

Sections 377 and 377A of the Penal Code – Impact on AIDS Prevention and Control

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Executive Summary

Twenty-five years after the start of the AIDS pandemic, 20 years after the first HIV infection was diagnosed in Singapore, the number of HIV infections continues to increase. Up till the end of 2005 there were a total of 2852 HIV infections, of which 1547 had developed an AIDS defining illness.

The majority of infections are seen in heterosexuals. However the number of infections seen in MSM has been increasing, whilst the number of infections among heterosexuals has remained stable over the last 5 years. The proportion of infections in to MSM behavior has increased in the last 3 years. Thirty percent of infections diagnosed in 2005 were reported in homosexual and bisexual males. The proportion of infections acquired through heterosexual sex in 2005 was 58.4%, 9.5% of these were female, 48.9% were in heterosexual males.

HIV infection is being diagnosed in younger MSM, this trend is evident in recent years. Of the 101 MSM diagnosed with HIV infection in 2005, 4 were in their teens, 24 were between 20 to 29 years, and 44 between 30 to 39 years of age at diagnosis. There is an expanding epidemic in MSM. Of grave and immediate concern is the diagnosis of HIV infection in younger MSM, even among teenagers. These are clear indications that prevention messages and awareness campaigns have not been effective in reaching out to the most vulnerable individuals.

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

Unnatural offences.

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

Outrages on decency.

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

Many former British colonies have repealed the 19th century laws that criminalise same sex behaviour e.g. Australia, New Zealand and Hong Kong.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

These laws are obstacles to effective AIDS prevention programs in the following ways-

- Discrimination against MSM
- Absent or scanty information on MSM
- Difficulty in reaching out to non-gay identified MSM
- Inability to address the needs of young MSM
- Censorship of MSM educational materials and events
- Interference with gay businesses

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

I Introduction

HIV/AIDS was first diagnosed in Singapore in 1985, in the early years of the epidemic most infections were found among men who have sex with men¹ (MSM). However transmission through heterosexual intercourse quickly increased to become the major transmission category, and MSM sex was often downplayed as a risk behavior. There are now reports increasing HIV epidemics among MSM in several countries in Asia.

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

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

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

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

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

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

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

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

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

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Section 377 became effective as part of the British-imposed Indian Penal Code from January 1, 1862, and was adopted by the colonial masters, also as Section 377 into the Straits Settlements Penal Code in 1871. The cloned and transplanted law came into operation in the Straits Settlements of Singapore, Penang and Malacca on September 16, 1872¹.

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

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

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

II Epidemiology of HIV/AIDS in Singapore

Singapore has a population of approximately 4.5 millions.

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

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

Males far outnumber females in the ratio of approximately 9 to 1. The majority of infections are seen in heterosexuals. However the number of infections seen in MSM has been increasing, whilst

the number of infections among heterosexuals has remained stable over the last 5 years (Figure 2). It is possible that this high male to female preponderance, the most disproportionate anywhere in the world, can be partly explained by misclassification of transmission categories; MSM who are not comfortable or confident will be inclined to declare that they are heterosexuals to health care workers.

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

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

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

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

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

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

III AIDS prevention programs for MSM in Singapore

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

The advent and increasing influence of the Internet has made it convenient and easy for individuals to seek sexual partners. In the 2006 MSM survey 53% of almost 1500 respondents cited the Internet as the most popular avenue where they sought potential sexual partners³.

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

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

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

IV Testimonies by young MSM with HIV infection

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

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

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

I was actually offered a job well before my graduation in some government research lab.

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

Chinese, 21 years, diagnosed at 21

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

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

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

I do believe that, no matter what, I cannot let my parents find out about this. Each passing day, I would just live my life just as normally I have been doing, but sometimes thoughts that I am going to need medication brings confusion into my head. I did not really have a way of dealing with

having HIV. But having thoughts about it running through my head here and there is kind of stressful. My family isn't really financially well off as one of my parents is retrenched. All I had in my mind is to soften my mother's burden and not letting her worrying over my condition...

