

**SECURING THE VOICE OF AFRICAN MEN  
WHO HAVE SEX WITH MEN (MSM) WITHIN  
HIV & AIDS DEVELOPMENT POLICY AND  
PROGRAMMING IN EASTERN AND  
SOUTHERN AFRICA**

**COUNTRY LEVEL REPORTS**



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## Angola

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

The study provides insufficient information about male same-sex sexuality as organized and expressed on an individual level. Criminal law and social stigma prohibit homosexuals from openly expressing their sexuality. The National Institute for the Fight against AIDS reported in 2007 [2] that according to anthropologist Americo Kwanonoka, Angolan society is not yet prepared to accept homosexuals. The same report provides anecdotal evidence of homosexuals being repeatedly persecuted as a result; few individuals are prepared to be open about their homosexuality. Social psychologist Carlinhos Zassala states that some Angolans use marriage as a way of avoiding stigma – once married they continue to have sex with other men [2].

The Dagara ethnic group of Burkina Faso believes being differently-oriented and being spiritually gifted go together. Many of the Dagara individuals who served as spirit guardians between this world and the Otherworld could be identified as people who had desire for those of the same sex.[14] In Angola, it is reported that many MTF cross-dressers who have sex with men were also said to be powerful wizards. [6]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

According to a posting on Manjam, a gay social network for dating work and travel, the Internet is the only mean to know other men is “forbidden” and “considered a crime”, there is no gay community cultural life at all, no bars, or other places for people to meet. As a result homosexuality is carried out under cover. Social psychologist Carlinhos Zassala explained that many Angolan gays use heterosexual marriage as a way of avoiding stigma, but once married, continue with homosexual relationships. [4]

3. Presence of an organized LGBT or MSM community

The data provides no evidence to support an organized LGBT or MSM community, apart from reference to the non-governmental organisation Acção Humana (Human Action) which tried to develop a prevention programme for gay men. The data suggests that as homosexuality is considered illegal, this has encouraged the LGBT or MSM community to become an ‘invisible population’. [7]

LGBT rights in Angola are very limited. Homosexuality has been against the law in Angola since colonial times under Portuguese law. Homosexuality is, according to the law "an offence against the public moral" and therefore prohibited. [10]

4. What is known about stigma and discrimination of male same-sex sexuality?

Cultural, religious, legal and social intolerance, inflamed by the homophobic views of the Ugandan President Museveni influence the homophobic stance of Angolan society. A 2007 INLS report quotes anthropologist Americo Kwanonoka, who validates why homosexuality is not tolerated in Angolan society, stating that Angolan Christian culture promotes heterosexual family units and “considers homosexuality as an affront to the laws of nature”, and as a result of these notions, gays are often persecuted, and few risk being open about their sexuality. [2].

## 5. What is known about social position and needs of MSM living with HIV/AIDS

There is a shortage of information on the composition of the social group of men who have sex with other men (MSM). The Institute for the Fight Against AIDS (INLS) reports that Ugandan President Museveni has referred to gay culture as “foreigners” and “a decadent culture passed on by Western nations”. Gays are considered to be an invisible population, ignored in government AIDS policies. The 2007-2010 National Strategic Plan for the Control of Sexually Transmitted Infections, HIV and AIDS excludes reference to the homosexual community or MSM. [10]

In Angola, a commonly-held assumption that only men with feminine mannerisms are homosexual means that many who have sex with other men do not self-identify as gay. The commonly-held assumption that only men with feminine mannerisms are homosexual means that many who have sex with other men do not self-identify as gay, pointed out Roberto Campos, an official with UNAIDS. “If the person fails to recognise himself as such, the message of safe sex doesn’t reach him. The fact is that unprotected anal sex presents a high virus transmission risk.” [1]

Angolan gays use marriage as a way of avoiding stigma, but once married, continue to have occasional sex with other men. In many cases, casual sex does not involve the use of condoms. [1]

## 6. Any on-going activities to counteract stigma and discrimination?

In 2007 by the National Institute for the Fight Against AIDS (INLS) reported a positive development for Angola's homosexual population. A study was launched in 2007 by the INLS, in partnership with the United States Centres for Disease Control, aiming to identify the habits and behaviours of this group, including their risks and vulnerability with regards to HIV. UNAIDS reported that this demonstrates an important political change. Before, gays were not a priority issue. Now they have stopped being invisible and have been included in discussions on public health and the HIV epidemic,” said UNAIDS’ Campos. [2]

## 7. Existence of homosexuality-related barriers to health care

The criminal laws and social stigma make it difficult to target AIDS-HIV education programs for LGBT people. The high level of poverty means that many people who are infected find it difficult to access medical care and other necessities of life. Efforts to develop educational program specifically for LGBT people have struggled to receive funding from NGO's.

IRIN/Plusnews have reported that during their 2007 epidemiological study carried out by the National Institute for the Fight Against AIDS (INLS), messages about safe sex were exclusively tailored to heterosexuals, leaving the gay population neither informed nor protected, and the lack of information creates problems at health facilities. All of the men interviewed expressed their wish to access HIV and AIDS services at a facility tailored to their specific needs. [2]

## 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Articles 70 and 71 (Penal Code of 1886 Articles 70 and 71) prohibit private, adult and consensual homosexual acts as, “an offense against public morality”. Criminal laws against

homosexuality were first introduced during Portuguese colonial rule and have remained after independence. The law stipulates that repeat offenders can be sentenced to labor camps. [3]

Lesbian, gay, bisexual, and transgender (LGBT) persons in Angola face legal issues not experienced by non-LGBT citizens. Both male and female homosexual acts are illegal in Angola. LGBT citizens are not expressly mentioned in the Constitution, ratified in 1992, but several provisions may impact the legal right of LGBT Angolians: Article 08 - Separation between Church and State; Article 20 - Right to the, "free development of his or her personality..."; Article 29 - Protection of marriage and family by the State.; Article 32(3) - Prohibits free expression that is contrary to the law.; Article 35 - Freedom of the press.; Article 47 - Right to health care. [10]

9. Any action under way to change legal status of homosexuality

No action has been indicated in the data presented to change legal status of homosexuality in Angola.

10. Any human rights based organizations active in this country that does or should address MSM issues?

Little reference is provided to human rights based organizations active in this country apart from referral to the non-governmental organisation Acção Humana (Human Action), National Institute for the Fight Against AIDS (INLS) and the International Gay and Lesbian Human Rights Commission.

11. HIV prevalence/incidence data for MSM and general population

Data from an epidemiological study carried out in 2007 by the National Institute for the Fight Against AIDS (INLS) showed that five percent of all HIV infections in Angola were among men who had sex with men (MSM). [3]

According to a posting on Manjam, a gay social network for dating work and travel, anecdotal information testifies that same sex sexuality do not exists officially, and therefore no official statistics exist, and the same with HIV, there are no official statistics regarding infection levels. It has however been reported that with HIV being high in the heterosexual community, it must also be high in the MSM community. [4] The 2007 report of the International Gay and Lesbian Human Rights Commission called "Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa," found that gays throughout most of the continent were excluded from HIV/AIDS programmes. However data from an epidemiological study carried out in 2007 by the National Institute for the Fight Against AIDS (INLS) showed that five percent of all HIV infections in Angola were among men who had sex with men (MSM). [2]

12. Is there understanding of specific risk factors for HIV transmission in MSM

According to Roberto Campos, an official with UNAIDS men interviewed by IRIN/PlusNews, the homosexual community repeatedly exposed themselves to risk. This is through casual sex often not involving the use of condoms. A commonly-held assumption in Angola, is that only men with feminine mannerisms are homosexual, and as a result many men who have sex with other men do not self-identify as gay. Unprotected anal sex presents a high virus

transmission risk. [2]

### 13. Current status of prevention, treatment and care for MSM

The National Institute for the Fight Against AIDS (INLS) and the International Gay and Lesbian Human Rights Commission have found that the homosexual community and especially MSM, throughout the continent were generally excluded from HIV/AIDS programmes. [2]

The Commission reported that the "silence regarding HIV infection among homosexuals" meant that messages about safe sex were exclusively tailored to heterosexuals, leaving the gay population neither informed nor protected. The lack of information also creates problems at health facilities. All of the men interviewed by IRIN/PlusNews expressed their wish to access HIV and AIDS services at a facility tailored to their specific needs. [2]

The 2008 UNGASS indicators for MSM acknowledges that Angola's HIV prevention programs reaches less than 20% of its MSM. [3]

However, August 2009, Hilary Clinton and the Angolan Minister of External Relations signed the "Partnership Framework between the Government of the Republic of Angola and the United States of America to Combat HIV/AIDS for 2009 – 2013". The agreement does mention MSM and indicates that Angola will scale up access to health promotion and STI/HIV prevention among commercial sex workers, truck drivers and MSM.

### 14. MSM related UNGASS indicators

In March 2008, Angola submitted its report on its progress towards implementing the UNGASS indicators for MSM. The report acknowledges that their HIV prevention program is reaching less than 20% of its MSM. [3] It did not submit data on the HIV seroprevalence among MSM, the level of understanding among MSM of HIV prevention, or the condom use among MSM. It did submit data on the percentage of MSM who received an HIV test in the last 12 months and who know the result.

### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

In Angola, there exist severe structural and cultural barriers to adequate prevention, treatment and care for MSM. As has been reported: Messages about safe sex have been exclusively tailored to heterosexuals, leaving the gay population neither informed nor protected, creating problems at health facilities; A commonly-held assumption in Angola, is that only men with feminine mannerisms are homosexual, and as a result many men who have sex with other men do not self-identify as gay, and have unprotected sex; Gay men often use marriage as avoiding stigma, whilst continuing with extramarital gay relationships. Homophobia permeates society, perpetuated through Angolan law, religious institutions as well as the homophobic views of the Ugandan President.

The criminal laws and social stigma make it difficult to target AIDS-HIV education programs for LGBT people. The high level of poverty means that many people who are infected find it difficult to access medical care and other necessities of life. Employment protection for people living with the disease exists since 2003.

Efforts to develop educational program specifically for LGBT people have struggled to

receive funding from NGO's. The first association, Acção Humana (Human Action), was launched in 2006 but has been unable to receive funding. In 2007, a study on AIDS-HIV estimated that roughly five percent of HIV infections are from men who have sex with other men.

National legislation to criminalize people who intentionally infect another person with AIDS-HIV has been debated in 2004 and 2007, but failed to pass. [3]

#### 16. Whether and how MSM are included in National Strategic Plans

MSM is largely ignored in government AIDS policies, including the 2007-2010 National Strategic Plan for the Control of Sexually Transmitted Infections, HIV and AIDS. [3]

In August 2009, Hilary Clinton and the Angolan Minister of External Relations signed the "Partnership Framework between the Government of the Republic of Angola and the United States of America to Combat HIV/AIDS for 2009 – 2013". The agreement does mention MSM and indicates that Angola will scale up access to health promotion and STI/HIV prevention among commercial sex workers, truck drivers and MSM. PEPFAR will promote stigma reduction interventions for hidden populations including MSM, and will provide interventions for MSM in defined hot spots; these interventions will include condom promotion, and promotion and provision of HIV counseling and testing services with referral and provision of treatment and care for those persons (MSM) testing positive. [3]

The partnership agreement provides a five-year joint strategic plan for cooperation among the government of Angola, the U.S. Government, and other stakeholders to support achievement of the goals of Angola's HIV National Strategic Plan for 2007-2010.

The agreement will enable the partners to work together to: Strengthen health systems Improve monitoring and evaluation; Bolster HIV prevention activities, particularly prevention of mother-to-child transmission; Address TB/HIV co-infection; Explore the role of male circumcision in Angola's epidemic and develop and implement policies accordingly; Address stigma and discrimination against people living with HIV/AIDS; Encourage people to get tested and stay negative; Promote the inclusion of people living with HIV/AIDS at all levels of program planning and implementation

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#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Further information needs to be provided apropos infrastructure present in Angola that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

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## **Botswana**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Lesbian, gay, bisexual, and transgender (LGBT) persons in Botswana face legal issues not experienced by non-LGBT citizens. Both female and male same-sex sexual acts are illegal in Botswana [38]. Homosexuality is stigmatized, and anecdotal information in reports provided, attests to discrimination against homosexuals.

Homosexuals exist in different layers of society, although society at large disapproves of homosexual behavior. Information provided regarding how same-sex sexuality is organized and expressed on an individual level, refers to experiences of a homosexual bishop, bisexual and homosexual teenagers, a transsexual athlete, a trans-lesbian school girl, and the experiences of a USA Peace Corps Alumni working in Botswana with homosexual individuals and others.

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Anecdotal information provided indicates that Botswana homosexual community prefer to join an organisation, which they feel, offers a degree of protection. An organisation such as *Behind the Mask*, strives to mainstream, through journalistic activism, lesbian, gay, bisexual, transgendered, and intersex (LGBTI) interests and to change negative attitudes towards homosexuality and same sex traditions in Africa. A 2007 report by MASK reflects these sentiments, quoting one of the members of the leading organisation in Botswana, the Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) Masego Ditlhokwa , who attended a LeGaBiBo function. Masego states that “Although no one can be arrested for being gay, we still have fear within. Most of us here are in the closet but when we are together like this we seem to be open because... we realise that we are not alone any more”. Lerato Motseoteng, a young lesbian is quoted stating that mainstream Botswana communities are ignorant of gay rights and needs, that Botswana is still yet to address gay rights issues, and that she is happy to be a member of an organization such as LeGaBiBo of which she feels will assist many people. [26]

The Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) has been involved in arranging social meetings, for example on World AIDS Day 2007, they held a get-together bash and pride party which attracted almost 200 members of the gay community. This party aimed to celebrate homosexuals in Botswana’s existence with pride and to strengthen trust between them. [26]

LeGabiBo was reported to be planning to add many fun activities during their meeting in order to attract gay youths to become members. It was felt that these parties provide the spaces where people become comfortable and when people are at ease, and where these individuals are able to unite in struggle for rights and recognition. [27]

3. Presence of an organized LGBT or MSM community

An organised LGBT community exists in Botswana: The Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) organises parties, meetings and advocacy, even with journalists. The Schorer funded Prevention and Research Initiative for Sexual Minorities (PRISM) is focused on HIV. The Botswana Network on Ethics Law and HIV /AIDS (BONELA) also works with MSM. BONELA also engages in advocacy for the inclusion of LGBT people in the national response to HIV/Aids. There is a population of MSM which is relatively urban, educated and prosperous. [19]

#### 4. What is known about stigma and discrimination of male same-sex sexuality

Website reports [19] indicate that homophobia is rife, and groups like the Mothers Union are publicly hostile towards LGBT people. As such, just showing up at an event hosted by the Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) is enough to risk ostracism and family shame and many MSM fear being blackmailed. Accessing MSMs (men who have sex with men) is problematic and the government does not include same sex behaviour in their information campaigns.

Like most other countries, there is a broad gulf in Botswana between what is acceptable in urban areas and in rural. Across Africa, the fight for gay rights clashes with devoutly religious societies, either Christian or Muslim. [29]

Research findings also refer to discrimination from religious sectors. The Anglican Church in Botswana joined a growing list of African Anglican dioceses that have refused to recognise the consecration of Revd Gene Robinson as Bishop-Coadjutor of the Diocese of New Hampshire in the United States, because of his sexual orientation. Bishop Robinson was consecrated as the first openly gay bishop. [3]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

A study (Baral, et al) conducted with men in Gaborone who had anal sex with another man found that 19.7% were found to be HIV positive using OvaSure HIV rapid kit testing. 20.5% of the participants said they were afraid to seek health services; 29.1% afraid to walk in the community; and 26.5% blackmailed because of sexuality. This is a powerful reminder of the level of stigma, discrimination and human rights abuses that these men face in their everyday lives. [19]

Chris Beyrer of the Center for Public Health and Human Rights at the Johns Hopkins School of Medicine in Baltimore indicated that 26% of Botswana men interviewed were blackmailed by the people they had trusted and come out to: family members and even healthcare workers. [13]

#### 6. Any on-going activities to counteract stigma and discrimination?

The Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) is involved in on-going activities to counteract stigma and discrimination. They are trying to get gay marriages legalized, and have drawn up their own constitution, a statement of the aspirations and beliefs of a particular group of Botswana which aims to: set out concerns raised by lesbians, gays and bisexuals in Botswana; educate the public about our existence; start a debate concerning gay desire to enjoy the same human rights as other citizens, without fear of discrimination; and to emphasise that a need to enjoy equal protection, under the law, of civil, political, social and economic rights. [19]

#### 7. Existence of homosexuality-related barriers to health care

The fear of imprisonment and persecution, present the major homosexuality-related barriers to health care. Research shows that MSM identify a need for HIV/Aids education, and the public health imperative has obliged government to deal frankly with prostitution (illegal but widely practised) and the sexual activities of marginalized communities in order to stop the spread of HIV.

## 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Homosexual conduct is illegal punishable with up to 7 years of imprisonment (Penal Code Articles 164, 165 and 167). Section 164 of the penal code, states that: "any person who has carnal knowledge of any person against the order of nature; has carnal knowledge of an animal, or permits a male person to have carnal knowledge of him or her against the order of nature is guilty of an offense and is liable to imprisonment for a term not exceeding seven years". Legally speaking, it is not against the law to be gay here; it is only illegal for two consenting adults of the same gender to have sex. [39]

July 2003: In its ruling, The High Court in Botswana said that, "Gay men and women do not represent a group or class which at this stage has been shown to require protection under the constitution. [37]

## 9. Any action under way to change legal status of homosexuality

Reports indicate that individuals and organizations have been trying to change the legal status of homosexuality in Botswana. Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) have been rejected by Botswana's Home Affairs department as a recognised gay organization. They have however been campaigning to change the situation [24]

Another example cited is that of a man who was accused of engaging in homosexuality in Botswana and who filed an application in the High Court challenging the country's laws on unnatural sexual liaisons [31].

The Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) have been trying to get gay marriages legalized. [19]

## 10. Any human rights based organizations active in this country that does or should address MSM issues?

Organizations cited in the research, addressing homosexual and MSM issues include amongst others, the Lesbians, Gay and Bisexuals of Botswana (LeGaBiBo) (a first Botswana lesbian, gay, bisexual, transgender and intersex project run by Botswana Network on Ethics Law and HIV /AIDS (BONELA) and Botswana Network on Ethics and HIV/ Aids (BONELA)'s Prevention and Research Initiative for Sexual Minorities (PRISM). [27]

LeGaBiBo has especially campaigned to give a voice and legitimacy to this sector. The Lesbians, Gays and Bisexuals of Botswana (LEGABIBO) Charter was drafted in response to those amendments to the Botswana Penal Code, which came into effect on the 30th April 1998 and extended the seven year maximum penalty, for men caught engaging in same-sex sexual relations, to women as well. Adopted in Gaborone, 20 August 1998, the Charter emerged at a workshop on Lesbian and Gay Rights on 2nd - 3rd May 1998, hosted by DITSHWANELO - The Botswana Centre for Human Rights, in Gabarone. It was drawn up by a group of concerned Lesbian, Gay and Bisexual people from all walks of life. It is hoped that this Charter will help to break down the negative image, and counter the prejudice and discrimination, currently facing the lesbian, gay and bisexual community in Botswana (also referred to as "the Community"). It states that "We, the Community, are rejected, victimised, assaulted and blackmailed." This is because of societal myths and because homosexuality is a taboo subject in our culture. That homosexual faces stigmatisation and prejudice from family members, friends, and society in general. The Charter calls for tolerance and understanding by the Government and people of

Botswana, in order to counteract the prejudice and discrimination we face. The Charter is not a legal document and so does not assert a set of legally enforceable or actionable claims. Rather the Charter is a statement of the aspirations and beliefs of a particular group of Botswana to: set out concerns raised by lesbians, gays and bisexuals in Botswana; educate the public about our existence; educate the public about our existence; start a debate concerning our desire to enjoy the same human rights as other citizens, without fear of discrimination; emphasise that this sector should enjoy equal protection, under the law, of Botswana's civil, political, social and economic rights. [8]

#### 11. HIV prevalence/incidence data for MSM and general population

HIV/AIDS has gained a substantial foothold in Botswana where the adult prevalence is recorded as 37.4%, the second highest in the world (National AIDS Coordinating Agency, 2003; UNAIDS, 2004a). With approximately 350 000 persons infected, the nation faces a critical threat given that HIV/AIDS perpetuates poverty, orphans children, depresses economies, and burdens already stressed healthcare systems. [17]

Chris Beyrer of the Center for Public Health and Human Rights at the Johns Hopkins School of Medicine in Baltimore presented findings from a programme of surveys of MSM and HIV in a number of African countries. In most of these countries there had been literally no data on MSM, Beyrer said. Male/male sex is illegal and stigmatised and, until recently, surveys of MSM would have been impossible. Recently, however, health ministries in some African countries have become more supportive of research and prevention work among this community and local non-governmental and community organisations have been willing to act as local hosts for the research programme. The Botswana Network on Ethics, Law and HIV/AIDS (BONELA) collaborated with the researchers to recruit interviewees. [19]

In 1998, it was reported that Botswana was the worst affected country in sub Sahara, where one of every four adults is infected; life expectancy is anticipated to fall further, to 41 years by 2005. [6]

Research [19] has been conducted with men in Gaborone who have had anal sex with another man. The study found that 3.4% of the sample self-identified as heterosexual, 66.7% as homosexual/gay and 29.1% as bisexual. 0.9% self-identified as transgender. 60.3% had disclosed sexual orientation to a family member and 24.2% to a health care worker. 20.5% of the participants indicated that they were afraid to seek health services. 26.5% had been blackmailed because of their sexuality. Other research (Beyrer, 19) also found that in a sample of MSM 19.7% were HIV positive but only 17.4 % were aware of their HIV status. Research has also found that condom use is, in fact, quite common [19].

