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**XVII International AIDS Conference
Forgotten Truths, Hidden Realities: Addressing the Dynamics
of HIV and MSM in Unfavorable Environments
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JOEL NANA: Hello. Good afternoon people, my name is Joel Nana and I work for the International Gay and Lesbian Human Rights Commission. Today, we have a session on hidden reality and forgotten truth. On our panel today, we have four distinguished gentleman from various parts of the world. I will start with Boris Dittrich who is the Advocacy Director of the LBGT Program at Human Rights Watch. He is a former member of the Parliament in Netherlands. Boris Dittrich sponsored the Same Sex Marriage Bill, the first one in the world in the Netherlands. He is a former member of the board of the Dutch National AIDS Foundation.

And, on my right Mac-Darling Cobbinah. Mac-Darling is the Executive Director of the Centre for Population Education and Human Rights, Ghana. He is a long time human rights activist and one of this years red ribbon awardees.

And, the gentleman just walking back to his seat is Ashok Row Kavi. He worked for 18 years as a journalist in India for publication and then as a gay activist and founded India's first gay news magazine. And, then as Founder-Chair of the Humsafar Trust, India's oldest gay NGO, now working U.N. AIDS as the desk officer for MSM and transgender and National Policy and Strategy Planning Officer for India's National AIDS Control Organization since 2006. He is a member of National AIDS Council.

And, the first presentation today will come from the gentleman in the middle. His name is Zoryan Kis. He is the MSM Advocacy Officer at All-Ukrainian Network of people living with HIV. Please help me in welcoming Zoryan [Applause].

ZORYAN KIS: Dear colleagues, hello and before I start my presentation I would like to thank the organizers of this session for the kind invitation and for opportunity to speak about the MSM issues. And, I think it is very important to speak today not about just MSM in general, but about MSM in my region, in my part of the world. So, I will now try to start my presentation, but what I see here is, here it is. So, my presentation title is HIV Prevention, Care, and Support for MSM in a Post-Soviet Country: Fighting with Old Stereotypes and New Realities.

So, the structure of my presentation will be pretty simple. I will start with key facts about the country then I will proceed with key facts about the HIV epidemic in my country and HIV epidemic in MSM in my country. Then I will speak about some statistics and data we have or we actually do not have in the Ukraine. Then I will speak about global fund and other donors as agents of change. Then I will speak about homophobia as an issue in my country and I will wrap up with lessons learned. So, key facts about my country.

This is a country in Eastern Europe obviously and its closest neighbors are Belarus, Hungary, Moldova, Poland, Romania, Russia Federation, Slovakia Republic. It is a country

the size of France and with a population of 46 million, which has declined by 2 million for last five years for various reason and HIV is not the last of them. It is a middle income country according to the World Bank and it is the 29th country for its gross domestic product in the world, but it is only the 83rd country in the world for GDP per capita. And, Ukraine got its independence in 1991, 17 years ago, but it is still struggling with its Soviet past.

What is the HIV epidemic like in Ukraine? Since its first registration in 1987 more than 122 thousand HIV incidents have been registered in Ukraine, but as you can see the estimated number of HIV positive people is much bigger, it is almost 400 thousand people. That means that 70 percent of them do not know they are actually HIV positive and the estimated HIV prevalence in the Ukraine is almost 1.7 percent in adult population, which makes it the worst and the fastest growing epidemic in Europe.

So, how many MSM are there in Ukraine? We have done some research and surveys and the estimate is between 177 thousand and 430 thousand MSM. Of them, more than almost 41 thousand are HIV positive and this is almost 17 percent of the whole main population that lives with HIV in Ukraine. I would like to apologize for the amount of data and numbers I am presenting, but I think it is essential for us to understand to compare it with our realities and our knowledge and our experience.

In Ukraine, there is no surveillance or any other researchers among gay and other MSM. As we have heard during this conference, this problem is not unique for Ukraine. Gay and other MSM would rather misreport their mode of transmission than admit their sexuality, which is an obvious indicator and consequence of stigma and discrimination. So, as you can see only 159 incidents of homosexual, so called homosexual transmission has been officially registered in Ukraine within 20 years and the vast majority of them were registered before 1994 or after 2005.

National data on most sexual transmission are not segregated by hetero and homosexual modes and large number of infections are reported as unexplained transmission. In Ukraine, I have spoken about this earlier, there is no research in Ukraine and we do not actually know what the epidemic is like in Ukraine among MSM. The first survey that can give us any additional idea about what the epidemic is like in MSM in Ukraine has been done last year, 2007, and here on the left art of this slide you can see its results.

My organization the All-Ukrainian Network of People who live with HIV has also done testing in four cities in Ukraine and its results are presented on the right part of this slide. And, I would like to draw your attention to the fact that the data of those two researches correspond for corresponding cities. As you see, the epidemic is mostly on the west of Ukraine and on the south, but not in the center in the capital

city of Kyiv. No statistics, no problem. This phrase has been indicative for Ukrainian government's response to many issues including HIV among MSM.

National data do not actually reflect the epidemics among gay men and other MSM in Ukraine. MSM remain invisible due to no national sexual behavior service ever done. Historically since 1995, the epidemic in Ukraine was driven by intravenous drug use and naturally most resources were and are directed to respond to this epidemic. However, in the 21st century the incidents among IV use is significantly dropping in favor of sexual transmission. Naturally the capacity of NGOs that work with MSM is significantly lower than the capacity of those NGOs who respond to the epidemic among IV use.

Ukraine is well known for its political instability and continuous governmental changes. However, this political instability has given us the civil society a chance to respond to epidemic and to assume full responsibility for it. Current Minister of Health is even finally now concerned that NGOs do what the government was supposed to do. In 2006, when the Ukrainian national proposal has been developed to the Global Fund [inaudible] funding MSM were recognized as a vulnerable group for the first time despite the fact that the lack of epidemiological data was used against it. This was only possible because four leaders of gay community were present at the stakeholders meeting where this strategy was developed.

