risk exposure. Tattooing and cutting also pose dangers.

HIV education, as well as other health issues, form an integral part of risk reduction in prisons and should be prioritized by all governments globally. In a world where governments do not do "good things for bad people" prisoners are often neglected and their human rights flouted. Approaches that educate, support and protect prisoners are often justified by protecting their partners and society upon their release. Albeit relevant this is not sufficient to deny a lifetime prisoner a lack of access to HIV education and access to antiretrovirals (ARV), for example.



Indicator 14 captures data for MSM and MSW only. It does not cover WSW or transgender people.

The AAI Scorecard methodology captures the countries performances in five broad 'grades', from A to E based on the data submitted by governments to the UNAIDs system. The grades are allocated according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%). More information on the AAI grading and scorecard methodology is available in the Framework Report available on the AAI website.



Male sex workers

The following section seeks to analyses country performance in terms of HIV knowledge for male sex workers (MSW) in both 2008 and 2010.

Scorecard grading on reported HIV Knowledge coverage

It is important to note that only 18 of the 192 countries reported data on HIV knowledge of MSWs in 2008 (15 countries in total) and 2010 (14 countries in total). 11 of these reported in both 2008 and 2010. 4 of these (Panama, The Former Yugoslav Republic of Macedonia, Indonesia, and Bangladesh) reported the same data from 2006-2007 Bio-behavioral surveys in both years.

Before analyzing the actual coverage of HIV knowledge, it is important to recognize the contribution made by the countries that have acknowledged the need to report on Indicator 14 for MSWs. The very fact that leadership is concerned with a vulnerable group of their population and is willing and able to direct resources to empirical evidence is notable and should be applauded.

These 18 countries and their leaders should be recognized for the role they are playing on both a national and global stage in setting a good example by reporting, even if their performance is low. Perhaps especially if their performance is low. It is a well known fact that governments do not like to report statistics that indicate their shortcomings, however, the fact that these countries have begun a process that will hopefully lead them to improvements is commendable and their transparency laudable.

The lack of collecting and reporting data on MSWs by the remaining 174 countries is in itself a significant example of the lack of focus on same-sex groups as well as sex workers and their experiences of the HIV response. AAI firmly believes that UNAID's aphorism "know your epidemic, know your response" is a necessary part of government obligation from both a human rights and epidemiological perspective. Governments that do not prioritize this data can be said to be failing their citizens and people within their borders.

This said, in some countries this data may have been collected and analyzed by civil society and their contribution may not reflect government ambitions alone but rather that of the effectiveness of national and/or international civil society instead. Family Health International has significantly contributed to many BSS for MSW and their methodology is reportedly used by 6 of the countries reporting in 2010. FHI works closely with governments so indeed this reporting may reflect not replacing governments responsibility but a supportive capacity provided by civil society.

Moreover, from a methodological point of view, the use of the same methodology, of similar sampling methodologies (often respondent driven sampling (RDS)) is useful in creating synergies between datasets and thus adding to the possibilities of comparing data.

Bearing in mind that some countries reported substitute data (data that does not exactly fit the conditions and constraints set by UNAIDS) it is necessary to acknowledge that these countries are still making an effort. This suggests that although their data did not meet the specific criteria set by UNAIDS for the indicator leadership still considers the reporting of the data important. Often countries with limited health care budgets fail to collect data on numerically smaller groups even though they are often the most vulnerable. This is justified by the rationale that there is a greater demand for funding in other areas of work for other groups. This is acceptable practice in some cases and needs to be considered and weighed on a country by country basis. However, oftentimes this substitute data is above the standard of UNAIDS demands and is not comparable with UNAIDS systems. Perhaps the data is available at municipal level for example, and so may reflect a country that has made significant strides in understanding their local challenges.

Similarly the 4 countries that reported the same data from 2006-2007 Bio-behavioral Surveys conducted in 2006-2007 should not be admonished. That the country has already conducted a BSS for MSW is significant, and although ideally all countries should conduct research every two years to monitor progress these countries still represent better response than most.

In the tables below, comparing 2008 and 2010, countries that reported in both years are in bold, whilst countries that reported the same figure for both rounds are in italics.