Same-sex sexuality in prisons is a concern as this contributes to the spread of HIV. BONELA advocates for distribution of condoms in prison.

According to the Botswana Federation of Trade Unions, "Reported homosexual and bisexual transmission of HIV is relatively low in Botswana, accounting for about less than 10% of AIDS cases, but MSM transmission is nonetheless considered an important mode of HIV transmissions in our correctional services". However, they acknowledge that "it is quite likely that the estimate reported underestimate the true percentage of AIDS cases attributable to MSM transmission of HIV". They also recognise that "most current programs are not reaching nearly enough people in unions, both in urban and rural areas, especially women and youth". They suggest that unions must also collaborate and partner with NGOs, community groups, and

people living with HIV/AIDS. [19]

BONELA was granted permission by the government to conduct a research survey on HIV prevalence among MSM (see Kapimbua, Y, et al, 2008).

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

At the launch of the Botswana Human Development Report 2000, President Festus Mogae of Botswana urged people of his country to change their strong held views about homosexuality in order for the nation to effectively stop any future HIV infections. [20]

Christine Stegling of the of Botswana Network of Ethics, Law and AIDS (BONELA), has emphasised the necessity of passing out a law that recognise gay and lesbian marriages which would be an indication of Botswana's commitment to human rights and fighting discrimination. Stegling warned that if gay people continue to feel marginalised or discriminated, they will not feel comfortable to seek HIV treatment in public health services or the tools that might prevent HIV. The strategies to fight the HIV/AIDS pandemic must include everyone, including people of non-heterosexual orientation and recognising their right to equality. [34]

## 13. Current status of prevention, treatment and care for MSM

No information is provided as to treatment and care specifically for MSM in the supporting information.

However, in terms of the broader society, the government of Botswana has dedicated itself to the HIV/AIDS challenge; President Festus Mogae heads the National AIDS Council and often refers to the pandemic in his speeches. The availability of funds means that organisations involved in intervention strategies have seemingly fewer obstacles to overcome than in other African countries, The public sector channeled profits from Botswana's mineral wealth to finance the world's first free antiretroviral therapy programme. The country's clear political commitment to eradicating HIV/AIDS (Wolfe, 2003) and the democratic and transparent nature of Botswana's institutions have created a high level of donor confidence. Specifically, funding from Merck, and the Bill and Melinda Gates Foundation, as well as academic interest by Harvard University in the US, has facilitated a donor presence in Botswana around HIV/AIDS issues. Moreover, the government has launched a national response that appears politically backed, multi-sectoral, and well-organised. The National Strategic Framework (Republic of Botswana, 2G03a) sets clear priorities for action, resource allocation and accountability; outlines indicators by which to measure defined objectives; and purports the importance of links and coordination among key stakeholders, including the public and private sectors and civil society. In many contexts, civil society is often viewed as the first line of action for HIV/AIDS interventions (UNDP, 2003) [17]

Botswana's national response to HIV/AIDS is led by the multi-sectoral National AIDS Council, which is chaired by President Mogae, and its secretariat NACA (Republic of Botswana, 2003b). The National AIDS Co-ordinating Agency (NACA) was formed in 1999 and given responsibility for mobilising and coordinating a multi-sectoral national response to HIV and AIDS. NACA works under the National AIDS Council, which is chaired by the President and has representatives from across society including the public and private sectors, and civil society. In 2002-2003 the Government of Botswana expended US\$69.8 million in direct costs fighting the epidemic, along with US\$41.8 million from foreign development partners. These figures do not include indirect costs such as infrastructure development and training (Republic of Botswana, 2003b). HIV/AIDS mainstreaming is prevalent within the Government of Botswana: each

ministry has an HIV/AIDS coordinator, several have coordinating units, and each district has a government-driven multi-sectoral AIDS committee that negotiates linkages, partnerships, and funding for ASOs. The HIV/AIDS response is guided by three key documents. First, the National HIV/AIDS Policy of 1998 aims to prevent and reduce the impacts of HIV transmission and STI, mobilise actors, and provide care for people living with HIV (Ministry of Health, 1998). It defines the roles of different actors, including government bodies, corporations, prevention and care organisations, individuals and external support organisations, and oversees all HIV/AIDS-related activities and resource allocation and mobilisation (Ministry of Health, 1998). The policy calls on all actors to implement their own HIV/AIDS intervention programmes and contends that the most effective interventions are those advocating changes in social and sexual behaviour (Ministry of Health, 1998). It addresses prevention strategies through the use of information, education, and communication, condom-use, counselling, promotion of gender equality, and encouragement of male roles in the community (Ministry of Health, 1998). The policy is regulatory, comprehensive and inclusive, and adopts a decentralised approach to fighting HIV/AIDS (Osei-Hwedie, 2001). Second, the National Strategic Framework of 2003 is a responsive and action-oriented document that aims to "eliminate the incidence of HIV and reduce the impact of AIDS in Botswana" (Republic of Botswana, 2003a). Its main functions are to communicate the national priorities and strategies that were developed for Botswana's long-term national vision and goals. Vision 2016 (Mutula, 2004), and to provide leadership to public, private and civil society to enhance cooperation. This cooperation is required in order to achieve the ultimate national response goal of eliminating new cases of HIV/AIDS and reducing impacts in Botswana (Republic of Botswana, 2003a). With prevention of HIV/AIDS transmission as the first priority, the framework also focuses on care and support provision, national response management, impact mitigation, and legal and ethical provisions (Republic of Botswana, 2003a). Formed through a consultative process, the framework articulates ten specific objectives (for example, decreasing mother-to-child transmission by 2009), as well as thirty priority strategies (for example, reducing stigma and discrimination). It discusses how it will ensure implementation, roles and responsibilities of national coordination, operationalisation of individual district responses, mobilisation of public-sector response, roles of different actors, sectors and media, resource requirements and development of the information management system. [17]

#### 14. MSM related UNGASS indicators

In 2008, Botswana did not report on its progress with regards to any of the UNGASS indicators for MSM.

Vision 2016 promises all citizens safety, security, freedom of expression and a tolerant nation, which, it is hoped will acknowledge and positively impact on the MSM community.

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

There is a shortage of information on the sexual practices, perception of risk of infection and their conditions of access to health services of MSM. It is inferred that the fear of homophobia towards members of the homosexual community jeopardise efforts undertaken to combat HIV. Homosexuality is taboo in traditional Botswana culture. It is commonly seen as a western, non-African problem. Botswana's primary LGBT rights organization is Lesbians, Gays and Bisexuals of Botswana (LEGABIBO). It has no official recognition from the government—and because it is not a registered organization, it cannot legally raise funds. A spokesman from the organization said, "the government has stated that it will refuse to register our organization because to do so

would be tantamount to registering an organization of criminals. [19]

The Lesbians, Gays and Bisexuals of Botswana (LEGABIBO) Charter was drafted in response to those amendments to the Botswana Penal Code, which came into effect on the 30th April 1998, calls for social and emotional support, through counselling services, for the Homosexual community, as well as information on HIV/AIDS, sexuality and other health issues; Clinics should have safer sex workshops that deal with all aspects of human sexuality; Health professionals should be sensitised to lesbian/gay/bisexual needs demands.; and the homosexual community should advocate safer sex practices. [19]

#### 16. Whether and how MSM are included in National Strategic Plans

MSM in specific, is not included in the National Strategic plan, however, the national manifesto, Vision 2016 promises all citizens safety, security, freedom of expression and a tolerant nation. The Vision 2016 describes a national manifesto for the people of Botswana and it claims to reflect the views of many different parts of Botswana's society. The development plans of Botswana Vision 2016 are based upon the four national principles, which are Democracy, Development, Self-reliance and Unity. It is hoped that through this manifesto, Botswana will be a compassionate and caring nation, not only in relation specifically to poverty eradication but also claiming that the negative impact of the AIDS epidemic in Botswana. Mask admin (2006 reports that HIV will never be halted unless MSMs are specifically included in government programmes. [35]

A 2010 LGBT Asylum news website report states that the Botswana's Ministry of Health intervened to block US funding for HIV/AIDS prevention efforts targeted at men who have sex with men (MSM) and their partners because homosexuality is illegal in Botswana, the Sunday Standard reported. The Botswana government has intervened to stop an initiative by the United States government to fund HIV-AIDS interventions targeted at same sex partners. Sunday Standard can reveal that the Ministry of Health stepped in at the eleventh hour to halt a call for proposals, issued by the US government under its Presidents' Emergency fund for HIV and AIDS(PEFPAR), for HIV-AIDS intervention initiatives for same sex partners, on the grounds that the its target groups are classified as unlawful in Botswana. [18]

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

There is little evidence in documentation of infrastructure for delivery of adequate HIV prevention, treatment and care specifically to MSM. However, it is reported that sub Saharan Africa countries, have generally stepped up prevention programmes for HIV/Aids, and have programmes to stop foetuses being infected, leading the initiative are countries such as Botswana. In Botswana, 24 per cent of adults between the ages of 15 and 49 are infected with HIV/AIDS. However, the mortality rate has been significantly slowed down by an aggressive treatment programme, which has seen a number of infected people getting access to ARVs.[30]

Hovorka, Erin E. Kiley, (2006) report that the HIV/AIDS national response has been operationalised through a well-established healthcare system that includes 28 primary and general hospitals, 552 clinics and health posts, and mobile units that made 725 stops in 1999 (Central Statistics Office, 1999). Health services are well subsidised by the government and many preventative services such as antenatal care and antiretroviral therapy are free. Services requiring a standard fee of two Pula are not denied if the patient is unable to pay (WHO, 2003). Approximately 90% of healthcare is publicly run through the ministries of Health and Local



Government, while the remainder is privatised (WHO, 2003). Almost all urban and 80% of residents living within 15 kilometres of a primary healthcare facility, although in some districts this percentage is substantially lower (The World Bank, 2004). The quality of care in Botswana tends to vary between rural and urban areas, with modern private hospitals in the capital city and several rural areas suffering from inadequate service (Hope & Edge, 1996). With 3.1 doctors per 10 000 patients, Botswana has the highest doctor to patient ratio in sub-Saharan Africa (Central Statistics Office, 1999) and its total expenditure on health as a percentage of gross domestic product is 6.6, the fifth highest in the African region (WHO, 2001). There are strong monitoring and evaluation systems for many aspects of health, such as HIV/AIDS prevalence, diseases such as malaria and polio, and uptake of the antiretroviral treatment programme (Lewis, Larsen, Groeningsaeter, Galeboe & Spambaniso, 2003; Central Statistics Office, 2004b). Given the advanced state of healthcare, Botswana's HIV/AIDS statistics are considered the most accurate in Africa (Mmidi & Delmonico, 2001). Sentinel surveillance in Botswana is tracked primarily through antenatal clinics, where an estimated 95% of Botswana's women attend (Allen & Heald, 2004).<sup>^</sup> LifeLine, an anonymous counselling service, and an HIV/AIDS reference laboratory have been operating since 2000 (Garbus, 2000). There are approximately 16 voluntary HIV testing facilities in Botswana, with plans for future facilities, free antiretroviral drugs for all citizens, and drug programmes for HIV-positive pregnant women (IRIN, 2004; Nolen, 2004).<sup>^</sup> Government-sponsored antiretroviral treatment has expanded quickly from 6 000 patients treated at four sites as of December 2002 (ACHAP, 2002) to over 17 000 patients treated at 16 sites by June 2004. A further 10 000 persons are enrolled and another 6 500 are being treated in the private sector (Wisnicki, 2004), [17]

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## **Burundi**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

In Burundi, homosexuality is not a matter of public discussion, and the legal status of homosexuality conveys much about the status of homosexuals. Taboos in the general public are prevalent. There exists mostly underground gay/lesbian society, but not being an issue of public discussion, even individual awareness of homosexuality is low.

Official gay or lesbian couples/families however mostly remain unheard of in Burundi. As for the legal status, state law provisions and Islamic law in this country also prohibits homosexuality in Burundi. Therefore, little is known about the MSM community and especially those living with HIV/AIDS. The Association Nationale de soutien aux Seropositifs et Sideens (ANSS) founder Jeanne Gapiya, has attributed this lack of information to the MSM community being “a hidden community”, and has blamed Burundian society as being in denial about their existence.

The National AIDS Control Council (CNLS), has included MSM in the list of people vulnerable to HIV. The CNLS recognize the MSM community in Burundi as a “marginalised group”, and although they would like to include the MSM community for meetings they have expressed difficulty in identifying who most of the MSM community are or how to reach them. [2]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

According to responses from Christian Rumu (chairman, Humure, Burundi's Gay Association) on the website Manjam Africa (the gay social network), there are no specific place where LGBT population are able to meet. There are no MSM/gay social venues, such as bars or clubs. [9]

3. Presence of an organized LGBT or MSM community

Homosexuality is illegal in Burundi, and some individuals have been prosecuted and convicted for their sexual orientation. On the other hand, there are very active and very visible gay and lesbian organisations in Burundi, that have succeeded in creating public debate on the issue.

HUMURE, previously called Association pour le Respect et les Droits des Homosexuels'(ARDHO), is an LGBT organization dealing with HIV/Aids prevention in Burundi; it works mainly with NGOs fighting against HIV/ Aids. This organization was initiated by Georges Kanuma who is reported to have faced the challenges of intense homophobia in Burundi to create the country's first LGBT group. [9] According to HUMURE there is an increase in homophobia and discrimination. However the organisation is working with civil society to try eradicate the climate of homophobia that has increased because of all the attention on the new laws. They are also looking for non-LGBTI allies.

In July, a situational analysis on the needs of the LGBTI community was started. This research, funded by the King Baudouin Foundation of Belgium and the National Council against AIDS, will determine the needs of the LGBTI community in terms of health (HIV / AIDS in particular). Very little is currently known about the MSM let alone those living with HIV/Aids.

4. What is known about stigma and discrimination of male same-sex sexuality

Stigma and discrimination perpetuates Burundian law, religious institutions and the homophobic

views of the Burundian President, Pierre Nkurunziza. According to the organization Humure (previously pour le Respect et les droits des homosexuels (ARDHO)), there has been an increase in homophobia and discrimination. However the organisation is working with civil society to try eradicating the climate of homophobia that has increased because of all the attention on the new laws. They are also looking for non-LGBTI allies. [8]

Discrimination perpetuates Burundian culture to the extent that, according to responses from Christian Rumu (chairman, Humure, Burundi's Gay Association) on the website Manjam Africa (the gay social network), there does not even exist in the local language Kirundi a specific name for gay people, people use Swahili or French terms to refer to a gay individual.

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

The study provides insufficient information about social position and needs of MSM living with HIV/AIDS. Criminal law and social stigma prohibit homosexuals from openly expressing their sexuality. Anecdotal evidence however shows that many married ('straight') men in the Burundian capital, Bujumbura, sleep with gay men "on the side". [4]

In 2007, the Association National pour le Soutien des Seropositifs (ANSS), a Burundian organisation supporting people suffering from Aids, publicly offered to work with sexual minorities to tackle the taboo around homosexuality in relation to AIDS [8]

#### 6. Any on-going activities to counteract stigma and discrimination?

Despite a hostile and homophobic environment, organisations in Burundi such as the Association pour le Respect et les Droits des Homosexuels' (ARDHO) have organised themselves in order to create awareness about, to advocate for and to protect gay rights. ARDHO has been working since 2003 for the recognition of the rights and the respect of sexual minorities in that country. As a pressure group, it works mainly with NGOs fighting against HIV/Aids. Despite evolving in a hostile and homophobic environment, ARDHO has managed to create contacts and to be proactive. Georges Kanuma, President of ARDHO, thinks that it is impossible for anti HIV/ Aids organisations to fight the disease when they do not talk openly about sexuality and still exclude homosexuality from their programmes. In 2009, ARDHO was planning to organise a conference to include local and international NGO's fighting against Aids themed 'Homosexuality and HIV/Aids'. [22]

#### 7. Existence of homosexuality-related barriers to health care

ARDHO, which distributes condoms and lubricants and also raises awareness of HIV among men who have sex with men, has never gained official recognition as a nongovernmental organization. In 2009, after the new Burundian legislature was introduced criminalizing homosexuality, Ardho reported that it intended closing its offices in Burundi's capital of Bujumbura because the new law may lead to arrest. [11]

There is a lack of information about MSM and HIV/AIDS. Georges Kanuma the head of a gay rights movement ARDHO, in Burundi (21 October 2008, PlusNews), stated that the general perception in Burundi is that HIV was a risk for men who sleep with women, not gay men. He was surprised to discover that water-based lubricants, and not petroleum jelly - which breaks down the latex that condoms are made from - should be used during anal sex to prevent HIV and other sexually transmitted infections (STIs). According to Kanuma because of the local perceptions of homosexuality, the distribution of lubricants and condoms has to be cloak-and-

dagger, with many secretly homosexual men asking for the items to be despatched in plain envelopes to offices or residences, by people not associated with ARDHO.

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

In Burundi, homosexual actions between men or women are now considered illegal with proposals (2008) to increase these sanctions.

A 2009 act (Article 567 of new Penal Code) to make same-sex sexual activities illegal will make it difficult to offer targeted health-care to MSM. In 2009, although Burundi's Senate voted against the draft bill in February, the lower parliament house reversed the decision and President Pierre Nkurunziza signed the bill into law on April 22. According to the new statute, people found guilty of engaging in consensual same-sex relations could face two to three years in prison and a fine of about \$84. [11]

Over 60 African and international human rights organisations deplored the Burundian government's decision to criminalise homosexuality demanding that it be reversed immediately.

