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Know Your Epidemic, Know Your Response: MSM and Their Needs in Middle and Low Income Countries
Kaiser Family Foundation
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ANDY SEALE: Good morning. Welcome to this session. It's good to see so many of you here. My name is Andy Seale, I'm the Senior Advisor for Gender and Sexual Diversity of the Global Fund, and we have a very exciting session in two parts this morning.

We're going to be looking at "Know Your Epidemic, Know Your Response: Men Who Have Sex with Men, and Needs in Lower and Middle Income Countries." Before we start, just a little bit about how we're going to organize the session this morning. We'll soon hear from Stef Baral who will give us the presentation that will form the first part of today's session, and then we'll hear from a distinguished panel of speakers who offer some perspectives really reflecting on Stef's findings from a community perspective, a youth perspective, religious and country-level programming perspective.

And then after everybody has spoken from up here, there'll be an opportunity, of course, for questions from the floor. I'd like to pass over now to Robert.

ROBERT CARR: Good morning everyone. My name is Robert Carr. I am the Director of Policy and Advocacy at the International Council of AIDS Service Organizations, and I'm very pleased to be co-chairing this session this morning. Why don't we go ahead and begin with our first speaker. He is Stef

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Baral. He was trained as a family physician and community medicine specialist in Toronto before joining the faculty in the Department of Epidemiology at the Johns Hopkins School of Public Health. Stef?

STEFAN BARAL: Thanks very much. So the title of my talk today is "Know Your Epidemic and Knowing Your Response," as Andy said, "MSM and Their Needs in Lower and Middle Income Countries." So there's really two key themes to my talk today. One is around knowing your epidemic and where we'll be describing the epidemiology of HIV among MSM. We'll describe how we've conceptualized the epidemic scenarios that describe varying HIV epidemics among MSM in lower and middle income countries. I'll also talk very briefly about the burden and risk factors for HIV among MSM.

The second key theme is really describing common HIV prevention interventions for MSM and what we've given thought to, what components of that would be, as well as describing some recent data that we have around prevention expenditures for MSM. And then I'll describe some of the results that we've had from a project in partnership with Futures where we've modeled the varying HIV epidemics in the general population according to varying responses for MSM.

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Finally, I'll give a brief overview and my other panelists will expand on this, the relationship between human rights, HIV and MSM, and some thoughts on moving forward.

So in terms of background, you know, we all know in this room at this stage that there's ongoing epidemics among MSM in multiple low and middle income countries. There's a series of newly-identified epidemics and previously unidentified studies - unstudied areas I should say, and in high income settings, we have seen resurgent epidemics among MSM in a variety of settings including North America, Europe and Asia.

Responses at this stage, we still have inadequate coverage in access prevention treatment and care and I know that our panelists will be expanding upon that. We, as well, as a challenge to scientists and community members, still have an inadequate toolkit for preventive services for MSM. And from a human rights standpoint, there's been multiple advances in LGBT rights awareness, empowerment and activism, but as we've seen either on the news or in country, there's been a major pushback on the MSM and LGBT rights effort.

So the strategy that we really use for this was a systematic search of the literature using a variety of different protocols. As well, we did an electronic global consultation and we really reached out to a variety of the

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existing networks and reached out to community partners and the academic partners from Africa, Asia, Middle East/North Africa, and really around the world and collected about 1,700 documents describing community best practices and epi and rights context.

Finally, we did a community validation, a face-to-face consultation that was held in Bangkok, where members from about 28 countries came and we discussed our findings. So this is the search protocol. Really, the key point of this is that we now have 133 prevalent studies from 50 different countries, which, in reality, is only about 12 countries more than we had when we did these sorts of searches in 2007, so it's been progress, but it's been slow.

This is the way that we've conceptualized the epidemic scenarios, the details of which aren't that important for this session, but just to say that we've conceptualized these scenarios recording varying prevalence rates in vulnerable populations including injecting drug users and the general population, as well as MSM. And this is really how these scenarios map out. So, there is some concordance with regions around the world, but again, these scenarios don't really map out to regions, and the epidemics in some countries map better to other regions, and we'll talk about that.

In terms of Scenario 1, this is really where MSM risks are the predominant exposure mode for HIV infection in the

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population, and so what you see here in the table is — in blue you can see the aggregate HIV prevalence rates among MSM, and in orange, you see that in the general population. And what you see in this area is that you have relatively well-controlled epidemics in general population, and quite concentrated in high epidemics among MSM.

And this really maps out Latin America and the Caribbean, but as well, countries like Ghana fit this epidemic scenario better than others.

In Scenario 2, this is where MSM risks are occurring with an established HIV epidemics among injecting drug users. So here you have aggregate — in blue you have the aggregate HIV prevalence among injecting drug users; in gray you have that in among MSM; and in orange, you have that in the general population. And what you see is these are relatively well-controlled epidemics in general population with quite concentrated epidemics among MSM and among injecting drug users. So this really maps out to the former Soviet Union, Central Asia, as well as Eastern Europe.

In Scenario 3, this is where MSM risks are occurring in the context of mature widespread HIV epidemics among heterosexuals, so this is really what we think of as our generalized epidemics. And in here, what you have is — in blue you have the aggregate prevalence rates among MSM; in orange,

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you have that in the general population; and in gray, you have the disaggregated data for HIV prevalence among men who are 15+. And as we know in the majority of generalized epidemics, these are really female-predominant epidemics, so we really wanted to compare men to their male counterparts in these settings. And you can see that universally their risks are higher for HIV. And again, this really maps out to Sub-Saharan Africa within the context of the generalized epidemics there.

So Scenario 4 was really the most complex of our scenarios and this is where MSM, heterosexual and injecting drug use transmission all contribute significantly to the HIV epidemic. So here what you see, blue is the HIV prevalence rates among MSM; in orange, you have that in the general population, and again, you see these really well-controlled epidemics and moderate epidemics in the general population, and quite concentrated ones in that of MSM. And again, this really maps out to south and Southeast Asia, but there are other countries that are fitting this epidemic scenario including Egypt and Senegal.

But let's keep in mind that, you know, while we have data from 50 countries, there's 94 other low and middle income countries that we don't have any data describing either HIV risks or prevalence rates among MSM, so the large part of the world remains unmapped, and we're really still in the very

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early stages of understanding HIV risks among MSM in these settings.

And beyond that, when assessing data quality, the vast majority of data that we have describing MSM in low to middle income countries including our own data, is predominantly both prevalence data and it's from convenience samples. So it really tells us where the epidemic was and not where it's going. And, importantly, it's likely not generalizable to the general population of MSM, and, for example, the majority of these samples — the majority of men that you can accrue in Africa in today's age are traditionally young, between 18 to 24.

When we look at prevalence rates among those reproductive-age MSM from 30 to 49, we see prevalence rates as high as 50 percent, so we have — we're a long way away from really being able to compare HIV prevalence rates in a meaningful way to those age-standardized rates among reproductive-age adults in the general population.

In terms of incidence data, we have incidence data from Kenya, Peru, Brazil, and then most recently presented from Frits Van Griensven's group in Thailand. Extraordinarily high rates of prevalence among MSM in these settings. So this was an ecological model that we developed a few years ago and I think that the point of really presenting this is that there

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are certain individual level risk factors that hold true for MSM irrespective of epidemic scenario and irrespective of region, including unprotected receptive anal intercourse, general ulcerative diseases, lack of circumcision for predominantly insertive men with high levels of bi-sexual concurrency, frequency in higher numbers of lifetime male partners, dual-risk injecting drug users.