They were also the members of the proposal development group.

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I would like to address the issue of homophobia, but before I have to admit that I am now stacking the wires down here so would you mind. Thank you. So, in 1991 the Ukraine was the first post Soviet Union Republic that decriminalized homosexuality. The condemnation of sex between adults, consenting men, was removed from the criminal court, but it was not removed from all other parts of legislation, which is 95 percent of legislation in Ukraine. It still remains most in selection for the police, what is called militia in Ukraine, for statistics committee and other institutions. The statistics committee has to collect data on how many crimes are committed by MSM in Ukraine.

On this picture, you can see a leaflet of a fast food chain and if it can produce such a leaflet in Ukraine it is an indicator of something. Police, medical professionals, media, government officials, other public opinion leaders become more vocal about in their homophobia as the community becomes more visible. Unfortunately, homophobia exists not only in the environments that we believe are naturally hostile, but also in the environments that one would expect to be tolerant and supportive, such as the third sectors and NGOs. However, working together with partner NGOs can bring the difference and it does.

We cannot provide inadequate response to the epidemic unless we have a community. We know that sex between men exists everywhere, but it does not necessarily mean that there

is a community, which can stand for its rights and respond to the epidemic. In many parts of the world, this community has to be created out of nothing. The funding we have in Ukraine is not only used to provide services, but also to mobilize and create the community.

I will now proceed with the lesson that we have learned in our work. So, the first obvious lesson is that the evidence is essential for successful advocacy work. The support of the major funders such as the Global Fund and the Elton John AIDS Foundation has been crucial to our work. A civil society is a powerful tool even in an unfriendly environment. Visibility and presence are the key to success. We have to be visible and present. Lifting of criminalization of homosexuality is not the end of the process, although it has to be done in many countries yet. It is just the start of our job.

Equality for gay men and MSM is impossible without positive provisions and end to discrimination legislation. We can remove it from the criminal court and other parts of legislation, but equality will not exist without an end to discrimination legislation. As we have heard in this conference before and on the MSM pre-conference earlier human rights and response to HIV epidemic have to be integrated and adequate response to the epidemic is impossible without a community.

Here are my contacts. I will also be happy to share my business cards afterwards. Thank you very much [Applause].

JOEL NANA: Thank you Zoryan. We have decided to take all the presentation, every presentation will be 15 minutes each and at the end of the presentation we will have 15 minutes for questions. So the next presentation, which was supposed to be the first, is Mac-Darling Cobbinah from CPEH Ghana. He will be presenting on overcoming homophobia, violence, stigma, and discrimination as a way to promote HIV prevention among men who have sex with men in Ghana, Mac-Darling [Applause].

MAC-DARLING COBBINAH: Good afternoon. The title of my presentation is Overcoming Homophobia, Violence, and Discrimination as a Way to Promote HIV Prevention among Gay Men in Ghana. So my name and I am from the Centre for Population Education and Human Rights Ghana. I have to state here that the background before the project started, our MSM project started three years ago, but before the project started we have no talk of condoms, no talk of lubricants, and no talk of STI treatment among the MSM community in Ghana. Our mission is human rights one to create a comfortable and strive for the full attainment of equal rights and we seek to inform adequate council and support people in matters relating to law, health, and social wellbeing.

Our aims and objectives, one is human rights and we also do gender sensitization, HIV and AIDS democracy and good governance and also partner with adult organization to abolish sociocultural practices that infringes on the rights of marginalized people. These are some of our current programs.

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We do human rights programs. We have young people's human rights programs in schools and communities. We also have the Sisters of the Heart Program, which talks about what goes with empowering the woman and the lesbian woman in this matter. We also have do breast cancer and cervical cancer screening and other HIV and STI related services.

We have the MSM HIV intervention, which I am going to talk about. One component of it is the training of pre-educators. We also have the STI services at the CEPHHRG drop in center. And then we offer LGBTIQ intervention programs and also fight against blackmail and extortion, which is big in Ghana in LGBT community. We also have education and information center in our office and we also provide video services and library services. We also organize film festivals.

The methodology and the techniques we use with the name of Centre for Population Education and we use population education methodology in most of our activities in Ghana. We also use the pre-education approach. We also use interactive theater or the popular theater, we call it, and we also use invisible theater within the communities and on the streets of Accra. We also use workshops, talk shops, and we also show movies and we have film festivals, distribution of condoms, just talk briefly about HIVs prevalence in Ghana. It tells you the areas in Ghana and HIV's prevalence. But, among these

areas, MSM, the prevalence of HIV is among MSM in Accra and Tema is 25 percent.

This is research conducted in 2006, between C-Pac [misspelled?] and [inaudible] and maybe with funding from the U.S. We ask why MSM are demarginalized and this slide tells you about how the MSM population bridged into the general population and the special groups we have within MSM.

This talks about the project objectives. One of the project objectives is to increase awareness of HIV AIDS and also prevention behaviors among MSM, friendly drop in center services. We also established referral network and this one we also acknowledge the fact that CPEH working with other populace, which is Ghana Health Services have established five friendly hospitals within Ghana where MSM working for services. And, we also promote the key behaviors among MSM, which is proper condom use and lubricants, getting tested, and know your status, promptly seeking STI services, disclosure of status, STI status and HIV status to help your partner also go in for test, and then adherence to treatment. We also promote fitfulness and partner reduction.

The project started in 2005 and now to date we have trained, we work in 11 communities outside Accra in the greater Accra region, which is Accra and Tema. And, then we have informal activities within some parts of Ghana. We have trained seven pre-educators now, but we have first trained ten pre-educators. So, we so far have trained 17 pre-educators and

then we talked about our collaboration with Ghana Health Services. And also, we have a system we call, me text me, call me, chat me, where we send messages to MSM on their mobile phones to reinforce messages that their pre-educators sent to them in their communities.