This after Burundian President Pierre Nkurunziza secretly signed a legislation criminalising homosexual conduct on 22 April 2009 despite an overwhelming rejection of such law by the Senate who voted against it in February. The new legislation makes sexual relations between persons of the same sex punishable by a prison sentence [11]

#### 9. Any action under way to change legal status of homosexuality

Laws against homosexuality have strengthened in Burundi. Burundi, has enacted legislation criminalising same-sex marriage, though little or no advocacy to promote such marriages has taken place. These laws appear to be emerging in response to an increasingly visible, outspoken, and organised sexual rights movement. New legislation, promulgated in 2009 in Burundi by President Nkurunziza, outlaws homosexuality. A staff reporter of Afrol News (2010) reported that the parliament of Burundi passed a law, making same-sex acts punishable by between three months and two years in prison, along with a substantial fine. Furthermore, that two-thirds of African nations maintain criminal penalties for consensual same-sex behaviour. [20]

A human rights group urged Burundi to reverse a law that makes homosexuality illegal, saying it risks worsening the harsh treatment of gays in the eastern Africa nation. The new law makes "sexual relations with persons of the same sex" illegal and punishable by up to two years in prison, Human Rights Watch said in a recently released report. [3]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

The lead organisations active in Burundi that addresses MSM issues is HUMURE (previously called Association pour le Respect et les Droits des Homosexuels'(ARDHO)) Humure is an LGBT organization dealing with HIV/Aids prevention in Burundi; it works mainly with NGOs fighting against HIV/ Aids. The Conseil National de lutte contre le SIDA (CNLS) is the national council fighting against Aids in Burundi.

#### 11. HIV prevalence/incidence data for MSM and general population

In July, a situational analysis on the needs of the LGBT community was started. This research,

funded by the King Baudouin Foundation of Belgium and the National Council against AIDS, will determine the needs of the LGBTI community in terms of health (HIV / AIDS in particular). Very little is currently known about the MSM let alone those living with HIV/Aids.

Burundi has a population of over 7 million inhabitants, 47% of whom are under 15. The HIV/AIDS prevalence is estimated at 3.4%, placing Burundi in 5th position among the most affected African countries. Officials announced that HIV infection had risen from 3.5 percent in 2002 to 4.2 percent in 2008. (<http://www.plusnews.org/>)

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

Recent act (Article 567 of new Penal Code) to make same-sex sexual activities illegal make it difficult to offer targeted health-care to MSM.

There exists a lack of information about MSM and HIV/AIDS, and general perception in Burundi is that HIV was a risk for men who sleep with women, not gay men. MSM are very secretive and some are involved in sex work. [8]

#### 13. Current status of prevention, treatment and care for MSM

According to *IRIN/PlusNews*, Burundi's National Council for the Fight against AIDS CNLS in its most recent national strategic plan identifies MSM as vulnerable to HIV and acknowledges the need for prevention activities targeting this community. [9]

In 2007, the Association National pour le Soutien des Seropositifs (ANSS) –a Burundian organisation supporting people suffering from Aids – publicly offered to work with sexual minorities to tackle the taboo around homosexuality in relation to AIDS

The Association Nationale de soutien aux Seropositifs et Sideens [ANSS] helps ARDHO with lubricants and condoms from donors in France, so that ARDHO can deliver them to MSM. The ANSS was one of the first organisations which assisted HIV infected individuals in 1993 and they were also the first to include MSM in their projects. [9]

#### 14. MSM related UNGASS indicators

In 2008 Burundi did not report on any of the 5 UNGASS indicators relating to MSM.[10]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

The recent act (Article 567 of new Penal Code) which makes same-sex sexual activities illegal will make it difficult to offer targeted health-care to MSM. Burundi's National Association To Support HIV-Positive People, or ANSS, and the local rights group Ligue Itaka, in response to the law issued a statement describing the potential consequences of the statute, and urged the government to decriminalise homosexuality: "We regret that the law will hamper Burundi's attempts to fight AIDS by further marginalizing an at-risk population" [9]

According to the new statute, people found guilty of engaging in consensual same-sex relations could face two to three years in prison and a fine of about \$84. [9]

#### 16. Whether and how MSM are included in National Strategic Plans

In the latest national strategic plan, CNLS included MSM in the list of people vulnerable to HIV.

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Following a period of civil war, Burundi's health system was destroyed and has subsequently faced severe economic constraints, creating an unreliable public health system. GHI activities in Burundi started in 2002, initially relying on NGOs and CSOs. In 2004, under pressure from UNAIDS and the WHO, a separate Ministry for AIDS (MoA) was launched. The MoA was directly linked to the presidency, to ensure political visibility in the fight against AIDS and to direct multisectoral interventions. The MoA was transformed in 2007 into a vice-ministry of the MoH in an attempt to integrate activities into the MoH, though a new separation from the MoH occurred in January 2009 for political reasons. The National AIDS Council (NAC) was created in 2002 following World Bank guidelines, to manage HIV-related funds and coordinate multi-sectoral HIV activities. As a result, each national ministry has an HIV unit that is in charge of HIV-related activities. [5]

In 1999, the President declared that HIV/AIDS was a national emergency and committed to addressing the epidemic as a national priority. A National AIDS Control Committee was created in 2001 to provide strategic direction to the country's response to the HIV/AIDS epidemic and to support the government in implementing HIV/AIDS control programmes.

Burundi has been successful in implementing a home-based treatment and care programme that has moved the management of HIV treatment, care and support activities closer to affected communities, with the involvement of people living with HIV/AIDS and a strong and active network of nongovernmental organisations. This has played an important role in strengthening community participation, increasing the number of people accessing treatment services, facilitating the monitoring of people receiving treatment and adherence to treatment and reducing stigma and discrimination. The coverage of voluntary counseling and testing services has increased steadily in the past few years. [5]

As pertains specifically to MSM, the Association pour le Respect et les Droits des Homosexuels (ARDHO) created brochures detailing all the means of transmitting HIV, including male-male sex, for distribution in mainstream health centres; ANSS planed to send a doctor outside of Burundi for special training in the health issues of MSM to provide them with better healthcare. Although progress is slow, ARDHO and its partners were unwilling to push the government too hard, preferring to negotiate from a public health platform before demanding for equality under the law. George Kanuma said. HIV prevalence in Burundi has been declining since the late 1990s, but many surveillance sites have recently indicated an upward trend; in May, officials announced that HIV infection had risen from 3.5 percent in 2002 to 4.2 percent in 2008. [4]

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## **Comoros [Federal Islamic Republic]**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Comoros is not gay intolerant, but this is a nation where gayness is not discussed. Only one reference to same sex couples is provided in the supporting documentation. [8] Comoros is not a socially liberal country.

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Anecdotal information indicates that gay bars where MSM meet, exist.[11] The internet is another source of socialising and networking.

3. Presence of an organized LGBT or MSM community

No reference is provided as to the presence of an organized LGBT or MSM community [11]

4. What is known about stigma and discrimination of male same-sex sexuality

The ILGA World Legal Survey states that there is no mention of homosexual activities in the penal codes of the Comoros, which is based on the Civil Law and Islamic Shariah legislation. Adultery (fornication) is prohibited, so there may be a ban on sexual activities between members of the same sex.

The Reunion Island is a French territory and is thus under French law. Homosexuality is legal. There are occasionally gay nights at clubs. Gay couples live together, yet despite this, the general attitude of the Reunionnais towards homosexuality is reported to be hostile. If a Reunionnais acknowledges homosexuality, they regard it as an export from mainland France. Homosexuality is considered the Westerner's disease. [8]

5. What is known about social position and needs of MSM living with HIV/AIDS

No information is provided. There is a lack of information on the composition of the social group of men who have sex with other men (MSM).

6. Any on-going activities to counteract stigma and discrimination?

No information is provided

7. Existence of homosexuality-related barriers to health care

Homosexuality is not a matter of public discussion, and the legal status of homosexuality does not state much about the status of homosexuals. Taboos in the general public are far more relevant and individual awareness of homosexuality can be low. [1]

8. Legal situation regarding same-sex sexuality plus extent of enforcement

Lesbian, gay, bisexual, and transgender (LGBT) persons in Comoros experience legal issues not experienced by non-LGBT citizens. Homosexual acts are not specifically outlawed, but Comoros does have laws applying to acts considered against nature. According to the

International Lesbian and Gay Association's May 2008 report, "impudent acts against the nature" are illegal in Comoros according to article 318 of the Penal Code. Such acts were punished with up to five years imprisonment and a fine of 50,000 to 1,000,000 francs. There is no recognition of legal rights for same-sex couples. There is no legal protection against discrimination based on sexual orientation.

Both male and female sexual acts are illegal in Comoros. Such acts were punished with up to five years imprisonment and a fine of 50,000 to 1,000,000 francs [11]

9. Any action under way to change legal status of homosexuality

No information provided.

10. Any human rights based organizations active in this country that does or should address MSM issues?

No information provided

11. HIV prevalence/incidence data for MSM and general population

Research suggests that the main mode of HIV transmission is heterosexual.

12. Is there understanding of specific risk factors for HIV transmission in MSM

The World Bank in a 1994 report pointed out the "high prevalence of sexually transmitted diseases and the low use of condoms" as a significant health threat with regard to the spread of acquired immune deficiency syndrome (AIDS), which already affected the islands. However, in the period prior to 1990 and extending through 1992, the WHO reported that Comoros had a very low incidence of AIDS--a total of three cases with no case reported in 1992, or an overall case rate of 0.1 per 100,000 population. [10]

13. Current status of prevention, treatment and care for MSM

The country has developed a national multicultural strategy / action plan to combat AIDS for the period 2008-2012. Target populations include incarcerated men but not MSM as such. Statistics suggest a prison rate of 30 incarcerated people per 100,000 person (UN). The policy is also concerned with sex workers. [8]

The country is reported as having a very low HIV prevalence. Comoros is USAID-assisted, and UNAIDS has been sharply critical of Comoros' HIV response [8]

14. MSM related UNGASS indicators

In 2008 Comoros did not report on any of the 5 UNGASS indicators relating to MSM. [8]

15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Reunion Island is a French territory and is thus under French law. Homosexuality is legal. There are male/male personals in the Island paper. There are even occasionally gay nights at clubs.

Yet, in spite of these facts, anecdotal information advises that the general attitude of the Reunionnais towards homosexuality is very hostile. If a Reunionnais acknowledges homosexuality at all, they regard it as an export from mainland France. That it is the Westerner's disease and no genuine Creole could possibly catch it. Thus, though there is a small existent gay life, to come out would cut one out of Reunionnais life. You would bring incessant perplexity to people, and in return would receive a good dose of ill-regard. For such a small island, to come out to one person means coming out to everyone. There is no place to escape to if things. [8]

## 16. Whether and how MSM are included in National Strategic Plans

MSM is not specifically included in National Strategic Plans however, in 2005 the Indian Ocean Commission (IOC) launched a regional HIV project; the «AIRIS-COI» project (Appui à l'Initiative Regionale de prevention IST/Sida). The project, which includes a large section for Monitoring and Evaluation, is mainly funded by the African Development Bank (ADB) to support Mauritius, Comoros, Seychelles and la Reunion in their response to HIV and AIDS. UNAIDS has signed a protocol with IOC to support the M&E aspects of "AIRIS-COI" and has held discussions and provided revisions to the Terms of Reference for the Observatory.

Consultations with all countries have shown that regional support in epidemiology and M&E is needed. The Indian Ocean states have either a low HIV prevalence or a small population. They cannot afford to address M&E issues individually due to lack of resources or lack of capacities. The Observatory has yet to be launched; however, it is being proposed as valuable support and in some cases an alternative to existing national systems.

After consultation with all partners it has been agreed that the Observatory should have two main roles:

1 Provide ongoing technical support to member states for the development and strengthening of their epidemiological surveillance and M&E systems, including;

- Upgrade the biological and behavioral HIV and STI surveillance system; the observatory will support the national HIV and AIDS M&E Units and Ministries of Health in selecting the groups that will be included in their sentinel surveillance system, in developing protocols, sampling and methodology. As the epidemic in the region is either low prevalence or concentrated, special attention will be given to surveillance among Injecting Drug Users (IDU), Sex-Workers (SW) and Men having Sex with Men (MSM). Technical assistance will be extended to data collection, data analysis and report writing. Financial support from the ADB may also be available for the implementation of surveys.
- Data from the health care systems will be collected at the national and regional level using standard methods and formats. The data will complete the surveillance system in determining the epidemiological profile of each country. WHO will be closely associated with all activities to guarantee the utilization of international standards and best practices.
- Already initiated by UNAIDS since 2007, the Observatory will pursue the Strengthening of national M&E systems for improved monitoring of the national response; The guidelines on "eleven components for a fully functional M&E system" may be used in this regard. Harmonization of frameworks and methods will be sought to allow regional comparison and optimize sharing of tools.

- Capacity building of member states in M&E and in Epidemiology; the Observatory will recruit an epidemiologist and an M&E expert to provide permanent support, training and coaching to national teams. [7]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Comoros is USAID-assisted, and UNAIDS has been sharply critical of Comoros' HIV response [8]

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## **Djibouti**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

The laws regarding homosexuality in Djibouti are vague and can sometimes be confusing, but it is generally understood that homosexuality is de facto illegal. Most people interpret the Constitution of Djibouti as decriminalizing homosexuality, but the government tends to adhere to Islamic law more than constitutional law, rendering homosexuality illegal. Because of a largely homophobic Muslim majority, homosexuals are not able to have much in way of a social life. If homosexuals in Djibouti wish to pursue their orientation, they must do it in secret, to avoid oppression from the government or people in general. [8]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Because of a largely homophobic Muslim majority, homosexuals are not able to have much in way of a social life. If homosexuals in Djibouti wish to pursue their orientation, they must do it in secret, to avoid oppression from the government, or people in general.[3]

Most people interpret the Constitution of Djibouti as decriminalizing homosexuality, but the government tends to adhere to Islamic law more than constitutional law, rendering homosexuality illegal. As such, MSM culture and meeting places are not visible in society. [3]

3. Presence of an organized LGBT or MSM community

Anecdotal evidence from a homosexual man from Djibouti states that although there are many gay and lesbian persons living in Djibouti, they live "undercover, unconfident and in fear". The man also notes that there is no organization in Djibouti to support the rights of gays and lesbians in the country.[4]

Homosexuality is illegal in Djibouti. In an 18 October 2004 article, Behind the Mask (BTM), "a non-profit media organisation publishing a news website intended for gay and lesbian affairs in Africa" indicates that public attitudes and laws concerning homosexuality in Djibouti are "far from liberal" and that this is perhaps as a result of the influence of Islamic law in the country (18 Oct. 2004). Cited in the article, a homosexual man from Djibouti states that although there are many gay and lesbian persons living in Djibouti, they live "undercover, unconfident and in fear". The man also notes that there is no organization in Djibouti to support the rights of gays and lesbians in the country. [4]

4. What is known about stigma and discrimination of male same-sex sexuality

Society is largely homophobic Muslim majority which does not permit homosexuality.

5. What is known about social position and needs of MSM living with HIV/AIDS

Because of a largely homophobic Muslim majority, homosexuals pursue their orientation in secret to avoid oppression from the government or people in general. [8]

6. Any on-going activities to counteract stigma and discrimination?

No information provided

## 7. Existence of homosexuality-related barriers to health care

No specific information provided is provided, however it is inferred that the persistent homophobic attitudes towards members of the homosexual community jeopardise efforts undertaken to combat HIV, both within this group and across the population as a whole. The clandestine existence that gay communities are forced to hide away in exposes them not just to the risk of HIV, but the rest of the population too: because they are unable to live openly as gay men, many MSMs also have sexual relations with women, or are even married, activists have highlighted. [1]

## 8. Legal situation regarding same-sex sexuality plus extent of enforcement

The laws regarding homosexuality in Djibouti are vague and can sometimes be confusing, but it is generally understood that homosexuality is de facto illegal, and that the government supports Islamic law. As such, MSM are secretive about their activities and there are no MSM meeting places. [8]

The relevant articles of the Penal Code of 1995 are articles 347 – 352 criminalizing “impudency acts” (un acte impudique) under the crimes section of “L’attentat a la pudeur”.

## 9. Any action under way to change legal status of homosexuality

No information provided

## 10. Any human rights based organizations active in this country that does or should address MSM issues?

Eight resident agencies (including the UNCT) constitute the UN System in Djibouti. [8]

## 11. HIV prevalence/incidence data for MSM and general population

No specific data provided as of HIV prevalence/incidence data for MSM. However, in terms of the general population, Djibouti has one of the highest HIV/AIDS rates in the world among young adults, with numbers steadily rising. According to UN estimates, some 14 percent of Djiboutian women in the age group 15 to 24 are HIV infected. [5]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

Information regarding specific risk factors for HIV transmission in MSM is not available.

According to the WHO, the primary mode of HIV transmission is through heterosexual contact. In addition to youth and women, other vulnerable groups are men in uniforms, sex workers, dockworkers and truck drivers. The country also hosts a significant number of foreign military bases and refugees. [1]

Research suggests that the rate of infection is exacerbated by “rapid urbanisation, and large population movements from trade, migrants and refugees... low literacy, the presence of military bases and a major trade corridor with Ethiopia, an active sex trade, low age of sexual debut among young men and teenage boys, and extensive use of *khat* by men” [1]

## 13. Current status of prevention, treatment and care for MSM



The country has received numerous grants from the World Bank for its HIV/Aids, Malaria and Tuberculosis response. [5]

#### 14. MSM related UNGASS indicators

In 2008 the country did not report on any of the 5 UNGASS indicators relating to MSM and it's government's human rights record is poor. [5]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

There is a lack of information about MSM as homosexuality is stigmatized by society and not discussed openly.

The persistent homophobia towards members of the gay community jeopardise efforts undertaken to combat HIV, both within this group and across the population as a whole. The clandestine existence that gay communities are forced to hide away in exposes them not just to the risk of HIV, but the rest of the population too: because they are unable to live openly as gay men, many MSMs also have sexual relations with women, or are even married, activists have highlighted. [6]

#### 16. Whether and how MSM are included in National Strategic Plans

The Djiboutian government is setting up and implementing a response against HIV/AIDS, sexually transmitted infections, malaria and tuberculosis, of which the latter two are important cofactors to HIV risk. Djibouti has one of the highest HIV/AIDS rates in the world among young adults, with numbers steadily rising. According to UN estimates, some 14 percent of Djiboutian women in the age group 15 to 24 are HIV infected. The new government project is to address this situation by supporting the implementation of Djibouti's HIV/AIDS National Strategic Plan, the National Malaria Strategic Plan, and the National Tuberculosis Strategic Plan through a wide variety of public sector agencies, private and non-governmental organizations, and community-based organisations. The programme also is to do so through a so-called "multisectoral approach," including prevention of the spread of HIV/AIDS by reducing transmission, in particular among high-risk groups; expanding access to treatment of opportunistic illnesses, malaria, and tuberculosis, providing care, support, and treatment of those inflicted with the diseases; and supporting multisectoral, civil society, and community initiatives for HIV/AIDS prevention and care, and malaria and tuberculosis prevention. The project is also to include four major components including capacity building and policy development; public health sector responses to HIV/AIDS management including prevention, treatment, and care of sexually transmitted infections and tuberculosis, and prevention, control and treatment of malaria; multisectoral response to HIV/AIDS prevention and care; and support to community-based initiatives for the three diseases. These activities are to "take into account the existing conditions and Djibouti's capacity both at the central and the district levels, recognising that at present capacity is weak at both levels," the project description says. The World Bank approved a US\$ 12 million grant to help the Djiboutian government implement the ambitious programme. [6]

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Across Djibouti, and particularly outside the capital, access to health care is limited by poor facilities and a lack of available equipment and supplies. There is a shortage of trained personnel - especially in remote facilities. Chronic shortages of medicines and medical supplies and poor management renders the health care system unable to provide quality care to a population which suffers from the world's second highest rate of tuberculosis, chronic and debilitating malnutrition and a burgeoning rate of HIV/AIDS infection. [7]

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## **Eritrea / State of Eritrea (Hagere Ertra)**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Little is known about how male same-sex sexuality is organized and expressed on an individual level in Eritrea. Little is known about the practical use of this law as the state-controlled Eritrean press does not report about homosexuality at all. But according to a report from the British Embassy in Asmara, people who participate in "such an act are prosecuted and punished whenever found guilty." In 2004, authorities reportedly expelled a number of foreigners from Eritrea on the basis of their sexual orientation. [9]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Little is known about gay culture in Eritrea. There is no protection against discrimination based on sexual orientation. Same-sex couples have no legal recognition. It is reported that MSM have been arrested and detained. [9]

3. Presence of an organized LGBT or MSM community

No evidence is provided about organized LGBT or MSM community. Constitutionally homosexuality is legalized, but gay civilians and military are either in prisons or can be executed.

