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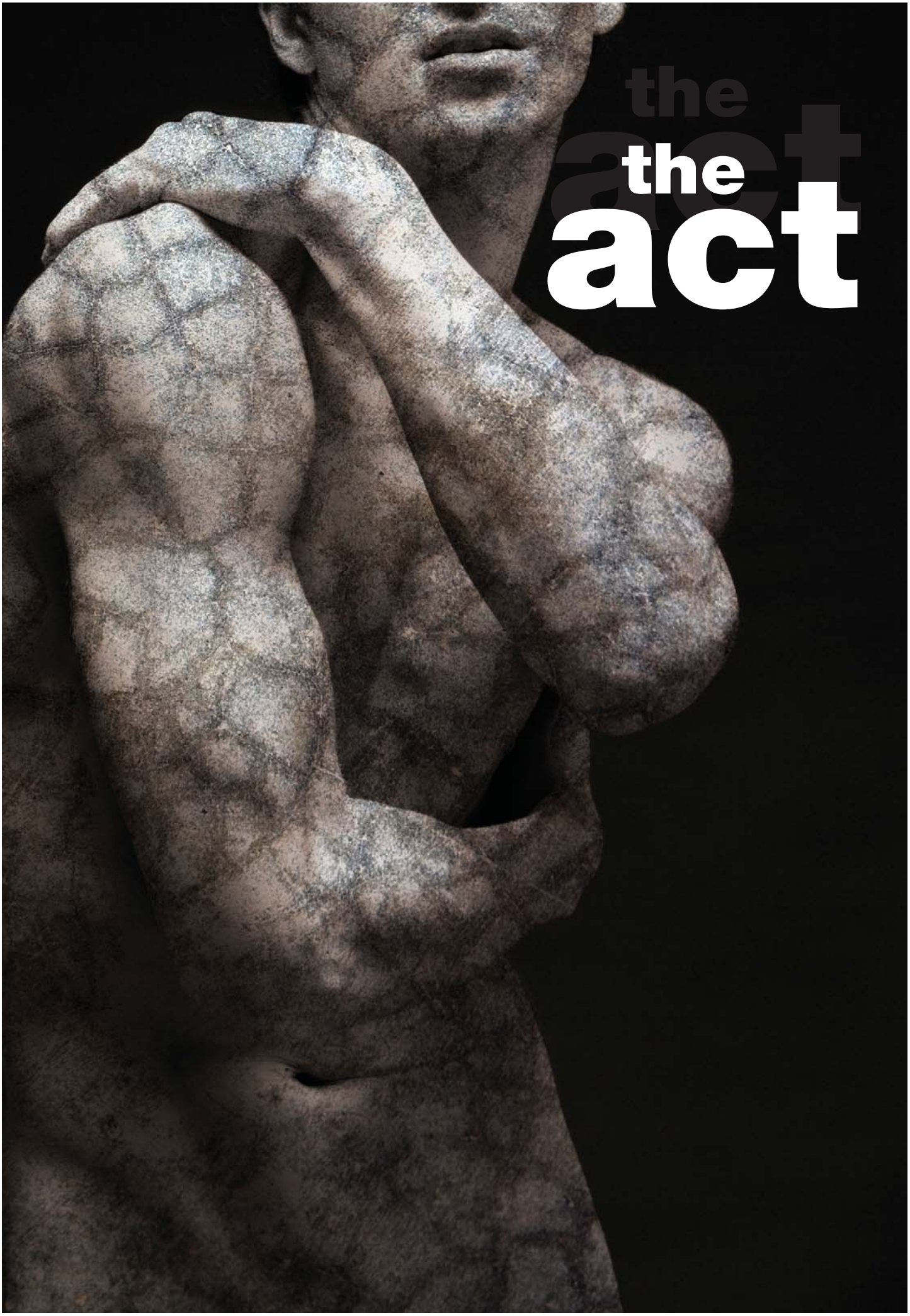

cover

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missionstatement

"AfA is a caring NGO committed to AIDS prevention, advocacy and support. Our mission is to prevent transmission of HIV/AIDS through continuous education targeted at vulnerable groups; to advocate for access to affordable care and against HIV/AIDS discrimination; and to provide support for PWAs, caregivers and volunteers."

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This issue of the ACT examines issues surrounding HIV prevention programmes addressing the needs of men who have sex with men (MSM) in Singapore. Since the start of the epidemic, MSM have been most severely affected of all communities. MSM formed the bulk of infections in the 1980s, this was followed by increasing numbers of heterosexually transmitted infections in the 1990s and 2000s. Proportionately however MSM have a much higher risk of contracting HIV infection than heterosexual males and females. In recent years increasing numbers of MSM are being diagnosed with HIV, the most concerning trend is the greater numbers of younger MSM detected than ever before. An increasing epidemic among MSM has reported almost everywhere in the world, and has been ascribed to several factors including reduced fear of AIDS in the wake of more effective therapies, "AIDS fatigue" among some MSM who may be less committed to condom use, an earlier age at sexual debut, increasing opportunities for sexual liaisons, ingrained marginalisation and discrimination of MSM, decreased funding for prevention programmes, and newer generations of MSM who have not witnessed the cruel reality of AIDS 10 to 20 years ago.

In recent years increasing numbers of MSM are being diagnosed with HIV, the most concerning trend is the greater numbers of younger MSM detected than ever before.

It is clear that a review and overhaul of our approach to addressing the urgent health needs of MSM is long overdue. The series of articles presented in this issue will hopefully be food for thought as well as a call to action.

A/Prof Roy Chan
Editor

5TH SINGAPORE AIDS CONFERENCE

"HIV in Singapore – The Challenge and the Hope"

2 December 2006

3 weeks ago I had the difficult task of counselling a man in his forties, single, well educated, much traveled, someone with an accomplished and productive career, I had to inform him that the 6 month old skin lesions that appeared on his body and arms were Kaposi's sarcoma, and that he had developed an AIDS-defining illness. This was confirmed by a positive HIV test and skin biopsy report. He was devastated.

It was disappointing that he had not come in earlier to seek testing and medical help, he could have avoided developing late stage complications if he had been started on effective anti-retroviral medications.

But he told me that he didn't think he could have been HIV infected before this.

What was more troubling however was my patient's intense fear of going to the Communicable Disease Centre. He asked me if there was a side door he could sneak into and out of the CDC, he was terrified of being spotted and being possibly associated with AIDS.

His story is not an isolated case, there are many who have gone through similar ordeals, and certainly many others will do so in future. It illustrates several of the problems associated with HIV infection and AIDS in Singapore. My patient's fear of AIDS made him unable to admit his own vulnerability to infection. He told me he had high-risk behaviours, but in the past; and because these are taboo and illegal, he kept these secrets even to himself, blocking them out of thoughts and hiding them in the deepest recesses of his psyche.

It is quite clear that although we may have had some measure of success thus far in preventing a major HIV epidemic in Singapore, we have a long way to go in our battle to overcome stigma, exclusion and denial – at all levels of society.

Honourable Senior Minister of State for Information Communications and the Arts, and Foreign Affairs, Dr Balaji Sadasivan, distinguished guests, ladies and gentleman.

On behalf of the Organising Committee I warmly welcome you to the Singapore AIDS Conference – the fifth in this series of biannual meetings where we take stock of what we have done, are doing, and hopefully gain a better understanding of what needs to be done. The theme of this year's AIDS Conference is – "*HIV in Singapore – the Challenge and the Hope*".

Overcoming stigma and discrimination is arguably the major challenge in implementing effective and sustainable AIDS prevention and care programmes here. There are many more, and I would like to mention a few that come to mind.

For patients – Challenges will include –

- How can i remain healthy
- How do I afford to pay for treatment
- How do I keep knowledge of my infection from my employers, colleagues and friends
- How do I maintain my self respect and dignity

For health care providers the challenges include –

- How to give support and encouragement to patients
- How to introduce safer and better treatments
- How to provide cost effective therapies

Challenges for HIV prevention include –

- Providing factual and practical information to young people
- Keeping prevention campaigns and messages fresh and relevant
- Overcoming obstacles to accessing marginalized communities and individuals

On this matter I would like to comment on a legal barrier that stands in the way of effective HIV prevention – and this is the sections in the Penal Code that outlaws sex between consenting males. Over the last 20 years we have been grappling with the problem of reaching out to and educating individuals that this law criminalises, and we have not been very successful. This law has makes it almost impossible to provide clear and accurate prevention messages in public awareness campaigns to target MSM. It has made it impossible to discuss openly and objectively homosexual behaviour and sexual orientation in schools and institutions of higher learning. It should not be surprising that we are reporting more and more young gay men with HIV infection. This law is also one of the main reasons for the prevalence of AIDS-related stigma and discrimination, and for pushing the epidemic underground and into the closet. I believe these sections are obstacles in our attempts to control HIV infection, they are dangerous and endanger lives, especially young ones, and it is high time for us to review them with a view to repealing them.

What are challenges for Advocates?

- how to address and overcome barriers standing in the way of effective AIDS prevention and care
- how to keep AIDS on the front burner, in public view, and not to stop until effective equitable and sustainable programmes are in place

And what would be out hopes?
That we will be able to move forward with real improvements to our prevention campaigns and intervention programmes, enhance our ability to help patients, and ultimately to stop the transmission of HIV in Singapore, and contribute to the regional and global efforts to stop AIDS.

This morning – it is our hope that you will learn from, contribute to, and enjoy this conference.

I would like to acknowledge and to thank

- my co-chair Dr Brenda Ang
- members of the Organizing Committee,
- for all the hard work and dedication, meeting regularly over the last 8 months to produce this marvelousy rich scientific programme
- all the speakers and presenters
- the Organizing bodies and Collaborating Institutions for their support,
- our generous Sponsors and donors – without whom it would have been impossible to stage this conference and to charge such nominal registration fees.

I would also like to especially mention the hardworking volunteers who have put up the exhibitions, who are manning the registration counters and booths, coordinating the AV equipment and powerpoints.

Last but not least I would like to express our deepest gratitude to Nina Sharma of Communication Consultants who has been with us from day one as our conference secretariat.

Thank you.

By A/Prof Roy Chan

SECTIONS 377 AND 377A OF THE PENAL CODE

Impact on AIDS Prevention and Control

Introduction

HIV/AIDS was first diagnosed in Singapore in 1985, in the early years of the epidemic most infections were found among men who have sex with men[1] (MSM). However transmission through heterosexual intercourse quickly increased to become the major transmission category, and MSM sex was often downplayed as a risk behavior. There are now reports increasing HIV epidemics among MSM in several countries in Asia.

(Men who have sex with men, or MSM, refers to any man who has sex with a man, thus accommodating a variety of sexual identities as well as those who do not self-identify as homosexual or gay. In some contexts, "males who have sex with males" may be a more accurate definition, since programming may be directed at males who are not yet adults e.g. individuals under 18 years of age.)

MSM behavior is part of most Asian societies and cultures. However it has been ignored by public health officials, politicians and scientists in this part of the world. Greater attention is now being paid to the role of MSM in the AIDS epidemic, with the realization that much more needs to be done to address HIV infection and risk behaviors in these communities.

Many MSM identify as heterosexual rather than as homosexual or bisexual, especially if they also have sex with women, are married, only take on the insertive role in anal sex, or only have sex with men for money or convenience.

The most visible MSM are male-to-female transgendered persons and transvestites. They generally self-identify as women and don female attire in as many settings as they can. A number are involved in sex work, often because attitudes in mainstream society make it difficult for them to find other employment. Their sexual partners tend to be non-gay-identified men, who are likely to self-identify as heterosexual and who do not view transgendered persons as men.

Singapore like other major urban centre has a growing numbers of men who self-identify as 'gay'. Being much more open about their sexuality with their friends, colleagues and families, gay men may be actively involved in community activities and congregate in gay identified venues. Many Asian societies are however still conservative, and many MSM succumb to pressure to get married and start families, while continuing to be involved sexually with other men.

Probably the largest segment of MSM are 'closeted' individuals who do not openly self-identify as gay, and who have either casual anonymous sexual encounters or highly clandestine relationships with other men. Some may be married and/or also have sex with women. A few may self-identify as bisexual.

Finally, there are those MSM whose natural preference is for women but who have sex with men because of limited access to women. This may be due to strict social segregation of men and women, or being in all-male environments over extended periods of time. Denied access to women, they release their sexual urges with other men, without leading to self-identification as gay or homosexual.

Although there is a growing number of self-identified gay men in Singapore, it is probably the case that such men are outnumbered by those would be unable to adopt such an identity because of cultural, religious, or legal constraints, and who will remain relatively invisible.