But it’s really the higher order risk factors that I want us to think about in terms of community level risk factors, stigma limiting the development of preventative services, access to voluntary counseling and testing and antiretrovirals, and even higher than that, the levels of public policy. So the majority of the countries in which we work, MSM are excluded from the national surveillance mechanisms, criminalization limits, preventive services and human rights context does the same, and we’ll hear more about that from our esteemed panelists.

And, again, just to keep in mind that sex between men — I should say, unprotected sex between men is not an inherently dangerous activity, but it really becomes that in the context of HIV, so you need HIV to really — to make this a risk factor.

Again, what we want to see here is this is a nice paper from Patrick Sullivan and all, and what it shows is that even in high income settings — and this data from Europe and North

America — we've seen that in the late '90s we saw a lot of benefit in terms or preventative services. And in the last eight to 10 years, we've seen an increase in the rise of HIV infections among MSM in these settings and so, just to say that these problems are complex and they are not limited to low and middle income settings.

And this is data, as well, from Asia showing the same thing, that in the high income settings of Asia, we're as well seeing increasing rates of HIV among MSM, so these are complex issues. [Applause] Thank you.

So the second key theme of my talk today is really around knowing your response, and we did this again with our systematic review and our global consultation. And there's two key themes that we learned from this: one is that there is positive data characterizing preventative services and preventative interventions for MSM in low and middle income countries, and this is really a challenge for us all to learn more and to understand this better.

And, as well, as Carlos Casares said very well today, that responding to multiple levels of HIV risks among MSM requires combination prevention interventions that are multi level and multi modal. So we use the modified grade approach for evaluating public health interventions for MSM and the way we did this was using three key parameters. We use efficacy

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data and we use biological plausibility. But what we also did was use community best practices because we recognized that this is an important component of grading evidences, learning from what's been done in the community and assessing that and including and integrating that into our evidence base.

We gave six grades from strong all the way down to inappropriate. And while I'm not going to get into the actual interventions at this stage, what I do want to discuss is the three key components of the combination HIV prevention interventions. Those are behavioral interventions, where we're increasing condom and lubricant use during sex, the secondary target of partner reduction. These are biomedical interventions and this is really where we're trying to decrease acquisition and transmission risks while not directly targeting the changing prevalence of risk practices.

And finally, structural interventions. Really, we know that there is a paucity of efficacy and effectiveness data for these interventions. You require really complex study designs to evaluate them and, I really challenge us all — community and academics and implementing bodies — to start implementing and better evaluating these interventions, so that we can learn and integrate them, because we do know that on the ground they're a crucial component of any preventative service for MSM.

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I think it was really important to highlight that in order to see results of our services, we really need to spend money as we would for any population. This is data from the Global HIV Prevention Working Group and it showed that in concentrated epidemics which map out to countries that are in our epidemic Scenario 1, 2 and 4, where MSM are one of the predominant risk groups, about 3.3 percent of total expenditures support MSM, so about three out of every hundred dollars.

In generalized epidemics, which is countries of epidemic Scenario 3 and 4, where we're seeing emerging evidence of HIV risk among MSM, we've a .1 percent of total expenditure, so that means they've got one dollar out of every thousand to support the needs of MSM.

Looking at this visually, data from a few years ago from Asia, what we're seeing in blue is the total HIV prevention expenditures in these settings comparing in red to the share of prevention expenditures for MSM. And what you can see is that there is a real disconnect between the evidence showing concentrated epidemics among MSM and the allocated expenditures. And the same holds true even in a place like Peru, so this is 2010 data. The green dot showing HIV prevalence and the bar showing expenditures, again, just really

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highlighting this disconnect between prevention expenditures and HIV prevalence in the population.

So we use the Goals Model that was developed by the Futures Institute to mathematically predict the general population HIV epidemics in a variety of different countries. And so the varying inputs that I won't get into now, but include demographics in sexual practices and HIV/STI rates, with outputs including HIV prevalence and incidents. Again, this is in the general population, not just that among MSM.

We refine the model by dividing MSM intervention into separate parameters, including outreach with condoms and lube, community level behavioral interventions, and inclusion of antiretrovirals based on a new finding of 92 percent efficacy of consistent antiretroviral use with discordant couples by donalidol [misspelled?].

We, as well, expanded risk categorization for MSM to low, medium and high, as well as MSM/IDU, and we did that because similar to heterosexuals, there's varying levels of sexual practices among MSM that really grade them from high to low risk. So some of the results — I know some of this has been shown already today, but just to quickly repeat it — if you follow the green line up, you see a slow but moderate HIV epidemic in Peru, again, in the general population. And if we

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do nothing, we'll follow —we'll continue to see an increase in that seen in the green.

If we stop antiretroviral treatment for MSM and stop prevention services, we see a rapid spike of infections among MSM, but if we increase coverage of services for MSM to 100-percent, as well as treating all HIV positive MSM, you really start seeing a curbing of the epidemic in Peru, again, in the general population. So what we see here is that markedly higher coverage of interventions for MSM is required to change the trajectory of the overall HIV epidemic in Peru.

Now looking at Ukraine. What we see here is following the green line out, we can see that, again, similar to Peru, stopping services for MSM slows the decline of infections in Ukraine. If we increase services for MSM, as well as treating all HIV positive MSM, we increase the rate of decline of infections in Ukraine significantly. However, in a setting like Ukraine, where the majority of infections are driven by injecting drug use, we really need to combine 100 percent of MSM coverage in addition to coverage – in increasing coverage for injecting drug users. Here we report on 60 percent coverage of injecting drug use because as it was recently reported in the Lancet series presented at this conference, that's likely the optimal level of coverage that you can obtain

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for injecting drug users in terms of some men not wanting opiate substitution therapy and needle/syringe exchange.

So it really shows that even in a setting like Ukraine, you really need to markedly increase coverage for IDUs, as well as MSM to decrease the population prevalence in incidents of HIV. So what it tells us, again, just to repeat this, 'cause I think these are important messages. Higher coverage of interventions for MSM does have a positive impact on the HIV epidemic in the general population in Ukraine, and combination with IDU interventions has the greatest impact on the epidemic.

Now looking in a setting like Kenya, this is a generalized epidemic with high rates. And I'm just going to focus on the last little bit there. We've seen a general decline in the Kenyan epidemic, but again, even in the setting of a general HIV epidemic and the general population, when we increase services to 100-percent for MSM, we do see benefit in the general population prevalence. And if you look at the numbers here, you see about a 10-percent benefit which is significant and it really highlights the importance of including MSM as part of a comprehensive HIV response in Kenya.

Again, just to repeat this, I think it's important. Even where the prevalence is high and mature in the heterosexual population, addressing the needs of HIV among MSM does play a key role in a comprehensive response.

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Finally for Thailand. Again, we're seeing similar and themed results here. In these settings, if you decrease services for MSM, as well as decreasing treatment for MSM, you see a rapid spike in infections, but when you do treat and increase coverage to 100-percent for MSM, you see a benefit in the general population epidemic. Again, in this setting with a significant component of injecting drug use, the best — the most significant benefit I should say is really seen where you take coverage to injecting drug users to 60-percent, as well as covering MSM, so the two really go hand in hand.