Anecdotal information relates that in 2006 when one homosexual sought to establish a legal association but was promptly turned down by the government. Afterwards, NGO officials say the individual had to leave the country due to harassment. [3]

4. What is known about stigma and discrimination of male same-sex sexuality

Stigma and discrimination is rife in Eritrea. There is no protection against discrimination based on sexual orientation. Same-sex couples have no legal recognition. MSM have been arrested and detained. Homosexuality is considered of western origin, and not tolerated in Eritrean society. [8] The Minister of Justice is reported to have said that homosexuals do not exist in Eritrea and that's why homosexuality is legal. "That means, still we have a responsibility to defend our people from this kind of cultural aggression from Europe." [8]

With respect to the treatment of homosexuals, the United States Department of State notes that homosexual persons in Eritrea experience "severe" discrimination by society and that in 2004, the government reportedly expelled a number of foreigners from Eritrea on the basis of their sexual orientation. In a September 2005 correspondence with the UK Home Office, the Foreign and Commonwealth Office (FCO) also reported that homosexual persons were "dealt with severely" in Eritrea and expresses the opinion that anyone whose sexuality had previously come to the attention of the Eritrean authorities could face problems in trying to re-enter the country and would be "ear-marked" [7]

5. What is known about social position and needs of MSM living with HIV/AIDS.

Islamic law in this country prohibits homosexuality and therefore, little is known about the MSM community and especially those living with HIV/AIDS.

According to anecdotal information, apart from tight government restrictions, social stigma has driven homosexuals into virtual hiding. For fear of arrest and humiliation, members usually switch from place to place and avoid revealing their identity at all costs. [3]

#### 6. Any on-going activities to counteract stigma and discrimination?

According to the Canadian rights activist, the criminalisation of consensual homosexual acts was a threat to public health as it “frustrated creating access to HIV prevention and awareness programmes for men who had sex with men.” Moreover, it was contrary to international law, human rights and “likely to exacerbate incidents of harassment, abuse, arbitrary arrests and unlawful detentions.” [8]

#### 7. Existence of homosexuality-related barriers to health care

No specific information provided is provided, however it is inferred that the persistent homophobic attitudes towards members of the homosexual community jeopardise efforts undertaken to combat HIV, both within this group and across the population as a whole. The clandestine existence that gay communities are forced to hide away in exposes them not just to the risk of HIV, but the rest of the population too: because they are unable to live openly as gay men, many MSMs also have sexual relations with women, or are even married, activists have highlighted. [1]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Same-sex sexual activity: Unclear. However, most sources say it is illegal;

According to Wikipedia, Lesbian, gay, bisexual, and transgender (LGBT) persons in Eritrea face legal risks not experienced by non-LGBT citizens. Homosexual acts are illegal in Eritrea, punishable by up to 3 years in prison. Same-sex sexual activity is prohibited in Section II of the penal code from 1960. Article 600 "unnatural carnal offences" can be punished for internment for between 10 days and 3 years. Same-sex couples have no legal recognition. Although homosexuality is considered a crime, child adoptions have been legalized in 2003. There is no protection against discrimination based on sexual orientation. [17]

Little is known about the practical use of this law as the state-controlled Eritrean press does not report about homosexuality at all. But, according to a report from the British Embassy in Asmara, people who participate in “such acts, are prosecuted and punished whenever found guilty.” In 2004, authorities reportedly expelled a number of foreigners from Eritrea on the basis of their sexual orientation. [4]

Ironically, the Constitution contains broad equality provisions. It also stipulates that every citizen has the right to equal access to publicly funded social services. [4]

#### 9. Any action under way to change legal status of homosexuality

Anecdotal information reports that there are calls for more stringent rules against the homosexual community whose exact size is impossible to determine due to fears of repression. Recently, the heads of the Orthodox, Protestant and Catholic churches, as well as Islam, adopted a resolution urging lawmakers to amend the constitution to ban the sexual orientation, which they termed a “pinnacle of immorality”. Ethiopian culture is heavily influenced by Paolos’ state-backed church, which urges conservative sexual practices. The taboo is so extreme that

even an association that works to help male sexual assault victims has been a victim of prejudice. [3]

Eritrean government officials in 2010, for the first time answered to rights activists' questions about the country's tough anti-homosexuality laws. Legalisation was out of question, the official said. At a recent UN review of the human rights situation in Eritrea, Rowland Jide Macaulay of the Canadian HIV AIDS Legal Network challenged the Eritrean government to "repeal all legislative provisions which criminalise sexual activity between consenting adults of the same sex." According to the Canadian rights activist, the criminalisation of consensual homosexual acts was a threat to public health as it "frustrated creating access to HIV prevention and awareness programmes for men who had sex with men." Moreover, it was contrary to international law, human rights and "likely to exacerbate incidents of harassment, abuse, arbitrary arrests and unlawful detentions." According to Girmai Abraham of the Eritrean Ministry of National Development, the Eritrean government rejected the demand to legalise same-sex activity between consenting adults, which was "in direct contradiction with the values and traditions of the Eritrean people."

10. Any human rights based organizations active in this country that does or should address MSM issues?

A few organizations are active working with addressing HIV AIDS though not in specific MSM issues, such as Eritrean faith-based and community organizations and the Norwegian Church Aid-Eritrea (NCA-E) which is the Eritrea Country Office of the Norwegian NGO, Norwegian Church Aid (NCA) and started work in Eritrea in the 1970s. International organizations such as USAID, the World Health Organisations and others are also operational in Eritrea.

General human rights issues are monitored by organizations such as Human Rights Watch (HRW), who have reported in 2009 that Eritrea is becoming a "giant prison" due to its government's policies of mass detention, torture and prolonged military conscription, according to a report published Human Rights Watch (HRW) said state repression had made the tiny Red Sea state one of the highest producers of refugees in the world, with those fleeing risking death or collective punishment against their families. There is no freedom of speech, worship or movement in Eritrea, while many adults are forced into national service at token wages until up to 55 years of age. [13]

11. HIV prevalence/incidence data for MSM and general population

Recent studies into HIV/AIDS in Eritrea have shown a steady increase in cases within certain sections of the population. While figures compiled since 1997 indicate that HIV prevalence in the adult population is around 3 percent, a recent survey of the army revealed that 4.6 percent of soldiers were HIV-positive. The same study showed an HIV prevalence of 22.8 percent among female bar workers. Since the first AIDS case in Eritrea was reported in 1988, the progress of the disease has been rapid. By 2001, more than 13,000 people had been registered as infected. About 2,500 of these cases were reported in 2001 alone. Other statistics also demonstrate how quickly the pandemic has expanded. In 1996, AIDS was claimed to be the 10th highest cause of death in Eritrean hospitals. By last year it was the second leading cause of death among patients over five years of age. [16]

12. Is there understanding of specific risk factors for HIV transmission in MSM

The government refuses to acknowledge that homosexual communities exist in Eritrea. Treaty bodies have repeatedly affirmed that laws criminalising homosexuality violate international rights to privacy and non-discrimination. As the High Commissioner for Human Rights Navi Pillay has also emphasized, “there remain all too many countries which continue to criminalize sexual relations between consenting adults of the same sex in defiance of established human rights law.” A resolution unanimously adopted at the NGO Forum to the African Commission on Human and Peoples’ Rights in November 2009 urges States to “comply with the African Charter on Human and Peoples’ Rights by repealing laws which criminalize sexual conduct between consenting adults of the same sex”. The current law is likely to exacerbate incidents of harassment, abuse, arbitrary arrests and unlawful detentions of homosexual people. As UNAIDS has noted, such laws also pose a threat to public health as they frustrate the important work of creating access to HIV prevention and awareness programmes for men who have sex with men. [15]

### 13. Current status of prevention, treatment and care for MSM

In 2004 the WHO estimated that there were only 3 physicians per 100,000 people. Eritrea has a national multicultural strategy/action framework to combat AIDS managed by a National AIDS Council in the Ministry of Health. This does not include MSM. [9]

As part of the country’s communication policy, HIV campaigns promote messages such as: Be sexually abstinent; Delay sexual debut; Be faithful; Use condoms consistently; Avoid commercial sex; Know your HIV status. HIV education is also part of the school curriculum (primary and secondary) and part of teacher training. The country also claims to offer targeted information on HIV risk reduction and HIV education to sex workers and prison inmates. It also engages in stigma and discrimination reduction, condom promotion, and HIV testing and counseling, amongst sex workers and inmates. These vulnerable sub-population groups, as well as women, young people and migrants, appear to be legally protected from discrimination. MSM are not listed as a target population. [9]

USAID assisted Eritrea with its national HIV/Aids behaviour change communications strategy called —Winning Through Caring. Since 1997, USAID/Eritrea has assisted the Eritrean Social Marketing Group (ESMG) with its national prevention condom social marketing program. The ESGM was permitted to distribute condoms outside of pharmacies.[12]

There are no laws or regulations protecting those who are infected and affected by HIV infection. There is however a People Living with HIV Association set up by the government, which is making an effort to address stigma and discrimination informally. The Ministry of Justice is not yet involved in the response to HIV. Treatment and care of HIV positive people started in August 2005 and over 1,200 people are receiving antiretroviral drugs. [12]

AIDS prevention efforts are critical in Eritrea. It is estimated that around 3% of the population (100,000 people out of 3.5 million) is HIV positive. Although this may seem low compared to other countries in Africa, the AIDS prevalence rate is on the rise and could face a major increase when the lingering border dispute with Ethiopia comes to an end. Apart from the 250,000-strong army (4.6% HIV prevalence in 2001), Eritrea’s AIDS prevention activities target other vulnerable groups such as commercial sex workers. In Asmara, 22 peer support groups (20 people each) have been set up to perform home based care and support for people living with HIV/AIDS. They meet on a weekly basis to help and train each other on prevention methods such as male and female condom use. Their video and training equipment have been procured through the Ministry of Labour and Human Welfare with Global Fund support. Two thousand truck drivers have also taken part in weekly training sessions on HIV, malaria and

tuberculosis provided by the National Confederation of Eritrean Workers. [14]

#### 14. MSM related UNGASS indicators

In terms of the UNGASS indicators, Eritrea did not report, in 2008, on any of the 5 UNGASS indicators relating to MSM. As such it did not report on: HIV seroprevalence among MSM; HIV testing among MSM; level of understanding among MSM of HIV prevention and transmission; condom use among MSM; or how many MSM are being reached by HIV prevention programmes. [9]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Religious and cultural barriers and persistent homophobic attitudes towards members of the homosexual community jeopardise any efforts undertaken to combat HIV, both within this group and across the population as a whole.

In its application to the Global Fund Round 8 Funding, Eritrea indicates that women are subjected to gender-based violence and discrimination. It acknowledges that sexual violence against women is grossly underreported. It also indicates that women are keeping away from VCT centres due to lack of confidentiality. One can only but imagine how difficult it must be to be MSM in this country. [12]

#### 16. Whether and how MSM are included in National Strategic Plans

The HIV/AIDS epidemic has been unfolding in the midst of a post conflict and apparently a no peace no war situation with thousands still internally displaced or just returning to their home villages. These are some of the factors that contribute to the spread of HIV/AIDS as well as the challenge the nation's capacity to mount an effective response to prevent its spread. This complex challenge of the nature of the HIV/AIDS has called for a multifaceted response to ensure that emergency action is undertaken as well as sustainable measures instituted to deal with long-term effects. Aware of the problem and the economic impact of HIV/AIDS, through a long consultative process, Eritrea has developed a National Strategic Plan (NSP) to respond to the HIV/AIDS situation in the country. United Nations Development Programme[14]

Eritrea developed its first five-year plan for HIV/AIDS control in 1997. The USAID-sponsored HIV prevention condom social marketing program began sales in 1998. In 2001, Eritrea signed a \$40 million credit agreement with the World Bank to establish the HIV/AIDS, Malaria, Sexually Transmitted Infections and Tuberculosis project (HAMSET). The HAMSET Project was launched by President Isaias when he spoke to the nation for the first time about the threat of HIV. The HAMSET Project finances an integrated and multisectoral approach to the control of HAMSET diseases. It has already financed the construction of a new national blood bank in Asmara. In addition, it supports voluntary counseling and testing for HIV in 20 hospitals around the country. Development of a life-skills curriculum for schools that will include HIV/AIDS education is also planned. Several smaller projects have been developed to assist the growing number of Eritreans living with HIV/AIDS and to prevent the further spread of the disease. For example, Norwegian Church Aid supports a program of the Eritrean Evangelical Church to help women get out of prostitution. In cooperation with the United Nations Population Fund and the Danish Embassy, the Eritrean Ministry of Health encourages community care and support for people living with HIV/AIDS. Implemented by Eritrean faith-based and community organizations, the Community-Based HIV/AIDS Care and Support, Mobilizing the Civil Society of Eritrea

Project, will provide basic nursing training to volunteers so they may offer homecare services to people living with AIDS. In 2001, a group of men and women living with HIV/AIDS formed Bidho (Challenge), the first Eritrean association of people living with and most affected by HIV/AIDS. The organization conducts workshops, training courses, and support groups to educate people about HIV/AIDS. It also plans to set up an HIV/AIDS information hotline. The Eritrean government and nongovernmental organizations are using innovative methods to reach the population with HIV prevention messages, such as involving well-known sports and entertainment personalities in television and radio campaigns; developing nationwide poster campaigns; implementing educational projects in schools, youth clubs, and camps for internally displaced people; and social marketing of condoms (which are readily available nationwide). The MoH is working to improve medical treatment for people living with HIV/AIDS. A pilot program to introduce antiretroviral drugs for the prevention of mother-to-child transmission of HIV will begin implementation in 2003. [16]

Though MSM are not listed as a target population, Eritrea has a national multicultural strategy/action framework to combat AIDS managed by a National AIDS Council in the Ministry of Health. This does not include MSM. As part of the country's communication policy, HIV campaigns promote messages such as: Be sexually abstinent; Delay sexual debut; Be faithful; Use condoms consistently; Avoid commercial sex; Know your HIV status. HIV education is also part of the school curriculum (primary and secondary) and part of teacher training. The country also claims to offer targeted information on HIV risk reduction and HIV education to sex workers and prison inmates. It also engages in stigma and discrimination reduction, condom promotion, and HIV testing and counselling, amongst sex workers and inmates. These vulnerable sub-population groups, as well as women, young people and migrants, appear to be legally protected from discrimination. [9]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

The internet suggests that the UN is active in Eritrea. USAID assisted Eritrea with its national HIV/Aids behaviour change communications strategy called "Winning Through Caring". USAID also assisted with programs aimed at the needs of *women* who engage in sex work. Since 1997, USAID/Eritrea has assisted the Eritrean Social Marketing Group (ESMG) with its national prevention condom social marketing program. The ESGM was permitted to distribute condoms outside of pharmacies. The country has access to regional procurement and supply management mechanisms for antiretroviral drugs, condoms and opportunistic infections. Research also suggests that preventive efforts by the military are also important and needed. [9]

According to UNAIDS, the Armed forces can play a vital role in fighting the spread of HIV. The first large-scale response to U.N. Security Council resolution 1308 was passed in July 2000, which called for member states to address HIV/AIDS in peacekeeping missions.

Dominique Mathiot, UNAIDS country coordinator of Eritrea, said that the military personnel are two to five times more likely to contract STDs than the general population, a factor that can increase during times of conflict. A UNAIDS report entitled "Fighting AIDS: HIV/AIDS Prevention and Care Among Armed Forces and U.N. Peacekeepers in Eritrea," features a case study on the efforts of the Eritrean Defense Force and the U.N. Mission to Ethiopia and Eritrea, the peacekeeping mission (*Panafrican News Agency*, 9/26). The UNMEE, working closely with the EDF, provided HIV prevention training to some soldiers, who then trained their peers. The initiative also included youth, hotel staff and commercial sex workers. The report found that if



equipped with the right information, knowledge and tools, the military can achieve lower HIV prevalence rates than the national average. [6]

Workplace based HIV/AIDS policy and programs that address HIV/AIDS in the workplace are also being upgraded/developed. The Community Capacity Enhancement Process, which is part of the UN contribution to the national response, facilitates social mobilization and strengthen the capacity of workers with special emphasis on gender to enable them effectively and actively participate in the reflection, participatory planning, implementation and monitoring of decentralized plans.

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## **Ethiopia / Federal Democratic Republic of Ethiopia**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

According to ETHIOGLBTI, a gay rights group in Ethiopia, homosexuality is perceived as taboo and nonexistent in that country and many homosexuals are still in the closet. [3] Under Ethiopian law, homosexual activity is punishable by up to 5 years imprisonment. A homosexual act is never considered a victimless crime in Ethiopian law; rather, the wording of the penal code recognizes that it is an act of an aggressor against a victim. [4]

Anecdotal stories suggest that MSM have their own code languages and symbols to help them recognize each other; there are also (secretive) places where they can meet. There are transgender men and research has explored cosmetics and dressing and behaving like 'women' among male sex workers in Addis Ababa. [15]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Religious and tribal taboos urge conservative sexual practices. Even an association that works to help male sexual assault victims has been victim to prejudice. Apart from tight government restrictions, social stigma has driven homosexuals into virtual hiding. For fear of arrest and humiliation, members usually switch from place to place and avoid revealing their identity at all costs. As such, they have developed an elaborate way of distinguishing and communicating with each other. [5] Anecdotal information indicates that although there are many gay and lesbian persons living in Ethiopia, they live undercover, unconfident and in fear. MSM have their own code languages and symbols to help them recognize each other; there are also secretive places where they can meet. A report in Global Gays states that there are plenty of gay people in and outside of Addis, especially around Piazza, Arat Kilo, Ambassador Theatre house, in province Bahar Dar, Awasa, Nazareth, Dera Dawa, there are many places that you find gay people. [15]

The GayEthiopians.com Web site, which was created by gay Ethiopians in Ethiopia and elsewhere, aims to bring together GLBT Ethiopians from all over the world to create a safe haven where they can find information on various issues that concern them. The Web site indicates that in Ethiopia, "[the] sexual orientation [of gay Ethiopians] is deprived of an honest recognition and acceptance. [Ethiopian] society hides behind long-established traditional beliefs.... At times, the situation may appear to be getting better, but the fact remains that gay rights and other human rights in Ethiopia are still being blatantly abused. GayEthiopians.com describes LGBT Ethiopians as members of an oppressed minority group. An online discussion group for gay Ethiopians posts the following disclaimer on its home page: "Please do not post real names, phone numbers, gay spots or hangouts in Addis or other parts of Ethiopia..." [1]

3. Presence of an organized LGBT or MSM community

The Ethiopian gays, lesbians, bisexual & Trans gender committee were established in 2007 on the aim of demanding & safeguarding sexual freedom in Ethiopia. ETHIOGLBTI is an LGBT rights group in Ethiopia; they organize meetings of LGBT people and document any attacks or incidents of abuse against LGBTI people; they are attempting to counteract stigma and discrimination. [16]

Ethiopia voted against ILGA having consultative status at the UN in January and on April 30, 2002. Berhane Meskel Abebe, the Ethiopian representative on the UN Committee on Non-

Governmental Organisations, said his country voted against ILGA because it does not go with Ethiopian society's belief and general culture and practice. [13]

#### 4. What is known about stigma and discrimination of male same-sex sexuality

Religious and tribal taboos make homosexual life extremely difficult to live openly in Ethiopia. According to anecdotal information, even to mention your sexual orientation is feared. Religious laws encourage stigma and discrimination. Homophobia, stigma and discrimination against MSM prohibit living openly. Mainstream Ethiopian social mores are broadly influenced by the Ethiopian Orthodox Church and Muslim religious life. Homosexuals are known to have been lynched by locals, intolerant of the LGBT people. Many citizens in Ethiopia believe that there was no such thing as a naturally gay Ethiopian. The anti-gay laws are enforced and MSM can be imprisoned for up to ten years. MSM live in fear of arrest and humiliation. Parents are publicly warned about the “hazards” of homosexuality. [13]

Ethiopia's government banned same-sex relationship even between consensual same sex adult in the criminal and penal code of the country chapter 600/601 from 5-10 years hard imprisonment. Acts of homosexuality result in imprisonment with sever corporal punishment and torture. This in turn violate Ethiopia's own Constitution and the analogous provisions of the African Charter on Human and Peoples' Rights (i.e. articles 2, 3, 11, and 28) and the International Covenant on Civil and Political Rights (ICCPR) (i.e. articles 2, 18, 19, 21, 22, and 26). [17]

The legislators referred to homosexuality an affront to Christianity and Islam, as this sexual orientation does not conform to the ideology of ultraconservative Ethiopian society. Gays and lesbians of Ethiopia prefer to live secretly with lack of confidence and constant fear. [17] According to anecdotal information, Ethiopia has an ever growing gay and lesbian's population. Society is largely homophobic, and thinks of homosexuality as a western influence (foreign import) and inexcusable sin, and gays and lesbians of Ethiopia suffer under the government's hostility. [17] Stigma, violence, discrimination, hatred, disrespect, intimidation, abuse, harassment, negative attitude, economic deprivation social injustice, kangaroo court trial, extra-judicial killing and murder. [13] The refusal of the Ethiopian governments to address violence committed against LGBT people creates a culture of impunity where such abuses can continue and escalate unmitigated. Often, such abuses are committed by the state authorities themselves, with legal sanction. [17]

Human rights abuses based on sexual orientation in Ethiopia violates the fundamental tenets of international human rights law which is signed & ratified by the Ethiopian government; the infliction of torture and cruel inhuman and degrading treatment (Article 5); arbitrary detention on grounds of identity or beliefs (Article 9); the restriction of freedom of association (Article 20) and the denial of the basic rights of due process of law. [17].