A		B		C		D		E	
Sweden	***100***	Suriname	75	Mexico	54	**Indonesia**	**37**	***Gabon***	***13***
Panama	**91**	Argentina	67	***Cuba***	***49***	**Bangladesh**	**30**		
		FYROMacedonia	**67**	***Togo***	***46***	***Thailand***	***23***		
				Zambia	41	***Pakistan***	***21***		
				Nepal	***41***				

Table 1: Grades of the 15 countries that reported percentage data on Indicator 14 for MSW in 2008. Countries that reported in both years are in bold, whilst countries that reported the same figure for both rounds are in italics.

A		B		C		D		E	
Panama	**91**	**FYROMacedonia**	**67**	***Sweden***	***60***	***Gabon***	***39***	Serbia	17
Nepal	***81***	***Cuba***	***62***	***Togo***	***50***	Bulgaria	38		
						Indonesia	**37**		
						Bangladesh	**30**		
						Thailand	***29***		
						Paraguay	28		
						Pakistan	***23***		

Table 2: Grades of the 14 countries that reported percentage data on Indicator 14 for MSW in 2010. Countries that reported in both years are in bold, whilst countries that reported the same figure for both rounds are in italics.

Limitations of the data

Excluding those countries that did not report, as well as those countries that did not report both years and reported the same figure we are left with 7 countries with which we can analyze data across time. Theoretically, these countries have provided us with data that can guide advocates, governments and other stakeholders to better understand HIV Knowledge in a particular country. However, in reality this is misleading and requires some further investigation.

Bearing in mind data limitations raised in previous elements, this section focuses solely on whether the data submitted to UNAIDS through the UNGASS reporting process is useful in evaluating trends in government performance with regard to HIV knowledge.

Advocates should know that using two sets of data to measure performance can be misleading although it may seem useful. Often different methods of collecting data (greater sample size, different questions etc) will adversely affect the comparative value of two sets of data. Thus any improvements or worsening signs should be viewed and interpreted in conjunction with information from national advocates.

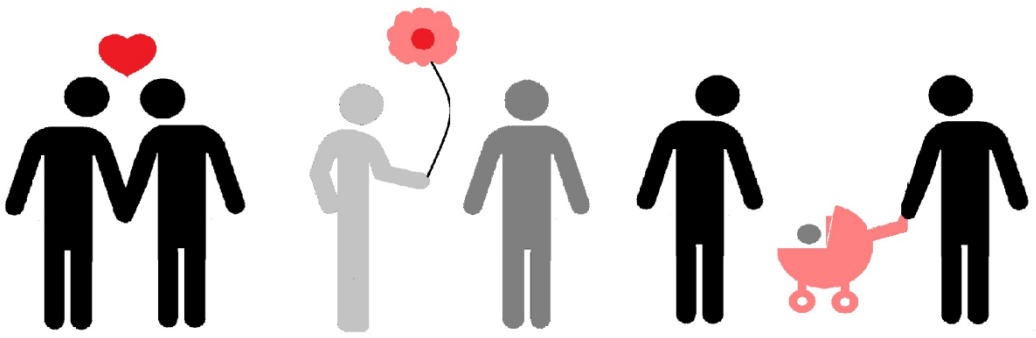
Country	2008 %	2010 %	2008 Grade	2010 Grade
Cuba	49	62	C	B
Gabon	13	39	E	D
Nepal	41	81	C	A
Pakistan	21	23	D	D
Sweden	100	60	A	C
Thailand	23	29	D	D
Togo	46	50	C	C

Table 3: Grades of the 7 countries that reported percentage data on Indicator 14 for MSW in 2008 and 2010. The data should be carefully viewed in conjunction with national evidence so that errors are not carried over into advocacy or policy and programming work.

Sweden for example shows a decline in coverage of MSW Knowledge between 2008 and 2010. However when finding the source data we discover that one male se worker was sampled in 2008 and 15 in 2010. This obviously has limitations of reflecting data for a country albeit one with a small population. However Sweden does stand out as a country that has engaged with laws around sex work, and the debate around this controversial issue ensues. See case study.