So overall, we have a stable epidemic in Thailand, but we really do need higher levels of coverage for MSM leading to overall declines in the general population epidemic, as well as increasing injecting drug use coverages is going to have a synergistic benefit there.

So from a conclusion from the models, what we see is that MSM-specific interventions including distribution of condoms and lube, as well as community-based interventions, does have a benefit on the general population, but it has to include the treatment of HIV positive MSM, as well as the extension of the antiretrovirals to all MSM as needed. And where injecting drug use plays a significant role, you, as well, have to address the needs of injecting drug users in addition to MSM to have the most benefit on the epidemic.

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The key point in this really being that benefit was seen in four out of four epidemic scenarios across the world. Human rights contacts, my fellow panelists are going to expand on these issues. I'm just going to go over them briefly. We presented to this conference a health impact assessment that we used to asses the role of criminalization of same sex practices as a risk factor for HIV among MSM.

We use participatory methods in a series of different case study countries. What we saw was that increase enforcement of laws criminalizing same sex practices has resulted in widespread fear and hiding which is in and of itself, a human rights abuse. But from a public health standpoint, it has also interfered with the ability to provide HIV prevention care and treatment services which is limited coverage.

Equally importantly, it has interfered with the ability of MSM to seek these services which has limited uptake of these services, so it's really had a dual effect and it's been significant in the settings where this has happened.

I have some very brief conclusions. We know now - and, hopefully I've made it clear throughout this presentation, and we have other documentation to continue making this clear - that HIV continues to disproportionately affect MSM in both high and low income settings, and there are both individual and

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structural drivers of HIV infection that are both equally important in this risk.

Moving forward, to improve the health outcomes of MSM in low and middle income countries, we really need a comprehensive effort focused, I think, on these two key themes, Knowing your epidemic - we need to keep generating high quality epidemiologic data. We need to characterize populations and characterize risk. We need to demonstrate need in this population. We need to inform prevention strategies, because there's not going to be one solution for all.

We, as well, need to know your response, and that's going to happen by adopting combination prevention strategies that address multiple levels of risk. But unless we take these services to scale, we're going to keep seeing increasing rates of MSM - of HIV among MSM, so it's key that we appropriately resource these prevention programs for MSM in response to the evidence-based need.

So there's a series of different people that played a key role in this presentation. Our team at Hopkins that helped and played a key role in the development of the methods, and the Futures Institute for providing technical support with the Goals Model, the Global HIV programs at the bank for supporting this both technically and financially, and as well, the other WHO partners including - the other UN partners including UNDP,

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UNAIDS and WHO for providing technical support. And I'd like to thank my other panelists and I look forward to hearing them, because they, as well, provided critical feedback on this presentation. Thank you. [Applause]

ROBERT CARR: Thanks so much Stef. I think we've had a lot of exciting information shared at this conference already, but for those of us in this room, we've never had such strong documented evidence around the impact on the broader investment in MSM, on the broader population, as well within the MSM communities, and so, it's really exciting that yourself, Chris and others who've contributed to this research have been able to share with us today. So thanks very much, Stef.

We'll now move on to some reflections from our panel and we'll start with Shivananda Khan. Shiv is the - as many of you will know - is the founder and Chief Executive of NAZ Foundation International. NAZ Foundation provides ongoing technical and development assistance to MSM groups, networks and community-based organizations across south Asia. And I think, Shiv, you're going to share some south Asia perspectives with us now. You're welcome.

SHIVANANDA KHAN: Looking around the room, I feel a bit overdressed, but then I thought I was coming to a party and here am I, sitting here without a party. Anyway, I'm speaking from two halves. One is from South Asia where we primarily

work, but I'm also working across Asia and the Pacific through advocacy work around some of the issues that are coming up from Stef's presentation. And I just want to reflect on some of these issues.

We've been waiting a long time for this data; I've been engaged in this area for 20 years and this is the first time I'm hearing this sort of data, when from a day-to-day perspective we watch people every day for the last 20 years getting infected and dying from HIV, those that we work with, men who have sex with men and transgenders. I think is a horrendous indictment, not only on the UN system, but on governments and many other NGO.

Right now, if you look at the data from Asia and the Pacific, if there is no increase in HIV interventions for MSM and transgenders, then something like by the year 2020 - which is only 10 years away – 50-percent of all new infections will be MSM or transgenders.

Right now in Asia and the Pacific, and as Stef pointed out, less than 4-percent of funding for HIV program is going towards services for MSM and transgenders. It's not only Asia and Pacific, it's the globe. Nine out of 10, nine out of 10 MSM and transgenders do not get services, and right now in Asia, every day there are about 200 people - MSM and

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transgenders - getting infected because they don't have services.

This to me - I don't know about you - but this to me is a silent genocide. [Applause] It's outrageous that for 25 years we've been fighting this virus and still they're killing us off because they don't invest. They keep saying, "Let's wait for the evidence; prove it." We've got the evidence now. Let's see what they're up to. [Applause]

There are three areas and we're holding the UN system and the Global Fund and DFID and USID and PEPFAR and everybody to account because we'll be watching and monitoring. You're not going to get away with it this time.

In our part of the world one of the key areas that we need to work with in terms of reducing stigma and discrimination is what some of you may have called homophobia, but I tend to call it gender phobia, because the issue of sexuality is very much around gender-based dynamics and the men who are targeted for violence, abuse and rape, it's because they're feminine.

You know, men can be buggers - whichever part of the world - but they're more buggers in our part of the world than, perhaps, other parts of the world. Buggers in the literary sense, not necessarily in the nice sense. We have to look at how feminization and women and girls are also looked at by the

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men. If you go to Pakistan and Afghanistan, Middle East, or even parts of India, you'll see what I'm talking about there.

So in terms of building an enabling environment, we need to look - not only look at the law, because you can change the law, but at the grass roots level, the impact still continues horrendously, like in India, they are repealing 377, but for the impact of the park and the cruising site, it can still be very, very difficult. We need to look at a whole range of social issues. We have to, somehow, despite the difficulties in the funding environment, we have to increase investment, 4-percent is totally inadequate. So we have to persuade the Global Fund not to cut back; we have to persuade the donors to give more money despite what Mr. - sorry - President Obama says. We have to make sure that DFID and all the key bilaterals increase their investment, rather than reduce their investment: targeted investment, not generalized investments.

Teaching school children about HIV doesn't necessarily reduce HIV. Teaching MSM and transgenders does. And then finally, we have to have more organizations, more community-based organizations that will work in the field to help us deal with the issues that we're having to deal with every day of our lives. It's not just about condoms and lubricants, for Christ's sake; it's about conditions: having clean water,

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shelter, food, poverty issues, employment issues, education issues. A lot of the guys we work with are thrown out of school because they happen to be feminized, or because they're being abused by their teachers and the staff and the students, so they can't finish their education. What are they going to do? They're going to go toward sex work. I could go on, so I'm going to finish - basically, I'm not very happy despite the evidence and I would like you all to say enough is enough; 25 we've been fighting this damn thing and we're still saying the same thing 25 years later. We have to be heard. It's up to you, it's up us, and it's up to all those big shots that keep telling us, "We need more evidence." Evidence is here. Thank you very much. [Applause]

ROBERT CARR: Thank you, Shiv. Our next speaker - and forgive me if I don't pronounce your name properly - is Nyambure Njoroge, who is a Presbyterian Minister and a leading theologian and ecumenist from Kenya. She is the Program Executive of the Ecumenical HIV and AIDS Initiative in Africa of the World Council of Churches in Geneva, Switzerland. Please.