Male-male sex is stigmatised almost everywhere. Some former British colonies have repealed the 19th century laws that criminalise same sex behaviour e.g. Australia, New Zealand and Hong Kong. Others like India, Pakistan, Malaysia and Singapore, still retain anti-sodomy laws. Most other Asian countries like China, Taiwan, Thailand, Indonesia, Korea, the Philippines and Japan, do not have laws that criminalize homosexual behaviour.

In Singapore the relevant anti-sodomy laws in the Penal Code are –

Unnatural offences.
377. Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animals, shall be punished with imprisonment for life, or with imprisonment for a term which may extend to 10 years, and shall also be liable to fine.

Outrages on decency.
377A. Any male person who, in public or private, commits, or abets the commission of, or procures or attempts to procure the commission by any male person of, any act of gross indecency with another male person, shall be punished with imprisonment for a term which may extend to 2 years.

Section 377 became effective as part of the British-imposed Indian Penal Code from January 1, 1862, and was adopted by the colonial masters, also as Section 377 into the Straits Settlements Penal Code in 1871. The cloned and transplanted law came into operation in the Straits Settlements of Singapore, Penang and Malacca on September 16, 1872 [1].

Section 377A was added to the sub-title "Unnatural offenses" in the Straits Settlements in 1938. Both sections were absorbed unchanged into the Singapore Penal Code when the latter was passed by Singapore's Legislative Council on January 28, 1955. Similarly-worded legislation was also introduced by the British into their other Asian colonies such as Hong Kong, Malaya and Burma the late 19th century.

Criminalisation of homosexuality fuels stigma and discrimination of MSM and persons living with HIV/AIDS (PWA). Dr Peter Piot Executive Director of UNAIDS and Under Secretary General of the United Nations has identified AIDS-related stigma and homophobia as two major drivers of the HIV pandemic. http://data.unaids.org/pub/PressRelease/2007/20070113_PR_ASEAN_en.pdf
http://data.unaids.org/pub/Speech/2006/20060602_sp_piot_hlm_en.pdf?preview=true. Homophobia, AIDS related stigma and discrimination are especially rampant and prevalent in Singapore, where there is currently not a single PWA who is out in public to talk about his or her infection.

This paper examines how sections 377 and 377A of the Penal Code that criminalise homosexual sex have obstructed programmes to prevent the transmission of HIV in MSM as well as among other heterosexuals. An urgent review with the view to repealing these laws is needed if we are to succeed in controlling the spread of HV infection in Singapore.

Epidemiology of HIV/AIDS in Singapore

Singapore has a population of approximately 4.5 millions. WHO estimates that there are 5500 [3100 – 14 000] persons living with HIV in Singapore, and the prevalence of HIV infection among adults 15 to 49 years of age is 0.3% [0.2 – 0.7%].

Twenty-five years after the start of the AIDS pandemic, 20 years after the first HIV infection was diagnosed in Singapore, and after 15 years of AIDS prevention programmes, the number of HIV infections continues to increase. Up till the end of 2005 there were a total of 2852 HIV infections, of which 1547 had developed an AIDS defining illness. The annual trend of newly diagnosed HIV infections is shown in Figure 1. Foreigners who test positive are not included in official reported figures, in contrast to most other countries where HIV infections detected among foreigners are officially reported and counted.

Males far outnumber females in the ratio of approximately 9 to 1. The majority of infections are seen in heterosexuals. However the number of infections seen in MSM has been increasing, whilst the number of infections among heterosexuals has remained stable over the last 5 years (Figure 2). It is possible that this high male to female preponderance, the most disproportionate anywhere in the world, can be partly explained by misclassification of transmission categories; MSM who are not comfortable or confident will be inclined to declare that they are heterosexuals to health care workers.

The proportion of infections ascribable to MSM behavior has increased in the last 3 years (Figure 3). Thirty percent of infections diagnosed in 2005 were reported in homosexual and bisexual males. The proportion of infections acquired through heterosexual sex in 2005 was 58.4%, 9.5% of these were female, 48.9% were in heterosexual males.

HIV infection is being diagnosed in younger MSM, this trend is evident in recent years (Figure 4). Of the 101 MSM diagnosed with HIV infection in 2005, 4 were in their teens, 24 were between 20 to 29 years, and 44 between 30 to 39 years of age at diagnosis.

At the AfA Anonymous Test Site (ATS) the number of MSM clients counseled and tested increased 19% from 1281 in 2006 to 1522 in 2006 (Figure 5). There were 96 MSM clients who tested positive by Rapid test, confirmed by EIA. The percentage of MSM clients testing positive increased from 4.8% in 2005 to 6.4% in 2006 (Figure 6). This is evidence of an expanding HIV epidemic in MSM in Singapore.

If we exclude those who were previously known to be HIV positive and who came to the ATS to confirm their result, the number and prevalence of HIV infections were 83 and 5.8% respectively. Although this sample of MSM may be biased towards those with higher risk behavior, the prevalence rate in MSM at this test site is significantly higher than heterosexual males (0.3%) and heterosexual females (1%). MSM are clearly at the highest risk of HIV infection in Singapore.

Symptomatic HIV seroconversion illness is an early acute phase of the infection and represents very recent infection. A local case series on HIV seroconversions presented by Wong, Lee and Leo2 described a total of 34 men who had definite or highly suggestive features of this illness between January 2003 and June 2006. The majority are young men who acquired the infection through high-risk sexual intercourse, 23 of the 34 men were MSM, 87% were below 45 years of age, 1 was a student and 2 were NSF.

In summary although the majority of HIV infections in Singapore are contracted through heterosexual sex, there is an expanding epidemic in MSM who now form 30% of newly diagnosed infections. Of grave and immediate concern is the diagnosis of HIV infection in younger MSM, even among teenagers. These are clear indications that prevention messages and awareness campaigns have not been effective in reaching out to the most vulnerable individuals.

AIDS prevention programs for MSM in Singapore

Prevention programs targeting MSM have been conducted through community mobilization and activities coordinated mainly by Action for AIDS (AfA) since 1989. These have included outreach events at entertainment venues frequented by MSM, like bars, clubs and saunas. Small media (pamphlets, fliers and brochures) have been the mainstay for disseminating information. Condoms and lubricants are distributed in selected events and venues, educational talks and safer sex behavioral workshops have also been conducted.

The advent and increasing influence of the Internet has made it convenient and easy for individuals to seek sexual partners. In the 2006 MSM survey 53% of almost 1500 respondents cited the Internet as the most popular avenue where they sought potential sexual partners[3].

AfA has introduced online interventions and educational projects in chatrooms frequented by MSM, these interventions have become an important integral component of AIDS education and prevention activities in Singapore as it has in many other parts of the world.

Over the years AfA has been able to involve and collaborate with gay-identified community groups, individuals, and businesses; high levels of trust and goodwill have been built. Campaigns and programs are funded through private donations and fund raising activities. Since 2003 AfA has received MSM specific program funding from the Department of STI Control, and since 2005 it has also received funding from HPB for prevention programs targeting MSM.

By and large these campaigns have been able to reach individuals who frequent MSM venues, i.e. those who identify as gay and who are relatively 'out of the closet'. The majority are educated and English speaking. It has been difficult to access those who have different demographics and who do not patronize MSM venues.

Testimonies by young MSM with HIV infection

The following are excerpts from testimonies provided by 5 young HIV infected MSM. These testimonies were written in December 2006, they provide an insight into real life experiences, feelings and thoughts of these individuals; they should form a backdrop to deliberations to review current AIDS related policies and strategies.

1 "My journey into the MSM world was when I was sixteen when I chanced upon gay chat channel in the MIRC. I met up with guys through the channels and in most sexual encounters, I would always use protection. However, there are a few instances when it wasn't used as I was too carried away...

I was an undergrad when I was tested positive. At that period, I was very depressed and I do not know what to do. Thus, I kept my focus to immediate tasks at hand then; which was studies. I took up part time job as tuition teacher and other research organization during holiday especially...

I was actually offered a job well before my graduation in some government research lab. However, when I went for the pre-employment checkup, even though there was no blood test done, I inform my doctor of my condition and my job offer was cancelled two days after they know of my condition. I needed the job very much to secure a financial stability so as to pay for my impending medication requirement in order to stay healthy and to be in the work force."

Chinese, 21 years, diagnosed at 21

2 "It is hard to place a timeline on when I discover or realize I was a gay. Given that I had an interest in guys when I was 12 or 13 years old. My first sexual encounter started when I was like 15 years or so, when I got to know the MIRC, Internet chat rooms where I find out there is a gay channel and sgboy channel inside. Through there, I met my first sexual encounter and I had my first anal sex without protection...

From then on, I met guys out for fun and sex until I had a 6 – 7 months of so-called relationship with this guy purely based on sex, which has a term of buddy sex. During the ending period of this relationship, I fell sick a lot of times while he has some nose issue with himself and the doctor but we still continued having sex sometimes. Although we met up regularly, we still do meet other guys up for fun. But in this buddy sex thing, there was not any protection used and most of the time he would ejaculate inside me. But when I had fun outside, the guys would use condoms...

It was when I was 17 years plus, I had a month of prolonged illness of flu, cough and sore throat. I remember it was in near December, Christmas seasons. I started getting sick, and after each recovery I would get sick again. Every visit to the neighborhood clinic made me spend more and more as each time the doctor would prescribe a stronger antibiotic for me. The last visit during that period cost about $90/-...

I do believe that, no matter what, I cannot let my parents find out about this. Each passing day, I would just live my life just as normally I have been doing, but sometimes thoughts that I am going to need medication brings confusion into my head. I did not really have a way of dealing with having HIV. But having thoughts about it running through my head here and there is kind of stressful. My family isn't really financially well off as one of my parents is retrenched. All I had in my mind is to soften my mother's burden and not letting her worrying over my condition...

I do believe that education to the young is the only way in helping us and the society in learning more about HIV, safe sex etc. No matter how young a person is we are exposed to the world in various ways which can influence us in some way. Educating the young in safe sex should be included with the various symptoms of all the sexually transmitted diseases like HIV."

Chinese 19 years, diagnosed at 18

3 "I knew I was gay when I was in secondary school. It was also during that time that I had my first sexual encounter. However I did not tell my friends in school about it. The first time I told a friend about my sexuality was when I was in junior college...

I believed I contracted HIV when I had unprotected sex with someone I knew over the Internet while I was serving the army. I had underestimated the importance of safer sex. I did not think I would be unlucky as to contract HIV. I had sexual encounters too early and the importance of safer sex did not hit me as being crucial. To me, it was more of a form of contraception than a protection against STIs at that time. HIV and other STIs were simply diseases which I thought were gory pictures showing infected genitals...

I am convinced that a better awareness of safer sex and the various STIs can protect individuals. They should be empowered with the necessary information in order to make an informed decision. I wished I knew the dangers of having unprotected sex as well as knowing how I could have protected myself. By casting sex as the forbidden fruit, it made me curious, and I am sure many others feel the same. Being open and honest about sex could be one way forward..."

Chinese 23 years, diagnosed at 20

4 "Coming to terms with my sexuality have been a battle since young.

Having separated parents, my childhood was often hinder by obstacles relating to financial insecurity and survival. I begin to know I like the shape, body and looks of a man compared to a woman when I was as young as 12 years old...

After my birthday at the age of 15, I encounter my first sexual experience with a much older man. As I am always attracted to more matured older man due to my lack of fatherly love during my childhood days...

We proceeded to have oral and anal sex and he penetrated me without a condom. He was so excited that he even ejaculated inside me...

My taste for men has never changed as I am still only attracted to man above 35, some did use a condom when they penetrated me but some don't. I cannot even count the number of times I got penetrated...

During this time, I do not know what safe sex is all about; I thought condom was an option not a preventive tool. If men want to use it its ok, if they don't its fine with me.."

Chinese 22 years

5 "You hear stories about what makes a guy turn gay, the nature vs. nurture theory, you've got to wonder about what makes you, you. One of my friends told me that he became gay when he was molested by his relative. He made being gay sounds like some those toys that just swell when you dip them in water. Would I be attracted to females if I didn't stumble onto sgboy.com that fateful day? Probably, but then I'm pretty sure there are other factors just waiting to bend me...

Getting infected was totally unplanned. I mean, you read about people getting infected and you probably think that you're not that unlucky. But then it happens to me. And that's when I start kicking myself for not heeding the warnings. The fortunate and unfortunate part, the person whom I think infected me was my partner. He has been my partner for almost 3 years now..."