Male sex workers have traditionally been one of the more complex groups of most-at-risk populations (MARPs) to access in order to complete accurate and useful research. What is interesting is that similar countries[1] that reported on HIV counseling and testing and HIV Prevention (Scorecard on LGBT Element 1 and 2, available on the AAI website) are seen reporting on HIV Knowledge coverage. This indicates a commitment to knowing and managing sub-epidemics and thus their effect on the general epidemic where applicable.

An overview of all country grades for MSM and MSW separately can be found at the end of this paper.



1 Bangladesh, Bulgaria, Cuba, FYRO Macedonia, Gabon, Indonesia, Nepal, Pakistan, Panama, Papua New Guinea, Peru, Serbia, Sweden, Switzerland, Thailand, Togo and Uruguay also reported on HIV Counselling and testing (HCT) for MSW in 2010, Indicator 8.
Bangladesh, Bulgaria, Burkina Faso, Cuba, Gabon, Indonesia, Mexico, Montenegro, Nepal, Pakistan, Panama, Serbia, Sweden, Togo and Uruguay also reported on HIV Prevention for MSW in 2010, Indicator 9.

Case Study
Sweden

In 1998 (enforced from 1999), Sweden passed the Kvinnofrid law which dictates that sex workers are victims of criminal perpetrators (sex clients) and that it is the purchaser of services that is punished not the victim. The actual law states that: "Anyone who for remuneration procures a temporary sexual relationship will be guilty – if their action is not punishable by some other offense according to the penal code – of purchasing sexual services, and will be sentenced to fines or prison for not more than six months."[iv]

Obviously the language of the law itself is troublesome, defining "the four key words 'remuneration', 'procures', 'temporary', and 'sexual relationship' are far from clear-cut."[v]

However, The Swedish government and people stand behind this law as the official government position is said to be: "Prostitution is considered to cause serious harm both to individuals and to society as a whole. Large-scale crime, including human trafficking for sexual purposes, assault, procuring and drug-dealing, is also commonly associated with prostitution. (...)The vast majority of those in prostitution also have very difficult social circumstances."[vi]

Supporters of the law argued that: it will empower women by:
i. make them think twice before entering prostitution
ii. make it easier to resist if others try to force them into prostitution
iii. many of those already in prostitution will quit if it becomes illegal
- It will have a symbolic value: Make clear that in Sweden we do not accept prostitution.
- The last years a new argument has been used a lot: The law can be used against trafficking. The Swedish government has invested a lot of money in promoting the law to other European countries. The strategy seems to have been to mainly focus on the trafficking argument, and not so much on the Geschlechtshandel argument.[vii]

Whilst respected academics and sex work activists such as Petra Östergren find evidence for the law not only being unique (other countries carry similar legislation), in attempting to eradicate sex work, but it does not limit its punishment to the purchaser of sex services but extends it to the sex worker[viii].

Additionally Ostergren states that the section which states that "it was claimed that if one wants to achieve a gender-equal society, then prostitution must cease to exist – not only for the above-mentioned reasons, but also because all women in society are harmed as long as men think they can "buy women's bodies".2 If the ban would have adverse effects for individual women who sell sex, or if it violates their right to self-determination would not matter. The gender-equal symbolic value of the Sex Purchase Act is more important." [ix]

Either side one chooses missing from the debate is the inclusion of male sex workers, female clients, and principally concerns should be raised over the lack of coverage of men who work as sex workers and that claims are being made by these academics that "We have also found reports of serious adverse effects of the Sex Purchase Act – especially concerning the health and well-being of sex workers – in spite of the fact that the lawmakers stressed that the ban was not to have a detrimental effect on people in prostitution.[10]

Men who have sex with men, bisexual and gay men

Scorecard grading on reported HIV Knowledge coverage

The following section seeks to analyses country performance in terms of HIV knowledge for men who have sex with men, including gay and bisexual men, in both 2008 and 2010.