NYAMBURE NJOROGE: Thank you very much for the opportunity to contribute to this panel. Certainly, you can see that I'm the odd one out, so I'll try to do my part.

SHIVANANDA KHAN: I am also a lady.

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NYAMBURE NJOROGE: Okay, I understand I'm not the only woman at the panel. [Applause] I'm here to speak from the religious perspective and I want to say that from 1986 the World Council of Churches was approached to address the issue of AIDS crisis because it had a faith component to it. And since then, we have not looked back, probably we would have done much more, but we continue to provide ecumenical response, particularly in the continent of Africa where I am doing my work for the last several years.

So from the beginning, the policymakers of the World Council of Churches asked for study, so that we could understand from the medical professionals and also from those who had been infected, what this AIDS crisis was about. And from that time, the policymakers agreed that everyone has the right to medical and pastoral care regardless of socio-economic status, race, sex, sexual orientation, and sexual relationship. And that still remains what gives us the mandate to do our work when we interact with our beneficiaries, our members of the World Council.

But from the onset, it is also very important for us to acknowledge that religions are many and there is no one particular perspective, even from Christianity itself. The World Council represents 350 churches from all over the world, and we don't always speak with one voice on particular issues.

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So that is important for us to register, and so we have the multiplicity of perspectives which sometimes are contradictory, confusing, confrontational, and even sometimes oppressive, even when we have liberating and affirming perspectives.

But it’s also important to say that talking about sexuality in many of our religious communities in the context of comprehensive HIV prevention has not been an easy aspect and security of men having sex with men is one of the most difficult and contested areas, and sometimes religious leaders and followers are known to use violent language in expressing their views.

Violent language only creates fear, judgmental atmosphere, and victimhood. It is also equally important to remember that we in the religious communities have been asked to respond and we have responded in many ways. And sometimes we have neglected to bring the most important part of this epidemic and that is to dig deep into our religiosity and our spirituality. For we know very well that human beings have physical, spiritual and sexual needs. So from the World Council of Churches perspective, we are scaling up working with church leaders on understanding the human being in all the three components and especially our sexuality, because that’s

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one of the most complex issues to understand from a religious perspective.

We also want to acknowledge that even including men who have sex with men, many of them are influenced by religious beliefs and values. We have noted that UNAIDS has estimated that 70-percent of the world's population adhere to one faith or another, and we need to respect that and we need to take faith into consideration in all our programs and activities. And here I want to emphasize that we are hoping that when we meet again in 2012, we will not just be put in a bridging context like we are in this small room, but we will be part of the bigger primary where religious communities can be invited to be speakers so that we can speak from our faith context, because we know that faith is fundamental for human life for many of us, even when we are not able to say that.

The other reality is that even those of us who don't practice our faith all the time, when we get into a crisis, that is one of the fastest things that we invoke, and so it is important for us to take faith into perspective in everything that we do, even in a conference like this one.

We know that fear and oppression such as in racism, in sexism, or in homophobia have never been good instruments of public health, and so we need to deal with fear that comes from the religious context.

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In many of our religions also, we know that we have values and principles of love, respect for the inherent human dignity and tolerance and justice. We even have instructions and teachings in some of our sacred texts that we might ask that human life is sacred, and all human beings are created in the image of God, and so there is no one who is a misfit in the eyes of God. I think that is important for all of us to acknowledge. [Applause]

In particular, in the Christian sacred texts, one of the fundamental instructions we have which is critical for us to do the work of HIV, and particularly when we talk about sexuality. We are instructed not to judge; judging is not our business, that belongs to God and we leave it to God. That's what our Christian text teaches.

Therefore, as a way of response together with other communities, it is very important for us to create safe spaces where religious people, people who are working on HIV, people living with HIV, and men having sex with men, to come into that safe space, and in a non-judgmental way we talk about these issues as we look for solutions in our communities.

I know that this is already happening in many of our places, but again this is not something that we have documented. It needs to be scaled up so that even when we have the scientific data as we have received it this morning, then

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we can be in one space. But that has to be done within our communities, it has to be contextual and it cannot be imposed form outside. Especially when I speak from the African context, I think this is very important that we do not have people imposing on us how to go about this. But we look for our own solutions how we address these difficult issues in these times when HIV continues to be a heavy burden in our continent. Thank you very much for listening. [Applause]

ANDY SEALE: Thank you Nyambura. I would like now to ask Zaryan, we're going to change the order of seating slightly to address the panel now. Zaryan Kis is the Executive Director of Fulcrum, and all Ukrainian charitable NGO.

ZARYAN KIS: Thank you Andy. I am Zaryan. I am from Ukraine and Ukraine is a lower middle income country, but it is also a country with a very unfair distribution of resources and a very unfair distribution of wealth.

Ukraine is a country with a fairly-established healthcare system and fairly-comprehensive healthcare system. But when it comes to the access to those services, young MSM appear to be most vulnerable and young HIV positive MSM appear to be even more vulnerable, and they are actually deprived of this access to healthcare assistance.

I would like to give you two examples of two young HIV positive MSM who I work with personally. One of them is 23

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years old and he lives in a small regional town about three hours by bus from the capital city of Kiev. He has come to our organization in Kiev only after his partner died in the AIDS center and his CD4 count was less than 50 cells.

Again, he only came to our organization because we were the only one and only because his partner died. He could not access healthcare services himself and we were able to link him with healthcare services and help him. He came from a very poor family.

Another guy from the capital city, coming from a very wealthy family with the highest education you can get in the Ukraine, speaking three languages, also came to our organization because he could not access the healthcare services. I was personally able to link him to an NGO working with a hospital to help him.

The question is: How many young, HIV positive MSM can I personally help? There are not so many other NGOs in Ukraine who can help those young, HIV positive MSM. About 70-percent of our clients are under 29 years old and most of them are at quite advanced stage of HIV. That means they were infected between 18 and 25 years old when they had no access to services, no access to information, and no access to people like them.

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By information I mean not only information about HIV or STIs, this is also information about sexuality, about safer sex, and information that helps a person to have self-esteem. I was very pleased to hear from Stefan today that covering 100-percent MSM in Ukraine would contribute to fighting the epidemics in Ukraine in general but currently only 6-percent of MSM have any access to services in Ukraine. By that access we mean that they have received one condom in six months. Is that really access to services? And how we reach 100-percent coverage for MSM in Ukraine when we don't have that much time.

As you could have seen at the slide, currently the HIV prevalence of MSM in Ukraine is about 10-percent. I have been criticized by the stakeholders which included government, NGOs and the UN system in Ukraine [Applause] for advocating for 60-percent coverage of MSM in Ukraine. Their argument was that there is not enough capacity, not enough NGOs who could work with MSM in Ukraine. I don't think this is a valid argument. What we have to do is to have more NGOs and more people working with MSM in Eastern Europe.

Of course this all comes down to funding. If you look at the map of the world, and we think how many donors work in Eastern Europe and Central Asia, of course we can find out that not so many. I think that there should be more funding for MSM work in the world in general and especially in the region of

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Central Europe and of Central Eastern Europe and Central Asia. Of course there are many issues; there are many barriers to that. One of them being that no so many people in that region speak English, but then it's up to the donors.