Chinese 24years, diagnosed at 23

Consequences of Sections 377, 377A of the Penal Code on AIDS prevention for MSM

Sections 377 and 377A are obstacles to effective AIDS prevention programs in the following ways –

1 Discrimination against MSM

The criminal status of homosexual sex has resulted in discrimination against and stigmatization of MSM in Singapore. The laws makes presumptive criminals of all homosexual males, homosexuals are treated as immoral individuals deserving of discrimination. As a result of the fear of being identified as homosexual, many do not seek timely testing for HIV and delay care, support and treatment for HIV-related illnesses. Delays in diagnosis and counseling increase the risk of onward transmission of infection to others and to poorer clinical outcomes as a result of delayed treatment.

2 Absent or scanty information on MSM

The discomfort with, avoidance of, or ignorance about homosexuality, in Singapore has resulted in insufficient research into same-sex identity and behaviour in the general population and MSM subcultures. For example there are no reliable population based studies of the number, socio-demographic characteristics, behavioral patterns or psychosocial aspects of MSM in the country. Research has hitherto been conducted mainly on convenience samples e.g. in STI (sexually transmitted infections) clinics and through MSM portals. This lack of data has hampered efforts to design effective HIV/AIDS education and prevention programs for MSM.

3 Difficulty in reaching out to non-gay identified MSM

Most MSM do not patronize gay venues, and are not reached by campaigns that are mainly centered in these venues. MSM must also be reached through broader methods including the mass media. However mass media campaigns are largely irrelevant to MSM, e.g. they contain messages advocating no sex till after marriage, and do not include MSM specific information like the promotion of condom use for anal sex.

4 Inability to address the needs of young MSM

It has been very difficult to reach out to young MSM who are contemplating or already having sex. Young MSM are especially at risk of STI including HIV infection because they are less able to access sources of information and advice about safer sexual practices for the following reasons –

- School-based programs do not have information and materials that discuss homosexuality in an impartial and unbiased manner, including emotions, identity, sexual practices, safer sex techniques and negotiation skills;
- Young MSM may fear seeking professional advice (e.g. from doctors, teachers, youth workers) because to do so would be to admit having committed a crime;
- Support groups and youth organizations for young MSM are practically non-existent; if they do exist they tend to keep a low profile to avoid drawing attention to themselves. Many young MSM will not know of sources of support and peer education;
- MSM venues and clubs operate under clear age-restricted rules to comply with licensing laws. Young MSM are thus not exposed to AIDS education messages and campaigns; young MSM are also less likely to be able to afford the cover charges levied at these clubs and venues. They are also less exposed to the social climate within the organized gay community, which strongly supports "safer sex";
- Young MSM may feel isolated and marginalized and regarded as not part of the broader society due to the criminalisation of their sexuality.

An application for funding of a program that included a component catering to young MSM was rejected because the government agency either did not think it was important or deemed that it was too sensitive a topic to address.

5 Censorship of MSM educational materials and events

Action for AIDS has on several occasions been asked to stop distributing materials containing information on homosexuality even though these materials were meant specifically for MSM venues and events. The reasons repeatedly given by the authorities was that because homosexual sex is illegal, it cannot be mentioned; therefore providing information on safe sex relevant to MSM is also illegal.

At a party catering to MSM, AfA was ordered to close its information booth by the police, the reason given for the order was that information materials contained references to homosexual sex.

As a result of the criminal status of homosexual sex, certain newspapers and organizations have criticized, sensationalized and scandalized educational materials targeting MSM, labeling them pornographic and illegal.

In 2005 the authorities refused to grant a performance permit for a concert by openly gay US Christian singers Jason and deMarco. The concert was to be sponsored by a local gay Christian support group, and proceeds from ticket sales were to be donated to AfA.

6 Interference with gay businesses

Several police actions targeting venues frequented by MSM have hampered and interrupted AIDS prevention programs there.

Some venue owners have expressed their fear and concern that the provision of condoms and lubricants in their premises may be used as evidence that they were promoting illegal homosexual sex. The criminal status of homosexual sex has made it very difficult to get all venue owners together and to commit their businesses to adhere to best practice health and safety standards. If owners are allowed to operate legitimate businesses, they will not be subject to arbitrary harassment and closures, there will be nothing to dissuade them from working with community organizations on HIV prevention activities, and to publicly commit to ensuring agreed safety standards in the venues.

Experiences and examples from countries that have repealed anti-homosexual laws and effect on HIV programs

It is easy to observe the negative impact laws and policies which criminalize homosexual behavior have on AIDS prevention activities. It is logical that such laws and policies will prevent access to those most at risk and will jeopardize efforts to reach out to and protect the target audience. It is not so easy to demonstrate the positive effects of legal and policy environments that don't harass or discriminate on the grounds of homosexuality.

However the following discussion presents examples and experiences of three former British colonies that have repealed laws similar to sections 377 and 377A. They are Hong Kong, New Zealand and Australia. All three former British colonies decriminalized around the start of the AIDS pandemic, all three have significant proportions of their HIV epidemic in MSM, and all three have been more effective and successful in their AIDS control programs than Singapore. I believe we can learn from their experiences.

1 Australia

Australia has a population of 20 millions.
WHO estimates there are 16,000 [9700 – 27 000] persons living with HIV, and the prevalence of HIV infection among adults 15 to 49 years of age to be 0.1% [< 0.2%].
http://www.who.int/hiv/mediacentre/2006_GR_ANN1A-L_en.pdf

All states in Australia have decriminalized homosexual acts, the first was South Australia in 1972, and the last state was Tasmania in 1997.

The Australian Institute of Criminology has reviewed homosexual law reform in Australia4. The paper cites a 1989 consultation paper by the Department of Community Services and Health (Australia 1989, p. 8) that recommended:

That laws criminalizing consensual adult homosexual acts in private be repealed. The age of consent for homosexual activity should be the same as for heterosexual activity. Many of the people who appeared before the panels argued that the illegal nature of homosexuality in some states created a barrier for workers attempting to carry out education and prevention programs with homosexual groups. Many people expressed concern at having their names on lists of organisations, such as AIDS Councils, which could be seized by police and used as evidence in prosecutions or lead to disclosure of their activities to employers or others.

The Australian Federation of AIDS Organizations in 1989 argued that the criminal status of homosexual behavior leads to difficulties at two levels, the public and the personal. At the public level these difficulties involve restrictions placed on the nature of programs and services offered to those at risk because the government cannot be seen as supporting or encouraging illegal activity. At the personal level individuals will be unlikely to have confidence in services that they might otherwise use if they fear there may be negative repercussions at a later date.

Bull et al report that it has been alleged that the attitude of a former state government towards homosexuality seriously restricted any response to the AIDS crisis. The Queensland AIDS Council suggests that *"there can be no serious doubt that lives have been lost in Queensland because of the laws...If there had been State government support for education and behavioral change programs for gay men then, from November 1984, it would not be unreasonable to claim that 25 percent of the cases of AIDS we now have wouldn't have occurred.*

Figures from the National Health and Medical Research Council provide further support for this assertion. As of June 1990, there were 892 known cases of HIV infection in Queensland. Eighty people had already died from full-blown AIDS. To make a comparison – Queensland has twice the population of South Australia, but more than twice the rate of HIV infection and more than twice the death toll. Sinclair and Ross (1985) have compared two populations of homosexual men that are similar apart from living in 'criminalized' and 'decriminalized' jurisdictions. The jurisdictions chosen were South Australia and Victoria. A questionnaire was used to obtain homosexuals' views in these states. At the time of data collection (1979-80) Victoria had a maximum penalty of 20 years for homosexual acts between males, while the South Australian law had been repealed in 1975.

The findings of this study suggested that there were few if any negative consequences of decriminalizing homosexual practices. It appears that the positive consequences of decriminalization include an improvement in the psychological adjustment of homosexual men and a decline, within the gay community, in the incidence of sexually transmitted diseases and public solicitation.

2 Hong Kong

Hong Kong has a population of 6.9 millions.

The epidemiology of HIV infection in HK SAR closely resembles that of Singapore in a number of ways. The cumulative number of HIV/AIDS at the end of 2005 was 2825 (Singapore 2852). The male to female ratio of infections in 2005 was 4:1 (Singapore 9:1); MSM formed 37% of infections in 2005 (Singapore 30%).

Hong Kong has over 50% more people than Singapore, however it has the same number of reported HIV infections than Singapore, i.e. our HIV problem is 50% bigger than Hong Kong's.

Hong Kong decriminalized sodomy in 1991. Today there are several gay community groups and AIDS organizations openly supported by the health department that are actively involved in AIDS prevention activities in Hong Kong as well as on mainland China.

Like Singapore, Hong Kong has also noted a rise in HIV infection in MSM. In 2006 the Hong Kong Advisory Council on AIDS conducted a community assessment and evaluation of HIV efforts on MSM in Hong Kong 2006.
http://www.info.gov.hk/aids/pdf/g171.pdf

The consultation recommended HIV prevention efforts in MSM in Hong Kong should follow 3 guiding principles –

- HIV prevention programs should be sensitive and specific for the culture of different sub-populations.
- the gay community should be empowered and actively engaged in the HIV prevention
- a non-discriminating and enabling environment in society is an essential element of a successful HIV prevention program.

It proposed the following set of 6 strategies –

- Scaling up current targeted prevention efforts
- Researching the HIV epidemiology and behavioral pattern
- Fostering greater gay community involvement
- Establishing regional collaboration
- Expanding current HIV-focused approach into a holistic sexual health approach
- Promoting an enabling environment in the society

"A successful HIV prevention in MSM community should be led by the gay community itself and with a strong support from the government, in terms of policy, funding and technical resources."

3 New Zealand

New Zealand has a population of just over 4 millions. WHO estimates the number of HIV infections to be 1400 [840 - 2300], and the prevalence of HIV infection among adults 15 to 49 years of age to be 0.1% {<0.2%].

New Zealand decriminalized homosexual sex in 1986.

In his 2006 presentation Dr Phil Parkinson[5] (Research Librarian at the Alexander Turnbull Library and a curator of the Lesbian and Gay Archives of New Zealand) recounts *"instead of seeking a purely medical model response (to HIV) as we still are when it comes to bird flu, New Zealand resorted to social engineering by decriminalizing gay sexual behavior."* He continues *"the interface between criminal law and public policy was of great concern - how on earth could an effective campaign against an epidemic be carried out if the very measures to prevent infection, such as the promotion of safety in sexual practices were vitiated by the confirmed criminal sanctions against those very practices? From the broader public health point of view decriminalization was an essential prerequisite to protecting the public health."*

The Director General of Health acknowledged that passing the Bill would be *"likely to promote the mental well-being of persons of homosexual orientation"* and that the passage of the Bill could offer some "positive benefits" for the AIDS campaign *"which would depend for their success to some extent on good communication and the effective and open dissemination of information"*. He concluded that the department *"cannot justify on health grounds the present legislative provisions regarding homosexuality. The department supports the proposed bill for the reasons described above"*.

International declarations, best practices documents, and recommendations relating to prevention of HIV among MSM

Numerous regional and global consultations and publications have reiterated the fact that the stigma, discrimination and criminalisation faced by MSM and transgendered people are major barriers to access to HIV prevention, treatment, care and support, and have called for the removal of laws and policies targeting MSM.

1 In 2001 the UN General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS adopted by all UN Member States emphasized the importance of addressing the needs of those at greatest risk of, and most vulnerable to, HIV infection.

UN General Assembly Resolution
S-26/2. Declaration of Commitment on HIV/AIDS – 2 August 2001
http://www.un.org/ga/aids/docs/aress262.pdf

Relevant paragraphs –

16. Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;

21. Noting with concern that some negative economic, social, cultural, political, financial and legal factors are hampering awareness, education, prevention, care, treatment and support efforts;

58. By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic;

64. By 2003, develop and/or strengthen national strategies, policies and programs, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behavior, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise

2 At the 2006 High Level Meeting on AIDS, UN member states and civil society members reiterated the commitment, underlining the need for participation of vulnerable groups and to eliminate all forms of discrimination against them.

UN General Assembly Resolution
60/262. Political Declaration on HIV/AIDS – 15 June 2006
http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

Relevant paragraphs –

24. Commit ourselves to overcoming legal, regulatory or other barriers that block access to effective HIV prevention, treatment, care and support, medicines, commodities and services;

26. Commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behavior, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services;

29. Commit ourselves to intensifying efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and developing strategies to combat stigma and social exclusion connected with the epidemic;

3 UNAIDS Policy Brief - HIV and Sex between Men
http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf

Relevant paragraph –

Actions for governments:
Respect, protect and fulfill the rights of men who have sex with men and address stigma and discrimination in society and in the workplace by amending laws prohibiting sexual acts between consenting adults in private; enforcing anti-discrimination; providing legal aid services, and promoting campaigns that address homophobia.