A		B		C		D		E	
Kyrgyzstan	89	Panama	78	Estonia	60	Lithuania	39	Sri Lanka	20
Costa Rica	85	Greece	74	Ecuador	59	Haiti	36	Philippines	10
		Armenia	74	Belarus	56	Guatemala	33	Georgia	0
		Papua NG	71	China	55	Bulgaria	32		
		Guyana	67	Viet Nam	55	Lao PDR	31		
		Kazakhstan	66	Cuba	54	Bangladesh	27		
		Mexico	66	Mauritius	48	Russian Fed	26		
				Ukraine	47	Thailand	25		
				Moldova	47	El Salvador	25		
				Romania	45	Mongolia	23		
				Bahamas	45	Honduras	21		
				Nepal	45				
				Nigeria	44				
				Indonesia	42				
				FYRO Macedonia	41				
				Peru	40				

Table 4: Grades of the 39 countries that reported percentage data on Indicator 14 for MSM in 2008.

A		B		C		D		E	
Hungary	100	Panama	78	Estonia	60	Lithuania	39	Albania	18
Argentina	96	Dominican Rep	73	Cuba	59	Bulgaria	38	Greece	10
Costa Rica	88	Belarus	72	Bolivia	55	Haiti	37	Honduras	8
		Ukraine	71	Togo	54	Bahamas	36	Iran	7
		Papua NG	71	Mongolia	54	Azerbaijan	36		
		Czech Republic	71	El Salvador	52	Philippines	34		
		Myanmar	68	China	51	Guatemala	33		
		Kazakhstan	68	Paraguay	49	India	30		
		Russian Fed	66	Latvia	48	Bangladesh	28		
		Serbia	65	Uzbekistan	47	Timor-Leste	27		
		Chile	65	Guyana	47	Thailand	26		
		Nepal	64	Nigeria	44	Georgia	25		
		Brazil	62	Indonesia	44	South Africa	24		
		Viet Nam	60	FYROMacedonia	41	Tunisia	23		
						Peru	22		

Table 5: Grades of the 50 countries that reported percentage data on Indicator 14 for MSM in 2010.

Significantly we can note that whereas 39 countries reported on Indicator 14 for MSM in 2008, an increase of 11 countries led to a total of 50 in 2010. Over the period we have a total of 59 countries reporting in both years.

Concerns such as 100% coverage in Hungary, (see previous elements and Framework Report for more detail) will not be covered in this section.

There is a general trend towards greater coverage of knowledge for MSM in the group of reporting countries, as more countries fall into the B Grade category in 2010 than in 2008. The number of countries in B grade is double the number from 2008, going from 7 to 14).

Although we see again reporting of the same figure for both years we reiterate, as above, that if a country deems it prudent to only expend budget on research every four years but is adequately addressing the needs of MSM, it is not necessary to criticize them. It is necessary however to note that this is not often the case and reporting every second round, and limiting budget to marginalized groups is often a politically weak option but all scenarios need to be carefully considered and thoroughly examined at national level.

Limitations of the data

This section seeks to address the limitations of the data that the questions posed to respondents places.

In order to arrive at the following: the percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission, the UNGASS recommendation is that the following questions be asked:

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

UNAIDS also suggests that questions 4 and 5 be replaced, if necessary, with the most popular misconceptions around HIV transmission.

In future developments of the indicator LGBT relevant questions should be included.

Can the use of lubricants reduce the risk of transmission?
Can using dental dams reduce the risk of transmission?
Does early withdrawal reduce the risk for HIV transmission?

These questions also remain relevant for heterosexual people as anal sex is not limited to men who have sex with men, and at the same time does not mean that it is the only form of sex that MSM engage in.

Women who have sex with women, bisexual and lesbian women

It is well known that women are more vulnerable to HIV infection, both due to physiological reasons, as well as social. Gender-based violence and discrimination disempower many women across the globe in terms of their ability to negotiate safer sex. Women who have sex with women (WSW), lesbian and bisexual women face additional discrimination, both from society as well as in the health care environment. Moreover homo-phobic or more correctly les-phobic rape increases these women's risk to a far greater degree.

Additionally, because sex between women is seldom understood in its detail, most believe that it carries a zero risk of HIV transmission. This in turn has led to the almost universal exclusion of WSW in HIV prevention efforts and research. Thus it is fair to say that the level of knowledge around HIV of WSW has never been prioritized even though they are a sexually active group and engaging in both same and heterosexual sex. Discrimination leads many of these women to lead a stealth lifestyle which means they engage in heterosexual sex and they need to be empowered to negotiate for that to be safer too. These realities are often considered unimportant by many in the field of HIV, using the excuse that this being a numerically small group of the population and thus not worth the focus.