They could fund their translators, interpreters to come to the region and fund work that is needed there. This is all I have to say now, and I'm very pleased that I have this chance to speak from the young person's perspective before I get 28 in 15 days. Thank you. [Applause]

ANDY SEALE: And our final panelist is Joel Nana. Joel is the Executive Director of AMSHeR, which is the African Men and Sexual Health and Rights Initiative. Thank you.

JOEL NANA: Thank you. I first want to thank Nyambure for your courage and we do not have enough people coming from the religious circles standing up and fighting with us. If we can have many more of this kind of people I think that we'll get somewhere some day. I would like to ask you all to applaud her loudly [Applause] for her courage and thank you.

I was asked to – or I had chosen to speak about the way forward. We have the evidence. I think a couple of years ago we already had some evidence with the work that Stef and Kris had done. [Applause] We already know that men who had sex with men were up to 19 times more vulnerable than the general

population and that was already a cause for action but yet nothing was done.

Today we are being told that if we tailor our intervention in a way that it includes these men, it will provide results that include the general population. What else are we waiting for? I think we do have the solution. The solution is services that target all the populations. That is when we know our epidemic. There is a need for us to know our epidemic, and there is a need to act accordingly. So it is important; that is the first recommendation that is coming out of this panel.

The second one is about funding. There is a need to increase funding. Not just increase funding for programs; increase funding to have many more activists or persons, professional, willing to work in this area in order to tailor our interventions to meet the needs. There is not enough people working on the question and there is a need for more. Those who are working on the issues have to be supported more.

There is a need for mainstream HIV organizations to work with MSM and [Inaudible] organizations in country and there is a need for governments to step up to the plates. Most of that funding also has to come from government.

We also talked about enabling environment, and I wanted to elaborate on that a little bit more. An enabling

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environment has three components. There is the law component, there is the law enforcement component, and there is the access to justice component. If any of these three is not fulfilled, you do not have an enabling environment. So we have to work towards an enabling environment. This would mean to repeal all sorts of law, policies and practices that hinder access to services.

We have to work with law enforcement agencies to ensure that they stop arresting people on the basis that they are presumed or a real sexual orientation or practices. We also have to ensure that access to justice is fulfilled and it is realized. This does not only mean being able to secure a presentation in court. It also means to realize all human rights that are guaranteed by the various covenants that have been signed by our various countries.

From an African perspective, I think that Nyambure wanted to talk about that some more but I want to elaborate on that. Of course human rights are universal, but in an African perspective, human rights are perceived as human and people's right. When we talk about human rights, we do not talk about just the individual. We talk about the community, because rights in Africa are viewed from a communitarian perspective. If we talk about the right to health of one, we definitely are talking about the right to health of all. Also, this also

gives some duties to the individual to ensure that realizing their own right does not impede on realizing of the rights of others and the communities. That was all. [Applause]

ANDY SEALE: Thanks very much to the panelists and also once again to Stef. Now is the opportunity to open up for questions from the floor. You'll see the four microphones along the side here, so if you have a question or a comment, please line up behind one of them and we'll take a group of questions before we reflect back to you. Please introduce yourself briefly and keep your comments or questions to the point and quite focused if you can. Microphone number 2.

JORGE SAAVEDRA: Jorge Saavedra, AIDS Healthcare Foundation, Mexico. While I know that two years later was not the time for Latins to be in the discussion panel, but anyway two years ago it was a time for us. Thanks Stef, for giving us the data and evidence to push for evidence-based strategies in all of our countries. Thank you because evidence-base gives us an opportunity to know our epidemics. But for structural changes, we need to know our epidemic and we need to know our politicians, because many of the structural changes come from political alliances and political issues and political things that we have done in Latin America many times.

Even gay marriage, now approved in Mexico City and in Argentina came initially from HIV strategies and then later for

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political alliances and equal rights. I think sharing things that have changed in Latin America can also be used as examples for the rest of the world. Thank you. [Applause]

ANDY SEALE: Thank you very much. We'll take the second person on number 2.

PAUL PERCHAL: Thank you. Paul Perchal and Gender Health. I just want to thank all the panelists for sharing their views and also to Stef for sharing some of the evidence.

I think we've made some progress since the last AIDS conference in terms of evidence around MSM; however I'm going to start with a comment first and then I have a question. I don't think the evidence is enough to convince decision makers at the country level right now. I think what they're going to want to know is what is the cost of these various interventions? What are the most cost-effective interventions and how much of the national HIV budget is this going to cost. So I guess my question for Stef is: Are you planning to do any costing work? Have you been doing any costing work? There's been some pretty impressive other studies presented in other sessions at this conference on the cost effectiveness and the impact of different combinations of prevention interventions, and particularly for MSM it would be interesting to know in different types of epidemics that you've outlined which are

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going to be the most cost effective and how much they're going to cost the national government.

ANDY SEALE: Thank you. We'll take one more question. Again, microphone number 2.

KEN MAYER: Hi, Ken Mayer from Fenway Health and Brown University. Excellent panel discussion, and those of you working repressive environments, you're really heroes in the struggle. I'm just curious if the panelists would like to reflect if we focus this on human rights, obviously that's fundamental, but only in HIV are we missing part of the package and should we be thinking more broadly about MSM sexual health. There's rampant STDs, hepatitis is going to be killing people, anal HPV, and should we be framing the conversation more broadly as we engage with governments and funders?

ANDY SEALE: Thank you. Actually we will take one more question from number 1 and then we'll go back to the panel.

MALE SPEAKER: Thank you. Mine is going to be a comment and seeking advice from especially Nana and Nyambure. I think being in this conference for the first time I am having the feeling that even the name of the conference should have been the National Sex Conference and not AIDS Conference because the whole question of human sexuality is not being addressed, especially when it comes to the religious groups. I come from Kenya and I represent a group that advocates for

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acceptance and full inclusion of LGBTF people in their respective faith.

But coming from Africa you hear that we don't talk about sex, and so when you are talking about HIV and AIDS which involves the sex, there are so few people to talk about it. What can we do in order to talk about HIV and AIDS in vernacular languages in Africa? And also the religious groups are also shy about talking about human sexuality. How can we include open discussions in our theological institutions and religious discussions so that it can become easy for the people to understand what we are talking about.

When we conduct our seminars, most of the time we conduct them either in French or English, and again that is lacking when it comes through what we want to put across the African people because they will always claim that they don't talk about sex, they don't talk about human sexuality. They don't mention the sexual parts. How are we going to get through this so that we can reach our people? Thank you.

ANDY SEALE: Thank you. Okay, so we have four questions for the panel. I think I'll start with Stef with the one directed to you. The second question was asking about what's next. This perhaps isn't good enough in terms of influencing decision makers. What's your thinking about taking

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this to the next level, so we've got some costings and some tools that can really affect a decision-making country.

STEFAN BARAL: Thanks very much for that question. I mean this work was sponsored by the bank so costing was indeed a major component of it. So there's a few things – we have been working – there's a health economist on our team and we have been reviewing costing as part of it and we have developed some cost modeling to go along with this; it just wasn't ready for this conference.

But there's a few issues at play there and I think the reality is that while we have some idea of what prevention strategies work in high income settings, we're really just learning and we're just at the beginning of the process of what's going to work in lower and middle income countries.