In Ethiopia, if someone is discovered or even suspected to be gay, no one will shake his hand; they want you to be burned in the ever-lasting flame. Many gays and lesbians of Ethiopia have committed suicide and flee out of their country in response to this and they still fear for their lives back in Ethiopia. The Ethiopian gays, lesbians, bisexual and transgender community based human right organization is established in 2007 on the aim of engaging in the areas of advocacy, relief and development for the sexual minorities of Ethiopian and Ethiopian origin, demanding and safeguarding sexual freedom in Ethiopia. [17]

Many gay Ethiopians live abroad as a result of the repercussions that follow their sexual orientation becoming known. An article on the Behind the Mask Web site cautions that accepted expressions of heterosexual male camaraderie common in Ethiopia, such as men holding hands, should not be interpreted as societal tolerance for homosexual conduct (Behind the Mask 14 June 2005).

Much of the government's reluctance relates to the increasing number of sexual assaults on minors especially boy children. Cultural norms dictate that no one is allowed to talk about sex (even heterosexual) in front of elderly people. Acceptance of public displays of male affection does not actually go along with an acceptance of homosexuality.

The AIDS Resource Center in Addis Ababa reported that the majority of self-identified gay and lesbian callers (75% were male) requested assistance in changing their behavior to avoid discrimination. Many gay men reported anxiety, confusion, identity crises, depression, self-ostracizing, religious conflict, and suicide attempts. In 2007 Addis Ababa reported at least 5 mob lynchings involving gay men.[citation needed] In December 2008, nearly a dozen religious figures adopted a resolution against homosexuality, urging lawmakers to endorse a ban on homosexual activity in the constitution.[3]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

Information is lacking about social position and needs of MSM living with HIV/AIDS, however, anecdotal information shows that Ethiopia is full of “under cover gays”, in all sectors of society. “I know there are many gay Government officials, Scholars, Artists, Business men, students and to your surprise I know many Orthodox Church priests/Monks/ and Pentecostal church Pastors and singers. Due to the cultural influence many gay people are forced to marry here but they are having an affair still. To be gay is not western culture it is how we created... Especially in Monasteries there are many gays but we don't want accept it [12]

#### 6. Any on-going activities to counteract stigma and discrimination?

Behind the Mask report that members of ETHIOGLBT (an LGBT rights group in Ethiopia) are meeting and working to effect positive change, something that they admit, will take time. The LGBTI community has implemented an initiative that aims to document violations geared towards the LGBTI community in that country. [20]

There has been a call for the government to reframe the HIV/AIDS prevention, care & treatment in the context of all males' sexual behavior. As a volunteers & professional health workers of grass root, nonprofit NGO working on Ethiopian sexual minorities' health, human right & economic empowerment especially those who are vulnerable & ignored one organization, the Rainbow-Ethiopia LGBT/MSM sexual health education & promotion initiative, encounters many problems. According to the state discriminatory practice MSM are denied access to health care service & basic health information targeted to life & needs. MSM are blamed unjustly for the spread of HIV/AIDS, and at the same time are omitted from the national HIV/AIDS prevention programs. The Rainbow-Ethiopia Integrated HIV/AIDS education & prevention Programme for Ethiopian gays (Men having sex with men) is an initiative by some Ethiopian sexual health and right researchers in the year 2007 to enhance a special emphasis on those Ethiopian who are socially marginalized & politically neglected social groups. [18]

The challenges the Rainbow-Ethiopia LGBT/MSM sexual health education & promotion initiative face so far are; to lobby the national health policy planners & administrators for the

transformation of the national HIV/AIDS education & prevention Programme of Ethiopia to be participatory, equitable, all inclusive, barrier free & right based. But, they show no interest to stop the massive death of the Ethiopian gays (Men having sex with men) by the epidemic of HIV/AIDS rather they threatened us to stop advocacy for those who are unnaturally engaged in sexual misconduct. Recently, FDRE ministry of health, Ethiopian AIDS resource center, HAPPCO & other stakeholders are announcing about the decline of prevalence & incident rate. It may be true among the heterosexual population is somewhat stabilized but there is growing tides of the epidemic of HIV/AIDS & its related risks among the Ethiopian gays (Men having sex with men) all over Ethiopia .We strongly believe that consideration & inclusion of those Ethiopian gays and/or all (Men having sex with men) in the HIV/AIDS prevention & intervention program will highly contribute to the mitigation of the incidence & prevalence rate at national level. We are not only menaced by the epidemic of HIV/AIDS but also by the second epidemic (which is an epidemic of discrimination, fear, bigotry & homophobia) which have a deeper effect than the HIV can ever. [18]

The Rainbow-Ethiopia LGBT/MSM sexual health education & promotion initiative aims to work jointly with policy makers, health practitioners, researchers, International stakeholders, funding agents, human right organizations & all concerned parties to ensure a conducive legal, policy and social environment to support programming to address HIV-related issues among MSM and transgender people in Ethiopia. These are the already identified types of services needed – including: Information and education about HIV and other sexually transmitted infections, and sustained individual-level and group-level support for safer sex and safer drug use to reduce risk of exposure to HIV ;Provision of, and education about the use of, condoms and water-based lubricants ;Confidential, voluntary HIV counseling and testing ;Detection and management of sexually transmitted infections ;Referral systems for legal, welfare and health services ;Safer drug-use commodities and services ;Appropriate antiretroviral and related treatments, HIV care and support ;Services to prevent and treat viral hepatitis ;Access to mental health services ;Referrals between prevention, care and treatment services ;Services that address the HIV-related risks and needs of the female sexual partners of MSM and transgender people ;For transgender people, in addition to the interventions described above, access to appropriate information, counseling and support on gender identity.. [18]

#### 7. Existence of homosexuality-related barriers to health care

The government refuses to acknowledge that homosexual communities exist in Ethiopia. The current law is likely to exacerbate incidents of harassment, abuse, arbitrary arrests and unlawful detentions of homosexual people, and such laws threaten public health as they frustrate the important work of creating access to HIV prevention and awareness programmes.

Societal stigma and discrimination against persons living with or affected by HIV/AIDS continued in the areas of education, employment, and community integration. Despite the abundance of anecdotal evidence, there is no data or statistical information on the scale of this problem. [25]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Mainstream Ethiopian social mores are broadly influenced by the Ethiopian Orthodox Church and Muslim religious life. Both male and female same-sex sexual activity is illegal' In Ethiopia. Lesbian, gay, bisexual, and transgender (LGBT) rights in Ethiopia do not exist; all homosexual activity is recognized by Ethiopian law as a sexual crime, and the promotion of homosexuality is overwhelmingly rejected by Ethiopian society. [26]

According to the 2007 Pew Global Attitudes Project, 97% of Ethiopian residents said that homosexuality *should* be rejected by society, which was the second-highest percentage rejecting homosexuality among the 44 countries surveyed, exceeded only by LGBT rights in Mali at 98%. [26]

In December 2008, nearly a dozen religious figures adopted a resolution against homosexuality, urging lawmakers to endorse a ban on homosexual activity in the constitution. Under Ethiopian law, homosexual activity is punishable by up to 5 years imprisonment. A homosexual act is never considered a victimless crime in Ethiopian law; rather, the wording of the penal code recognizes that it is an act of an aggressor against a victim. Consequently, the offense of the aggressor is considered aggravated, when it results in the suicide of the victim. [26]

Laws covering homosexual activity: Sections 600 and 601 prohibit homosexual acts between men and between women, with a penalty of 10 days to 3 years' "simple imprisonment". This penalty may be increased by 5 or more years when the offender "makes a profession of such activities", or exploits a dependency relation in order to exercise influence over the other person. The maximum sentence of 10 years' imprisonment can be applied when the offender uses violence, intimidation or coercion, trickery or fraud, or takes unfair advantage of the victim's inability to offer resistance. The maximum sentence can also be applied when the victim is subjected to acts of cruelty or sadism; when the offender transmits a venereal disease although fully aware of being infected with it; when an adult is charged with committing homosexual acts with persons under 15 years of age; or when distress, shame or despair drives the victim to committing suicide.

#### 9. Any action under way to change legal status of homosexuality

There have been calls from religious leaders for more stringent rules against the homosexual community whose exact size is impossible to determine due to fears of repression. It is reported that heads of the Orthodox, Protestant and Catholic churches, as well as Islam, adopted a resolution urging lawmakers to amend the constitution to ban the sexual orientation, which they termed a "pinnacle of immorality". [5]

In 2008, for the first time in the country's history, hundreds of homosexuals in Ethiopia signed a petition in order to appeal to the prime minister for equal right; however, their appeal was blocked before it reached the prime minister's office. More dramatically, the first unofficial gay marriage took place at Sheraton Addis Hotel in the capital between two male Ethiopians during the same year, and just recently, in January 2009, the first semi-official gay event had been organised in Addis Ababa. This act led Ethiopian clerics to seek constitutional ban on homosexuality in December 2008. [7]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

The Rainbow-Ethiopia Integrated HIV/AIDS education & prevention Programme for Ethiopian gays (Men having sex with men) is an initiative by some Ethiopian sexual health and right researchers in the year 2007 to enhance a special emphasis on those Ethiopian who are socially marginalized & politically neglected social groups. According to the state discriminatory practice MSM are denied access to health care service & basic health information targeted to life & needs. MSM are blamed unjustly for the spread of HIV/AIDS, and at the same time are omitted from the national HIV/AIDS prevention programs. [18]

Ethiopia voted against ILGA having consultative status at the UN in January and on April 30, 2002 citing that it contradicts Ethiopian belief and general culture and practice. [13]

#### 11. HIV prevalence/incidence data for MSM and general population

No information was provided on prevalence/incidence data for MSM and general population. The Fifth National HIV/AIDS Report in 2003 indicated a total of 1.5 million persons living with HIV/AIDS in the country with an adult prevalence of 4.4%. The prevalence greatly varies in urban (12.6%) and rural areas (2.6%). There is also higher rate of infection among women (5.0%) than men (3.8%). Although urban areas have greater prevalence, infection is stabilizing while there is gradual but steady rise in prevalence in rural areas. [10]

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

Research (Kloos, H et al, 2007) has shown that there are high rates of unprotected anal intercourse among MSM in the country, and that many believe that HIV is transmitted more 'effectively' through vaginal, rather than anal, sex. [16]

Women, youth, young commercial sex workers, the rural population and orphans and children in general are the most vulnerable groups identified. Women, due to economic, educational, and biologic factors as well as various harmful traditional practices are considered more vulnerable than men. Age, emotional development and financial dependence as well as poverty and awareness about the disease are major factors of vulnerability among youth and in rural communities.

Although the country has a number of positive policies, strategies and legal frameworks, pertinent to HIV/AIDS prevention and control, there are also serious structural and economic barriers to implementation.

There is not enough integration between the legal framework and HIV/AIDS risks e.g. protection of girls/women and helping rape victims. The national strategy has not specifically included women among the vulnerable groups. Rural areas are only to a limited degree benefiting from interventions including services like information, Voluntary Counseling and Testing and Anti Retroviral Treatment. There are also barriers of cultural and social norms and practices. Gender inequality is the most important. Stigma and discrimination and harmful traditional practices like female genital mutilation, early marriage, abduction and widow inheritance are also common. [10]

#### 13. Current status of prevention, treatment and care for MSM

Scholars and gay activists claim that criminalizing homosexuality prevents the homosexual community from seeking medical help or counseling in case of suspected sexually transmitted diseases including HIV/AIDS in fear of prosecution. According to Balcha, the HIV/AIDS protection program and Medical experts seem to ignore the implication of excluding homosexual persons from protection and care programs which might have a direct link to the general population well being. [7]

Ethiopia is one of the hard stricken countries by the HIV/AIDS epidemic having 1,037,267 PLWHA, equal to the entire population of Botswana. Ethiopia has a high prevalence of HIV/AIDS. Single-point estimates show adult HIV prevalence of 2.1 per cent for 2007. The 2005



Ethiopia Demographic and Health Survey (EDHS 2005) had indicated a national-level adult prevalence rate of 1.4 per cent among adults aged between 15 and 49 years (6 and 0.7 per cent in urban and rural residents, respectively). The rate in the capital, Addis Ababa, was 5 per cent. While Ethiopia is still a highest prevalence area for HIV/AIDS, there are many factors that increase the nation's exposure to the rapidly spreading disease. These factors include the stigmatization and exclusion of street-based male sex workers (SBSW), leaving them among the most vulnerable of the population. Since, Addis Ababa is a capital city with a multifaceted economical, social & political problems, higher rate rural to urban migration & the home of, INGOs, foreign sex tourists center with an active sex trade it is especially important to assess and educate the SBSWs (Street Based Sex workers) concerning HIV/AIDS and STIs (Sexually Transmitted Infections), as well as provide them with care, referral and support. It is approximated that there are at least 50000 SBSWs in Addis (out of them 5000 are young male sex workers) in a places like secret bars, streets & broker meditation secret places. [18]

#### 14. MSM related UNGASS indicators

In 2008 Ethiopia did not report on any of the 5 UNGASS indicators relating to MSM. [17]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

No specific information provided is provided, however it is inferred that the persistent homophobic attitudes towards members of the homosexual community jeopardise efforts undertaken to combat HIV, both within this group and across the population as a whole. The clandestine existence that gay communities are forced to hide away in exposes them not just to the risk of HIV, but the rest of the population too: because they are unable to live openly as gay men, many MSMs also have sexual relations with women, or are even married, activists have highlighted.

#### 16. Whether and how MSM are included in National Strategic Plans

The National AIDS Policy was drafted in 1991 and approved in 1998. A National Strategic Framework was formulated in 2002 with focus on reducing transmission. It was replaced by a strategic plan in December 2004 with focus on community mobilization of target groups including youth (15-29 years of age), rural communities and people living with HIV/AIDS. [10]

With the National HIV/AIDS Strategy Framework now in place, many hope the government will work with community, religious and traditional leaders to help diminish the stigma of HIV/AIDS. [19]

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

TCP Ethiopia is a program established through an invitation by Ethiopia's Minister of Health in 2004. A TCP country coordinator located in Addis Ababa oversees TCP in Ethiopia. Working in schools, anti-aids clubs, during coffee ceremonies, and with Ethiopian NGOs, TCP's coordinator, an assistant, and many volunteers have conducted countless workshops introducing the condom through the art pin strategy. Programs have taken place in Addis and outside Addis in rural locations including Awassa, Shashemane, and Bussa. [23]

TCP works with primary and secondary partners. Most partner organizations use both the

Condom Art Pin and 30 Seconds: A Visual Voice strategies to complement what their groups' programs in HIV/AIDS prevention. Some are also part of LIFE GUARD our peer condom distribution program. Some contribute either to the video project or the art pin strategy, and one partner makes art pins for distribution at major AIDS conferences.

The University of California San Diego – Ethiopia (UCSD-E) is a foreign operation/program that provides technical assistance for HIV prevention, care and treatment to the Uniformed Services of Ethiopia (USE), which includes the National Defense Forces of Ethiopia (NDFE), the Federal Police of Ethiopia (FPE), and the Federal Prison Administration (FPA). UCSD has worked in Ethiopia since 2005, established an office in Addis Ababa in 2006, and is funded by the President's Emergency Fund for Aids Relief (PEPFAR) thru the Global AIDS Program (GAP) of the Centers of Disease Control and Prevention (CDC). UCSD-E implements its program through collaboration with the Federal Ministry of Defense, Defense Health Department, the Federal Police and Prison Health Institutions, the Federal Ministry of Health, and the HIV/AIDS Prevention and Control Office (HAPCO). [24]

The CDC Ethiopia office was launched in April 2001. The CDC Global AIDS Program provides extensive technical expertise in Ethiopia in the areas of blood safety, antiretroviral treatment services, laboratory infrastructure, and strategic information.

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## Kenya

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

While they may still be a long way from the freedoms of South Africa (where marriage equality became law in 2006), Homosexuality in this nation of 38 million are not as repressed as in most adjacent countries. According to Lourence Misedah, program director for Ishtar, a Nairobi-based organization promoting sexual health for Kenyan men who have sex with men (MSM), Kenya has always been a safe haven for neighboring LGBTI people when they face persecutions in their countries. As it is in most of Africa, homosexuality between consenting adults is still officially illegal in Kenya (carrying a potential prison sentence of anywhere from five to 14 years), but the laws are rarely enforced and these days serve mostly as simple (but powerful) demoralizing mechanisms.

Undeniably, prejudice and danger still lurk for gay Kenyans, but grassroots organizing and activism that's taken shape within its gay community over the last few years, with the help of a handful of young freedom fighters (with the assistance of the Ford Foundation, the Elton John AIDS Foundation, the Open Society Institute, and others). [1]

Kenya is a patriarchal and hetero-normative society, and religion, both Islam and Christianity, are deeply entrenched, and as a general rule the many local ethnic cultures are intolerant of homosexuality. As a result, the majority of Kenyan men who have sex with men (MSM) still marry women and father children. Kenya's current male homosexual scene appears as a patchwork of MSM, MSW (male sex workers), and a very small but perhaps growing number who identify as gay. Prostitution is a big part of Kenyan MSM culture. Customers are not tourists but local Kenyan men. [1]

In a study published in the June 2007 edition of AIDS, researchers estimated that at least 739 MSM were selling sex to other men in and around the city of Mombasa, a "sizeable population that urgently needs to be targeted by HIV prevention strategies. [15]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

The website called gaykenya.com. GayKenya.com specially does not sport a name banner on its web site to protect members and inquirers from being exposed at Internet shops in Kenya, is primarily an advocacy group to government ministries and bureaucracies that deal with legislation, health care and human rights. They lobby for decriminalization of homosexuality in Kenya. Their studied approach involves gathering respected pronouncements from reputable organizations (dealing with sexuality and health) and authoritative individuals (medical and legal experts) attesting to the normalcy of sexual differences and to the constitutional rights of all Kenyans. They also include academic research data and human rights reports from national and international organizations. The arguments they present, first, urge government health officials to consider that criminalized homosexuality significantly inhibits sexually active high-risk MSM's from seeking HIV care and counseling about safe sex, which in turn perpetuates the disease. Second, to understand that the same punitive law promotes homophobia in the workplace and leads to otherwise qualified personnel being removed or prevented from skilled work, thus diminishing the quality of Kenya's work force. GayKenya.com also offers on their web site a live chat room, forums for discussions, information and referrals for health care and relevant news reports. There are about 30 members of the group headed by a steering committee. [2]

Certain big-city bars, most famously Gypsy in Nairobi, are "gay-friendly," but these are subject to the changing whims of venue owners. In Mombasa, mostly-straight discos Florida and Tembo are among the current gay hangouts of choice.