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

Chinese 19 years, diagnosed at 18

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

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

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

Chinese 23 years, diagnosed at 20

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

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

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

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

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

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

Chinese 22 years

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

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

Chinese 24years, diagnosed at 23

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

1 Discrimination against MSM

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

2 Absent or scanty information on MSM

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

3 Difficulty in reaching out to non-gay identified MSM

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

4 Inability to address the needs of young MSM

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

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

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

5 Censorship of MSM educational materials and events

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

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

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

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

6 Interference with gay businesses

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

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

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

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

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

1 Australia

Australia has a population of 20 millions.

WHO estimates there are 16,000 [9700 – 27 000] persons living with HIV, and the prevalence of HIV infection among adults 15 to 49 years of age to be 0.1% [< 0.2%].

http://www.who.int/hiv/mediacentre/2006_GR_ANN1A-L_en.pdf

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

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

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

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

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

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

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

3 Hong Kong

Hong Kong has a population of 6.9 millions.

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

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

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

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

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

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

It proposed the following set of 6 strategies –

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

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

3 New Zealand

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

New Zealand decriminalized homosexual sex in 1986.

In his 2006 presentation Dr Phil Parkinson⁵ (Research Librarian at the Alexander Turnbull Library and a curator of the Lesbian and Gay Archives of New Zealand) recounts *“instead of seeking a purely medical model response (to HIV) as we still are when it comes to bird flu, New Zealand resorted to social engineering by decriminalizing gay sexual behavior.”* He continues *“the interface between criminal law and public policy was of great concern – how on earth could an effective campaign against an epidemic be carried out if the very measures to prevent infection, such as the promotion of safety in sexual practices were vitiated by the confirmed criminal sanctions against those very practices? From the broader public health point of view decriminalization was an essential prerequisite to protecting the public health.”*

The Director General of Health acknowledged that passing the Bill would be *“likely to promote the mental well-being of persons of homosexual orientation”* and that the passage of the Bill could offer some “positive benefits” for the AIDS campaign *“which would depend for their success to some extent on good communication and the effective and open dissemination of information”*. He

concluded that the department “cannot justify on health grounds the present legislative provisions regarding homosexuality. The department supports the proposed bill for the reasons described above”.

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

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

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

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

Relevant paragraphs –

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

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

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

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

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

UN General Assembly Resolution 60/262. Political Declaration on HIV/AIDS - 15 June 2006

http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

Relevant paragraphs -

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

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

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

3 UNAIDS Policy Brief – HIV and Sex between Men

http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf

Relevant paragraph –

Actions for governments:

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

4 CDC HIV/AIDS Fact Sheet - HIV/AIDS among Men Who Have Sex with Men -

<http://www.cdc.gov/hiv/resources/factsheets/msm.htm>

Social Discrimination and Cultural Issues

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

5 The World Bank. Confronting AIDS. Public Priorities in a Global Epidemic -

<http://www.worldbank.org/aids-econ/confront/confrontfull/>

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

Efficient and Equitable Strategies for Preventing HIV/AIDS

There are three activities in which governments have an indispensable role in ensuring the efficiency and equity of prevention programs: providing public goods related to prevention; reducing the negative externalities of risky behavior by promoting safer behavior among people who are most likely to contract and spread the virus; and promoting equity by ensuring that the

most destitute are not denied access to the means to protect themselves from HIV. These activities will reduce the spread of HIV most quickly and will benefit everyone in society, including those with low-risk behavior and the poor.

Cost-effectiveness and the accessibility of target populations.

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

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

Guideline 5 – Anti-discrimination and Protective Laws

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

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

VIII Summary Points

- 1 HIV infection is increasing in Singapore, especially in MSM. Current strategies appear to be ineffective in controlling HIV infection.
- 2 Research and information on MSM are lacking. Educational campaigns and interventions that address the needs of MSM are inadequate.
- 3 Education and provision of services for young MSM are particularly deficient, putting young MSM at the greatest risk of HIV infection.
- 4 The ability of the AIDS Control Program to reduce HIV transmission in MSM is significantly weakened by anti-homosexual laws.
- 5 Former British colonies that have repealed anti-homosexual laws are more successful than Singapore in reducing HIV transmission in MSM and general population.
- 6 Effective AIDS strategies should be supported and not undermined by policies and laws.
- 7 Decriminalisation of homosexual sex will significantly enhance educational and behavioural change programmes; it will reduce stigmatisation of and discrimination against MSM as well as persons living with HIV infection. Decriminalisation is necessary if we are to have an effective HIV Control Programme in Singapore.