So to say that while we are developing some costing and we have some ideas around how to do that, we really do need to get a better understanding of what's going to work and what's going to work by epidemic scenario or in different regions and different countries. From that we do need to develop packages and understand what the unit costs of those packages are and then what the attributable fraction of MSM are so that we can make meaningful calculations around what sort of a total package would cost.

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Others have done this before and I have to say that I don't think that those numbers are used often because they're not that related to reality as we see it. So I think the key issue there is really that we need to move to prevention. I think we've developed a database and I think as Joel said, we've really been doing this for a few years. We're trying to evolve the case, but nonetheless it's the same case which is something that I hope that we've made by now; which is that gay men and other MSM are elevated risk irrespective of region and irrespective epidemic scenario.

I think now we really need to transition to doing service provision and doing it in a way that's clearly evaluated, with clear technical guidance for implementing bodies that are doing it, as well as clear support for the communities that need to engage these men and that need to ultimately affect these prevention strategies.

I think that with those two combinations we're then going to learn how we can affect decision makers. Just one more point on that, decision makers respond best to data from their own country and that's something that I've learned. Even within Sub-Saharan Africa, if it's not data from their own country, it's much more easily dismissed. It really highlights the point that we need to develop epidemiologic data in each of these settings to be able to have individual, one-on-one

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conversations with policymakers from those countries. Then only then are we going to be able to move forward.

ANDY SEALE: Thanks Stef. I'll now ask each of the panelists in turn to reflect back. Just a quick reminder panel, we had questions about political issues; how do we really get to know our politicians and strategize around the political elements that are needed. I think Stef has partially touched on this. How can we broaden out HIV to have a better understanding of broader sexual health [Applause] and especially to Joel and Nyambure and this question about what can we do more in an African context to talk more openly, including some of the issues around language about sexuality. Let's start with Zaryan.

ZARYAN KIS: Okay thank you Andy. Well in terms of the question about political and working with politicians in Ukraine or in Eastern Europe, I should say that this work hasn't yet started. A lot of politicians allow themselves to express very openly about LGBT issues, but unfortunately not from a good perspective. They were very critical about LGBT and MSM and this is a very popular trick in the election campaign when the one party accuses another one of being supportive of MSM and then the other party says, no we are not, so actually no one is supportive. Then another politician accuses the other one of being homosexualist which we can read

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in this Russian program and it goes throughout the program every time there is MSM in English program, there is homosexualist in the Russian version which is a very derogative term and we have to start from the language.

So far I don't have the answer for this question how we can bring these issues in political agenda in Ukraine or Eastern Europe or Central Asia because unfortunately they are already there but in a negative way.

The other question was related to speaking about MSM sexual health and MSM and probably LGBT health in general rather than speaking about HIV. HIV, from my perspective, at least for the next five years it is very important to concentrate on HIV and other SDIs in Ukraine and in the region because this is a very important issue, and working with HIV, dealing with HIV and other STIs we can at the same time address the issues of sexual health.

There are two problems with product context of MSM sexual health. First, this will probably not be funded as good as working with HIV, and second, the issue of HIV can be lost in this broad context which is very new for the region. So I think that for at least five years we should concentrate on HIV and STIs in this region. Thank you.

ANDY STEALE: Thanks Zaryan. Joel?

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NYAMBURE NJOROGE: I want to respond to the question of scaling up human sexuality in teaching of human sexuality in Africa but also the dilemma we face because of many of our communities; our charities in particular – I cannot speak on behalf of the other faith communities – but are rooted in the rural areas and they use the African languages. For the program that I coordinate in Sub-Saharan Africa we have approached our training sessions and we include teaching on human sexuality two ways. We are going to the church's directory, working with different levels of the leaders, but also people who work on HIV, but in particular people who are HIV positive. They are always part of our resource person so that we can learn from the experiences.

In that context, we produce literature that is helpful on a different level. But this is where the question of funding comes in. We are able to do that primarily in English, French, and we are improving also producing literature in Portuguese. But every time we have the request to have the literature translated into the local languages and the funding there becomes a big issue because you may appreciate that translation is not a simple thing to do, it's expensive. In all the literature we produce from the World Council we give it free of charge to the churches. The other approach we have taken is mainstreaming HIV curriculum in our seminaries that

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are teaching the future clergy and the future theologians and future scholars. There we also produce the literature which again we have a high demand for translating that literature to local languages.

Beyond translation, we have also the request that people theologize their right, their God language, in their own language. Again, that is the dilemma we are facing when it becomes to funding.

I appreciate that we need, indeed, to scale up the teaching of sexuality. I must admit that adolescents and young people have made that demand all the time, anytime we have training. They say that parents are not providing that information, and the churches are not providing that information. They get it from the media. They get it from other sources. They are not always getting the right information. The challenge is huge.

The last thing I want to say in that context is that in the last ten years religious communities in Africa have done a lot. What we have not been able to do is to document the good practices that are out there. Again, that is a question of capacity and a question of funding. I think since we have a Global Fund person with us at the front, I think this needs to be taken up because the last statistics we have is that from the Global Fund money only 5.4-percent

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has gone to religious communities globally. We provide not just the training but healthcare and the hospitals that belong to religious communities. We have not actually benefited from the Global Fund as we should match the work that is being done by religious communities. The challenge is there and we will continue to work together to see what the solutions are.

ANDY SEALE: Thank you Nyambure. Joel would you like to add —

JOEL NANA: I think that's the problem. That is the dilemma because it is true that we don't talk about sex in Africa. We do it a lot, but we don't talk about it. That is actually the problem facing gay men and anyone who talks about sex. As you were asking a question I just tried to remember my own sexual education at home. I remember that I was young and I had been going to different places. When I was moving to South Africa, my father sat me down and he said, and my father is a medical doctor, he said, when you get there if you go with men, use condoms, that was all. When you get there, if you go with men, use condoms. That is if you have sex with men, you have to use a condom. He couldn't say sex.

I also remember in my vernacular language, when we say I will have sex, they use a parable that literally means

to beat up the stubborn child. That is having sex. It is a parable that translated literally means that. The problem is actually, perhaps I think the challenge for us is to adapt to that language, to talk about the issues in the way that it has been spoken in our own cultures and maybe not be so blunt about sex, I don't know.

HIV brings another challenge. We have to talk about this. We weren't talking about this or we weren't talking enough about it. It is time to talk about it. I also remember that women, for example, when they were getting married, they have various rites, ceremonies that they go through, but none of that involves calling sex. It is through ritual processes and through speaking in parables, but never talking about the issue itself.

People talk about how, and I say it myself, how homophobic Africa is, but I also know that most of my friends who have been living in their communities and even in their houses with their boyfriends would never have said that they are gay have faced no problems. It is the moment you start talking about it, you start bringing the sex factor that it becomes a problem. Yes, we have to find a way to talk about sex.

There was the issue about sexual health, the whole sexual health. When I talk about sexual health, when I talk

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about health and HIV, I always look at it in the human rights lens, and from that lens I am thinking about the realization of the highest attainable standard of health. You cannot realize that right if you do not realize all the other rights. Thanks, that's all.

ANDY SEALE: Thanks Joel. Shiv would you like to share your thoughts around sexually, politicians and a broader sexual health agenda?