4 CDC HIV/AIDS Fact Sheet – HIV/AIDS among Men Who Have Sex with Men –
http://www.cdc.gov/hiv/resources/factsheets/msm.htm

Social Discrimination and Cultural Issues
MSM are members of all communities, all races and ethnicities, and all strata of society. To reduce the rate of HIV infection, prevention efforts must be designed with respect for the many differences among MSM and with recognition of the discrimination against MSM and persons infected with HIV in many parts of the country.

5 The World Bank. Confronting AIDS. Public Priorities in a Global Epidemic –
http://www.worldbank.org/aids-econ/confront/confrontfull/

This document addresses AIDS control programmes in terms of economics and cost-effectiveness.

Efficient and Equitable Strategies for Preventing HIV/AIDS
There are three activities in which governments have an indispensable role in ensuring the efficiency and equity of prevention programs: providing public goods related to prevention; reducing the negative externalities of risky behavior by promoting safer behavior among people who are most likely to contract and spread the virus; and promoting equity by ensuring that the most destitute are not denied access to the means to protect themselves from HIV. These activities will reduce the spread of HIV most quickly and will benefit everyone in society, including those with low-risk behavior and the poor.

Cost-effectiveness and the accessibility of target populations. Although it is highly desirable to focus public interventions on those who are most likely to contract and spread HIV, identifying and reaching these individuals can be difficult, especially where legal sanctions and social stigma cause these people to want to avoid being discovered. The costs of reaching those most likely to contract and spread the virus can have a significant impact on the cost-effectiveness of interventions.

6 International Guidelines on HIV/AIDS and Human Rights – 2006 Consolidated Version. Published jointly by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS.
http://www.ohchr.org/english/issues/hiv/docs/consolidated_guidelines.pdf

Guideline 5 – Anti-discrimination and Protective Laws
States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

(h) Anti-discrimination and protective laws should be enacted to reduce human rights violations against men having sex with men, including in the context of HIV, in order, inter alia, to reduce the vulnerability of men who have sex with men to infection by HIV and to the impact of HIV and AIDS. These measures should include providing penalties for vilification of people who engage in same-sex relationships, giving legal recognition to same-sex marriages and/or relationships and governing such relationships with consistent property, divorce and inheritance provisions. The age of consent to sex and marriage should be consistent for heterosexual and homosexual relationships. Laws and police practices relating to assaults against men who have sex with men should be reviewed to ensure that adequate legal protection is given in these situations.

Summary Points

1 HIV infection is increasing in Singapore, especially in MSM. Current strategies appear to be ineffective in controlling HIV infection.

2 Research and information on MSM are lacking. Educational campaigns and interventions that address the needs of MSM are inadequate.

3 Education and provision of services for young MSM are particularly deficient, putting young MSM at the greatest risk of HIV infection.

4 The ability of the AIDS Control Program to reduce HIV transmission in MSM is significantly weakened by anti-homosexual laws.

5 Former British colonies that have repealed anti-homosexual laws are more successful than Singapore in reducing HIV transmission in MSM and general population.

6 Effective AIDS strategies should be supported and not undermined by policies and laws.

7 Decriminalisation of homosexual sex will significantly enhance educational and behavioural change programmes; it will reduce stigmatisation of and discrimination against MSM as well as persons living with HIV infection. Decriminalisation is necessary if we are to have an effective HIV Control Programme in Singapore.

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5 Legitimation through disaster? AIDS and the Homosexual Law reform Campaign, 1983-1993, Phil Parkinson (in press).

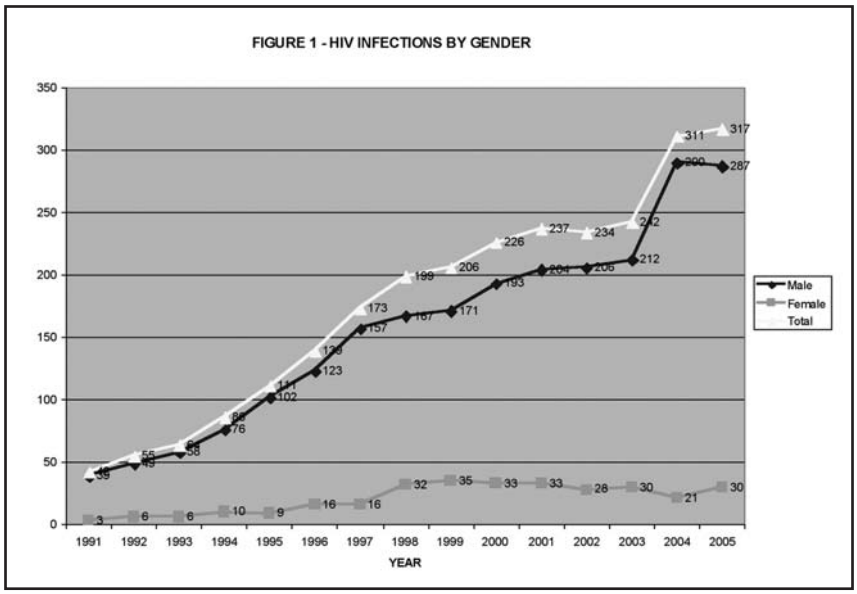


FIGURE 1 - HIV INFECTIONS BY GENDER
350
300
250
200
150
100
50
0
1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005
YEAR
Male
Female
Total
39 49 58 76 102 123 157 171 193 204 206 212 287
3 6 6 10 9 16 16 32 35 33 33 28 30 21 30
55 66 86 111 139 173 199 206 226 237 234 242 311 317

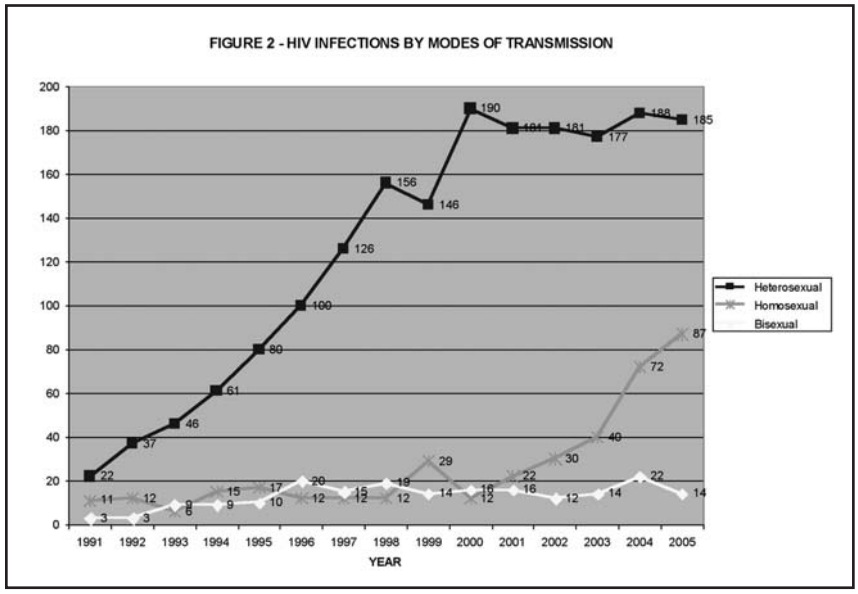


FIGURE 2 - HIV INFECTIONS BY MODES OF TRANSMISSION
200
180
160
140
120
100
80
60
40
20
0
1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005
YEAR
Heterosexual
Homosexual
Bisexual
22 37 46 61 80 100 126 146 156 190 181 181 177 188 185
3 3 6 9 10 12 12 12 14 12 16 12 14 22 14
11 12 9 15 17 20 15 18 29 16 22 30 40 72 87

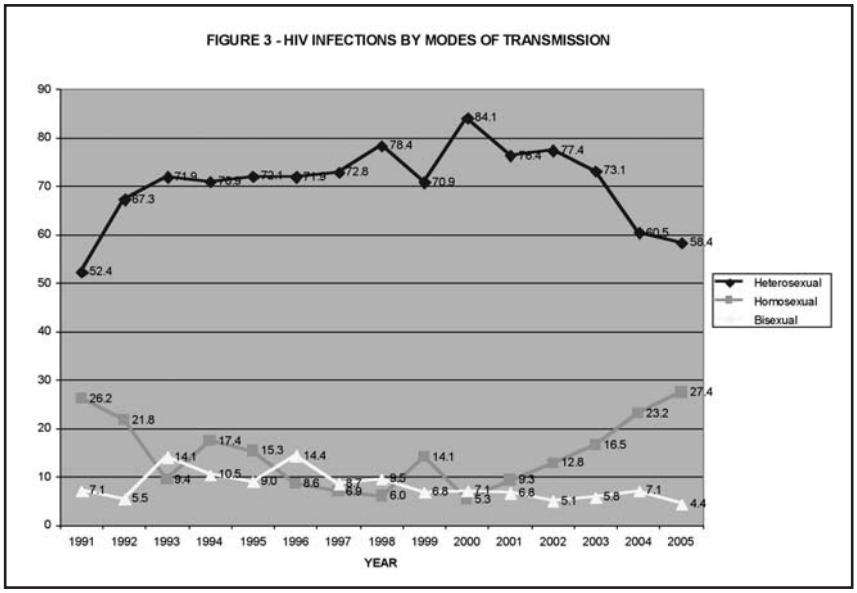


FIGURE 3 - HIV INFECTIONS BY MODES OF TRANSMISSION
90
80
70
60
50
40
30
20
10
0
1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005
YEAR
Heterosexual
Homosexual
Bisexual
52.4 67.3 71.9 70.9 72.1 71.9 72.8 78.4 70.9 84.1 76.4 77.4 73.1 60.5 58.4
7.1 5.5 9.4 10.5 9.0 8.6 6.6 6.0 6.8 5.3 6.8 5.1 5.8 7.1 4.4
26.2 21.8 14.1 17.4 15.3 14.4 8.7 9.5 14.1 7.1 9.3 12.8 16.5 23.2 27.4

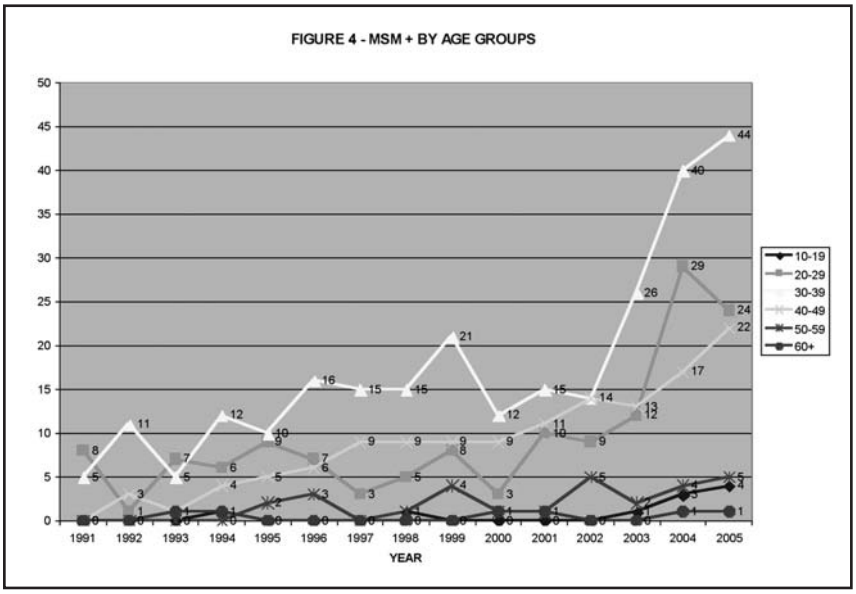
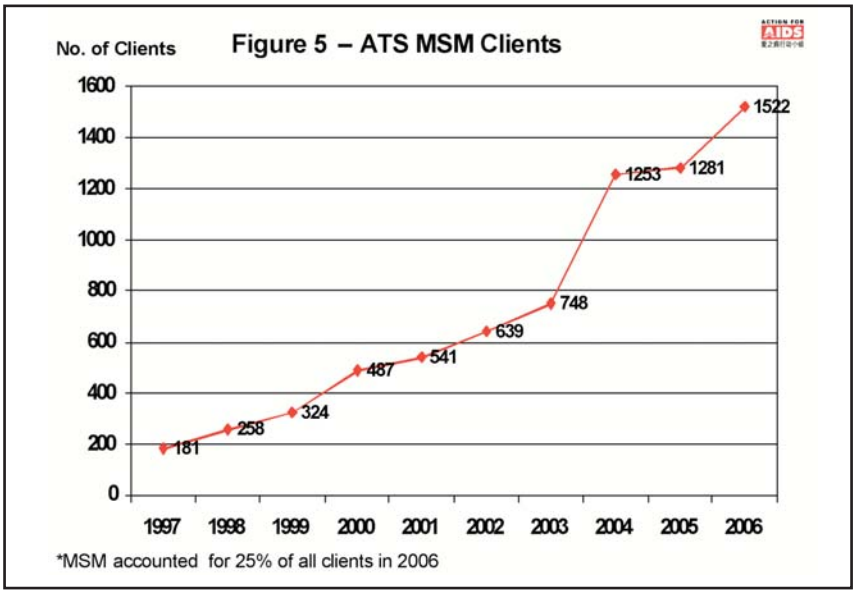