References

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3 Koe S. 2006 MSM Survey. 5th Singapore AIDS Conference, 2 December 2006.

4 Homosexual Law Reform in Australia, Melissa Bull, Susan Pinto and Paul Wilson. Trends and issues in crime and criminal justice. January 1991. <http://www.aic.gov.au/publications/tandi/ti29.pdf>

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

FIGURE 1 - HIV INFECTIONS BY GENDER

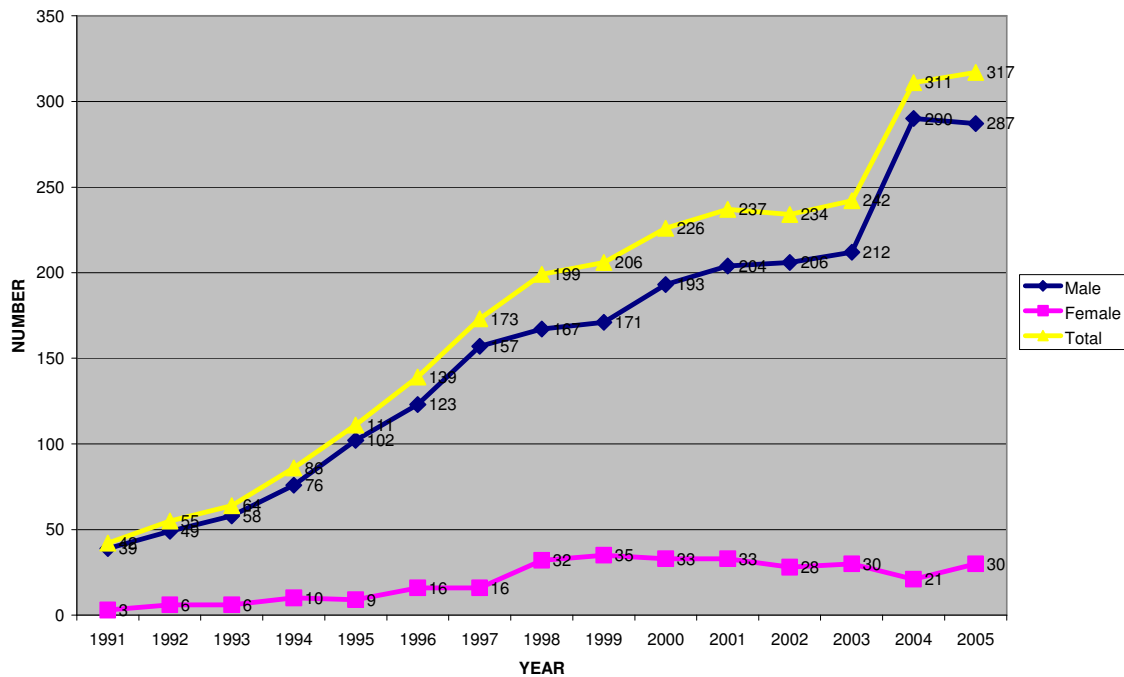


FIGURE 2 - HIV INFECTIONS BY MODES OF TRANSMISSION

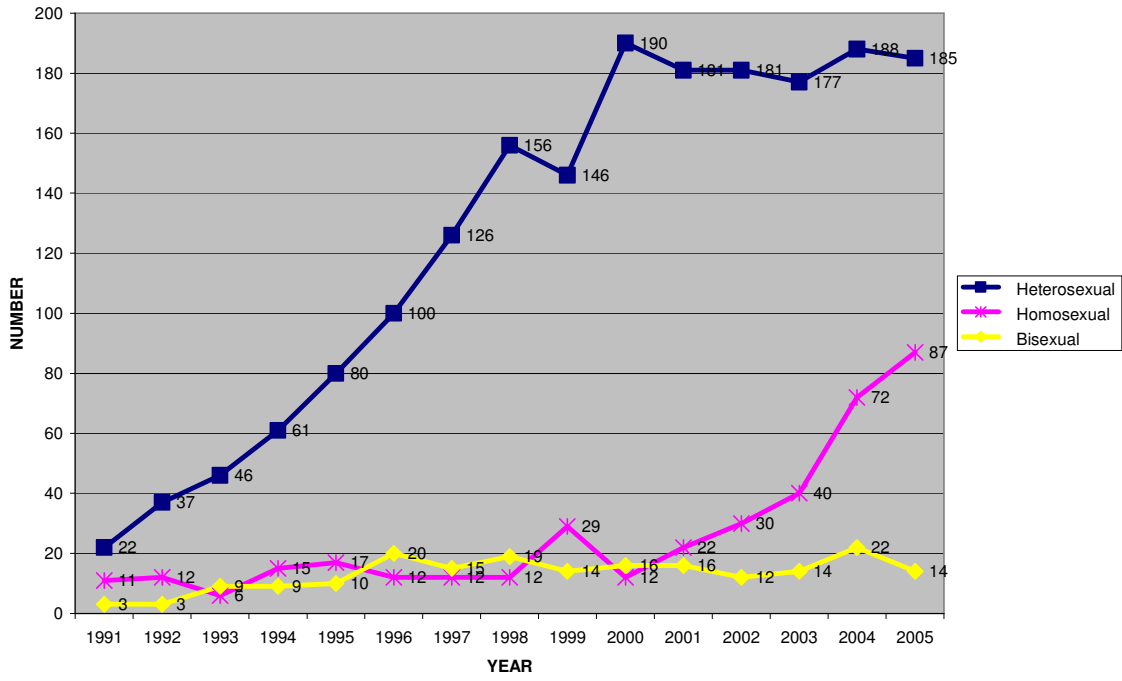


FIGURE 3 - HIV INFECTIONS BY MODES OF TRANSMISSION

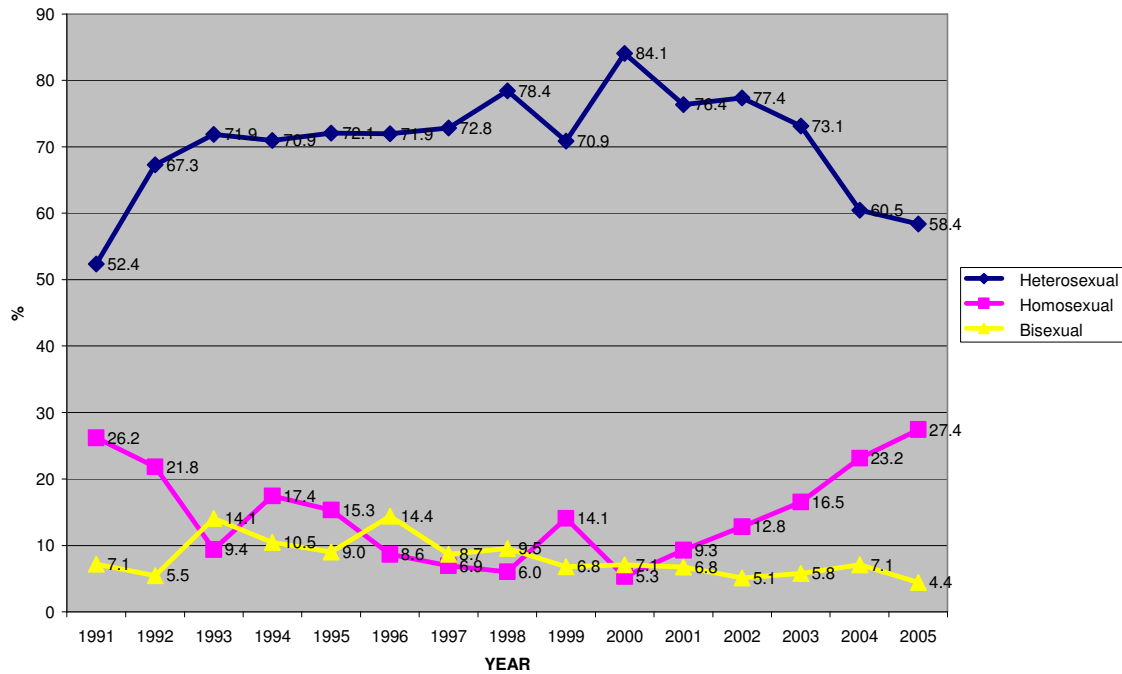