We have some of our targets and [inaudible] to date. I must say that we have achieved most of our targets. One of the difficult areas is people who show up the centers for treatment and for testing and then we lend it to as it stands of homophobia, stigma within the community so people do not feel comfortable walking into the drop in center for services or to the friendly service centers. We have a monitoring and evaluation system. We meet weekly to evaluate the processes within the communities. We look at the challenges that appear at educators offices and then the project coordinator that provides field visits. We have funders also visiting frequently and then we have a monthly monitoring report writing system to our funders who are always the late funder is Academy for Educational Development to the [inaudible] project.

And, then we document most of our activities so now when you come to Ghana there are other organizations that are helping working with MSM in Ghana because we documented the first phase and the second phase of the project. Key achievements to date that is now increase of awareness of HIV among the HIV community and then there is development materials, project materials for MSM specific established at

the [inaudible] drop in center and we have also had [inaudible] surveillance study last year, which shows that 25 percent of MSM are positive in Accra and Tema.

We are also working with 11 health personnel and six government hospitals who have been sensitized to provide HIV AIDS related services. We have so far reached 2,305 MSM with educational materials, referral services, and others. Our challenges have been with law dissection 29 of the criminal court of Ghana, it is an old British law, which says MSM homosexual activity is unnatural and other Ghanaian laws. We have also suffered a lot of stigma and discrimination and homophobia within our communities. We also have the problem with self stigma where MSM feel it is my fault. I deserve to be discriminated against I deserve to be beaten. We have problem with lack of funding for our programs because most people do not want to put money into our programs.

We also have a problem with high costs of STI drugs, so you see France with prescriptions in their notebooks and they do not because they cannot buy these drugs at the pharmacy. We have a lot of denial by friends, family, our pastors, religious leaders, I sat in the internet cafe with my pastor and he never looks at my face. I called him several times and he pretended that he never met me before.

Lessons learned. We have learned that it is possible to implement HIV AIDS program in a hostile environment such as Ghana and also MSM have learned to seek early treatment. We

have accepted ourselves and HIV AIDS treatment programs. When we first started the program people think we are BNI, we are with security agents trying to get them arrested, but now they have accepted that we are one of them and we are here to help. And also, MSM peer educators and MSM have learned to overcome stigmatization within their communities. We collaborate with some of these organizations in our work and we also want to acknowledge our donors. Our main donor has been Austria Lesbian Foundation for Justice and recently we also received some funds from MSM Initiative to buy lubricants and condoms.

You can contact us. We are in Accra and email [inaudible]. Thank you for listening [Applause].

JOEL NANA: There seems to be a consensus that stigma and discrimination follows HIV and AIDS and to try and find tools to address this issue I would like to call on stage Boris Dittrich who is the Advocacy Director at Human Rights Watch. He will present to us The Yogyakarta Principle, which is the tool that has been developed by international expert on human rights to address human rights violations on the basis of ones sexual orientation and gender identity.

BORIS DITTRICH: Thank you very much Joel. Thank you for being here all of you. When I received the invitation and the people who invited me told me the title was Forgotten Truths, Hidden Realities, actually I thought why is that the title and why not for instance Forgotten Realities and Hidden Truths. Because, when you come and think about it and when you

talk about sexual orientation about homophobia you see that a lot of these stigma and discrimination issues are dealing with hidden realities and hidden truths and forgetting realities and truth. As you know, all around the world gays, lesbians, bisexuals, transgender people, intersex people they face discrimination simply because their sexual orientation or gender identity does not fit the standard set by the majority of their society. And, in everyday life LGBTI people may face discrimination in terms of rejection by their family or by the rest of society, but of course also by state authorities.

You must know that in seven countries in the world legislators have decided to make homosexuality a capital crime and in about 77 countries in the world homosexuality is criminalized with prison sentences up to 20 years. I would like to give you because otherwise it will stay a little vague, I would like to give you two concrete examples of HIV people, people with HIV AIDS who have been discriminated in their country.

My first example is Uganda. In Uganda, homosexuality is criminalized and on May 2, 2008, Mr. Apouli [misspelled] the Director General of the Uganda AIDS Commission stated that, "Gays are one of the drivers of HIV in Uganda, but because of meager resources we cannot direct our programs at them at this time." The NGO Sexual Minorities Uganda, SMG it is called, staged a peaceful protest at a June 2008 HIV AIDS implementers meeting in Kampala, Uganda and they said that homophobia drives

AIDS and that neglecting the LGBT community drives HIV.

Instead of listening to these human rights defenders they were arrested by the police and they were detained.

Two weeks ago, after they had been released and charged with trespassing the conference compound, two weeks ago one of these human rights defenders was detained again after he left the court building. He was tortured by the police and while he was being tortured the police wanted to know about other homosexuals. And, they wanted to know about organizations that support HIV AIDS activists. So, in this atmosphere people with HIV AIDS have to work and of course that is a terrible situation. My second example is about Egypt, another horrifying example.

Waves of arrests, literally detention of homosexual men in recent months while in jail doctors joined the witch hunt and performed mandatory AIDS test without the consent of the detainees. And, the results of these tests and the answers to the questions the doctors asked were included as evidence in the criminal files against these men. Doctors from Egypt's Forensic Medical Authority performed forcible and abusive anal examinations on these men in order to "prove they had had sex with other men." And, the prisoners who were tested HIV positive were held in prison hospitals, chained to their beds and they were treated without any dignity or any respect. And, unfortunately I have to tell you that these arrests are still

going on in Egypt as of today. I really think Egypt; the Egyptian government should be ashamed of itself [Applause].

If you want further information you can go to the Human Rights Watch website. In countries where criminalization of homosexuality has been irradiated, it does not mean that the LGBTI community is not being discriminated any more.

Homophobia is paramount in many countries in the world. Many of the states who signed human rights treaties, they say okay we have signed such a human rights treaty, but actually they are treating it like a menu in a restaurant because they just pick and they choose. They say we are in favor of human rights, but not for everybody, not for MSM for instance. And, of course, this is a violation of the basic concept of human rights because human rights are universal and indivisible and they apply to everybody, to all human beings.