FIGURE 4 - MSM + BY AGE GROUPS
YEAR
10-19
20-29
30-39
40-49
50-59
60+


No. of Clients
Figure 5 – ATS MSM Clients
*MSM accounted for 25% of all clients in 2006

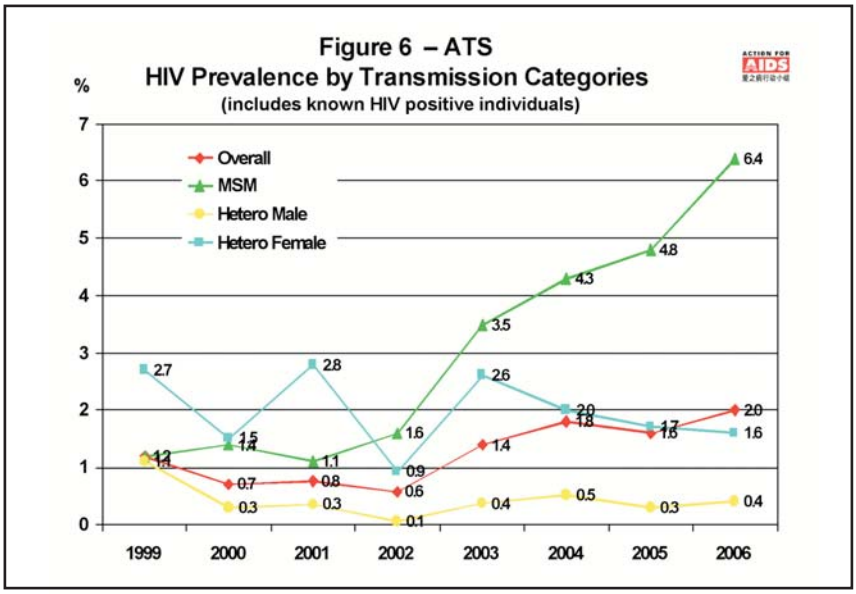
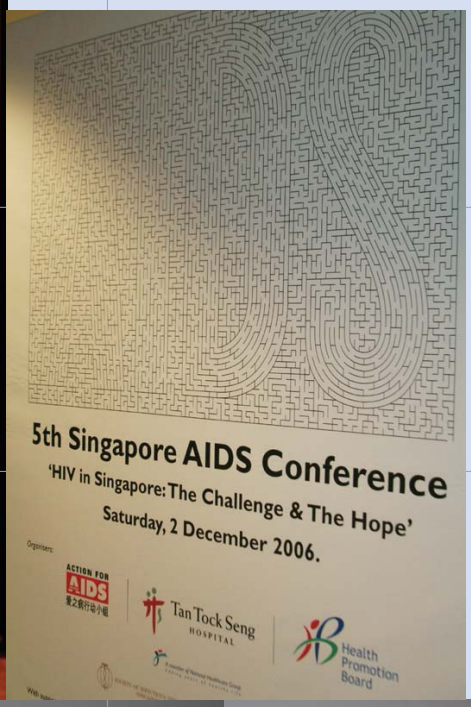


Figure 6 – ATS
HIV Prevalence by Transmission Categories
(includes known HIV positive individuals)
%
Overall
MSM
Hetero Male
Hetero Female

"HIV in Singapore – The Challenge and the Hope"

2 December 2006

Speakers Q&A for Symposium 5



The 5th Singapore AIDS Conference (SAC), jointly organised by Action for AIDS, Singapore, Tan Tock Seng Hospital and Health Promotion Board, was successfully held in conjunction with World AIDS Day, on the 2nd December 2006 at the SICCI.

The conference drew a record number of delegates and guests of about 500 which also saw a good number of sponsors from the British High Commission, Singapore and major pharmaceutical companies. Amongst the guests invited were the Guest-of-Honour, Dr Balaji Sadasivan, Senior Minister of State and keynote addressee, Dr Swarup Sarkar, Regional Adviser on Prevention and Strategic Information, UNAIDS and key opinion leaders from around the region. As the theme of the 5th SAC was "HIV in Singapore – The Challenge and The Hope", the two plenary sessions and five symposia were centered on topics in pertinence to mainly the social challenges on Youth, MSM (Men who have sex with men), women and other vulnerable groups such as sex workers, clients and prison inmates. In addition, a specific clinical symposium was dedicated to discuss issues relating to medical treatment, management and care relating to HIV/AIDS.

Guest-of-honour Dr Balaji (left) A/Prof Roy Chan Opening Address (right)

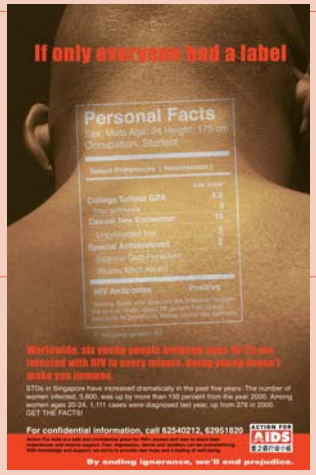
Delegates from Health Promotion Board

Digital Art Against AIDS 06

After a hiatus of 4 years, Art Against AIDS was revived in 2006. To keep abreast with the burgeoning digital art and media scene in Singapore, the Art Against AIDS committee sent out a call for entries for 4 different digital art categories: Photography, Video, Animation and Graphic/Poster Design. In an attempt to encourage open and critical thinking, no specific theme was set, though participants were encouraged to deal with HIV/AIDS prevention messages or the experience of PWAs.

Digital Art Against AIDS 06 received 130 entries in total, mostly from arts students under 30. The winning entries were exhibited at the National Library and the outdoor plasma screen at The Heeren Shops for duration of 1 month, with constant access to human traffic.

Photography Category Top Prize – "Red Alert"



Graphic/Poster Design Category Top Prize – "If Only Everyone Had A Label"

Graphic/Poster Design Category Special Mention Prize – "For The Children"

Graphic/Poster Design Category Distinction Prize – "No Cure"

Photography Category Distinction Prize – "As Much As We Need Water"

Two key events were held: The Challenge and The Hope Exhibition (NLB) on 5 – 26 Dec 06, and the Prize Presentation and Outdoor Plasma Screen Launch (The Heeren Shops) on 6 Jan 06.

The main sponsor, iShop by Club 21, generously donated Apple iBooks as top prizes. The committee is also grateful to venue sponsors, The Heeren Shops, Eastpoint Mall and the National Library Board, as well as design and production supporters, Chemistry and Embassy.

Photography Category Merit Prize – "Cracked"

By Dr Stuart Koe

KABP Survey on HIV and AIDS Amongst MSM IN SINGAPORE

Introduction to Behavioral Surveillance Surveys

Successful HIV prevention depends on changing risk behaviors, not simply knowledge of HIV and how it is transmitted. This includes increasing the rate of condom usage, and reducing the rate of inconsistent condom usage. The study on knowledge, attitudes, beliefs and practices (KABP) serves not only as a monitoring tool to evaluate the efficacy of HIV outreach programs to MSM over time, but is also a tool that can be used to identify gaps in existing programs, identify attitudes or beliefs that are leading to risk behaviors.

Behavioral surveillance surveys (BSS) have been shown over several years to make an important and useful contribution to informing the national response to HIV. These surveys use reliable methods to track HIV risk behaviors over time as part of an integrated surveillance system which monitors various aspects of the epidemic. They are especially useful in providing information on behaviors among sub-populations who may be difficult to reach through traditional household surveys, but who may be at especially high risk for contracting or passing on HIV, such as men who have sex with men (MSM).

Most surveillance efforts to date have concentrated on tracking AIDS cases or the spread of the HIV virus itself. When HIV prevalence is rising, it gives a good indication that prevention programs are failing, but no indication of why. Stable or falling HIV prevalence could mean fewer new infections, or it could mean more deaths. And because a person can live with HIV for many years before it is detected, HIV prevalence figures reflect a mix of old and new infections, and are not useful for documenting recent changes in new infection rates.

On top of that, HIV surveillance by itself is of limited use in places where HIV infection is still relatively uncommon. Continued low prevalence in a population may mean that members of the population do not engage in behavior that would expose them to HIV, perhaps because HIV prevention programs have been successful. Or it may simply mean that the virus has not yet reached a critical mass in that population. If risk behaviors do exist but are not recorded, the opportunity to plan programs to reduce risk before the virus explodes through a population with risk behavior will be lost.

Effective prevention is prevention that enables people to adopt safer behaviors and protect themselves from the risk behavior of their partners. But unless something is known about existing risk behavior, it is not possible to support relevant safe alternatives.

Behavioral data can indicate who is most at risk of contracting or passing on HIV infection and why. It can help communities and program planners come up with initiatives carefully focused on breaking the links in the chain of transmission. Without information on HIV-related risk behavior, public health officials and others are unlikely to be able to prioritize their interventions so that they have
the greatest impact in curbing the spread of HIV.

Behavioral data can pinpoint specific behaviors which need to be changed, and can also highlight those that are not changing over time in response to program efforts. This information should lead to a rethinking of prevention approaches, and the design of new, and more effective interventions.

A good behavioral data collection system will give a picture of changes in sexual behavior over time. The system will record a reduction in risky sex just as it will record persistent risk behavior or shifts in the pattern of risk.

These changes should give an indication of the success of a package of activities aimed at promoting safe behavior and reducing the spread of HIV, both in the general population and in groups with high risk behavior.

Showing that behavior can and does change following national efforts to reduce risky sex is essential to building support for ongoing prevention activities.

The 2006 AfA/Fridae MSM KABP Survey

In April 2006, Action for AIDS Singapore, in collaboration with Fridae.com, conducted the third online behavioral sex survey of men who have sex with men (MSM) in Singapore. The survey aimed to gain an in-depth understanding of the attitudes and behavior of MSM, with the objective of using the results to design HIV prevention campaigns to be more effective in addressing MSM issues.

The study was based on a set of questions called the Behavioral Surveillance Survey (BSS) format developed by Family Health International (FHI) and IMPACT (Implementing AIDS Prevention and Care Project). Statistical analysis was provided by Professor George Bishop from the National University of Singapore.

The study was conducted over three weeks from 1 to 30 April, the 2006 MSM Survey received 3276 respondents, of which 1479 (45.1%) were Singapore residents.

Analyzing only the Singapore data, the study found that 97.8% had knowledge of HIV and how it is transmitted, and 80.1% had ever had an HIV test (57.2% had done so in the last 2 years). Nevertheless, of the 81.3% who reported sexual activity in the last three months, 51.1% report inconsistent condom usage with boyfriends or regular partners, and 32.8% report inconsistent condom usage with casual partners in the last 3 months.

Basic Demographic Data of Singapore Residents

Ethnicity

Chinese	80%
Malay	7.3%
Indian	3.3%
Eurasian	2.0%
Caucasian	3.9%
Others	3.5%

Nationality

Singaporean	83.9%
Malaysian	7.5%
Others	8.6%

Education

Post graduate degree	12.4%
University degree	35.1%
Polytechnic	26.3%
Junior College, Pre University, ITE, Secondary school or less	26.2%

Age

Less than 20	6.8%
20-24	21.1%
25-29	26.2%
30-34	21.4%
35-39	14.1%
40-44	5.3%
45 and above	5.2%

Orientation

Gay	77.9%
Bisexual	14.1%
Heterosexual	2.4%
Undecided	4.9%

Attitude towards one's own orientation

Proud	25.2%
OK	58.5%
Wish I was different	11.6%
Ashamed	1.2%

"Do you want to change?"