Kenya's strongest homosexual contingents are in its largest cities, the capital Nairobi (about 3 million people) and coastal Mombasa (about 700,000), though the latter has experienced more concentrated homophobia of late. The Council of Imams and Preachers on the coast have been active in promoting intolerance.

Kenya's third biggest city, Kisumu, and its oldest town, Lamu, are two other locales where there is a gay presence. The gay communities in other places are highly discreet, but operate in "buddy groups". Even in the larger cities, social networks play an important role in the fabric of Kenyan gay life, since meeting at each other's homes is safer than meeting in bars.

The GALCK (Gay and Lesbian Coalition of Kenya) Resource Center in Nairobi is an umbrella union of Kenya's four main advocacy groups, GALCK debuted in 2006 and helmed the popular and pioneering 'Q Spot' which is the first designated GLBT safe space in Kenya, the QSpot showcased homosexual art and performance, and also offered support, counseling and HIV testing. [1]

In 2008, Angus Parkinson has lived in Kenya for five years working in HIV health care programs described the gay movement as still nascent, still sorting out, still defining goals, strategies and organizational schemes. At most the movement goes back fewer than ten years of lean-funded covert work. The movement, if it can be called that, is weighed down by the darkness of cultural, religious, political and legal homophobia that runs through the social blood of the various tribal, religious and political cultures in Kenya. Homosexuality is a criminal offense here; women are not mentioned in the laws. There is no gay center in Nairobi, no particular place for estranged gay youth or alienated adults to find hands-on advice, food or shelter (other than in private HIV offices). There is no LGBT publication, no outward signs or campaigns, no rallies, no fair media representation. But things are changing. [1]

### 3. Presence of an organized LGBT or MSM community

GALCK (Gay and Lesbian Coalition of Kenya) is a community centre and advocacy group that brings together organizations that work for emancipation and realization of human rights for the LGBTI people in Kenya. Another organisation is called ISHTAR MSM.

GALCK has links with the Kenya National Human Rights Commission, Liverpool VCT, Care and Treatment, and the National Aids Control Council. It is formally involved in the on-going process of drafting a new HIV/AIDS Strategic plan for this country and in the review of the National Voluntary Care and HIV Testing Form. It was also commissioned by Kenyan authorities to study widespread homosexual practices in the country's crowded prisons.

Organizations such as Gaykenya are working to improve access to basic rights and freedoms of gay and lesbian people by calling upon the LGBTI people to register as voters and participate in the civic life. This way they hope to work with politicians and political parties in changing the offensive sections of the penal code.

GALCK brings together 5 organizations that work for emancipation and realization of human

rights for the LGBTI people in Kenya. These Groups, include, ISHTAR MSM, which is principally involved in reduction of HIV/AIDS infections among Gay people in Kenya. Minority Women in Action (MWA), works on rights realization for Lesbians and bisexual women. The other two are Gaykenya and Tomik whose work focuses on rights advocacy and creating a favourable legal environment for the LGBTI Kenyans. Transgender Education and Advocacy (T.E.A.) is the last group to be formed in 2008 that focuses on the human rights and social well being of transgender and intersex identifying individuals.

Since the centre was first opened, GALCK has been able to make tremendous progress, in its work through building coalitions with mainstream organizations, like Kenya Human Rights Commission, and HIV/AIDS bodies notably Liverpool VCT, Care and Treatment and National Aids Control Council. Indeed thanks to this relationship, GALCK has for the first time been formally involved in the on-going process of drafting a new HIV/AIDS Strategic plan for this country. Further to that, GALCK is also involved in the review of the National Voluntary Care and HIV Testing Form, so that information collected and counselling given during the VCTs, is reflective of the needs of the LGBTI community in Kenya.

Kenya's major gay organizations include: GALCK (Gay and Lesbian Coalition of Kenya) [galck.org] an umbrella body of four of Kenya's most important gay groups (GayKenya, Ishtar, TOMIK and MWA), GALCK's made its mission to uphold the interests and concerns of all Kenyan queers. Its important Resource Center opened in September 2008. GayKenya [gaykenya.com] Founded in 2004, GayKenya is the media advocacy arm of the country's homo movement, and was the first gay group registered with the Kenyan government (as Kenya Gay and Lesbian Trust or KEGALE). Ishtar MSM

Based in Nairobi, Ishtar's main aim is the advancement of sexual health rights for Kenya's men who have sex with men. TOMIK (The Other Me in Kenya) is a social network of Kenyan professionals (mostly journalists and lawyers), TOMIK advocates for the decriminalization of homosexuality. Minority Women in Action (MWA) [minoritywomen.org] Kenya's only organization promoting empowerment of gay, bisexual and trans women, MWA serves individuals from across East Africa. Liverpool VCT (Voluntary Care and Treatment) [liverpoolvct.org] Closely aligned with GALCK, Nairobi-based Liverpool VCT began as a pilot HIV counseling, testing and treatment center in 2001, and has proven so successful and vital that its staff now numbers over 200. International Center for Reproductive Health Kenya (ICRHK) [icrhk.org] Sponsored by Belgium's Ghent University and based in Mombasa, ICRHK offers HIV treatment and prevention counseling for all people. Notably for the gay community, it established an MSM drop-in center and trained 40 local male sex workers as peer educators. [3]

#### 4. What is known about stigma and discrimination of male same-sex sexuality

It was revealed at a June 2007 conference on Peer Education, HIV and AIDS, in Nairobi, that MSM face high levels of stigma and discrimination.[16]

In terms of stigma and discrimination, it is reported that there is a dominant belief that homosexual men are thought of as feminine and playing a woman's role. They are considered to be transgressing gender roles. Opposition to LGBTI people comes from groups such as the Council of Imams and Preachers of Coastal Kenya. LGBTI people are routinely blackmailed, harassed by the police, held in remand houses for long without charges being preferred against them, and presented in court, on trumped-up charges. Nairobi and Mombasa are perceived as a little more tolerant of homosexual behavior as Kisumu.

A documentary reflecting the issues of 'Being gay in Kenya' is in production and with it, producers say they want to break the myth that gays and lesbians do not exist in the country, as believed by some members of society. Comprising of first hand experiences of gay Kenyans, the documentary reveals issues of homophobia, stereotyping and stigma in a society in which the majority feel that homosexuality is unAfrican and unbiblical. In the documentary, some participants reveal how they have had to stay in the closet for fear of being identified as gay, while others are said to live double lives in order to fit into society. The documentary will be used to sensitise society and the lesbian, gay, bisexual, transgender and intersex (LGBTI) community during trainings, often held by Gay Kenya. [4]

The Kenyan Ministry of Health in collaboration with the National AIDS Control Council and CDC launched the campaign to bolster communication and awareness of HIV/AIDS and TB to reduce stigma and discrimination associated with the diseases. The multitiered program, which was launched in 2008, encourages health workers to be tested for HIV and to learn about the link between HIV and TB. The program also will provide treatment for health workers who are living with HIV or TB. Under the program, HIV-positive health workers will encourage colleagues to be tested for HIV and TB and to seek treatment. The program was launched at selected clinics in Nairobi and Nyanza, the two provinces with the highest rates of TB and HIV/AIDS in the country. The program aims to reduce stigma and discrimination associated with HIV and TB. Many health workers in the country do not know their HIV status, which has hindered the government's efforts to reduce HIV-associated stigma and provide adequate health care at public clinics. Health workers who know their HIV status will be able to provide better care for patients. Nelly Muga, an HIV-positive health worker in Machakos, Kenya, said that some health workers living with HIV or TB have "misplaced professional pride" and believe it is "shameful for a medical practitioner to confess to being HIV-positive." Many health workers do not receive HIV or TB tests even when they have symptoms of the diseases, which has led to unnecessary deaths. [6]

##### 5. What is known about social position and needs of MSM living with HIV/AIDS

A male prostitute reported that despite the stigma that faces homosexuals, more specifically from society, police, and the church, their clientele is made up of people in these very segments. [16] This fact was supported by Agnes Runyiri of ICHR said at a June 2007 conference on Peer Education, HIV and AIDS, in Nairobi that although homosexuality is considered taboo, un-African and anti-Christian, homosexuality is very common in Kenya, and clients include politicians, businessmen, religious leaders [16]

Others talk of the many gatherings often held, populated by respectable members of society, such as teachers, lawyers and even politicians. "Most people I interviewed do not blame anybody about their sexuality, they say it has been a feeling from childhood despite the fact that most people say that this is a behavior adopted either from high school or maybe one was sexually molested by an uncle or a cousin", Javine Ochieng of Gay Kenya, an LGBTI human rights organisation in Kenya said. [4]

##### 6. Any on-going activities to counteract stigma and discrimination?

National HIV programming has recognized stigma and discrimination as important drivers of the HIV pandemic both within the sexual minorities and the general population. Men who Have Sex

with Men – MSM contribute 15.2% of all new infections in Kenya. Of these, 60% are engaged in heterosexual relationships. [13] MSM faces double stigmatization and discrimination when they test positive for HIV. There are no groups to protect the human rights of MSM. The few groups such as ISHTAR that work with MSM lack resources to effectively carry out their activities. MSM are criminalized and the right for consensual sex is not recognized.

An increase in the number of MSM-friendly health-care providers and services would lead to an increase in the number of MSM seeking and using services. Awareness of MSM issues should be increased among health providers and communities. NACC should advocate including MSM in programming. Public health facilities should be sensitized to accommodate and provide services to MSM. This should be countrywide and include rural areas. [20]

International Day Against Homophobia (2009), saw a remarkable commemoration of the day in Kenya with panelists from the mainstream human rights organizations, such as the Kenya National Commission on Human Rights and the Kenya Human Rights Commission. MSM (men who have sex with men) is included in the Kenya National Strategic Plan yet there are no intervention programs on the ground apart from the initiative of a few organizations. The Kenya AIDS Vaccine Initiative (KAVI) made a strong emphasis on the importance of inclusion of MSM as a sub group in the HIV/AIDS Vaccine research in ensuring an effective vaccine for all taking into consideration the different strains of HIV. [14]

#### 7. Existence of homosexuality-related barriers to health care

Research shows that male sex trade for clients of both sexes is fairly common as is unprotected anal sex. Research has also found extremely high HIV-1 prevalence and low condom use among MSM.

Homosexuality is illegal in Kenya under the Penal Code, Section 162 and as a result there is ignorance and stigma surrounding men who have sex with men (MSMs) and male sex workers (MSWs). This has resulted in the lack of prevention, care and management in HIV programmes. A 2002 study conducted by the International Centre for Reproductive Health (ICRH) and the Population Council indicated that Male Sex Workers (MSW) existed in Mombasa and the surrounding areas. The study defined the MSW as “any man who regularly receives money or gift in exchange for sex with other men”. An MSM, in contrast, is just a man who has sex with a man and refers to the act itself. Agnes Rinyiru, part of the ICRH, claimed that MSW in Kenya were increasing in numbers and in visibility, where MSWs identified themselves. The study estimated that there were more than 771 male sex workers in Mombasa alone. They are at an increased risk of transmitting or getting infected with HIV or STIs. [11]

Voluntary and Counselling and Testing centres do not reach out to MSM. MSMs’ fear of stigmatization if they reveal their sexuality, results in them self-medicating, and this leads to increased HIV prevalence. It also leads MSMs fabricating stories to the doctors, which resulted in incorrect medication being prescribed. [11]

This fear also plagues their private lives and people have committed suicide in fear of revealing their sexuality or due to the reaction from their parents. Some sons are even kicked out of their own homes, as a result of the stigma of immorality that is attached to homosexuality in Christian Kenya. There is clearly ignorance and avoidance of approaching MSMs needs in society. Healthcare providers are not trained to provide services to MSM and unaware of the sexual health and HIV needs they have. There are no appropriate and sensitive counselling services and HIV and sexual health campaigns only talk about vaginal sex as route of transmission. This



clearly took its toll, where there was a low risk perception of HIV/STI and a poor knowledge base of HIV/AIDS, and unprotected anal sex in MSW ensued, as people are unaware that anal sex can transmit HIV. Water-based lubricants are not readily available, as they are too expensive. Vaseline or lotions are being used, which can lead to tearing of a condom and consequently a higher HIV prevalence. MSWs had little knowledge about water-based lubricants. This ignorance about male to male sex accounted for the high prevalence of HIV in MSMs, a study found that 47% of MSMs were HIV positive. STI infections were common in MSMs therefore; access to information and resources relating to MSMs should be on the agenda and integrated into the prevention and management of HIV/AIDS. [11]

More than half of male sex workers in Mombasa, Kenya who predominantly have male clients may also be having intercourse with women, according to findings presented at the 17th Conference on Retroviruses and Opportunistic Infections in San Francisco. Adrian Smith, MSc, of the University of Oxford in the United Kingdom, said that as many as 59% of men who have sex with men sex workers may have regular transactional encounters with one or more female partners. This fundamentally changes ideas on the directionality of sex work. The aim of the study was to determine the nature of interactions between the HIV epidemics among MSM and heterosexual populations in Africa. A lower HIV prevalence among MSM sex workers who had sex with women was observed, than in those who only had sex with men.

The workers received money for sex from 144 women. MSM sex workers paid the women for sex in 18% of the encounters. Among single-episode contacts, 99 of 138 were paying female clients. Payment was given in 45 of 77 recurring sexual relationships. Penetrative intercourse occurred in 99% of the sexual encounters between women and MSM sex workers. Those encounters were broken down as follows: 87% vaginal, 54% anal and 43% for both. Among the sexual acts, unprotected penetrative vaginal sex occurred in 38% of encounters, and unprotected anal sex occurred in 46% of encounters.

Little is known of the personal risk awareness and motivations for women seeking sex with MSM sex workers, Interventions should consider that MSM sex workers may be having female partners.”

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Sections 162 to 165 of the Kenyan Penal Code criminalize homosexual behaviour and attempted homosexual behaviour between men, which is referred to as "carnal knowledge against the order of nature". The penalty is 5 to 14 years' imprisonment. The age of consent is 16. Lesbian relations are not prohibited in the law. [22]

Homosexuality remains criminalized in Kenya, and even though there are few prosecutions in the country on the sections of the penal code (162 - 165), that criminalize it; LGBTI people are routinely harassed by the police, held in remand houses for long without charges being preferred against them, and presented in court, on trumped-up charges. Closely related to this, is a cartel of corrupt police officials who routinely extort and blackmail LGBTI people with the threat of arrest and imprisonment if they do not give those bribes. [22]

According to the 2007 Pew Global Attitudes Project, a strong 96% of Kenya residents said that homosexuality should be *rejected* by society, making it one of the highest rejections of homosexuality in the 44 countries surveyed.<sup>[3]</sup> Sections 162 to 165 of the Kenyan Penal Code criminalize homosexual behaviour and attempted homosexual behaviour between men, which is

referred to as "carnal knowledge against the order of nature". The penalty is 5 to 14 years' imprisonment. The age of consent is 16. Lesbian relations are not prohibited in the law.

In August 2006, a bill known as "Njoki Ndungu bill" was published into law, with the aim was to consolidate all the sexual offenses into one body. The bill was published into law in August, but did not change very much the previous sections of the penal code. As such it remains a criminal offense that is punishable by 14 years and five years in the case of attempt. [22]

It is not a crime in Kenya to be homosexual. While engaging in sex "against the order of nature" is a crime, being gay or living a gay lifestyle is not. People cannot be arrested on suspicion of being homosexual. [12]

Same-sex marriages in Kenya are a non-entity; they therefore cannot be a crime. If two friends of the same sex wish to commit in friendship to one another, such commitment is not a marriage, and even if they regarded it as such, the Government has no obligation to regard it as a marriage since marriage is between members of the opposite sex. [12]

#### 9. Any action under way to change legal status of homosexuality

There are at least eight organizations, which are campaigning for the legalization of homosexuality and which give advice to gays and lesbians, for instance informing them about AIDS and HIV. Lawrence Mute, commissioner with the Kenyan National Human Rights Commission (KNHRC), wants the government to repeal all sections of laws criminalising same sex relationships and sodomy. [12]

Kenya's LGBTI community has called on government to embrace legislation that will amend and bring about laws that recognise their rights thus protecting them from homophobia. [21]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

Kenya National Commission on Human Rights speaks out against anti-gay hate speech. The state HIV/AIDS campaign has explicitly addressed homosexuals since 2006. MSM are included in the Kenya National Strategic Plan. Health centres that serve MSM have been set up with the help of the International Centre for Reproductive Health (ICHR). Other Voluntary and Counselling and Testing centres do not seem to reach out to MSM probably because most healthcare providers are not trained to provide services to MSM and they are unaware of the sexual health and HIV needs they have. However, some health providers have been trained on MSM specific STI related needs. [12]

Organizations such as Gaykenya are working to improve access to basic rights and freedoms of gay and lesbian people by calling upon the LGBTI people to register as voters and participate in the civic life. This way they hope to work with politicians and political parties in changing the offensive sections of the penal code. [22]

GALCK brings together 5 organizations that work for emancipation and realization of human rights for the LGBTI people in Kenya. These Groups, include, ISHTAR MSM, which is principally involved in reduction of HIV/AIDS infections among Gay people in Kenya. Minority Women in Action (MWA), indicated earlier, works on rights realization for Lesbians and bisexual women. The other two are Gaykenya and Tomik whose work focuses on rights advocacy and creating a favourable legal environment for the LGBTI Kenyans. Transgender Education and Advocacy (T.E.A.) is the last group to be formed in 2008 that focuses on the human rights and social well

being of transgender and intersex identifying individuals. [3]

Liverpool VCT, Care & Treatment with Constella Futures recently supported the National AIDS Control Council to undertake consultative meetings with sex workers, men who have sex with men and injecting drug users in Nairobi and Mombasa in order to inform the national Joint AIDS Programme Review. From these meetings, involving both 'beneficiaries' (i.e. SWs, MSM and IDUs themselves) and organizations providing services to these groups, ten key cross-cutting priorities for an effective HIV response for these most at-risk populations emerged.[17]

#### 11. HIV prevalence/incidence data for MSM and general population

Men who have sex with men (MSM) in Kenya urgently need targeted, HIV risk-reduction prevention information, according to the first study describing HIV prevalence and risk factors in a large group of East African MSM. The study is published in the November 2007 edition of *AIDS*. [9]

In contrast with Western studies, the role of homosexuality and anal sex in the African HIV epidemic has received little attention. While active populations of MSM have long been known to exist in East Africa, their vulnerability to HIV infection has been largely ignored.

Between August 2005 and April 2007, 285 MSM were identified; 114 men reported sex with men exclusively (MSME) and 171 men reported sex with both men and women (MSMW). MSM formed approximately one-third of the vaccine-feasibility enrollment population screened; other risk groups screened included 339 women and 210 men at high risk of heterosexually acquired HIV infection. HIV prevalence was 43.0% (95% confidence interval (CI), 34–52%) for MSME and 12.3% (95% CI, 7–17%) for MSMW. Overall HIV prevalence for MSM at enrollment was 24.5% (95% CI, 19.7–30.7%). By contrast, HIV prevalence at cohort enrollment was 31.5% (95% CI, 27–36%) for female sex workers and 12.4% (95% CI, 8–17%) for high risk heterosexual men. Overall, 25.3% of MSM reported previous HIV testing, of whom five MSME and two MSMW disclosed that they had tested HIV positive.