Now inspired by a meeting with the former high commissioner for human rights Louisa Arbor, a group of experts on international human rights law convenes in the Indonesian city of Yogyakarta, this was at the end of 2006. From all over the world, these experts brought their knowledge and their expertise. They came from Pakistan to Kenya, from Botswana to Thailand, from Europe and Latin America, to Nepal, from the United States to China. Many of these experts work within in the UN system. And, these experts they codified all existing human rights based on international treaties and jurisprudence and they translated these existing human rights to sexual

orientation and gender identity. What they wrote down was not invented.

Everything they codified in the document, and the document is called the Yogyakarta Principles, everything they codified was grounded in existing human rights law or jurisprudence and you must know that the Yogyakarta Principles hence are not a wish list, it is not a list of dreams, a summary of dreams, no they are existing legal rights. For example, Principle 18, it addresses the right to be protected from medical abuses. It is undisputed in the world that all human beings have the right not to be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility. So it is evident that this right also applies to let us say homosexual men or lesbian women. So, Egypt is clearly violating this right Principle 18 of the Yogyakarta Principles.

The Yogyakarta Principles and the hard copy looks like this and before I forget I took about 50 hard copies of these Yogyakarta Principles with me so if you are interested at the end of the session I am glad to give you one of the hard copies. And, in this hard copy you find 29 principles on the application of international human rights law in relation to sexual orientation and gender identity. And, they affirm the primary obligation of states to implement human rights. Each principle it accompanies by detailed recommendations to states and other stakeholders. One of the most important principles

is number 2, the rights to equality and nondiscrimination. In the recommendations to states, it says that states shall repeal criminal laws that prohibit consensual sexual activities between people of the same sex who are over the age of consent.

In my presentation, I would like to focus on Principle 17. And, Principle 17 reads as follows. Everyone has the right to the highest attainable standard of physical and mental health without discrimination on the basis of sexual orientation or gender identity. In the recommendation it says that states shall take all necessary legislative administrative and other measures to ensure enjoyment of this right and to ensure that all persons have access to health care facilities, to goods, and services. Clearly in the examples Egypt and Uganda violated this principle. But, not only those two countries also other countries.

In countries where a different sexual orientation or gender identity is met by social stigma like Russia, for instance, or some other eastern European countries vulnerable groups like men having sex with men will not be easily reached by AIDS workers. In such a context, people are afraid to come out of the closet. They do not want to incriminate themselves. They do not want to become an outcast in their society. HIV AIDS programs cannot be effective if not targeted towards these vulnerable groups so there is severe under reporting, which leads to a higher prevalence within this community and society

at large. You have heard all about this at other sessions during this conference.

According to data from UNAIDS it is estimated that at least 5 to 10 percent of HIV infections worldwide occur through sex between men so this figure varies considerably between countries and regions. For instance, in the United States 50 percent of new infections occur within the homosexual community. In communities where homosexuality is not accepted, MSM also have sex with women while they are living their clandestine lives. The day before yesterday I attended a meeting about Togo [misspelled?] where there was a presentation about men having sex with men in Togo and it appears that about 47 percent of the men who have sex with men in Togo are married and also have sex with women or girls. So, it is clear that also girls and women are at risk.

On the converse, UNAIDS experience reveals that recognition of the rights of people with different sexual identities, both in law, but also in practice combined sufficient scaled up HIV programming to address HIV and health needs are necessary and complimentary components for a successful HIV response. Worldwide anecdotal evidence highlights that in many countries where sex between males is not criminalized and where stigma and discrimination have been reduced MSM are more likely to take up HIV prevention, care, and support, and treatment services.

Now, how to reach the highest attainable standards of health. In order to obtain equal rights and be refrained from discrimination, governments should allow the LGBT community to organize, to express their opinion, to express their sexual orientation without any repercussions to grant them freedom of assembly, freedom of movement, rights the LGBT community does not have for instance in Russia at the moment. Capacity building empowerment of the LGBT community is benevolent for health issues in any given country.

So, you see that the state of human rights in a country influences the prevalence of HIV AIDS. And, when new policies will be developed to include MSM, transgenders, sex workers, injecting drug users, and health programs it is crucial, it is really crucial that one realizes that these are distinct groups each with their own history, each with their own social codes. Each group requires specific attention and effective policies can only be developed with the input of these groups themselves in order to obtain the highest attainable standard of physical and mental health as described in Principle number 17.

Organizations involved in planning global and regional HIV responses like country coordinating mechanisms and national AIDS control plans must insure that HIV related services are available to MSM and that funds dedicated to these services at the national level are proportionate to the impact of HIV on MSM in that specific country. National AIDS commissions and other bodies should monitor the way the money is spent. In

order to develop adequate policies it is important to include MSM in national surveillance and independent epidemiological and behavioral research studies. Only such an approach amounts to the highest attainable standard of physical and mental health as is listed in Principle 17 of The Yogyakarta Principles.

So, let me conclude because I know that my time is up. Actually, I call upon all participants to put pressure to their governments to end criminalization and also to end discrimination of people on the basis of their sexual orientation or gender identity. It is not only because sexual minorities are like everybody else entitled to nondiscrimination and equality, but also because it improves their health and that of the broader society. Yesterday, I was invited to attend a meeting of members of Parliament, it was organized by the International Parliamentary Union and as you know there are many members of Parliament from all over the world attending this conference and they use a Guide to HIV AIDS.

I guess, and I think it is really important, that you as NGO members for instance, that you target these members of Parliament who are here at the conference and that you talk with them about, for instance, why do you still criminalize homosexuality in your country. And, do not accept the answer, please do not accept the answer that homosexuality is against culture or tradition or religion because we are talking about

human rights. Our human rights should be available for everybody. Thank you very much and if you would like to have a hard copy of The Yogyakarta Principles please come and collect it. There is also a website and it is www.yogyakartaprinciples.org and on this website you can read The Yogyakarta Principles in all the official UN languages and within the near future also in a few other languages. Thank you very much for your attention [Applause].

