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Paper to National HIV/AIDS Policy Committee

Ms Braema Mathi, Vice-President, Action for AIDS

braema@gmail.com

This paper is a result of consultations and discussions with members of Action for Aids - specific groups of Men Having Sex with Men (MSM), Heterosexual Men, and Women's Group members, educators, People with HIV and inputs from both professionals and caregivers from support services.

This discussion comes in three parts: Prevention; Treatment; Intersectionalities

1. Prevention

The main points are as follows:

1.1 Sexuality Education Programmes

- 1.1.1 There is a need for greater openness to talk about sexuality in schools in spite the rowing Years series from Ministry of Education. Standards in teaching/discussing sex re arbitrary and could do with greater consistency in being more open and include topics of gender identities, safe sex approaches, condom use and workshops to discuss value systems rather than a top down approach in morality. Sexuality education must cover topics on gender and power, new masculinities, gendered positions in a relationship and in sexual relationships. The trainers for such programmes too need to be sensitized to such approaches in a more defined manner.
- 1.1.2 There is a need for parents to have a greater role in their child's sexuality education. There could be an opt-out consent from parents to give more space to schools and approved agencies to conduct sexuality education classes without worrying about the parental objections.
- 1.1.3 There is still a lack of adequate training programmes among the young to become effective peer educators. We need to invest in sexuality education among the young as they might be in a better position to work with their peers on gendered positions, gender identities and safe sex matters. For example focus group discussions and a Action for Aids survey among adult Heterosexual Male Group showed that males do not have any high recall rates of any preventative campaigns at school or in later years. Neither do they have a very good understanding on STD transmission. In terms of condom use they admit to low levels of condom usage citing reasons that using condoms are uncomfortable and less sensitive & that they are unable to reach climax. In terms of testing, most of them are unwillingly to go for tests – as they seem to want to put the onus on their partners to be clean. For example one of the focus group participants said – “My wife was tested negative during her pregnancy one year ago, so I am clean”. These responses show the absence of gendered discussions in sexuality education, public education messaging and information. And it is easier to work at these positionalities with trained facilitators using audited and tested programmes.

1.1.4 There is a huge potential in deepening sexuality education discussions with men when they are doing their National Service.

1.1.5 It is important that HIV/AIDS education is conducted as a continuum with STD education and vice-versa. Both stem from lack of awareness and unsafe sexual practices. And speaking of them – HIV and STDs – in separate discourses does not add up as the fundamental problem is still unsafe sex.

1.2. Public Education (IEC)

1.2.1 We need a campaign that is less oriented to blame but aimed at helping us to view the affected person with greater empathy and as one in need of our comfort. This will enable the public to become more open and less judgmental in dealing with PLWHIV or PLWA.

1.2.2 We need to address the strict alignment of our public messages to the National Agenda on pre-marital sex and that the family and marriage are the only institutional norms. The reality of people's behaviour extends beyond such boundaries. For example we have a growing number of singles who are sexually active as part of their normal behaviour. And there are also contradictions in State policies that do not align with this National Agenda - the tolerance towards sex workers is often seen as a concession as it is part of our culture but it invades marriages. What is important here in the public messaging is to accept the differences in people's behaviour, avoid unnecessary labelling ('adults into casual sex' for example), develop a greater sensitivity in the use of language and creativity to target specific groups boldly and more directly and avoid deepening stereotypes of women and men in their portrayal or discussions - for example portraying women as temptresses luring men into sex or that all gay men succumb to HIV. This approach will be more inclusive, offer greater buy-in across communities and will not put people's backs up.

1.2.3 Accessing women through education is a challenge and we need to spend the money to train people in four languages, have IEC materials in four languages, empowerment classes in four languages to move the women's agenda forward. Relying on the goodwill and dedication of volunteers will not work for sustainable progress in this area.

1.3. Access and Control

1.3.1 We need more information that needs to be shared at the community level (e.g. the number/profiling of men and women who are transiting between Riau Archipelago and Singapore) so that civil society groups can develop sensitive programmes that can have a greater impact on the ground.

1.3.2 Information that is shared needs to be disaggregated by gender and income type for any meaningful intervention programme.

1.3.3 We need better access to condoms and public education in entertainment venues, exit/entry points into the country and residential campuses such as University

Halls. This way the message of safe sex is real and not hidden away, reinforcing the idea that it only applies to a small group of people or to a delinquent group. The installation of condom machines in budget hotels (with transit packages), public toilets, tertiary institutions, toilets in certain shopping centres, ferry terminals and other places with high volume of people are equally important.

- 1.3.4 The availability of testing kits needs to be mainstreamed into all aspects of the healthcare (as is already being discussed) BUT it is better to implement this ONCE the MOH has ensured that all frontline staff are trained well to maintain confidentiality and sensitivity (there are one too many stories of careless behaviour among staff that there is a level of discomfort among PLWHIV). For testing to become effective it needs to be subsidised by the State just as how mammograms are being subsidised. The costs can be kept low if they are part of the health screening exercises. And GPs need to be trained in dealing with the sensitivities around handling a person with HIV plus raising his/her awareness to all the support structures that are available to the person diagnosed as a positive case.
- 1.3.4 Action for Aids as the main NGO dealing with HIV/Aids could do with reviewing its own role and re-brand beyond the common perception that it only looks into issues related to homosexuality or just Men.