No	90.3%
Yes	5.6%

Who are you out to

To family	32.2%
To co-workers	39.4%
To gay friends	90.2%
To straight friends	56.6%
To church	6%
Not out to anyone	7%

Analysis of the basic demographics of the respondents showed that whilst these Singapore residents had the same general ethnic breakdown as the average Singaporean, they nevertheless were much better educated than the general public (47.5% had a university or post-graduate degree).

Median age group of respondents was 25 to 29 years of age, and almost 78% identify as gay. 83.7% felt "OK" or proud of their sexuality, and almost a third are out to their families. 90% have other gay friends, and only 7% are completely in the closet.

Summary of Findings

Of the 1479 Singapore residents analyzed, 81.3% were sexually active within the past three months. The remaining 17.4% were excluded from further analysis.

Number of sexual partners

1	30.1%
2 to 5	49.6%
6 or more	19.7%

Location of Sexual Activity

At home	65.7%
Hotels	28.6%
Saunas	25.6%
Car	8.0%
Public Toilets	9.3%
Cruising grounds	5.3%

How did you meet your sex partner(s)

Boyfriend/regular partner	42.8%
Internet	43.5%
Saunas	24.4%
Clubs/Bars	11.1%
Met through friends	10.8%
Work	3.7%
Public cruising grounds	7.8%
Gym	5.9%
Swimming pools	4.6%

Of those who are sexually active, 70% had more than 1 sexual partner. Most of the sexual activity occurred either at home, or in a hotel, whilst almost 30% report having been to a sauna. Since this was an online survey, it is not surprising that the Internet was the most common way reported for finding new sex partners.

HIV Testing

Awareness of anonymous test site

	2003	2004	2006
Yes	37%	56.9%	90.2%

HIV Testing History

	2003	2004	2006
Yes	59.6%	50.1%	81.3%

Have you ever had an HIV test

Never	18.8%
Within last 12 months	46.9%
1 to 2 years ago	18.4%
2 to 4 years ago	9.7%
More than 4 years ago	5.9%

By comparing data with similar studies conducted in 2003 and 2004, it is clear that recent efforts to promote HIV testing amongst MSM has been remarkably effective.

Knowledge of the Action for AIDS-operated anonymous test site has risen from 37% in 2003 to over 90% in 2006. Furthermore, the percentage of respondents who have had an HIV test has risen from 59.6% to 81.3% in the same period, with 46.9% having been tested in the past 12 months.

Condom Usage

Many questions in the survey asked about condom usage during anal sex. The respondents were grouped into those who used condoms every time (100%), or those who were inconsistent in their condom usage (less than 100%).

Correlation between testing and condom usage

	Never had test	Had HIV Test
100% Condom Use	17.46	83.33
<100% Condom Use	19.05	80.95

From the analysis, it was evident that the rate of consistent condom usage did not increase with HIV testing. In other words, knowledge of one's HIV status alone does not necessarily change risk behavior.

Protected Anal Sex on the increase

	2004	2006
Boyfriend only	12.6	12.13
Casual only	22.5	13.79
Both	19.6	42.69

Unprotected anal sex on the decrease

	2003	2004	2006
Boyfriend only	39.3	24	19.77
Casual only	22.9	10.2	5.4
Both		15.9	11.88

By comparing with data from the 2003 and 2004 studies, it is evident that protected anal sex is increasing amongst the respondents, rising from 19.6% in 2004 to 42.69% in 2006. Similarly, the rate of unprotected anal sex is decreasing.

This suggests that education and outreach efforts between 2003 to 2006 have been effective to a degree in changing risk behaviors in the MSM community.

Reasons for not using a condom

	2003	2004	2006
Boyfriend	43.3	65.8	33.31
Had Sex Before	14.2	44.6	11.54
Condom not Available	5	14.2	7.23
Looked Healthy	14.3	31.7	12.04
Had HIV Test	11	20.6	11.63
Feels Better Without Condom		9.3	16.69

The reasons given for not using a condom have also changed. The statistics for almost every reason has decreased, with the exception of "feels better without a condom", meaning there are a number of people who are consciously making a decision to bareback because they prefer sex without a condom.

Overall, it was found that there is still a high level of inconsistent condom usage amongst the respondents. 51.1% report not using condoms regularly with regular partners or boyfriends, and 32.8% don't use condoms regularly with casual partners.

Reasons varied for not using condoms all of the time during anal sex with same sex partners, but the most common reasons were

- Regular partner or boyfriend
- It feels better without a condom
- Impulse
- My partner looked healthy

In fact, "knowing" one's partner prior to the encounter was the highest risk factor for not using condoms regularly, with 51.1% of these reporting inconsistent or no condom use, followed by 39.6% of those who picked up partners from clubs (with "too drunk or wasted" as a common excuse), 36.4% of those who met through the internet, and lastly 33.6% of those who met at saunas.

People with HIV/AIDS (PHA)

35 out of 1479 respondents self-reported being HIV positive.

Inconsistent condom usage remains the highest risk factor for HIV, with a seven fold increase in the likelihood of someone being HIV positive if they did not regularly use condoms. Not using condoms regularly was also correlated with higher rates of sexually transmitted infections.

Conclusion

Based on the findings of the study, despite the respondents having a high level of awareness of HIV and how it is transmitted, and high rates of recent testing, there remains a significant rate of unsafe sex occurring amongst MSM.

It is evident from the survey that there exists gaps in the respondents' understanding of HIV transmission, and what is considered safe sex. Many continue to undertake risky behavior consciously.

Even though rates of safe sex appear to have increased when comparing recent data to the 2003 and 2004 studies, and rates of unsafe sex have decreased in the same period, there still remains a significant number who are practicing unsafe sex consciously, despite their knowledge about HIV transmission.

There has also been a marked increase in the number of people who have had an HIV test recently, however this has not translated to safe sex behavior.

It is imperative to plug these gaps in understanding, and address the myths and misconceptions that MSM in Singapore may have regarding HIV and safe sex behavior. One of the highest risk behaviors is unsafe sex between individuals who already know one another, and hence have an implicit trust between each other. Other risk taking behaviors include forgoing condoms because anal sex "feels better" without one, or taking risks while drunk or high.

The primary goal of ongoing outreach programs is to increase consistent condom use.

With the ***think again** campaign, we have designed a series of messages that address the gaps we found from the 2006 MSM Survey. It challenges people to reconsider some of their ideas about HIV, AIDS, and their own personal behavior. Instead of merely reminding people of the existence of HIV, it targets specific behaviors and encourages MSM to practice safe sex.

*The full ***think again** campaign can be found at www.afa.org.sg/thinkagain.*

Stuart Koe has a Doctor of Pharmacy, specializing in HIV medicine. He is currently a Director of AIDS Concern in Hong Kong, and Trustee of the Action for AIDS Endowment Fund in Singapore. He has been a long time AIDS activist, and has collaborated with various AIDS NGOs and INGOs across Asia, Australia and the USA in the fight against AIDS.

By Paul Toh & Bryan Choong

MSM programmes within *Actions For AIDS*

MSM programmes within Action for AIDS have been put in place since its inception in 1988; however, it has grown more structural and systematic over the years. Walking down memory lane, I could remember the early nineties where groups of concerned MSMs (Men having sex with men) gathered together to form committees to organize HIV education and outreach programmes ranging from plays on HIV to parties like Rubber Ball.

As HIV infection was predominantly contained within the MSM community in the late eighties to the early nineties, MSM prevention programmes have an edge in HIV education and advocacy over the years over other prevention programmes, like Heterosexual Males Outreach, Women outreach programme, as well as, Youth programme.

Funding for MSM prevention programmes have always being ad-hoc, until in 2003, when more donors have decided to fund AfA in generating a more structural outreach programme targeting specifically at MSMs. This gives birth to the first MSM outreach programme within AfA. Brochures, postcards and posters were created to target specifically at the MSM community. As Singapore becomes more liberated on the issue of men-to-men sex, although retaining Penal Code 377A, which is the sodomy act, more gay saunas have sprung up, thus resulting in a more acceptance stand of the authorities and society at large.

Condoms pick up rates have also risen over the years in gay clubs, saunas as well as other establishments patron by MSMs. In 2006, AfA distribute close to 100,000 condoms and 50,000 packages of lubricants to gay establishments comprising of the 7 gay saunas and the 6 major gay clubs in town. The current AfA MSM programme is divided into 6 different components consisting mainly of :

1.1 Outreach to gay saunas
1.2 Outreach to gay clubs
1.3 Internet Outreach
1.4 MSM resource and Drop-in Center
1.5 Interactive Theatre Workshop
1.6 English and Mandarin seminars
1.7 MSM counseling hotline

During one of the outreach to a gay sauna, AfA managed to conduct an audit on 216 MSMs on the 16 December 2006 on condom usage. Out of the 216 MSMs surveyed, 187 said they use condoms on every occasion they patronize this sauna and only 3 MSMs said they did not use condoms while 15 others said they did not have any anal sex during their visit. The results at this particular gay sauna clearly shows that usage rate of condoms are high although we do not dispute the fact unsafe sexual practices are still occurring at such premises among some patrons.

MSM Drop-In Centre and Hotline Services

With reference to the MSM resource and Drop-In centre, as well as English and Mandarin seminars and MSM Counseling hotlines, these programmes are executed in collaboration with Oogachaga (OC), another community-based organization specialized in these areas.

AfA provided support to OC in operating the first ever MSM Drop-In centre in Singapore. Trained counselors are stationed each Saturday and Sunday afternoons to provide counseling for MSMs. The issues discussed ranged from managing relationship to sexual negotiation. In addition to that, the counselors also provided safer sex information.

To date, OC has provided counseling service to 26 MSMs since its inception in February 2006. Clients would usually call to make a counseling appointment. The profile of "clients" comes from all walks of life ranging from young MSMs in their "coming out" stage to mature MSMs facing relationship issues and specific sexual concerns. Another sub-component of the Drop in centre is the OC Men support groups where MSMs meet to provide peer support to each other in a healthy setting. 21 MSMs attended the two support groups conducted in this period.

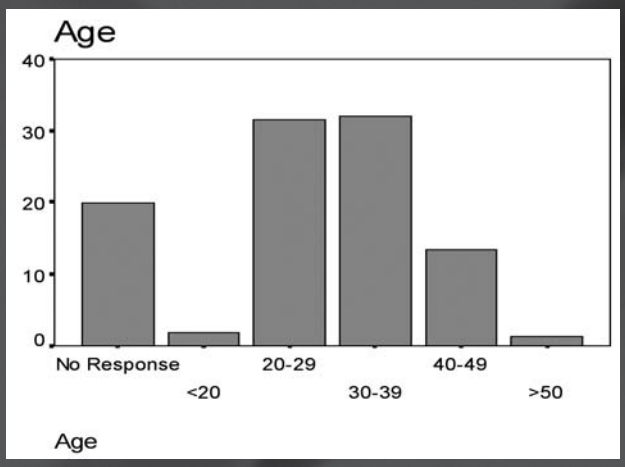
The OCMSM Hotline service provides anonymous telephone counseling. There was no caller ID on the mobile number to reassure the callers of their confidentiality. This service has successfully bridged the service gap where closeted gay men or MSMs do not wish to have face-to-face counseling. A total of 191 calls have been received on the hotline service.

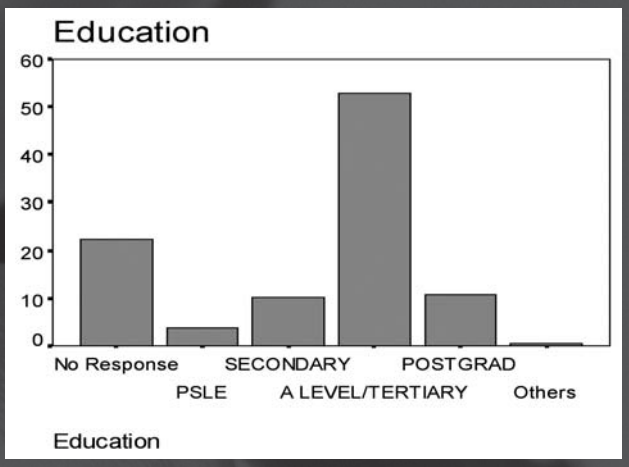
As for the English and Mandarin Seminars and workshops, OC have achieve much in establishing a foothold into the Mandarin speaking MSM community by organizing two Mandarin workshops. The Mandarin Speaking MSM community has been a hard-to-reach target segment in the past and AfA have decided to partner with OC in targeting at this specific segment. So far, the Mandarin seminars have been gathering up steam discussing issues of HIV prevention, which were never discussed within the English speaking segment of the MSM community. An estimated number of 380 participants attended these English and Mandarin workshops and seminars.