JOEL NANA: Thank you Boris and I would add to calling upon the government to decriminalize homosexuality that change depends on all of us and ourselves we should start fighting stigma. We should not take it. We should fight stigma discrimination against us and against people around us.

Before moving to our fourth presentation, I would like to take two questions from the public. Questions? You have to move to the lady for the mic.

MALE SPEAKER: Yes, I have a question, two questions in fact for the presenter from Ghana. The first one is you said that sexual relations between men is unnatural according to the law, on the other hand, you have heard activities in some hospitals with the government staff that have been sensitized to work with MSM. I am quite interested because I think it is a kind of gateway in to working in difficult environments. How did it happen? What are the conditions, are the conditions that it should be low profile or so? And, then the second

question is how come gay people were less stigmatized after your interventions? Could you clarify that? Thank you.

MAC-DARLING COBBINAH: Hello, hello, yes I must say that our program is a collaborative one with the Ghana Health Service who are already working on some other most at risk population and so the capacity of these medical people and nurses were filled to accept MSM so that is what makes it easier. But, the government does not accept homosexuals. And, we also have to acknowledge the fact that most of our activities are done still underground and in our communities the police come into our office and they want to know what we do and they come and have meetings in front of our office and they will be pointing at the office. We do not know what they talk about and then everyone gets scared, but it just tells you how powerful peer education approach works because the peer educators are supposed to only talk to their peers.

We do not have problems with the law and talking to straight man or any homophobic person on the streets.

JOEL NANA: Thank you Mac-Darling. The second question?

SOYAN IM: My name is Soyan IM [misspelled?] from the HIV Vaccine Trials Networks. First of all, I really enjoyed all of the talks. I am from the U.S.A. where the gay community is very open in relation so it is very interesting and very sad for me to hear these stories. My question is for Zoryan from Ukraine. I went to another session where a researcher from

China was talking about the MSM in Gwanjo [misspelled?] and he mentioned that most of the MSM were very young and low income and with low education and they were kind of floating as well. They did not have permanent homes and I wonder if that is the situation in Ukraine as well because of all the discrimination and stigma I wonder if this leads to a lot of the young MSM leaving their homes and having unstable situations overall and if that probably leads to even bigger problems?

ZORYAN KIS: Thank you very much for the question and I do not have an easy answer for it because we still need more research about this situation and we do not have it now. But, from my experience and from what I know this is very much like in Ukraine because most of young MSM will leave their home or would not be accepted by their parents and will have to leave their homes. And, they will be attracted to big cities such as Kyiv or Odessa and they would sell sex for food or housing. And, this is very much like so in Ukraine and I have seen myself [inaudible] young MSM cruising areas in the city in Kyiv, but thank you for this question and I think I will try to initiate the research of this situation in Ukraine after I come back, but thank you very much if this answers your question.

JOEL NANA: Before moving to our fourth presentation I would just like to add a comment to what Mac-Darling said. I know it is not my place. There have always been a clash in Africa in most of the countries where there has been some research on MSM and HIV. There has been a clash between the

police [inaudible] and the will to make things change by health practitioners and in countries like Senegal where homosexuality is illegal we have seen that they have introduced men who have sex with men as a vulnerable population in their strategic plan to fight HIV and AIDS. This was done by health practitioners who believe that by including these people and addressing the issue they would find HIV and AIDS while the government do not necessarily have the political will to decriminalize homosexuality.

And now, we have to move on to Row Kavi from India. He will be presenting on the invisibility of a core high risk group. The title of his presentation is The Journey of India's Colorful Communities of Marginalized Sexualities Waking up to the Genocide of HIV and AIDS. Thank you.

ASHOK ROW KAVI: Thank you. First of all let me apologize. I had to leave the podium because I was not well so I think I am okay, a little steady. It is very interesting because the presentations up to now have given you a very good idea that because of stigma and discrimination there is a great difficulty, it is a barrier to working with these populations essentially where HIV, AIDS, and STI control is there. I am going to take you to an overview of one of those civilizations because I do not consider India a country. It is more than a country. It is a civilization. And, I do not see my presentation there. Is something wrong? Oh yes, there you are. I am going to start with a small personal story.

This is a picture taken through the window of a taxi summer of 2001. And, it is a transgendered assistant of mine looking through the window. She was begging at the traffic junction and she belonged to the ethical religious cult called Hijras who are transgendered, male to female transgender, and it is very interesting because though they are in your face. And, the paradox is that they are so visible there is no enumeration or census figure for this minority of men who do not identify as males at all.

So, I start from there. She came to work for my organization as Humsafar. Unfortunately, she was already HIV positive. At that time, there was no ART treatment in the government, public hospitals and she died with us two years after that in 2003. I just wanted this face to remain in your memory so you will not forget what is happening to huge numbers of Indians today. India as always historically had a tradition of men having sex with men. In Hinduism, for example, God is recognized as unlimited and not tethered by gender restrictions. The oldest literature of mankind, the Vedas, for example, mentioned concepts about sex men who are not or males who are not really identifying as men, the words used are nopunsicar [misspelled?] [inaudible] real warriors are not supposed to fight with these men and they have a sacred status in much of the rituals.

In fact, there are transgendered Gods, homosexual Gods, and last year one of the temples had nearly 4-1/2 million

single men visiting it. The God called Harriaputra [misspelled?], which means the son of Shira and Vishnu and Iappa [misspelled?] Shrine is one of the most sacred shrines in India, a lot of men go there. So, how ever much these shrines and Gods are attacked by the modern Indian secularists, Marxists, fundamentalists of all kinds they still remain and that is the wonder of India. It is so much in you face and yet over the last 20 years what we are seeing is slowly the rise in the public health landscape of these minorities, which nobody seems to know about. The last size estimate, which I did for the National AIDS Control Organization gives you a fluff figure of 2.35 million men having sex with men who are vulnerable.