Of MSM who reported anal intercourse, 37% reported that all episodes had been without condoms. Over three-quarters of MSM (82%) reported at least one episode of unprotected anal intercourse with any partner in the last three months. Eighty-six (75%) MSME and 69 (40%) MSMW reported recent receptive anal sex. Both anal receptive and insertive sex was reported by 25% of MSME and 32% of MSMW.

Men who reported sex with men exclusively had a high HIV prevalence (43.0%), which was significantly higher than bisexual men (12.3%). MSME were also more likely than MSMW to have serological evidence of active syphilis (7.0% versus 1.2%).

Receptive anal sex in the past three months was strongly associated with HIV infection (unadjusted OR, 4.7; 95% CI, and 2.4–9.2). This association persisted when adjusted for age group, religious group, partner preference, anal intercourse without condom, intravenous drug use, paying for sex and prior negative testing for HIV-1 (OR, 6.1; 95% CI, 2.4–15.5).

Recent intravenous drug use was strongly associated with HIV infection, but this was rarely reported. Only four participants (1.4%) reported the use of intravenous drug use in the last 3 months. HIV-1 infection was also associated with increasing age (OR, 1.1 per year; 95% CI, 1.04–1.12).

While exclusive sex with men was associated with HIV infection (OR, 6.3; 95% CI, 2.3–17), comparing MSME with MSMW, there were no differences in numbers of regular or casual partners. However, MSMW were significantly more likely to have paid another person for sex and MSME were significantly more likely than MSMW to have practiced receptive anal intercourse and significantly less likely to have practiced insertive anal intercourse.

Most MSM (74%) reported selling sex for money or goods in the previous three months, of whom 40% reported buying sex as well. MSM selling sex was more likely to report unprotected sex with casual partners in the last week. Most clients (93%) were local residents. However, the researchers suggested that the high number of sex workers in this study is not general to all MSM in Mombasa as their sampling method was more likely to recruit sex workers. Only 49 MSM (17%) reported neither selling nor buying sex in this study.

The authors concluded that the high HIV prevalence seen among MSM in this study contrasts with the 2005 UNAIDS estimate for adult prevalence (15 – 49 years) of 6.1% (95% CI, 5.2–7.0%) in Kenya and calls for urgent public health action.

[9]

In Kenya, female and male sex workers, injecting/intravenous drug users, and men who have sex with men (MSM) are considered primary MARPs. A 2008 Modes of Transmission study in Kenya revealed that commercial sex workers and their clients accounted for 14 percent of new HIV infections, while MSM and prison population's together account for 15 percent of new infections. The study also found that injecting drug users were responsible for 3.8 percent of new infections. Speaking at the launch, UNAIDS executive director Michelle Sedibé highlighted the paradox of the intention to increase HIV programming among MARPS while at the same time criminalizing the activities that put them at an elevated risk of contracting and transmitting HIV.[4]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

Despite increasing awareness of the role that men who have sex with men (MSM) play in the dynamics of HIV transmission, the Kenyan government continues to exclude them in its response to HIV and AIDS.

Homosexuality is illegal in Kenya under the Penal Code, Section 162 and as a result there is ignorance and stigma surrounding men who have sex with men (MSMs) and male sex workers (MSWs). This has resulted in the lack of prevention, care and management in HIV programmes.

Voluntary and Counselling and Testing centres do not reach out to MSM. MSMs' fear of stigmatization if they reveal their sexuality, results in them self- medicating, and this leads to increased HIV prevalence. It also leads MSMs fabricating stories to the doctors, which resulted in incorrect medication being prescribed. [11]

Healthcare providers are not trained to provide services to MSM and unaware of the sexual health and HIV needs they have. There are no appropriate and sensitive counselling services and HIV and sexual health campaigns only talk about vaginal sex as route of transmission. This clearly took its toll, where there was a low risk perception of HIV/STI and a poor knowledge base of HIV/AIDS, and unprotected anal sex in MSW ensued, as people are unaware that anal sex can transmit HIV. Water-based lubricants are not readily available, as they are too expensive. Vaseline or lotions are being used, which can lead to tearing of a condom and consequently a higher HIV prevalence. MSWs had little knowledge about water-based

lubricants. This ignorance about male to male sex accounted for the high prevalence of HIV in MSMs, a study found that 47% of MSMs were HIV positive. STI infections were common in MSMs therefore; access to information and resources relating to MSMs should be on the agenda and integrated into the prevention and management of HIV/AIDS. [11]

### 13. Current status of prevention, treatment and care for MSM

Kenya AIDS Vaccine Initiative (KAVI) made a strong emphasis on the importance of inclusion of MSM as a sub group in the HIV/AIDS Vaccine research. In 2008, the Kenya National AIDS Control Council co-hosted a meeting with the Population Council to bring together researchers, advocates and national AIDS programme managers from other African countries to review the status of research and evidence around HIV and men who have sex with men in Africa. Prevention, treatment and care is largely through GALCK/Liverpool VCT [12]

### 14. MSM related UNGASS indicators

In terms of the MSM UNGASS indicators (2008), Kenya reported an HIV seroprevalence rate among MSM exceeding 15% and indicated that 40-59% of its MSM had taken an HIV test in the last year. It did not report on the percentage of MSM who know how to prevent HIV; or the percentage of MSM being reached by HIV prevention programs. However, it did indicate that 60-79% of MSM used a condom the last time they had sex. [12]

### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Criminalization puts most at-risk populations like commercial sex workers, injecting drug users and men who have sex with men in the shadows. Sex work, homosexual acts and the use of illicit drugs are all outlawed in Kenya and are punishable by long terms in prison. It is difficult to reach groups whose actions are deemed to be at odds with the law.

Ways should be examined that will improve and hasten provision of services; in the long term, and that change policies and laws that criminalize and discriminate against these groups.

While the plan has been welcomed by many stakeholders in the HIV/AIDS field, there is some concern about the fact that Kenya remains almost completely dependent on external funding for its AIDS programmes.

Nelson Otuoma, a representative of The National Empowerment Network of People Living with HIV/AIDS in Kenya called on the government to put in place measures that will ensure that funding for HIV treatment is generated locally, because this is the only sustainable way to ensure that people who need treatment get it. Kenya's HIV national prevalence stands at 7.1 percent; an estimated 166,000 Kenyans become infected with HIV every year, 34,000 of whom are infants. [21]

### 16. Whether and how MSM are included in National Strategic Plans

Kenya has launched an ambitious strategy to fight HIV/AIDS that aims to reduce new infections by at least 50 percent over the next four years and focus more on most at-risk populations (MARPs). The third Kenya National AIDS Strategic Plan, which runs from 2009/2010 till 2012/2013 aims to reduce AIDS-related mortality by 25 percent. [12]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

The International Centre for Reproductive Health Kenya (ICRHK), sponsored by Belgium's Ghent University and based in Mombasa, offers HIV treatment and prevention counselling for all people. It also established an MSM drop-in centre.

The International Centre for Reproductive Health – Kenya (ICRHK) was recently awarded an MSM Initiative Community Award by amfAR. With this award ICRH – K intends to train 60 MSM peer educators in Mombasa, Ukunda and Lamu Districts, Coast Province, Kenya in basic counseling skills on STI and HIV AIDS prevention, in referral and in peer support. Moreover, the project will provide refresher training to 100 peer educators in the same skills and knowledge. It is expected that the MSM peer educators' basic counseling and refresher training will result in reduction of new HIV infections and in effective support system through: Increased uptake of HIV prevention and related services; Increased/refreshed skills in peer education; Capacity for effective basic counseling; and increased effective referral and follow-up [5]

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## Lesotho

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Even though there are no laws criminalising homosexual conduct in Lesotho many homosexuals live secret lives, fearing possible discrimination from their families and community, should they come out.

Talking about being a lesbian in Lesotho, 30 year old Kgati Maila who resides in rural villages says people in her community, influenced by cultural beliefs, view homosexuality as an inhuman act of evil. Even sharing her story with Behind the Mask seems to be difficult for this working class woman, who has been in the closet for more than 13 years. [13]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Information is not available on MSM cultural life. Even though there are no laws criminalising homosexual conduct in Lesotho many homosexuals live secret lives, fearing possible discrimination from their families and community, should they come out. [13]

It is not clear whether homosexuality is illegal in Lesotho. The constitution is silent. There is nothing that explicitly states that same-sex relations or the acts of these relations (i.e. sodomy) are outlawed. There clearly is no protection for these statuses either. [1]

The constitution also protects basic civil liberties, including freedom of speech, freedom of association, freedom of the press, freedom of peaceful assembly and freedom of religion. However, male same-sex sexual activity is illegal in Lesotho, but female same-sex sexual activity is legal. Sodomy is prohibited as a common-law offence. It is defined as “unlawful and intentional sexual relationship per anum between two human males”. [6]

3. Presence of an organized LGBT or MSM community

Thabiso Kikume coordinates a one-year-old unregistered LGBTI support group called Matrix Discussion Group in the country’s capital Maseru. The group was, according to Kikume, started by a group of gay men from the US and some from Maseru, who saw a gap in the country regarding the issues around LGBTI community. The group meets secretly every Saturday, at a local church, to discuss issues affecting homosexuals in the area. He adds that the group is looking at registering as a gay organisation and approaching the government, with a view to have the LGBTI community recognised in Lesotho. [12]

4. What is known about stigma and discrimination of male same-sex sexuality

More than two-thirds of African countries have laws criminalizing homosexual acts, and despite accounting for a significant percentage of new infections in many countries, men who have sex with men tend to be left out of the HIV response. Going underground continues to fuel the epidemic, according to UNAIDS executive director Michél Sidibé. These vulnerable groups need to have the same rights everyone enjoys: access to information, care and prevention for them and their families. [2]

Male same-sex sexual activity is illegal in Lesotho, but female same-sex sexual activity is legal. There is no protection against discrimination based on sexual orientation or gender identity. [13]



Cultural, religious and tribal taboos encourage homophobia. Thabo Thelingoane, the secretary-general of the Construction and Allied Workers Union (CAWULE), demanded that the Council of Non-Governmental Organisations (LCN) stop assisting programmes involving homosexuals on the grounds that Basotho are a Christian nation and Christian principles do not allow them to promote homosexuality. [11]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

MSM in Lesotho tend to live invisible lives because of the taboos around homosexuality. According to a World Bank study, no size estimation has been conducted on men who have sex with men in Lesotho, and additional research is needed to identify the size, risks and specific HIV prevention needs of Lesotho's MSM population. [15]

#### 6. Any on-going activities to counteract stigma and discrimination?

Lesotho does not have non-discrimination laws or regulations which specify protection for MSM. MSM are also mentioned in the country's Global Fund Round 8 application; the form indicates that Lesotho wants to understand their HIV-related risks and vulnerabilities. Findings will help policy development.

The LGBTI support group Matrix Discussion Group was started by a group of gay men from the US and some from Maseru, who meets secretly at a local Maseru church to discuss issues affecting homosexuals in the area. [12]

#### 7. Existence of homosexuality-related barriers to health care

Since most messaging around HIV is strictly heterosexual, most of the men in the general population (including heterosexual, homosexual and MSM) believe that HIV "comes from the woman." Anecdotal evidence suggests that most MSM do not wear condoms, or if the condoms break, don't think to search out PEP (post-exposure prophylaxis) or other treatment.

Nearly one in four are living with HIV, an analysis of national prevalence and behavioural data found that most new infections were occurring because people had more than one partner at a time, both before and during marriage. But Lesotho has no prevention strategies to address the problem of concurrent partnerships, or target couples who are married or in long-term relationships. [2] MSM may have three or more female partners on the side, this apart from numerous male partners. Since most messaging around HIV is strictly heterosexual, most of the men in the general population (including heterosexual, homosexual and MSM) believe that HIV "comes from the woman," and that having sex with a man is in and of itself a form of contraception. Many MSM do not wear condoms, or if the condoms break, don't think to search out PEP (post-exposure prophylaxis) or other treatment. MSM are not aware that anal sex is one of the riskiest forms of transmission. [1]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Sexual orientation and gender identity are neither protected nor overtly criminalised in Lesotho's Constitution. Sodomy laws are in place that could be used to prosecute homosexual behaviour but reported sodomy offences are due to rape between men. Though there are no specific protections for sexual orientation or gender identity, there are general clauses talking to freedom from discrimination of any sort and the overall rights of equal treatment, fairness before the law and respect. These clauses could be gateways into explicit freedoms and protections for the LGBTI community in Lesotho. [10]

Lesbian, gay, bisexual, and transgender (LGBT) persons in Lesotho face legal challenges not experienced by non-LGBT residents. Male same-sex sexual activity is illegal in Lesotho, but female same-sex sexual activity is legal. Male same-sex sexual acts are illegal in Lesotho, in contrast to South Africa, which completely surrounds the country. Same-sex couples have no legal recognition. There is no protection against discrimination based on sexual orientation or gender identity. [13]

Though there are no specific protections for sexual orientation or gender identity, there are general clauses talking to freedom from discrimination of any sort and the overall rights of equal treatment, fairness before the law and respect. These clauses could be gateways into explicit freedoms and protections for the LGBTI community in Lesotho. The only law which explicitly deals with homosexuality in Lesotho is the common law offence of sodomy. In itself this law only deals with a certain portion of homosexuality, namely consummation of a sexual relationship by men. In Lesotho sodomy is an offence against the law and morality. The prohibition on male homosexuality in Lesotho has been given a statutory flavour by Section 187 (5) of the Criminal Procedure and Evidence Act<sup>1</sup>. Under Schedule 1 part II of the same Act, sodomy has been listed as one of the offences in respect of which arrests may be made without a warrant. Female same-sex conduct has never been illegal, as with other former English Colonies. The law in Lesotho is totally silent on female homosexuality. The arguments that are raised against male homosexuality are not convincing because they can equally be raised against female homosexuality. [7]

#### 9. Any action under way to change legal status of homosexuality

No reference is made in the literature to action under way to change legal status of homosexuality

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

“Men as Partners,” is a comprehensive program that seeks to transform the male gender norms of a culture to be more susceptible to gender equality through male engagement and men’s health. Participants are educated about sexuality, sexual orientation and homophobia. [10]

#### 11. HIV prevalence/incidence data for MSM and general population

The literature review did not identify any recent HIV prevalence or sexual behaviour data on MSM in Lesotho. However, there is evidence that male-male sexual relationships exist, particularly in gender exclusive settings like mines and prisons, and that it is very highly stigmatised and therefore hidden. The international literature shows that: The majority of African MSM also have sex with women (e.g. Onyango-Ouma *et al.*, 2005); Once HIV is introduced into MSM networks, the men’s female partners and offspring are at risk of HIV infection (van Griensven, 2007); Many MSM experience high levels of sexual violence (Auvert *et al.* 2005, Onyango-Ouma *et al.*, 2005); In rural Eastern Cape, 3.6% of men reported having ever had sex with a man (Jewkes *et al.*, 2006); Most ex acts were coerced or forced, and often single events. Having had sex with a man was a major risk factor for HIV infection (OR 3.6). Only one of the study participants identified himself as gay. The importance of male-male transmission within Lesotho’s epidemic has not been systematically researched

Lesotho is severely afflicted by HIV/AIDS. According to recent estimates, the prevalence is about 29%, one of the highest in the world. The United Nations projects that this will rise to 36%

within fifteen years resulting in a sharp drop in life expectancy. [6] Lesotho has the third highest HIV prevalence in the world - just under one in four people in the country are living with HIV. In 2008 there were around 21,000 new adult HIV infections and approximately 12,000 people died from AIDS.<sup>2</sup> Over half of the 260,000 adults living with HIV in Lesotho are women. The AIDS epidemic in Lesotho has had a devastating impact on the country. Crippling poverty combined with AIDS has caused average life expectancy to drop to 51 years.<sup>5</sup> The impact on individuals, families and the whole nation is being felt as adults become too sick to work, and children orphaned by AIDS are left to run households. [8]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

Since most messaging around HIV is strictly heterosexual, most of the men in the general population (including heterosexual, homosexual and MSM) believe that HIV “comes from the woman.” Having sex with a man is in and of itself a form of contraception. Thus, most MSM do not wear condoms, or if the condoms break, don't think to search out PEP (post-exposure prophylaxis) or other treatment. [1]

Nearly one in four are living with HIV. An analysis of national prevalence and behavioural data found that most new infections were occurring because people had more than one partner at a time, both before and during marriage. But Lesotho has no prevention strategies to address the problem of concurrent partnerships, or target couples who are married or in long-term relationships.

HIV prevalence is generally higher in urban areas than in rural areas. The major challenge in dealing with the pandemic is to tackle the rise in the number of new HIV infections while at the same time increase access to treatment. The Know Your Status campaign is considered as the gateway to the national HIV and AIDS response.

There is need to address the main drivers of the epidemic, which are among others multiple and concurrent sexual relationships, alcohol and drug abuse, poverty and food insecurity, gender inequality and gender based violence as well as intergenerational sex.

[9] HIV awareness education and condom social marketing has been targeted towards sex workers, migrant labourers, factory workers, young people and long-distance taxi and truck drivers. The 2002 Behavioural Surveillance survey found that knowledge about AIDS was particularly low amongst miners and taxi drivers.[9]

Between 2007 and 2008, UNAIDS and the World Bank partnered with the national AIDS authority to find out how and where most HIV infections were occurring in Lesotho, and whether existing prevention efforts and expenditure matched these findings. The research revealed that most new infections occur because people had more than one partner at a time, and that the country had spent just 13 percent of its national AIDS budget on HIV prevention efforts.

## 13. Current status of prevention, treatment and care for MSM

There is a Lesotho National AIDS Commission (NAC) and the Ministry of Health has an HIV/STI Directorate. However, the NAC is not always recognised as the main coordinating body and some HIV projects do not feel the need to submit data to them. The country has told UNAIDS that it does have non-discrimination laws or regulations which specify protection for MSM. MSM are also mentioned in the country's Global Fund Round 8 application; the form indicates that Lesotho wants to understand their HIV-related risks and vulnerabilities. Findings will help policy development.

The country has a national multicultural strategy to combat AIDS for the period 2006-2011. As part of its information, education and communication strategy, Lesotho's messages to the general population include: be sexually abstinent, be faithful, reduce the numbers of sexual partners, use condoms consistently, engage in safe/r sex, fight against violence against women, greater involvement of men in reproductive health programmes.

Target populations (vulnerable groups) include sex workers, uninformed forces, adult men and men who have sex with men. MSM are targeted with information on risk reduction, stigma and discrimination reduction, condom promotion, HIV counselling and testing, reproductive health including STI prevention and treatment. The country claims that there are no legal barriers to stop vulnerable groups from accessing HIV prevention programmes.

The government of Lesotho has implemented several HIV prevention strategies, including educational campaigns, work-based HIV prevention initiatives, the targeting of high-risk groups and prevention of mother-to-child transmission. An estimated \$26.5 million was spent on HIV prevention between 2006-07. Since July 2001 low-priced male condoms have been supplied through community-based distribution systems. In the first year of the project, the number of shops selling condoms in Lesotho almost tripled and the number of condoms distributed through the private sector more than doubled.

Community organization SHARP! (Sexual Health and Rights Promotion) has provided free condoms through resource centre's and local outlets such as police stations, village chief compounds and border posts.

#### 14. MSM related UNGASS indicators

Lesotho did not report against of the MSM UNGASS indicators. [10]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

According to anecdotal information in HIV and AIDS prevention information, protective barriers, psycho- social support, care and treatment among MSM is nonexistent among major stake holders in HIV and AIDS including government intervention. There is no research or seroprevalence rate among MSM. In general, health service providers, including those in the counseling field, are not willing to address the issues faced by MSM, and there are no clinics or hospitals providing services for MSM to check on STI's and other sexually transmitted diseases.