This marginalization of WSW is evident not only in governments' actions, but in the development sector too. There needs to be a demand for greater inclusion of funding, research, behavior change communication and understanding of the experiences of WSW with regard to HIV. In 2011 we are seeing this become a reality but the focus needs to grow and continue for years to come.

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Regarding the UNGASS reporting process, the total lack of indicators on these women reflects the current mainstream opinion that these women do not merit inclusion in a global M&E system.

Thus a content analysis was done on the country narrative reports in lieu of the lack of indicators that capture WSW. As a means to measure if any countries are doing work on improving the HIV knowledge levels of WSW.

In our content analysis (methodology available in the Framework Report available on the AAI website) we found only 4 references to WSW and HIV knowledge in three country reports (excluding NCPIs).

Thus in 2010, Norway (1 reference), Sri Lanka (1 reference), and Venezuela (2 references) made mention of WSW and knowledge in their country reports.

Case Studies

Norway

Closer inspection of the three countries reveals that Norway's health directorate works very closely with Gay and Lesbian Health Norway, providing funding (one of the two biggest recipients of funds from the directorate), coordinating training with nurses on LGBT and HIV issues, and otherwise implementing the over 60 measures identified in the action plan "Bedre livskvalitet for lesbiske, homofile, bifile og transpersoner2009-2012" (Better quality of life for lesbian, gay, bi-sexual and transpersons 2009-2012). [x]

Sri Lanka

In the 2010 Country report Sri Lanka deals with MSM, beach boys and LGBT. This recognition of the differences is a step in the right direction. The report states that The AIDS Foundation is supporting a CSO called Equal ground in their work, "which is involved with these groups to carry out awareness programmes, debates on their sexual and reproductive needs and rights. In 2009, they were able to cover 63 direct beneficiaries, 18 organizations in 20 regions of the country.

Knowledge on basic facts of HIV has increased from 26.2% to 58.4% at post intervention. A telephone hotline was established and members were trained to provide information for the inquiries. Around 2096 people have been indirect beneficiaries of these programmes although most of them do not belong to this sub population."xi

Venezuela

Venezuela also notes that there needs to be the realization of research studies on the risk factors related to human rights violations of LGBT people, the creation of specific health systems and the extension of health systems in general for TG, lesbians and bisexual women and gay and bisexual men. Additionally the report adds that there needs to be an expansion of information campaigns for the prevention of HIV transmission for LGBT people, including other vulnerable groups and gender diverse people.[xii]

Importantly, the report also calls for the recognition of sexual orientations and gender identities or expressions in the technical descriptors in the guidelines developed by UNAIDS, to ensure the inclusion of gender diversity in the UNGASS country reports to ensure universal access.[xiii]

Venezuelan leadership should be lauded for this stance and their leadership and accountability to LGBT acknowledged and praised.

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

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

Transgender men and women

Transgender people are at increased levels of risk of exposure to HIV due to lower levels of knowledge around transmission, as well as other factors such as how to negotiate safe sex, how to access post-exposure prophylaxis and. treatment options.

This knowledge factor, compounds other social and political issues that increase risk for TG people. Stigma, discrimination, lack of training amongst healthcare personnel, as well as barriers to income all creates vulnerability around TG people with regard to HIV.

Compounding this is the shortage of HIV campaigns that target trans people in order to empower them. Bockting et al (1998), Dewey (2008), Kenagy (2002) and Nemoto et al (1999 and 2004) all find TG people have lower levels of HIV knowledge and thus increased risk[xiv,xv,xvi,xvii]. Kenagy has been able to identify that female to male (FTM) transgender people have significantly lower levels of AIDS knowledge than male to female (MTF) transgender people. [xviii]

Although the limited research in this group shows greater vulnerability, little research has been done to provide advocates with empirical evidence to demand grater inclusion. Demonstrative of this is the lack of an indicator which reflects the knowledge levels of TG men and women in the UNGASS reporting process.

However, a few countries did report on transgender issues in the 2010 reporting round. The UNGASS process does ask countries to identify their vulnerable populations and some countries, most especially in Latin America and South East Asia have done exactly this.