SHIVANANDA KHAN: In a study that I did in ARISA, I was asking husbands and wives how do they define sex. All the wives says, it's work. All the husbands said, it's duty. Husbands do duty not sex. Wives do work not sex. We need to be clear that I am not sure if you do duty or work in the context of MSM. Language is a real problem. As a piece of advice to my African colleagues and to some of my other colleagues here, when we use the word sexuality or masculinity or femininity, these are very monolithic, hegemonic terms and I would advise you to start thinking in the plural. There are a range of sexualities.

When we talk about human sexuality, we should talk about human sexualities. It can encompass this broad range of sexualities there, same thing with masculinity. Sometimes I am more feminine, sometimes I am very masculine. I could be butch, I could be fem. My type of masculinity is under

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the term masculinities. I think if we stick to these singular terms, we actually block our vision quite a lot.

Going back to social frameworks. I work in Afghanistan, Pakistan, and Bangladesh and somewhat slightly difficult countries, dealing with religions as well. We have to address how people live. What languages they use. What are their feelings and expressions of how they relate with each other as a social framework. There is not, we have a lot research in epi stuff but there is very little anthropological and ethnographic and social research around different frameworks of male to male sexualities and transgender issues. We need more information of that if we are going to design effective programs that can make a difference in our lives.

When I am sitting in a village outside of Kabul, with kalashnikovs walking around and what have you, we can't think in a way if I was sitting in a bar in Vienna. It is a whole different context. We don't have enough knowledge about that as well. It is not only about who is screwing whom, and whether we will be getting the virus, but how we live as individual human beings, which is an interesting thing, because a lot of the debate around religion and HIV is how you define human-hood. Who is a human being?

By the way, in terms of sexual health, WHO has a

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draft definition of sexual health written in 2002 which includes mental, social, psychological, and physical. In other words, health is a concept of wellbeing not just the absence of disease, and in a lot of the work that we do in our part of the world, we talk about wellbeing which includes everything, including the right to pleasure. I think if you can bring the right to pleasure into our definition of sexual health, let's have a bit more fun as much as anything else. Condoms can be very boring. Let's have some fun with condoms. Anyway, that is enough.

ANDY SEALE: Thank you, Shiv. Stef, before we open up for a final round of questions, I would like to just give you the opportunity to add anything.

STEFAN BARAL: I just wanted to go back to Dr. Saavedra's point and I think it is important. I think that the advances that have happened in Latin America are things that we really need to learn a lot from, not only in terms of the programming that's been enacted, but also in terms of the structural interventions that have been laid out. How they have been operationalized, how they have been implemented, how there were funded, just really going from the ground up. How was the community involved. These are all lessons that we are trying to learn from.

There have been organizations that have tried to pull

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together communities and academics that deal with these issues from different parts of the world, including the MSMGF and UNVP and others.

We had a community workshop yesterday where we had about 120 participants from different parts of the world sharing these sorts of lessons in and around behavior interventions, biomedical structural interventions, and as well as a fourth component guidance for research among MSM in these setting. The key message really came from, there is a lot of knowledge out there, we just really need to find and develop the networks to be able to share that knowledge better and learn from each other outside of the confines of these conferences that happen every two years.

ROBERT CARR: We have time for one more round of questions and comments. Sir, microphone 3.

KEVIN FROST: Hi, Kevin Frost from amfAR. Three quick comments that I would love the community member panels to comment on. First I think there is a growing body of evidence about what's happening in MSM. I think we have to recognize what Stef was saying earlier and that is, there is a real paucity of evidence about what works in low and middle income countries and we have to figure out how we are going to overcome that. I heard Joel speak on a panel yesterday in which he said, I think half joking, that we are tired of

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workshops in Africa. I think the reality is that just because we believe we know what works among these communities, I think we have to convince donors. The way to do that is through evidence.

It brings me to my second point which is we also have to confront the reality that at the grassroots level in low and middle income countries we lack organizational and technical capacity to build the kind of evidence base that is going to prove to donors that we know what works. Until we build that capacity we are not going to be able to generate that evidence. We need to think about what it's going to take to build that kind of capacity. Obviously, it is going to take investments from donors, but I think it goes well beyond that.

The third comment I just want to make really is to Nyambure, when I and we are a donor obviously, we have supported MSM organizations around that world, but when I hear ecumenical leaders and political leaders and even sometimes community members say that they don't want to have, whether it be foreign donors or governments or others, impose their sense of beliefs or their value structure onto a local context, that that may not be appropriate. I understand and agree that cultural sensitivity is an important component and that we should be listening and we should be understanding,

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but the converse is true as well. As donors we too have values, we too have cultural contexts and so I get angry when my government, the US government, gives money to the Ugandan government at the same time they're considering a bill to criminalize male/male sexual behavior. I think we have a responsibility to be true to our values as well when we give money.

What I guess I would recommend in that and would love to hear your comments on is that I would prefer to hear us talk about this in terms of partnership, not in terms of what you do versus what we do. Rather how do we work together to achieve common values, common structures that are going to best serve men who have sex with men on the ground.

[Applause]

ROBERT CARR: Thanks you Kevin. The gentlemen at Mic Number 2. Is that David?

DAVID SMART: Yes it is. Good morning. David Smart, I'm from Trinidad. I think there is a couple of comments that I want to make is that in order for us to know how to respond, we need to know the communities that we work with. I am saying this from a Trinidad perspective, where less than 2-percent of the last budget that went to AIDS work went to the MSM population. We don't have problems with condoms; we don't have a problem with lube, but yet we still have a high

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prevalence rate of people dying from HIV and AIDS. It begs me to question what is not working with prevention strategies. Is prevention solely based on giving out condoms and lubes or should we really be looking at it differently?

It is nice to hear religious people talk about what they are doing, but I think we need to recognize that culture and religion in fact oppresses a stigma against gay men and gay women and transgender individuals. Until we begin to recognize that prevention has to go beyond the issue of handing out this literature and handing out condoms and lubes, it has to deal with this stigma of being gay, of being a lesbian, of being a transgender then I think we are failing at that aspect. That is just by personal opinion.

Again, we talk about prevention but I am not hearing anything about positive prevention. I am not hearing anything about those people who are positive. It seems as if we have sealed off on their lives, that once you are HIV positive, that is the end of you, you don't have sex anymore. I need to start talking about that as well. Basically, that is my, and now in Trinidad we are making the case to defragment MSM because they are not identifiable gay men and they are gay men. How you reach those groups of people are very differently? Thank you.

ROBERT CARR: Thank you David. Just a request to the

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folks asking questions or making comments, we are quickly running out of time so if you could be brief, we would appreciate it. Thank you. Go ahead.

MALE SPEAKER: My question is for, again for the religious conversation, I want to thank Madame Njoroge for coming here, it is really brave and I think it is a great first step in involving the religious community in this discussion. However, I did notice that, I am Darren, I worked in Lisutu for about four years with MSM, HIV positive people and other sexual minorities. I kept hearing again and again everyone thought this population, HIV positive, MSM thought they were cursed by God, which wasn't true. It is more about how the religious community perceives them and discriminates against them.

The title of this session is Know Your Epidemic, Know Your Response and MSM and Their Needs, so I am curious as to what the World Council of Churches is doing specifically to address this MSM issue within their council of churches. I believe I only heard you say MSM once and I have heard you talk about sexual education in general. I want to know what specifically is happening with MSM and the council of churches. Thank you.

ROBERT CARR: Thank you very much. I am afraid we only have about six minutes before we have to leave the room.