Interactive Theatre was another component of the MSM Outreach programme within AfA. The Seven Month Itch, an interactive play by The Necessary Stage was staged at Mox's café to outreach to the more culturally-inclined MSMs.

On the communication forefront, AfA have created history by developing our first ever MSM Advertising Campaign called "Think Again". The "Think Again" Campaign is revolutionary as it identifies various gaps between the sexual behavior of the MSM community and their knowledge of the prevention of HIV / AIDS transmission. Developed by Fridae.com, the "Think Again" Campaign is the first ever marketing communication campaign targeting MSMs at various venues from saunas to bars as well as the Internet. This campaign was developed after an intense MSM Survey conducted on-line by Fridae.com and AfA.

In a nutshell, AfA tries to identify and fulfill all gaps of HIV prevention within the MSM community. However, given the steady trend of increase of HIV infection rates among MSMs, locally and regionally, AfA would need to engage more partners in assisting us in identifying the gaps to generate new campaigns to target the ever changing sexual behavior of MSMs in Singapore.





By George D. Bishop, Ph.D.

Whither MSM HIV Prevention?

APPLYING BEST PRACTICES

Of late there has been much discussion of increases in rates of HIV transmission among MSM in Singapore, what this means, and the best ways to address the problem. Although official statistics on new HIV infections show that heterosexual contact still accounts for roughly 60% of transmissions in Singapore, there has been a leveling of new infections among heterosexuals. However, for each year since 2000 the number of new infections through homosexual transmission has, on average, been roughly 50% higher than the previous year. In 2000 12 new cases of homosexual transmission were reported whereas in 2005, the last year for which we have complete data, the number was more than 7 times that at 87. And, of course, these only represent the infections we know about. It's likely that the actual numbers are some multiple of that.

So what to do? Clearly something needs to be done, but what? In addressing this question there is much to learn from best practices for HIV prevention both in Singapore and abroad.

Basic principles

The best HIV prevention programs generally are based on several basic principles. First is the principle of non-judgmentalism, addressing the issues involved in a rational and matter of fact manner rather than passing judgment on those considered to be at risk. In dealing with issues of sexuality it's all too easy descend into moralistic mud-slinging, referring to alternative sexualities as being "sinful, abhorrent and deviant," among other things. This approach does nothing to address real issues and only discredits those slinging the mud. Rather, best practices involve addressing the issues on a realistic and non-judgmental basis. This kind of non-judgmentalism is at the root of Singapore's successful HIV/STI preventions with brothel-based commercial sex workers (CSWs) as well as overseas interventions with men having sex with men (MSM).

Second, best practices draw on validated theories from the behavioral sciences. For example, Singapore's successful HIV/STI prevention work with CSWs drew on several well known and empirically substantiated behavioral intervention theories as have interventions done with MSM overseas.

Third, best practices start with a detailed understanding of the dynamics of the behavior involved. In order to be able to successfully change risky behavior it's essential to understand where that behavior comes from. As such in order to address questions of MSM risk we need to have a good understanding of the risks that MSM take and why they take them. The periodic surveys by Action for AIDS in conjunction with Fridae.com provide a beginning for gathering such information and provide essential data for the development of effective interventions.

Fourth, best practices take into consideration the psychological and social factors that affect the lives of those at risk, what in the behavioral sciences we call "psychosocial factors." And what might these be? Research on HIV risk among MSM has identified several factors as contributing to risky behavior. Among these are negative societal attitudes concerning homosexuality (often referred to as homophobia), the acceptance of such views by MSM (internalized homophobia), lack of self-acceptance and related low self-esteem among MSM, anger about perceived or real discrimination, over-confidence in one's ability to avoid infection, low social support for same sex relationships, lack of positive role models, both for developing stable relationships as well as consistently engaging in safer sex behavior, and lack of skills as well as low confidence when attempting to negotiate safer sex with a partner, among others. Of course, not all of these factors affect every MSM or operate in every situation but taken together across persons and situations if left unattended such factors can form a lethal mixture.

Fifth, and very closely related to points three and four, best practices focus on the specific needs of the community in question. With respect to HIV prevention among MSM this means listening to MSM about their lives and needs as well as how various aspects of their lives affect their risk behaviors and then developing programs that address their specific needs. This is a far cry from the all too common top-down approach of specifying goals and programs at a government or institutional level and then mandating these for the community. By taking more of a "grassroots" approach instead programs are more likely to address the real issues and thus be more effective.

A sixth key principle in programs following best practices is the incorporation of skills training. There is often the assumption, whether explicit or not, that making people aware of the risks they're taking and calling for behavior change will result in risk reduction. This is very often emphatically not the case as simply raising awareness and calling for change doesn't address the question of the skills needed to bring about that change. With respect to HIV prevention among MSM reducing risk involves specific skills such as appropriate condom use, saying "no" to risky sex when a partner is insistent, avoiding particular types of risky situations, and negotiating relationship parameters, among others. Successful programs address such issues and help MSM develop the necessary skills.

Finally, prevention programs are most successful when they operate within a context of social and institutional support. Unfortunately, too often such support is either absent or significantly diminished by the social stigma associated with alternative sexualities or even by legal or regulatory barriers to the production and dissemination of safer sex information and programs for MSM. In such cases the effectiveness of prevention programs is inevitably reduced.

Best practices – An example

So what might a successful program for HIV prevention among MSM look like? To date we have no compelling examples in Singapore but we can look at programs overseas. One of the best programs for addressing HIV prevention among MSM is the Mpowerment Project (http://www.mpowerment.org/) developed by Susan Kegeles, Robert Hayes and Thomas Coates of the Center for AIDS Prevention Studies of the University of California, San Francisco. Originally tested in California and Oregon, Mpowerment has been cited by the US Centers for Disease Control as a model program and has been replicated in several cities across the US. Although targeted specifically at young gay men (18 to 29 years of age) there's no reason why the framework for this program can't be applied to other age groups as well.

Mpowerment begins with the premise that the most successful program for prevention of HIV infection among MSM is one that specifically addresses the needs of MSM at a community level. Further, the program draws on extensive research and theory available concerning HIV prevention and its social dynamics and capitalizes on the importance of peer influence for behavior change. Finally, Mpowerment sets out to mobilize the gay communities in the locales where it's conducted, encouraging participants to take ownership of the design and implementation of activities so as to increase commitment to the program and its goals.

In the original Mpowerment project the program itself was run by a Core Group, 12-15 young MSM who served as the decision-making group for the program deciding its name, logo, goals, methods for outreach and other details of the program. The Core Group was in turn supported by a Community Advisory Board, consisting of "community elders" from the LBGT, public health and academic communities who provided advice to the Core Group on a regular basis.

The program comprises three key components. First is a concerted peer outreach in which young MSM volunteers speak with their peers and engage in outreach activities at venues frequented by MSM to spread the word about the program and enlist others to help in promoting the safer sex message. The goal is to initiate a self-perpetuating process whereby MSM would come into the project, learn about and adopt safer sex practices and then return to their social networks and encourage their friends and acquaintances to do the same. To encourage participation an emphasis is placed the use of fun activities at existing venues as well as at social gatherings created as a part of the program. To this end the program includes a community centre for the program where participants meet for planning sessions, program activities, and socializing. The program also sponsors a variety of social events, ranging from dance parties to picnics, hikes and bicycle rides, all including activities designed to promote safer sex and risk reduction.

The second key element is the use of small group discussions, termed M-Groups, that engage groups of 8 to 10 participants in discussions designed to promote risk reduction. Peer led, these groups specifically address issues identified as encouraging unsafe sexual behavior including misperceptions about safer sex, the belief that safer sex isn't enjoyable, poor skills for communicating about sexual issues, and interpersonal concerns. M-Groups follow a specific outline of topics and format, developed through focus groups, and are designed to be fun and interactive and also to promote development of skills for condom use and the negotiation of safer sex with partners.

The peer outreach and M-Groups are rounded out with the third element, a publicity campaign within the gay community to promote the program and encourage involvement.

So, does this approach work? The evidence gives a resounding yes. Community surveys comparing sexual risk behaviors before and after the initiation of Mpowerment showed that in the community where the program was first introduced the rate of unprotected anal sex showed a 27% reduction over the course 8 months. In similar surveys done in a comparable community without Mpowerment the rate of unprotected anal sex showed a small increase during the same time frame. In addition, when asked about problems resisting unsafe sex, enjoyment of unsafe sex and effectiveness of their sexual communication skills those surveyed in the community with Mpowerment reported less enjoyment of and fewer problems resisting unsafe sex as well as more effective sexual communication skills. By comparison, no improvement was found in the community without the program. When Mpowerment was later instituted in the community initially used as the comparison the same pattern of risk reduction was observed.

What about Singapore? Can such a program work here? There's no reason in principle why it can't. However, much hinges on mustering the social and political will to realistically address the issues related to HIV risk among MSM and implement this type of proven program.

HIV/AIDS is hitting Asia in a big way, and Asian MSM are now bearing the brunt of it.

In July 2004, Dr Bates Gill, the Freeman Chair in China Studies from the Center for Strategic and International Studies in Washington, testified to the Asia and the Pacific subcommittee of the US House of Representatives' Committee on International Relations. He entitled his testimony "The Coming 'Second Wave': HIV/AIDS in Asia".

When Dr Gill sounded that alarm more than two years ago, HIV/AIDS among Asian MSM (Men who have sex with men) was not considered a serious issue. He made no mention of it in his testimony. In just two short years, the situation has completely changed. HIV infections among MSM in many parts of Asia are now showing a sharp rise.

Dr Gill states that: "The center of gravity of the global epidemic is shifting perceptibly eastward from Africa and increasingly affects Eurasia." This shift that Dr Gill noticed is now in full swing. The most recent update released by UNAIDS, published on 21 November 2006, show that South and Southeast Asia is now in second place behind only Africa with a total of 860,000 new infections in one year, and about 7.8 million persons living with HIV/AIDS. Let's take the smaller figure of 860,000 and think what it means. It means almost one new infection every 36 second. By the time you've read this far, two more people have already become HIV+ somewhere in South and Southeast Asia.

The situations in some of the hardest hit countries are staggering. In India, 12.5% of MSM in Mumbai are HIV+ while in Andhra Pradesh it is 18.2%. In Phnom Penh Cambodia, HIV prevalence among MSM in 2003 was already estimated to be 14.4%. In Indonesia, 22% of transgender sex workers (Waria) are HIV+. In Bangkok Thailand, more than 1 in every 4 (28.3%) MSM you meet is likely to HIV+. MSM also contribute to a disproportionately large amount of new infections. Being no more than 5-10% of the total population, they contribute to 22% of new infections in Singapore. In Japan HIV infections among MSM has recently seen a 64% increase.

If we compare the prevalence rate among the general population and among MSM, the difference becomes even more stark. In Ho Chi Minh City Vietnam, a MSM is 20 times more likely to be HIV+ than his heterosexual counterpart. In Hong Kong, MSM are 25 times more likely to be HIV+. In Japan, 44 times more likely. In China, 46 times more.

An even more worrying trend is how hard new infections are now hitting MSM youths. In Thailand, prevalence among youths between 16-21 years old rose from 13% to 23%. In Myanmar, prevalence among adult is 1.3% but among young people 15-24 years old is 2.2%. In Singapore, STD and HIV prevalence among youths are also rising sharply.

These high prevalence rates are the result of low rates of condom use among MSM. In Myanmar, 60% of young men use condom consistently. In Singapore only 42% of MSM use condom for anal sex. In Thailand only 20-30% of sexually active young Thais use condom consistently. In Shenzhen China, authorities report that less than 20% of MSM use condom consistently. In Siam Reap Cambodia, MSM condom use rate is only 16%. In Philippines, only 6% of sex workers use condom with all their clients. In Japan, MSM anal sex is so ignored by the Japanese government that there is no data on MSM condom use. As a rule of thumb, consistent condom use needs to be 80% or more to prevent the rapid spread of HIV in a population.

If that is not scary enough, many governments across Asia are still dragging their feet in facing up to these staggering numbers of MSM afflicted by HIV/ADIS. Deep seated prejudice and stigma are causing many governments to refuse launching full scale outreach and safe-sex public education programs for MSM or to impede those launched by NGOs. For example, police raids on saunas in Malaysia have caused owners to ban outreach workers.

This is extremely short-sighted because the cost of prevention is several orders of magnitude less than the cost of caring for an HIV+ patient, even before taking the loss of productivity into consideration. Dr Peter Piot, Executive Director of UNAIDS puts it very bluntly: "Asian nations face a choice. They can act now or pay later...There is no question about what needs to be done to fight AIDS in Asia. The only question is whether the governments and people of Asia will have the courage to do it."