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Case Studies

Argentina

Argentina states in the 2010 report that in their project on Strengthening Epidemiological Surveillance Study on HIV for Transgender People that there is a need for more research. They acknowledge that "from the standpoint of health, there are few transgender-focused activities aimed at prevention in general, and against HIV / AIDS and STIs in particular. In addition, access to care for the disease of HIV / AIDS may be limited due to low socio-economic status, to shame to expose the status of trans people, and the lack of knowledge and information about HIV / AIDS." A strong component of the strategy of Argentina is to improve the information and data available on the epidemic in the country. Transgender people are included in the list of vulnerable populations targeted for campaigns to increase knowledge.

Argentina also reports on a study on the Conditions of Vulnerability to HIV/AIDS and Problems of Accessing Health Care for Gay and Trans people in Argentina. The study aims to understand the issues and although Argentina is leading the way in doing this kind of work, we hope to see larger studies with larger sample sizes in the future. Argentina also speaks to the need to recognize the human rights of transgender people and not just the epidemiological issues.

Uruguay

Country report in 2010 Uruguay mentions that in October 2009 Uruguay passed Law 18.620 which acknowledges the right to gender identity and to change one's name and gender in order to fully and freely develop one's personality. This should be commended as a laudable step from Uruguay in establishing equality. Uruguay also states that because the country has a concentrated epidemic, epidemiological studies have now recently begun in 2008 on knowledge, practices for trans, as well as MSM and MSW.

Malaysia

The country report for Malaysia refers to the fact that "The situation affecting transgender persons is relatively well known through contemporary local studies of this population. [...] Though the level of HIV and AIDS knowledge in this community remains low, condom use during transactional sex is often observed by transgender sex workers as indicated by the IBBS (condom use with last client was 95%).Despite the findings of studies concerning transgenders which have indicated that the issue of HIV vulnerability in this community is critical, outreach and interventions with this group remain challenging. There are a number of comprehensive programmes which been made available to address this concern."[xix] Certainly a sign that Malaysian leadership is beginning to show progress, whether this is government or civil society led is questionable as worryingly, the report also reminds us that "transgender persons can be charged with indecent behaviour under Minor Offences Act 1955, if they are found to be cross-dressing. The term 'indecent behaviour' has not been defined in the Act, and therefore, it is up to the discretion of the police to determine what constitutes 'indecent' behaviour. They can also be detained by religious authorities."[xx] The report does not address implementation of the law.

All too often transgender people are grouped with other vulnerable groups, and although there may exist some crossovers there needs to be specifically taregetd prevention efforts globally to both MTF and FTM transgenders. And these efforts should be considered a matter of urgency.

Conclusions and Recommendations

Conclusions

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

- **Insufficient response to existing indicators on Knowledge for LGBT:** Although indicators exist only for MSM and MSW, and not for WSW and TG, too few countries are reporting on these indicators. Because these groups are most vulnerable it can clearly be said that most countries do not "know their epidemic", nor do they "know their response."
- **Lack of capacity building around use of data:** There is inadequate attention being placed on how the data can be used by advocates, its limitations and strengths. This indicates a lack of transparency as the real applicability of the data is inaccessible to most.
- **WSW and TG indicators for knowledge do not exist:** This issue needs to be urgently addressed at both UNAIDS and country level. The ongoing and entrenched marginalization of these individuals must stop and leadership in government, multi-laterals, bi-laterals, funders and civil society must react and begin to monitor such basic empirical evidence such as the knowledge levels of WSW and TG.
- **Some countries are making headway:** Several countries are setting excellent examples in paving the way for equality for LGBT people. Notable are the countries that have reported continuously on MSM and MSW indicators, but that have also included TG and WSW in their policy, programming and implementation. This can be said to be truly accountable leadership.