We are not taking about men who identify as homosexual or as transgendered. We are talking from the public health point of view and that alone is 2.35 million. Now, if you say let us get back into the public health phase I am trying to give you a very quick, broad overview so that you can then ask me questions and I can clarify. The first AIDS case was detected in India in 1986 and soon HIV was reported from almost all states and union territories of the country. There was a national AIDS committee set up and soon after India was one of the first countries which had a vertical national AIDS control organization that sat in daily and really had control over all the national state AIDS control society.

It is very interesting to point out to you that health is a sector that is only handled by each state and India

seriously takes its federal structure so daily actually talking down to each state was not really light. Even today there are tensions in the health sector between the center or the federal government and the state government. But, they are still trying to work together. The first and second national AIDS control programs, which are called NACP, were launched in 1989 and 1999 respectively. You will be surprised to know that in 1989 I was there at Montreal and there was a bureaucrat from the Health Ministry who actually made a statement that there were no homosexuals in India. It reminds you of Iran's president right.

This happened in 1989 and soon now you are seeing that it is a core population so what was the transition, what happened from that period, the first pilot projects were started hesitatingly in 1999. My organization the Humsafar Trust was one of the first, which was the pilot in the whole country to work with just 1,000 men. And, the first stories that came out of the HIV prevalence and STIs were horror stories. It was 13.8 percent as a baseline figure and some of that indicated condom use of 20 percent, health seeking behavior was 30 percent, the number of partners per month was 11 on an average of casual partners. They are not talking of lovers. So, you can see as NACPP, that is the National AIDS Control Programs Progress, a slow and steady rise in the consciousness that there was this population and how are we to engage it because it is a paradox.

Everybody knows that there are sexual minorities in India; many of these sexual minorities are treated as sacred. They are part of the social religious landscape and yet the government was not conceding that they are a very intricate and important part of the public health issue around AIDS control. The focus was on heterosexual contact and injecting drug use and mother to child transmission and transfusion of unsafe blood. Today, from the time the first sentinel surveillances were done all over the country today India has 1,700 sentinel surveillance sites and they expect it to double in the next five years. So, you can imagine the government is very serious of these only 46 centers are for men having sex with men exclusively and for transgender. So, the focus was not female sex workers and injecting drug users the [inaudible], site, which is transparent in a sense, it never updated usually, but it does not matter. It kept on insisting that 98 percent of the transmission was heterosexual.

And, HIV transmission through anal intercourse among MSM and transgender was not considered at all as a root for HIV transmission. It was in NACP3, that is in 2003, 2004 when people like me from communities who are shouting on television, who brought television programs to a standstill, who went into Parliament and lobbied with members of Parliament that they started really worrying because there were issues here not only regarding human rights, but that is very important, but the fact is that NACP3 was a very serious effort at getting in all

these communities which are at risk. But, the wonderful part about the Indian government it always wakes up at the 11th hour. To not go acknowledge that is the National AIDS Control Organization acknowledged MSM and transgendered as one of the three core high risk populations. That is nearly after 15 to 18 years of the National AIDS Control Program.

And according to the 2006 sentinel surveillance data over 90 percent of HIV transmission was due to under protected vaginal and anal sex, that is when it came in. That was the first shot and it was brought in by epidemiologists of the National AIDS Research Institute in Pune, which is again a premier institute. India, I can proudly say had established an institute only for HIV AIDS research. And, that is when they sort of threw it on the table that anal sex was very much a high risk behavior that had to be considered. In India, anal sex is not considered sex at all. It is considered to be musty mischief. So, you know even bringing it to that level was difficult, yeah. Much of the transmission, it was established within groups or networks of individuals and there came in other implications of homophobia. The silent genocide among MSM, and with TG communities with 49 percent HIV prevalence as MSM and TG population size was not enumerated, not ascertained, not sort of even got a grip upon HIV prevalence rates as established by the government can be questioned. According to the independent surveys a little over 40 percent of HIV burden

among the high risk groups is carried by MSM and transgendered populations alone.

The rule of the community based groups that the MSM and TG organizations have now become the center in the government AIDS programs, how quickly we have come to the center of the stage. Massive advocacy efforts are on with the police adopted the commission of police to the judges of the Supreme Court, the high courts, and you would be surprised there is a time for homophobia that we expected. They are willing to listen, but they do not know how to get at it. [Inaudible], social exclusion of MSM from the human rights abusers and service denial the communities role is now central in trying to remove the anti-sodomy laws that were even during the time of the British, you can imagine.

The British brought in their anti-sodomy laws. India never had anti-sodomy laws for 4,000 years and suddenly in 200 years you had whole groups of gay men, transgendered criminalized. Thank you very much. I am looking forward to your questions. Thank you [Applause].

JOEL NANA: Stigma and discrimination drives the spread of HIV, 15 minutes for questions.

JOSEPH: Hello.

JOEL NANA: Joseph moves towards the mic.

JOSEPH: My name is Joseph and my question goes to the Kenyan representative and the representative from Ukraine. In your presentation, which I would say is very remarkable seeing

that you are [inaudible] various countries I did not really get what you do in sense of young, gay men or men who have sex with men who are homeless because I feel that this group of people are the ones who are more vulnerable to HIV infection? Thank you.

JOEL NANA: Second question.

ROB SAQUATON: Oh, I just wanted to bring out. I think it is great that you are at least trying to push your governments and your localities to push for better data collection. My name is Rob Saquaton [misspelled?] from the U.S. I guess just a couple of statements actually. Even though I guess people think of the U.S. as maybe one of the more forward countries in terms of LGBT rights we have lost a lot of ground under George W. Bush. I think the latest thing that happened is that the next U.S. census that comes up in 2010 they have been instructed not to count couples that mark themselves as married because they got legally married in Massachusetts and California so they want to deny the existence of our marriages and our relationships.