2. Treatment/Care Management

- 2.1 Treatment is still expensive especially for those from the lower-income. This comment is made in spite of the access to generic drugs from Thailand and India. Some members in the discussions gave a breakdown that shows how access and cost of drugs amounts to almost two-thirds of their income. This situation will only get worse as the drugs become more expensive as their condition deteriorates.
- 2.2 We need to tackle the issue of drug companies and patency rights at the National level and assess how we can deal with International Agreements on this matter.
- 2.3 We also need to review the list of standard and non-standard drugs with respect to ARV so that we can alleviate the financial burden for PLWHIV, PLWA and increase their longevity and enhance their productivity as part of the labour force.
- 2.4 While we applaud the State for setting up funds to alleviate the financial burden for PLWHIV it is important to note that private donations cannot replace a lack in policy which entails reviewing the availability of drugs for treatment.
- 2.5 Children and Women cannot be made special cases though they are more acutely vulnerable in terms of funds to support them. All people living with HIV deserve support, funds, facilities and fair application of the criteria scheme to assess their predicament and render appropriate assistance.
- 2.6 There needs to be greater professionalism of medical practitioners from all disciplines. The specialisation of CDC as the treatment facility for all people with HIV has led to some others in the profession abdicating their responsibilities in terms of managing disclosure adequately, treating the person for other ailments without

putting the pressure on the patient to go to the CDC and/or giving support. In fact the often heard comment during the focus group discussion with PLWHIV, PLWA was that they felt like a “pariah” if they were at a restructured hospital for another ailment. If this is indeed a norm it is unacceptable behaviour for the medical profession.

2.7 Should we decentralize HIV/AIDS treatment?

2.8 There is a need for more caregivers and medical social workers at the CDC which is under-staffed going by the support work they have to do at the CDC. As AIDS and HIV involve dealing with people who very easily lose hope and need greater propping up, it would be appropriate to review this patient-staff ratio. In a focus group discussion it was clear that patients who have developed a personal relationship with their doctor or medical social worker, felt that they should not impose as they could see how over-worked staff were. There is a need for more specialists in HIV treatment and it seems that there are fewer than 10 currently. Many MSWs at the CDC suffer from burn-out due to the intensity of the work.

2.9 MOM should include in their advisory on HR-training policies(together with Singapore Human Resource Training Institute) that all employers include in their induction programme a module that deals with staff who have other needs – the disabled, the person with HIV etc etc – to sensitise staff.

3. Intersectionalities

3.1 The State’s policy of wanting to classify HIV/AIDS just as a disease can be limiting in itself. We cannot put the clock back as to how the disease was first managed or publicized. This disease includes aspects of the human tragedy of judgment and exclusion that form an inevitable part of managing this disease. The State needs to see this as both a disease – prevent, treat, support – and that it has wider implications on society’s norms and behaviour. As such this task force needs to recommend a few stakeholders – MOE, MCYS, MND, MHA, MINDEF, MLAW, MOM– to form a multi-sectoral task force.

- MOE needs to review its curriculum on Sexuality Education and look for the spaces to have more intensive workshops with the students and the option for parental involvement.
- MCYS needs to review its support processes, review its access to holistic management of the family for a PLWHIV. In some instances as in other countries PLWHIV are also on social entrepreneurship and micro-credit programmes. The Women’s Desk has to also be part of this process to keep watch on how women are implicated and co-ordinate for policies.
- MND needs to review its housing policies to offer community-based self-reliant models for PLWHIV and their families to manage their home.
- MHA on the policies regarding ‘licensed’ sex workers, undocumented sex workers or trafficked into the business who will have little recourse to negotiate for safe sex practices with their clients who could be Singaporeans and foreigners who could then partner Singaporeans too.
- MINDEF to use the space with NS recruits to deepen sexuality education discussions.
- MOM to look at policies on testing and governance of foreign workers.

- 3.2 There should be Legislation against Discrimination to include people with HIV and others too. In this aspect it will be good to understudy the holistic approach on Legislation pertaining to HIV/AIDS as has been put into practice in countries such as Cambodia and Philippines. Is there such a scope for Singapore and will that work better for us?
- 3.3 The State needs to review its policies with regards to all foreign workers. There is over-testing for the work permit holders and female domestic workers while testing for expatriates seem to be less frequent. As we agree that the HIV virus is borderless and not class-conscious it is important that we review this policy with regards too to how we deal with our own citizens as there is no space for any group to be dropped off the surveillance radar if we wish to contain HIV.
- 3.4 There is a need for all those who have been tested for HIV and their positive results to be harmonised into one system so that research too can be enhanced as well as the patient is better managed.
- 3.5 The State needs to gender-mainstream its approach to HIV in a dedicated manner. We CANNOT deal with HIV without looking into gendered roles among men and women, gender identities and homosexuality. While this is risk-taking at State level it is important that the other Ministries, the Private Sector and the Civil Society Groups do take on a bigger role in developing Gender as a component in the curriculum itself.
- 3.6 Homosexuality needs to be decriminalized as an act if we wish to deal with gender identity and sexuality education discussions in a more open manner and not drive anyone to feel that they have to hide or pretend.
- 3.7 Singapore is part of ASEAN and the Heads of State have made a commitment to reducing the incidents of HIV at the recent ASEAN Summit meeting in Cebu. There is an ASEAN Task Force on HIV and Singapore is the Vice-Chair of this committee at the moment. Singapore can take on a role to enable ASEAN to co-operate on IEC materials at all Immigration points within ASEAN as well as on budget carriers and national airlines.
- 3.8 Singapore is part of UNGASS and is a signatory to CRC and CEDAW which does not allow any form of discrimination against the child or the woman. International Labour Organisation (ILO) is also raising awareness to the needs of PLWHIV and measuring the productivity of such workers who have access to treatment. We are part of this global movement and it is important that we too embrace non-discriminatory practices through our policies.