Recommendations

- **Civil society needs to start demanding that governments begin to collect data** on the most marginalized populations, and the ones most at risk, LGBT. Countries must no longer be allowed to ignore the existing indicators for MSM and MSW and must show leadership by making resources available to "Know their epidemic".
- **There needs to be more funding made available to build capacity in advocates and activists in terms of using empirical evidence** for their work. A greater understanding of the usefulness of data, the influence it can have and the limitations that exist, are powerful tools for advocates globally.
- **Activists need to start demanding more indicators, better quality data, more reporting and the inclusion of WSW and TG indicators.** There needs to be an urgent solution to the inclusion of applicable indicators for TG and WSW. The existing questions should be evaluated at country level for applicability.
- **Accountable leadership should be acknowledged:** Countries that have succeeded should be rewarded for their efforts and applauded for leading from the front. Their efforts should be used to set examples for other governments but also as a way for lessons learnt to be shared with others as they venture into this new territory.

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

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

North America		
Canada	ND	ND
United States of America	ND	ND
Oceania		
Australia	ND	ND
Fiji	ND	ND
Kiribati	ND	ND
Marshall Islands	ND	ND
Micronesia, Federated States of	ND	ND
Nauru	ND	ND
New Zealand	ND	ND
Palau	ND	ND
Papua New Guinea	B	ND
Samoa	ND	ND
Solomon Islands	ND	ND
Tonga	ND	ND
Tuvalu	ND	ND
Vanuatu	ND	ND
South and South East Asia		
Afghanistan	ND	ND
Bangladesh	D	D
Bhutan	ND	ND
Brunei Darussalam	ND	ND
Cambodia	ND	ND
Democratic People's Republic of Korea	ND	ND
India	D	ND
Indonesia	C	D
Iran	E	ND
Lao People's Democratic Republic	SI	ND
Malaysia	ND	ND
Maldives	ND	ND
Myanmar	B	ND
Nepal	B	A
Pakistan	ND	D
Philippines	D	ND
Singapore	ND	ND
Sri Lanka	SI	ND
Thailand	D	D
Timor L'este	D	ND
Viet Nam	B	ND

SubSaharan Africa		
Angola	ND	ND
Benin	ND	ND
Botswana	ND	ND
Burkina Faso	ND	ND
Burundi	ND	ND
Cameroon	ND	ND
Cape Verde	ND	ND
Central African Republic	ND	ND
Chad	ND	ND
Comoros	ND	ND
Congo	ND	ND
Côte d'Ivoire	ND	ND
Democratic Republic of Congo	ND	ND
Djibouti	ND	ND
Equatorial Guinea	ND	ND
Eritrea	ND	ND
Ethiopia	ND	ND
Gabon	ND	D
Gambia	ND	ND
Ghana	ND	ND
Guinea	ND	ND
Guinea Bissau	ND	ND
Kenya	ND	ND
Lesotho	SI	ND
Liberia	ND	ND
Madagascar	ND	ND
Malawi	ND	ND
Mali	ND	ND
Mauritania	ND	ND
Mauritius	ND	ND
Mozambique	ND	ND
Namibia	ND	ND
Niger	ND	ND
Nigeria	C	ND
Rwanda	ND	ND
Sao Tome and Principe	ND	ND
Senegal	ND	ND
Seychelles	ND	ND
Sierra Leone	ND	ND
Somalia	ND	ND
South Africa	D	ND
Sudan, North	ND	ND
Sudan, South	ND	ND
Swaziland	ND	ND
Togo	C	C
Uganda	ND	ND
United Republic of Tanzania	ND	ND
Zambia	ND	ND
Zimbabwe	ND	ND

Western and Central Europe		
Albania	E	ND
Andorra	ND	ND
Austria	ND	ND
Belgium	ND	ND
Czech Republic	B	ND
Denmark	ND	ND
Finland	ND	ND
France	ND	ND
Germany	SI	ND
Greece	E	ND
Hungary	A	ND
Iceland	ND	ND
Ireland	ND	ND
Israel	ND	ND
Italy	ND	ND
Liechtenstein	ND	ND
Luxembourg	ND	ND
Malta	ND	ND
Monaco	ND	ND
Montenegro	ND	ND
Netherlands	SI	ND
Norway	ND	ND
Poland	ND	ND
Portugal	ND	ND
Serbia	B	E
Slovakia	ND	ND
Slovenia	ND	ND
Spain	ND	ND
Sweden	SI	C
Switzerland	ND	ND
The former Yugoslav Republic of Macedonia	C	B
United Kingdom of Great Britain & Northern Ireland	ND	ND

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