And, also LGBT activists in the U.S. were successful in getting basically basic information about our health outcomes on the health people 2010, which is basically the guideline for ten years for how LGBT for how health resources are allocated research to the U.S., but since then since Bush came to power basically that has been at a standstill. And, I guess the other thing I want to remind you is that even though it looks

like you are making progress with rights beware of backlashes. The best example is with Canada after gay marriage was instituted where there was a lot of political backlash and increase in gay bashing and violence.

JOEL NANA: Thank you. We will take a third question. We will allow the presenters to reply before taking other questions. On the other side.

GIRA MOYA: I am Gira Moya [misspelled?] from Mauritius. I want to ask my colleagues from India about if they get support from region leaders for your organization against discrimination and stigmatization. That is all. Thank you.

JOEL NANA: Thank you. Who will start?

MAC-DARLING COBBINAH: I must confess that there is a lot of gay men on the streets of Accra who have been sent from homes who are coming from the other regions and walking on the streets of Accra selling sex. Like I said, one of the challenges of our program is funding. We have plans in place to work with gay sex workers in Accra and migrants from Liberia and then what [inaudible] who come to Ghana and then we also find sex workers other means to survive. So, we have a lot of work.

ZORYAN KIS: I would like to thank for the questions in terms of homeless MSM. I would like to say that we do not do much in Ukraine for MSM in general I have to admit. Our programs in Ukraine have just started last year in ten regions

of Ukraine including Kyiv and Odessa, which are as I mentioned are the cities that most homeless MSM are attracted to. And, I also have to say that the programs in Ukraine and other eastern European countries are more general and are not yet specialized for homeless MSM, for MSM of specific age, for MSM of specific ethnic groups, or for MSM of specific cultures. And, we are coming to that, but so far we are just starting and thank you for the idea of working with homeless MSM. It has been around in Ukraine for a long period of time, but again we need funding and models, successful models. So, we want to share a successful model of work with homeless MSM. I really appreciate that.

And, I would like also to give a short comment on the comment of our colleague from the United States. Thank you for this comment. We have also always been aware of the fact that there will always be backlashes and there will always be homophobia. And, even in developed countries we have to always work because homophobia is there and it is not that it is only in the eastern European countries or those countries who are just starting the work. It is everywhere and we have to work always.

BORIS DITTRICH: Yes, I would also like to comment on the question or actually the remark of the gentleman from the United States. The Netherlands was the first country to introduce same sex marriage and adoption by gay couples. But, strangely enough after that had been achieved you hear a lot of

comments by the general public that they do not really believe there is any discrimination any more because they say, but you have gay marriages. So, it is very important to try to show the general public that there are discrimination areas and that it is very important to address these issues and that gay marriage should not be used as some kind of token. But, it is of course one part of human rights that has been established in the Netherlands, but indeed homophobia is everywhere and also in the Netherlands, specifically in certain groups. So, actually you have to fight homophobia everyday, everywhere.

ASHOK ROW KAVI: I am not sure I agree that there is general homophobia that you see in Europe and America and India. What there is, is compulsory heterosexuality, you see. Your homosexual identity could be way out on the table. There are members of Parliament who are openly homosexual, but as long as they have done their social duties nobody really cares about their sexuality. It is a very strange paradox that the Madras High Court has actually taken for inheritance laws, marriage between the third gender, transgender and a male as legal. There are scores of lesbian marriages in India, definitely marginalized more than the men. They seem to have more courage than men in going forward and getting married in Temples.

There is not any basic hatred for the, I do not see that as lesbophobia, what they are protesting, the mainstream is that you have to get married in a heterosexual family. So,

how, I would like to argue that out would be another discourse altogether, but it is important to put that on the table.

JOEL NANA: Thank you, we will take three other questions. Start from my right.

MARIA EXTRAND: Hi, I am Maria Extrand [misspelled?] University of California, San Francisco. I have a question for Ashok. Thank you for a very interesting overview. I noticed on your slides that you had combined all the data for gay men and transgenders and it seems to me based on your description of the two groups that they are actually very different and I would expect that risk behaviors and prevalence would be different for the two. Do you have the data broken down?

ASHOK ROW KAVI: Oh thank you Maria for pointing that out. Actually when the sentinel surveillances started for MSM, under that umbrella transgendered were lumped in and the transgendered community took very strong objection because in India they consider themselves not men and therefore totally separate. Hence, in the operational guidelines for the future NACP3, it was I and my group that suggested that it should now be termed MSM and transgender and the only sentinel surveillance site, which desegregated data that comes in, was really Bombay and after that now Bangalore has started. The differences are so amazing in the sense three times higher HIV prevalence among transgender males compared to MSM whose identity is not around gender.

But, again there is a problem Maria in the sense that the fluid identities in India where MSM there are identities, which are between MSM and transgender who call themselves double deckers. There are [inaudible] identities and there are more than about eight or nine identities that are fluid. And, what we are talking of hedras [misspelled?] identity is those belonging to the religious ethnic cult. There are lots of transgender who do not follow that identity and do not want to be known as hedras. So, there is a complex situation here, but you are very right when we desegregated the data it was another horror story. I mean in Bombay it was 8.5 percent among men having sex with men and among hedras it was 26 percent. So, you cannot neglect the difference. Thank you for asking.

JOEL NANA: We will move to our left.

SHAWN CASEY: Hi, Shawn Casey from Hartland Alliance in the U.S. Following up on a previous question that raised the issue that many MSM that you are reaching in your organizations are young and/or low income or vulnerable for other reasons so I am curious. I want to ask the three implementing individuals up there how you reach those rich, well connected, not vulnerable MSM who exist in every country, but who do not want to have contact with LGBT organizations, who do not want to be reached because it might out them and it might risk their social capital? And, I also wanted to know if any of you have done operational research through your MSM prevention

interventions to know what has worked in terms of behavior change and perhaps what has not. Thanks.

JOEL NANA: Then on the right.

MALE SPEAKER: Yes, I just have a quick question about The Yogyakarta Principles and I am wondering if there has been any conversations or if you have any recommendations on monitoring and reporting and perhaps enforcement of the important document that you have talked about?

JOEL NANA: Next.