In order to give the panelists a chance to respond to the questions, I am afraid we are not going to be able to take any further questions. Very sorry about that. Zaryan, do you want to begin, and this is your opportunity to make your final remarks as well.

ZARYAN KIS: I will try to be as quick as possible. The first question was about prevention and what is working what is not, and I am confident that just condoms and lubes distribution does not work if we do not distribute and provide information on how to use them properly. Condoms do not only have to be accessible free of charge and the NGOs especially lubes, single use lubricants, also have to be accessible at the drug stores and supermarkets. They have to be accessible everywhere.

There is a big question of whether strong condoms should be distributed within MSM or are regular condom enough. This all has to be, we need a big piece of research here of what works and what doesn't. I know that Stefan has done a lot of that work and if you have been to other presentations by him you can find out what works and what not.

The other question was about positive prevention and it's a very valid question. Thank you very much for that question. We are now trying to apply this approach in our

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work, because we work with HIV positive MSM. We are also building this approach into the Ukraine's Global Fund proposal for 2010. This will be done in Ukraine. Of course, this will catalyze this work, positive prevention work in the regions, because in many sense Ukraine has been a catalyst of MSM work in the region. Thank you.

ROBERT CARR: Thank you, Joel, and if you could please address the issue of cultural sensitivity that was raised by a number of the questiontioners.

JOEL NANA: Cultural sensitivity? What is that?

ROBERT CARR: There was an issue about —

JOEL NANA: Let me address the work— [interposing]

ROBERT CARR: Yes, go ahead.

JOEL NANA: I will be thinking about the cultural sensitivity. Okay, what works, what doesn't work? Clearly the current prevention methods are working perfectly well for straight sex but they don't work for men who have sex with men. At least, we have been saying this all through this conference. Men who have sex with men are criminalized in 38 out of 53 countries on the continent. I am talking from the African perspective. The 15 other countries do use some other kind of law to still criminalize them, so clearly the laws are bad. The law enforcement is horrible because they get arrested and there is no access to justice. The

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environment is not enabling. Definitely, they don't access those services.

Even if there were, the environment was enabling there is no lubricant. From Cameroon, where I come from, the little tube of lubricant is about five dollars. We are talking of places where live where people live with less than a dollar a day. How can one use money to buy a five dollar tube of lube? That can is just not possible. So that doesn't work. About the cultural sensitivity, can you please repeat what the question was about?

ROBERT CARR: The question was about competing values and the idea that homosexuality is somehow not part of cultures —

JOEL NANA: That is an argument that we have been hearing over and over again. Homosexuality in unAfrican, before I address that question I want to caution us also because we tend to use the argument that homophobia is not African as well. Usually, we say that homophobia is the product of colonization. I say no. Homophobia that was institutionalized through the laws is. We are all human beings. We are capable of fear. We are capable of ethnic hatred, capable of racism, so we are also able to love and hate and we are also able to express homophobia. Where there is homosexuality there is homophobia. We have to start

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agreeing on that, that there is an African homegrown homophobia.

Now cultural sensitivity. We have seen that in many countries where people receive funding to address eligibility issues. When the funding is coming from America, people are saying that they are being manipulated by the Americans. When themselves those laws that were put in our various appellate court were drafted with money that came from America also. There is some kind of dilemma there because we are just going to the same source of funding to fight a law that you put in place with money that you got from that same source of funding.

I think that cultural sensitivity and using that is often use to silence the activist. Nevertheless, I do think that we also have to be sensitive in the way we address the issues on the continent. There are, we see for example in the case of Uganda, where some people just, the language that we use. It would be easy to me, a Cameroonian to write this statement and say that the laws that is being put, implemented by my country is barbaric. I think it will carry a whole other meaning if the person who writes that is, for example, the John Hopkins Center for Human Rights. I think that we have to be sensitive on those issues and understand what it is that we can say, what it is that we cannot say and

how it is that when we cannot say them, we can address them nevertheless.

NYAMBURE NJOROGE: There were two questions that were directed to me and I will try to respond. I think everything needs a level of interrogation because when you say we talk of partnerships, I perfectly agree with you and we are doing that, especially when we work ecumenically. We have to be in partnership with our churches beyond the borders of Africa, but we also had unfortunate experiences where the word partnership has been used but it has not been in the real sense of the word partnership. The aspect of listening is important.

Also interrogating some of the experiences that we have gone through in the name of partnership and so this is part of the package and so it is important. The listening part is mutual; it’s not just from one side to the other, so that needs to continue. It is also a question of listening as to what the priorities are for the communities when we need to address these difficult issues. We have entry points into some of the difficult issues and I will very briefly give the example, the Bible has the language of sex, sexuality, sexual violence —

ANDY SEALE: Nyambure, can we really keep it short —

NYAMBURE NJOROGE: We are using that as an entry

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point to talk about these difficult issues and I think we are making headways. The African men are starting African masculinities because they want to be involved.

The second question was how the World Council is addressing the question of men having sex with men. The discussion at the moment is that we need to scale-up the discussion and the studies on human sexualities as it has been said before, and that would include all the varieties of sexualities, but that is just a conversation that is beginning. How we do that. We want to include the medical, the scientists to help us have an entry point which do not have a moral perspective to it so that we may understand scientifically what it means to be a sexual being before we can even talk about the other issues. Thank you.

ANDY SEALE: Thank you Nyambure. Shiv?

SHIVANANDA KHAN: Very brief.

ANDY SEALE: Thank you.

SHIVANANDA KHAN: We need human resource development right across the board. Give us more money. I am not sure whether the word cultural sensitivity is appropriate, I prefer cultural awareness. Cultural sensitivity is used to do nothing. Thirdly, it's not only know your epidemic, know your communities. Thank you.

STEFAN BARAL: Just to respond to Kevin from amfAR, I

think that absolutely we need more evidence from communities doing this work on the ground, but I think the same thing can be said for the large implementing bodies that get 25 million dollar grants to do this work; they also need to use evidence in terms of their responses. I agree we need more evidence but we need that for all the way up and throughout the continuum of people providing prevention services for MSM. I think it is a challenge to us, it is a challenge to the implementing bodies, and it is a challenge to the funders to make sure that we can fund that sort of works as well. Thanks.

ANDY SEALE: Before I hand over to Robert to finalize I would like to offer my personal thanks to everybody on the panel and to everybody in the audience, particularly those who have asked questions and engaged. I think clearly we should've had more opportunities like this this week because this is a conversation that needs to continue and I hope that we will work closely with the IAS for the next conference to ensure we have more opportunities, because we haven't even touched the surface on some of these crucial issues in this session.

ROBERT CARR: Just as a closing, I am listed as being from Jamaica, I worked in Jamaica for 11 years. I only left at the very beginning of this year and this issue of

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"cultural sensitivity" is a very powerful one that is used to shut down democratic dialogue. The reality is that there are gay communities in every country in the world. We are part of every society. We have a right to be part of every society. What's so dangerous and insidious about this whole issue of cultural sensitivity is that it's actually used to shut down that dialogue in an extremely undemocratic way. It is the cover under which a lot of repression takes place, including police violence, and including the kind of genocidal refusal to act that Shiv referred to earlier.

With that I thank you all for coming to the panel. I fully agree with Andy we have to work together to see how we can have more sessions like this in DC. Thank you very much. [Applause]

[END RECORDING]

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