Government inaction on the one hand is exacerbated by the invisibility of MSM on the other. As the Therapeutics Research Education AIDS Training (TREAT) report on Asia (published Aug 2006) noted: "Safe sex practices are adopted and maintained only if they become normative behavior that is embraced by a community. But what if there is no MSM community to embrace them?"

In parts of Asia where MSM behaviors are still stigmatized, e.g., China, India, Indonesia, Malaysia, Japan, etc., apart from a younger generation of gay identified men, many older MSM in rural areas are married and engage in sex with men surreptitiously. They do not identify as gay nor admit to their extra-marital sexual practices. They are also less likely to practice safe sex. And they cannot be targeted for MSM outreach in the conventional way because they blend into the general population. This means that the many lessons learned in the West for outreach to gay-identified men are not easily applicable in such regions.

The state of Andhra Pradesh in India is now the leader in the race to find an effective prevention strategy suitable for Asia. Hindustan Times reported in August 17, 2006 that: "People in Andhra Pradesh recently woke up to find that the morning paper wasn't the only thing being slipped under their doors. Along with it was a message of safe sex, a free three-pack of condoms. Looking for ways to popularise condom use in the face of the alarming spread of HIV/AIDS in the state, health officials had the condoms delivered along with the daily paper to 50 villages and four towns in the backward Telengana district."

This is a brilliant strategy because it is a cheap way to deliver safe-sex public education to large segments of the population. The public education message can include information on all forms of safe-sex practices. In that way, even MSM who are hidden among the general population can be reached.

As the experience of America shows, if we ignore the HIV/AIDS epidemic among MSM, the result is the spread of the virus into the general population. The same pattern has already happened in Asia. The TREAT Asia report notes: "Many countries that neglected MSM prevention efforts are now struggling to contain HIV everywhere." Politicians and the general public are reluctant to face the reality that sex happens across class, education, race and all other social divides. No social class can be an island. When the "It cannot happen to me" syndrome is influencing public health policy, it puts the whole country at risk.

Speaking at the Opening Session of the 16th International AIDS Conference in Toronto in Aug 2006, Bill and Melinda Gates challenged the world's politicians to see sex workers not as vectors of HIV infection but as essential allies and crucially well-placed educators. Similarly, instead of blaming MSM, seeing us as essential allies and crucially well-placed educators will go a long way in preventing the kind of tragedy in Africa from descending onto Asia.

The key question for MSM all across Asia now is to ask ourselves what I can do to stop the spread of HIV among my community. Each of us could contribute in our own ways. Some of us could put pressure on our government to learn from Andhra Pradesh and act. Others could volunteer in their local HIV/AIDS agencies. Still others could talk about it with their friends and family to engender a ground swell of awareness to galvanize action. But above all, every one of us must start practicing safe-sex consistently, tell all our friends of our conviction, and advise them to do the same. Yes, talk about safe-sex with all your gay or MSM friends as often as you can. They might not listen to an outreach worker, but they certainly will listen to you. Tell them, in your own words, why you think it is important and why you are now doing it. It is up to each one of us to drive the condom use rate in our countries up to 80% and beyond.

We all know what must be done to prevent the spread of AIDS from crippling our community. So now go and do it!

projects & programmes

Formed in 1988, Action for AIDS (Singapore) is a non-governmental organisation and a registered charity. Activities are planned, implemented and coordinated by volunteers and a small number of staff. AfA is funded, through the generous donations of private individuals and organisations. In order to realise our objectives, the following are some of our main activities.

I **educational** programmes

The ACT
This publication has articles dealing with medical, social, cultural and personal issues. It also reviews and updates AfA's activities. It is distributed free to members and volunteers, to schools, libraries, community organisations, medical and dental clinics and hospitals.

Editor-in-chief
– *Roy Chan*
the.act@afa.org.sg

www.afa.org.sg
The webpage contains information on HIV/AIDS, AfA activities, the latest HIV/AIDS statistics, a Q&A page, and links to other AIDS web pages – both local and foreign. Do visit the website for information on our activities or for updates on HIV/AIDS in Singapore and the region.

Contact: info@afa.org.sg

HIV Education in the Workplace
Education is the most important strategy to prevent the spread of HIV. We provide trained educators who can speak to groups and organisations to help raise AIDS awareness.

Coordinator
– *Benedict Thambiah*
Telephone • 90037566
hew@afa.org.sg

High Risk Heterosexual Men Outreach Programme
To encourage heterosexual men who engage in high risk sexual practices, volunteers distribute safer sex packs at venues frequented by this target group. The programme also conducts online outreach – in websites, e-bulletin boards and chatrooms.

Coordinator
– *Lionel Lee*
Telephone • 90233509
hmo@afa.org.sg

MSM Outreach Programme
The Programme conducts research projects on MSM in Singapore, runs outreach at real and virtual MSM venues & events; develops MSM-specific safer sex material, and conducts safer sex workshops. Volunteers do not have to be MSM, or even male, to help out.

Coordinator
– *Paul Toh/James Foong*
Telephone • 62951820
paul.toh@afa.org.sg/
james.foong@afa.org.sg

MSM Resources
MSM Resources is an online service to provide information, support & referral for gay, bisexual & other men who have sex with men (MSM) on issues of safer sex, sexual health & healthy sexuality in Singapore. http://www.afa.org.sg/msm/

Coordinator
– *James Foong*
msm.resources@afa.org.sg

WSW Outreach Programme
This programme provides support for lesbian and bisexual women pertaining to HIV/AIDS and STIs.

Coordinator
– *Eileena Lee*
Telephone • 90272766
wsw@afa.org.sg

Youth Outreach Programme
Youths take the lead in conducting educational sessions for non-school-based youth. The aim of the Youth Programme is to provide HIV/AIDS information to, and create awareness among teenagers.

Coordinator
– *Indulekshmi Rajeswari*
youth.outreach@afa.org.sg

AMPUH (Anak Melayu Islam Melawan Penyakit Unik HIV/AIDS)
AMPUH was set up by a group of Muslim volunteers to tackle the rising numbers of Muslim patients infected with HIV virus or suffering from AIDS. It hopes to raise community awareness of HIV/AIDS, encourage active community participation and enhance community support for Muslim HIV/AIDS patients.

Coordinator
– *Abdul Hamid Hassan*
Telephone • 97631250
ampuh@afa.org.sg

Project StreetWalker
Volunteers provide material and information in relation to HIV/AIDS and STI to freelance sex workers.

Coordinator
– *Jonathan Chua*
psw@afa.org.sg

II **support** and **welfare** programmes

Endowment Fund for Anti-Retroviral (ARV) Medications
ARV medications are all considered non-standard drugs. The AfA Endowment Fund provides financial assistance to needy PWAs who cannot pay for these medications. We also maintain a separate fund for pregnant HIV+ mothers who cannot afford ARV Drugs to prevent mother-to-child transmission.

Coordinator
– *Roy Chan*
info@afa.org.sg

The Buddies Programme
Volunteers in the Buddies Programme offer emotional and practical support to HIV-positive people and their loved ones through weekly visits to the ward, and by befriending those who are healthier and appreciate company and friendship.

Coordinator
– *Alan Tan*
Telephone • 93366592
buddies@afa.org.sg

Life Goes On (LGO) and Club Genesis (CG)
LGO and CG are self-help patient support groups funded and supported by AfA. They also network with self-help groups regionally and share experience and Information that are mutually beneficial. Through LGO and CG, PWA interests and rights are represented in all of AfA's activities, at both organizational and participatory levels, with confidentially preserved. LGO caters to infected heterosexual men and women, while CG caters to infected MSM. PWAs plan, coordinate and perform hospital, home support and welfare activities, and also to assist in AfA activities.

LGO Coordinator
– *Lionel Lee*
Telephone • 90233509
lgo@afa.org.sg

CG Coordinator
– *Raphael Meyer*
Telephone • 91068634
club.genesis@afa.org.sg

Survivors
This support group helps the networking of relatives and friends of PWAs who have passed on. Survivors help each other come to terms with their losses and move on to help others learn to live with AIDS in their families and relationships.

Contact: info@afa.org.sg

Family Support Network
This group helps HIV+ patients and their family members to come together in a safe and emotionally supportive environment to share their thoughts and experiences of dealing with the infection. HIV+ patients with no family support are also welcomed. Personal counselling is provided to HIV concordant and discordant couples (regardless of sexual orientation) and HIV+ pregnant women. Harm and risk reduction information and advice are also made available.

Contact: info@afa.org.sg

Muslim+
This peer support group brings together Malay/Muslim HIV+ patients within a safe and emotionally supportive environment to share their thoughts and experiences in coming to grips with the infection from an Islamic perspective.

Coordinator
– *Nooraini Abdul Rahim*
Telephone • 98351982
muslim.plus@afa.org.sg

Women and Girls Outreach
This programme aims to address issues peculiar to women and young girls through research and targeted material and campaigns.

Coordinator
– *Braema Mathi*
women.outreach@afa.org.sg

III **clinical** services

Anonymous HIV Testing & Counselling Clinic
This is the only place where anonymous HIV testing is available in Singapore. Experienced counselors are on hand to provide pre-and post-test counselling for our clients. Test results are available within 20 min of doing the test.

The DSC Clinic
Blk 31, #01-16 Kelantan Lane
#01–16, Singapore 200031
Operating Hours: 6.30 to 8.00 pm on Tue & Wed, 1.30 to 3.30 pm on Sat (except public holidays)

Coordinator
– *Benedict Jacob Thambiah/Lalitha Nair*
Telephone • 90037566/62939648
ats@afa.org.sg

HIV/AIDS Hotline – Tel: 62540212, 96600237
The Hotline provides information and counselling services on all aspects of AIDS.

Contact: info@afa.org.sg

IV **other** projects

Legal Assistance
We provide free legal advice and assistance to PWAs and their families on how to deal with difficult employers and workplace issues, draw up wills, and advice on issues related to the Advanced Medical Directive, we have also been asked to assist and investigate in specific instances where discrimination against PWAs has occurred.

Coordinator
– *Thomas Ng*
legal@afa.org.sg

The Candlelight Memorial
This is an annual international event held to remember those who have died from AIDS. The Memorial provides an opportunity to come to terms with death and AIDS. It has become a powerful symbol of the presence of AIDS in Singapore , and a timely reminder for the community to renew its commitment to fight AIDS discrimination. The memorial is held on the last Sunday in May.

Coordinator
– *Benedict Jacob Thambiah*
Telephone • 90037566
candlelight@afa.org.sg

Singapore AIDS Conference
These biennial multisectorial conferences on AIDS were successfully organised in 1998, 2000, 2002 and 2004. Over 600 delegates from government and non-governmental organisations, volunteers, the press, and businesses attended the last one. The 5th Singapore AIDS Conference will be held in December 2006.

Secretariat
– *Nina Sharma*
comcon@pacific.net.sg

Art Against AIDS
Started in 1996, this biennial competition uses art as a medium to help raise AIDS awareness and encourage community participation in AIDS prevention.

Coordinator
– *Dawn Mok*
art.against.aids@afa.org.sg

Riding for Life
Biennial cycling awareness- and fund-raising event.

Contact: info@afa.org.sg

Executive Committee

President	–	Roy Chan
Vice-President	–	Braema Mathi
Secretary	–	Dawn Mok
Asst Hon Secretary	–	Thomas Ng
Hon. Treasurer	–	Caroline Fernandez
Committee Members	–	Lee Cheng Chuan
		Nooraini Abdul Rahim
		Raphael Meyer
		George Bishop
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Staff

Executive Director	–	Lionel Lee
Programme Director	–	Paul Toh
Project Coordinators	–	Benedict Jacob-Thambiah
		James Foong
Office Administrator	–	Lionel Lim

If you would like to make a donation, please make your cheque out to
"ACTION FOR AIDS, SINGAPORE",
and post it to
21 Norris Road, Singapore 208263.
As all donations are tax deductible, please include your NRIC, FRIN or RCB number and full name.

You may also donate online through the NCSS Donation Portal – *www.donations.org.sg*

If you would like to be a volunteer, write to us at the above address or send an email to afa@pacific.net.sg

Alternatively, please call
62540212 *for enquiries.*

if he lets you screw him without a condom,

do you honestly think you're the only one?

You're not. There have probably been others,
& some of them may be HIV positive.

Protect yourself, wear a condom.

think again

ACTION FOR AIDS
爱之病行动小组

For more information, login to
www.afa.org.sg/thinkagain