MALE SPEAKER: I will try to make this quick. When I walk around the pharmaceutical booths and I look at the imagery, I was speaking to some folks there, and the imagery internationally always is of, and I am not saying they should not be there, of women and their children, but when I talked to someone that I know that works for one of the countries they said well we do MSM stuff locally. I said well what about internationally because this is an international issue and in that way we sort of become sanitized when we become international. And, those that come from countries that are not represented are not seen in those images and therefore we are perpetuating the thing that we are trying to fight against in order to please their shareholders that make, you know, we do not want to piss them off so they do not make money.

JOEL NANA: Thank you we will take the last questions and then allow the panel to respond.

CARMEN LOGIEN: Hi, my name is Carmen Logien [misspelled?] from the University of Toronto. Thirteen days ago, I met with the sexual minorities of Uganda, SMG, which is one of the case studies. That was two days before one of their members was detained and tortured. And, what I was struck by was that so many organizations receive U.N. AIDS funding, yet refuse to work in the Ugandan context with sex workers or MSM and including the Foundation for Human Rights whose executive director says they do not support the rights of gay and lesbian people. So, how do we hold these, how can U.N. AIDS funding, which is supposed to be supporting the rights of MSM and sex workers how do we hold organizations accountable to provide these services especially when you are talking about federal human rights agencies? [Applause] thank you.

JOEL NANA: Who starts?

MAC-DARLING COBBINAH: Yes, I must also say here that our program had training for two division MSM who are a bit wealthy and then they organized different division programs. They organized parties, group discussions, which is separate from the peer education programs and then our office goes and has discussions with these groups. But, there are those who do not want to be associated with the program and we are still working in the process to get someone within their class to speak to them.

ZORYAN KIS: I will try to be brief because as I see we are on the hour and out of time and in terms of the question

how do you reach MSM. My previous answer answers this question that our programs are not yet very specialized. But, to my opinion, the only way to reach MSM is through business venues such as clubs and night clubs and bars. And, in Ukraine we do face lots of problems with them because we are accused by the gay business that we are interfering with their business with trying to do any prevention work or any information work in that so this is a challenge in Ukraine. And, regarding the other question about operational research I will have to make a clarification here that my organization, the network of people who live with HIV, does mainly national level advocacy and care and support programs for HIV positive MSM.

The prevention programs are implemented in Ukraine mostly by the International HIV AIDS Alliance in Ukraine and they do, do operational research and I think they are available on their website. But, still we do not have that much. The programs for MSM do not run in Ukraine for such a long time that we can have any data on what works and what does not. So, we still have to work for a longer period of time to know what really does work. Thank you.

BORIS DITTRICH: Thank you for the question about monitoring and enforcement of The Yogyakarta Principles. What I can say is that actually all stakeholders in a specific country should put pressure on their own government to endorse the Yogyakarta Principles and to implement human rights for vulnerable groups in such a country. But, on an international

level I can tell you that the Yogyakarta Principles were introduced by Brazil, Argentina, and Uruguay in November 2007 at the United Nations and yesterday morning I had a meeting with the Mexican government. Also, Mexico is using the Yogyakarta Principles. I can tell you that the European Parliament voted in favor of a resolution to end discrimination and in this resolution reference is made to the Yogyakarta Principles.

There are specific Parliaments and governments who endorse the Yogyakarta Principles like the Netherlands and Belgium. And, I would like also actually to announce that in the first week of December in the General Assembly at the United Nations in New York they will be taking an initiative presented by France, but it is a cross regional initiative and it will be a declaration on ending discrimination in terms of sexual orientation and gender identity. And, of course, that is not the same as a resolution by the United Nations endorsing the Yogyakarta Principles, but it is a step on the way to that goal. You must realize that for instance at the Human Rights Council in Geneva a majority of the countries that are members of the Human Rights Council do not even want to discuss sexual orientation or gender identity. So, we are still far away from this goal, but it is a major challenge and one day we will get there.

ASHOK ROW KAVI: I think I have to answer in two parts.

The first is of course operational research, my model

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organization, Humsafar Trust, works on approximately 215 sex sites in Bombay City, but these are public sex sites. We do not get to reach MSM who themselves have ceded from the organization. The organization remains open to all classes and casts and communities, but if you refuse to come there because you feel only the poor go there then it is not our fault and you can go to a richer hospital where you feel you can get the services you want. We have approximately eight research projects flowing out of our huge outreach program and STI referrals to public hospitals.

And, some of them are very important to the sense they have never been thought of as in the public health sector like what is the mental baseline. Why do men having sex with men have such a large number of multiple partners? Although it is politically incorrect to ask it, but it is a very important indicator in HIV prevalence and therefore that is one of the operational research that we have. We have other operational researches that are going where what is impediment to condom use? Why do men not use condoms? Is it accessibility? Is it because of lack of pleasure? So, all these are going on simultaneously in parallel with the outreach program.

Secondly, regarding the human rights I feel that a lot of us who are working at grass roots level understand that there is a need that to marry human rights because without human rights coming into your outreach and your public health program really there is no use working on empowering MSM and

gay men and transgender. So, there are two tracks, on one hand you do the work around health issues and on the other track there will be gay organizations and MSM organizations or lawyers' organizations, which work around human rights issues of sexual minorities and that is what is happening in India. Because if I were to work on health issues, which are not my expertise or my core competency I will be really letting out the prevention program out of hand and I will be having very few MSM who will be thinking of human rights.

At the same time, the human rights organizations are looking at HIV issues and we have a very comprehensive HIV AIDS bill in there that is coming up. I am not very sure the members of Parliament are very enthusiastic about it, but it has principles of the Yogyakarta Principles, which are married into it, but they are concerning HIV AIDS as a public health issue. So, that is where it stands today in India. Thank you very much.

JOEL NANA: Thank you all for coming. Thank you Boris, Zoryan, Ashok, and Mac-Darling. We have come to the end of our session. Thank you for coming [Applause].

[END RECORDING]