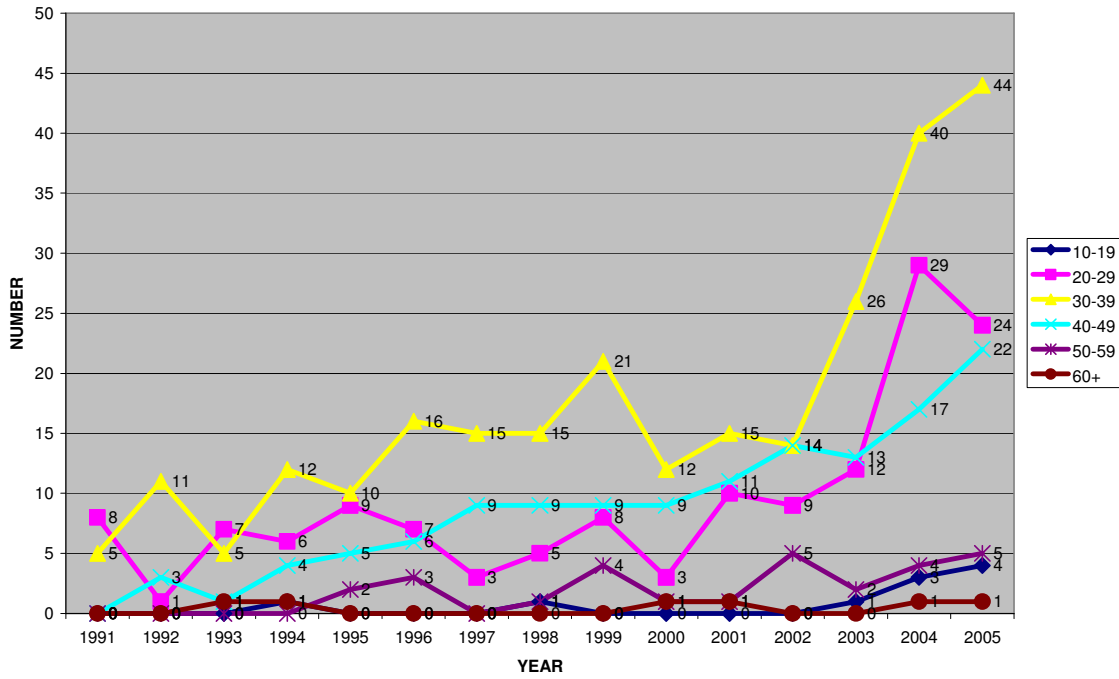
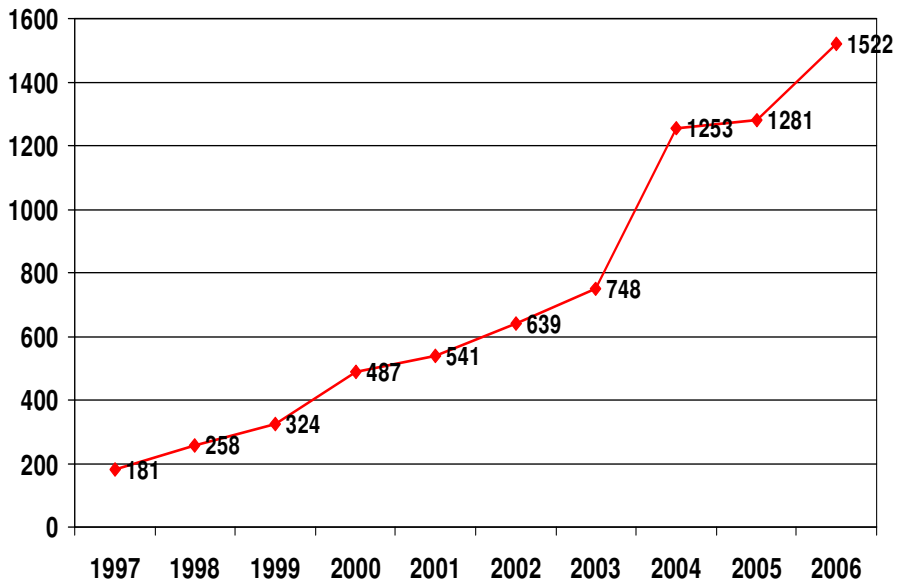


FIGURE 4 - MSM + BY AGE GROUPS



No. of Clients

Figure 5 – ATS MSM Clients



*MSM accounted for 25% of all clients in 2006

Figure 6 – ATS
HIV Prevalence by Transmission Categories
 (includes known HIV positive individuals)