Lesotho faces a serious and worsening HIV/AIDS problem. One quarter of the people 15–49 years old in Lesotho is HIV positive, among the highest rates in the world. Generalized poverty and social dislocation because of migratory labour are the two main factors driving the HIV epidemic. The epidemic has a mature pattern, with a high case–fatality ratio, many orphans and vulnerable children, increasing mother-to-child transmission, decreasing life expectancy, declining productivity affecting the national economy and very high demands on the health care system. Not only are the numbers of people with AIDS increasing drastically, the number of new HIV infections is very high, with no indication that the epidemic is stabilizing. Surveillance data from five antenatal surveillance sites indicate worsening trends in HIV infection, with the median HIV seroprevalence rate at these five sites estimated at 5% in 1993 to over 25% in 2003. Very high HIV infection rates exceeding 50% are also reported among people with tuberculosis and, among people with sexually transmitted infections, exceeding 60%.

[14]

#### 16. Whether and how MSM are included in National Strategic Plans

Lesotho's AIDS effort is guided by the National AIDS Policy and Strategic Plan for 2006-2011. NAC as the national coordinating authority is mandated to ensure that all partner programmes and activities are based on national priorities as articulated in the Strategic Plan, which is central reference point for national priorities for action and funding. The government intends to reverse the epidemic by focusing on HIV prevention through condom promotion, prevention of mother to child transmission, and providing antiretroviral treatment for all those in need. MSM is not specifically mentioned in the National Strategic Plan.

The Government of Lesotho took concrete actions to address the AIDS epidemic through the declaration of HIV/AIDS as a national disaster, development of the National AIDS Strategic Plan, and the establishment of the Lesotho AIDS Programme Coordinating Authority (LAPCA) under the Prime Minister's Office. The LAPCA was set up in 2001 to coordinate the multisectoral response to HIV/AIDS, but several factors have hindered it in fulfilling its strategic role, thus undermining its effectiveness and adversely affecting the national response. In 2005, the government passed a bill establishing the semi-autonomous National AIDS Commission (NAC) and National AIDS Secretariat (NAS) to coordinate and support strategies. Lesotho is in the process of drafting the next HIV strategy, for the period 2005 to 2008.

Lesotho committed itself to the World Health Organization goal of having 28,000 people on antiretroviral therapy by the end of 2005, and in May 2004 opened its first comprehensive HIV/AIDS center to provide antiretroviral therapy. Supported largely by donors; the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); and international private organizations; local and international nongovernmental organizations (NGOs) and community-based organizations (CBOs) have provided the mainstay of the response to HIV/AIDS in the country, especially in the area of community mobilization. Most of these operations are small and localized to specific geographical areas in urban centers. The biggest challenge remains the establishment of national networks and civil society organizations on HIV/AIDS, most importantly among people living with HIV/AIDS and within the NGO network. A number of private companies are implementing successful HIV and AIDS workplace programs, such as LSP, the brewery, and some security companies. The apparel and textile industry, Lesotho's biggest private employer, has established an innovative sector-wide and comprehensive HIV workplace program. It is a public private partnership with the Government of Lesotho, buyers, employer and employee associations and donors. To date (May 2009) ALAFA (the Apparel Lesotho Alliance to fight AIDS<sup>11</sup>) provides close to 90% of the 42,000 employees with prevention services, and up to 80% with treatment services. [13]

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

In 2005, a scheme was launched in Lesotho's capital, Maseru, to increase HIV awareness among hard-to-reach migrant workers and their families. The programme aims to increase knowledge of HIV/AIDS and condom usage, and access to voluntary counselling and testing services. Sporting tournaments, training and outreach activities promote HIV prevention and testing services.

The Lesotho AIDS Programme Coordinating Authority was established within the Office of the Prime Minister in 2001 to coordinate and oversee national efforts to address the HIV epidemic.

Successive national AIDS strategic plans have been developed to set forth a strategy of multisectoral collaboration in HIV prevention and control efforts.

A National AIDS Commission was established in 2004 to coordinate implementation of the National HIV/AIDS Strategic Plan, superseding the Lesotho AIDS Programme Coordinating Authority. The Government of Lesotho has recognized the urgent need to scale up the overall response of the country to HIV/AIDS. The government has established structures and frameworks in response to the HIV/AIDS epidemic, including the Lesotho AIDS Programme Coordinating Authority, district AIDS task forces, the United Nations Theme Group on HIV/AIDS in Lesotho, bilateral agencies and a national multisectoral task force. A Directorate for HIV/AIDS was formed in the Ministry of Health and Social Welfare to provide technical advice and to advance the health sector's response to the epidemic. Health sector reforms launched in 2000 have focused on building system capacity both through the public and private sector. A national programme for preventing mother-to-child HIV transmission has been developed and implemented, and antiretroviral therapy pilot programmes are being implemented. A national plan for scaling up access to antiretroviral therapy is being developed. Modules for training health workers have been developed and training is underway using the WHO Integrated Management of Adult and Adolescent Illness (IMAI) approach. A "Know Your Status" campaign was launched in 2004 to encourage people to know their HIV status, thereby building HIV/AIDS knowledge, shifting attitudes and influencing behaviour on HIV/AIDS, with a focus on HIV testing and counselling. A comprehensive National Operational Plan to Achieve Universal Access to HIV Testing and Counselling by the end of 2007 was launched in December 2005 with the participation of multiple stakeholders. The approach is community-based, with emphasis on developing the skills of lay and paramedical personnel to provide critical HIV-related services. Broadly, the key components of the strategic approach for ensuring universal access to HIV testing and counselling specify that every household in Lesotho will be offered an HIV test and personal counselling following community level education and mobilization; that communities will choose how HIV testing and counselling will be carried out for their members, choosing among house-to-house counselling by a community health worker from within or outside their community, mobile testing and counselling on fixed dates and provider initiated testing and counselling in health facilities; that every person tested and counselled will be referred to post-test services, according to their HIV status; and that community-level testing and counselling will be rolled out at the same time that HIV prevention, care and treatment services are scaled up at the health centre level. Despite clear strategies proposed in the National HIV/AIDS Strategic Plan, inadequate skills and financial resources have compromised the translation of the strategies into specific plans for implementation. Training various categories of health workers is critical for scaling up access to testing and counselling and post-test services. Strategies to roll out the provision of antiretroviral therapy from hospitals to health centres need to be reinforced. Laboratory capacity to diagnose and monitor the people receiving antiretroviral therapy needs to be strengthened. Limited access to essential drugs, high drug prices, lack of services for preventing mother-to

- In 2003 WHO and UNAIDS estimated Lesotho's total treatment need to be 54 000 people, and the WHO "3 by 5" treatment target for the end of 2005 was calculated to be 27 000 people (based on 50% of estimated need). The government has set a national treatment target of 28 000 people for 2005, in line with the "3 by 5" target. The country planned to put 5000 people on antiretroviral therapy by the end of 2004 and the remaining 23 000 by December 2005. This target has been extended further to 2006.
- Treatment for people living with HIV/AIDS has only been implemented on a small scale. During 2003, an estimated 1000 people received antiretroviral therapy. Most of the treatment of people living with HIV/AIDS occurs through the private sector, which has made antiretroviral therapy available since 2001 for those who can afford it. As of August 2004, about 2500 people were receiving antiretroviral therapy. By May

2005, 5000 people were receiving antiretroviral therapy, and by December 2005, 8400 people were receiving antiretroviral therapy.

- Located on the outskirts of Maseru, the Senkatana Centre, a free treatment centre funded almost entirely by the pharmaceutical company Bristol-Myers Squibb, has placed nearly 600 people on antiretroviral therapy since it opened in May 2004.

- The government opened the first of its antiretroviral therapy clinics in November 2004 at Maluti Hospital, which belongs to the Christian Health Association of Lesotho. Antiretroviral therapy services have also been provided in Senkatana Centre, through an agreement between the Government of Lesotho, Bristol-Myers Squibb and the community, since 2004. The draft national plan for scaling up access to antiretroviral therapy plans to expand provision in a stepwise manner in health facilities in both the low and the highlands. By December 2005, there were 22 sites providing antiretroviral therapy in the country.

- Voluntary counselling and testing facilities are also gradually increasing, from 18 at the end of 2003 to 102 by December 2005. Sites providing services for preventing mother-to-child transmission have also increased from 8 in June 2004 to 20 by December 2005.

The Ministry of Health and Social Welfare is responsible for implementing the national HIV/AIDS response with support from various partners. The Ministry of Health and Social Welfare through the Directorate for HIV/AIDS has established a procurement office for HIV/AIDS health products. The HIV/AIDS Health Products Coordination Unit was established with the support of Boston University; it manages the procurement of antiretroviral medicines, and the National Drug Supply Organization manages storage and distribution. A draft procurement and supply management plan has been developed, and a first consignment of drugs has been ordered through the International Dispensary Association following WHO prequalification and based on Médecins Sans Frontières recommendations on affordable antiretroviral drugs. Since October 2004, the William J. Clinton Foundation HIV/AIDS Initiative is providing technical assistance to the treatment plan, including support for procuring drugs and diagnostics at low prices. WHO, UNAIDS and UNICEF support national partners in implementation. WHO also provides normative guidance, as well as support for training health workers. The Christian Health Association of Lesotho provides an estimated one third of the country's health care through a network of eight hospitals and 73 health centres and plays an important role in delivering HIV/AIDS services. A range of nongovernmental organizations, United Nations agencies and bilateral donors work alongside the government in mobilizing communities and supporting people living with HIV/AIDS. Nongovernmental organizations contributing to the national response include the Lesotho Network of People Living with HIV/AIDS, Lesotho Save the Children and Lesotho Youth Organization. UNICEF supports activities related to programme communication; the Expanded United Nations Theme Group on HIV/AIDS in Lesotho and the World Food Programme provide support for programme communication and material and nutrition support. [14]

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## **Madagascar**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

In Madagascar homosexuality is not specified in the penal code (is neither legal nor illegal). Stigma and discrimination is high and perceived to be invented by the vazaha (“foreigner”). The country has no NSP. NO visible gay culture but a very evident “homosocial culture” (men holding hands; caressing each other, sitting on each other’s laps) [7]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

The gay scene in Madagascar is small and there are no known Madagascar gay bars or Madagascar gay clubs available for the gay community. [5] There are however a number of cafes where the local gay community collects to socialize.[2]

An aspect of being gay in Madagascar is that many of the people, especially the men, state that homosexuality didn’t exist in their country, and it was something that was invented by the vazaha (foreigner).

According to anecdotal information, there is the belief that homosexuality didn’t exist. Malagasy tend to be a homosocial culture in which the men tend to spend more time with each other holding hands, caressing each other, and sitting in each other’s laps than they do with their girlfriends or wives. In addition, many of the men cross-dress by wearing women’s hats, blouses, and sandals because for many of them there is no real distinction between the respective “his” and “hers.”

3. Presence of an organized LGBT or MSM community

There is a National Aids Committee (CNLS).

4. What is known about stigma and discrimination of male same-sex sexuality

Anecdotal evidence suggests that many of the people, especially the men, believe that homosexuality does not exist in their country, and that it is something that was invented by the vazaha (foreigner). [6]

5. What is known about social position and needs of MSM living with HIV/AIDS

Homosexual men were essentially found in the capital and the big tourist towns working in restaurants, bars, and hotels where homosexuality wasn’t frowned upon like in the smaller more rural towns. [6]

6. Any on-going activities to counteract stigma and discrimination?

No information is available

7. Existence of homosexuality-related barriers to health care

HIV-prevalence rate is lower than in other southern African countries but levels of stigma and

discrimination are high. Research suggests that a high prevalence of curable sexually transmitted infections exists.

Factors favoring the spread of HIV are present such as: high prevalence of curable STDs increasing poverty prostitution and tourism. The internet suggests that the governments acts to curb sex tourism with punishment for prostitution and pornography [12]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Homosexuality is legal but there is no recognition of same-sex relationships. Homosexuality is legal in Madagascar. The age of consent is not 21. Neither homosexuality nor is sodomy mentioned in the criminal laws of Madagascar. The government acts to curb sex tourism with punishment for prostitution and pornography. [11]

#### 9. Any action under way to change legal status of homosexuality

No information is available

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

Sambatra Izay Salama promotes health through the fight against HIV/AIDS among vulnerable populations of Madagascar. Its objective is to: Reduction of the prevalence of AIDS/HIV IST on the vulnerable populations living in the Sisal programs intervention areas; Increase of sound attitudes with regards to IST/HIV/AIDS among the highly vulnerable populations (prostituted, homosexuals.....). ; Decrease of the exclusion and increase of number of infected malagasy people been taken in charge (PLWHA)

#### 11. HIV prevalence/incidence data for MSM and general population

According to USAID, data about men who have sex with men is lacking for Madagascar because of stigma and discrimination. However, data does suggest that the country has one of the highest rates of sexually transmitted infections in the world.

USAID has started a peer education approach to reach MSM and mobile men with money.

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

Madagascar is among very few countries in Sub-Saharan Africa with an opportunity to slow the HIV epidemic and avert the socioeconomic destruction that is evident in high-prevalence areas. With the internal and external migration of workforce to keep up with the labor needs of these economic zones, Madagascar will be faced with an increased problem containing HIV, which would have a negative effect on the economic and development efforts. If these problems are not proactively addressed, Madagascar could actually reverse the benefits brought to the country through the period of economic prosperity and increase its health and social burden. [10]

Even though low, the HIV prevalence in Madagascar is increasing, as seen among pregnant women attending antenatal clinics; prevalence in this population rose from 0.064% in 1995 to 1.1% in 2003. Madagascar's rapid increase in HIV prevalence is likely influenced by a variety of conditions, including low literacy, widespread poverty, limited access to health and social services, high rates of partner change, and an increasingly transient population. Madagascar also has some of the highest rates of sexually transmitted infections (STIs) in the world. Services for prevention and treatment of HIV, such as counseling and testing and antiretroviral

therapy, are being offered, but only a small portion of the Malagasy in need currently benefit from these interventions. At the end of 2003, Madagascar had only 13 sites offering counseling and testing services to 2,082 clients annually. Treatment for HIV is still limited in Madagascar, with only one site in the country currently offering antiretroviral therapy at the end of 2003. As of September 2004, only 30 of an estimated 17,000 adults in need of treatment for advanced HIV were receiving antiretroviral therapy [10]

With less than 1 percent of the population estimated to be HIV positive, Madagascar is one of the few low HIV-prevalence countries in sub-Saharan Africa. Recent expansion of Madagascar's surveillance system has yielded more representative data, lowering the national HIV prevalence rate from 0.5 to 0.2 percent, according to UNAIDS. The 2007 Biologic Sentinel Surveillance found a prevalence rate of 0.83 percent among pregnant women in Sainte-Marie and 0.35 percent in Morondava. However, several factors, including low levels of HIV awareness and risky behaviors, particularly among youth, have put Madagascar in danger of an HIV/AIDS outbreak. UNAIDS estimates that 49,000 people in Madagascar are HIV positive. [7]

As of the end of 2003, there were an estimated 140,000 people living with HIV/AIDS in Madagascar, up from 100,000 in 2001.<sup>1</sup> Recent studies suggest that the HIV/AIDS prevalence rate in Madagascar has begun to increase.<sup>1,2, 3</sup> Although Madagascar's HIV/AIDS prevalence rate (the percent of people living with the disease) is still relatively low (1.7%) compared to the sub-Saharan African region overall and to its neighboring countries, <sup>1,4</sup> there is concern that high levels of sexually transmitted infections (STI's) such as syphilis, could fuel the HIV/AIDS epidemic in this low-income country, as could other factors such as poverty and limited access to health and social services.<sup>2,5,6,7,8</sup> The Government of Madagascar formed a National AIDS Committee in 2002 and is currently operating a National Strategic Framework on HIV/AIDS. <sup>4, 5.</sup> [7]

Populations and Regions Affected include: Women account for more than half (58%) of adults estimated to be living with HIV/AIDS in Madagascar; Among young people ages 15-24, the estimated number of young women living with HIV/AIDS in Madagascar was more than three times that of young men; In 2003, 8,600 children<sup>11</sup> in Madagascar were estimated to be living with HIV/AIDS and there were an estimated 30,000 AIDS orphans. [7]

### 13. Current status of prevention, treatment and care for MSM

USAID is dedicated to assisting Malagasy programs working to maintain, if not reduce, the country's low HIV prevalence. Current USAID efforts are focused on implementing behavior change interventions targeting vulnerable groups, expanding access to necessary prevention products and services, and helping the government develop data to improve the decision making process.[3]

### 14. MSM related UNGASS indicators

In terms of the UNGASS indicators, Madagascar did not report on any of the 5 MSM indicators.

### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

*Knowledge of HIV/AIDS:* Although most Malagasy have heard about HIV/AIDS, studies have found that significant misconceptions about HIV/AIDS remain.<sup>5</sup> For example, among young

people ages 15-24, less than half (46%) of women and 43% of men knew that a healthy looking person could be infected with HIV.5 . [7]

*Access to Antiretroviral Therapy (ART):* There is little access to ART in Madagascar. As of June 2004, six people in Madagascar were receiving these medications (less than 1% of the 16,000 people estimated to be in need of ART as of December 2004).<sup>[7]</sup>

Although HIV-prevalence rate is lower than in other southern African countries, levels of stigma and discrimination are high.

#### 16. Whether and how MSM are included in National Strategic Plans

No information is provided

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

##### International Support/Major Donors

- The United States is one of the main donor governments providing funding and other support to address Madagascar's HIV/AIDS epidemic, although Madagascar is not one of the 15 focus countries of the United States' President's Emergency Plan for AIDS Relief (PEPFAR). The U.S. also provides support for HIV/AIDS efforts around the world through its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund).
- The Global Fund has approved three HIV/AIDS grants in Madagascar

Table 1: HIV/AIDS in Madagascar<sup>1, 3, 10,</sup>

Indicator	Madagascar	Sub-Saharan Africa	Global
Estimated number of people living with HIV/AIDS, 2003	140,000	25 million	37.8 million
Percent of adult population estimated to be living with HIV/AIDS, 2003	1.7%	7.5%	1.1%
Estimated number of deaths due to HIV/AIDS, 2003	7,500	2.2 million	2.9 million
Women as percent of adults estimated to be living with HIV/AIDS, 2003	58%	57%	48%
Percent of young women, ages 15-24, estimated to be living with HIV/AIDS, 2001	0.19 – 0.28%	8.9%	1.4%
Percent of young men, ages 15-24, estimated to be living with HIV/AIDS, 2001	0.05 – 0.08%	4.4%	0.8%
Estimated number of AIDS orphans, 2003	30,000	12.1 million	15 million
Number of people estimated to be receiving antiretroviral therapy (ART), 2004	6 (June 2004 est.)	310,000 (Dec. 2004 est.)	700,000 (Dec. 2004 est.)
Number of people estimated to be in need of ART, December 2004	16,000	4.0 million	5.8 million

Alliance Madagascar was one of the first organisations to focus on prevention of HIV and sexually transmitted infections with high risk population groups, successfully raising the profile

of marginalised populations and putting them at the heart of the country's HIV response. One example of this was the programme's work with vulnerable women in the Gates Foundation-funded Frontiers Prevention Programme (FPP) running from 2003 to 2006.

The Alliance also supported the national networks of people living with HIV and sex workers to take action against stigma and discrimination. The networks compiled a record of cases of abuse and used this information to advocate for better access to health centres and employment opportunities.

The programme also supported the creation of local HIV committees in 20 priority districts, conducted a number of studies on vulnerable populations and sex work in Madagascar, and supported the development of the national five year action plan for vulnerable populations in collaboration with UNAIDS/UNDP.

After eight years of successful programming, the Alliance office in Madagascar closed at the end of October. Alliance Madagascar had been at the centre of the HIV response in the country, and facilitated the development of major networks of marginalised and vulnerable groups including people living with HIV, vulnerable youth, men who have sex with men, and sex workers. [1]

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## **Malawi**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Homosexuality is illegal in Malawi and punishable by up to 14 years in prison, which has prevented the development of an open gay community. A survey conducted by Dr. Eric Umar – a psychology lecturer at the College of Medicine – a constituent college of the University of Malawi – revealed that there are an estimated 10, 000 gays who operate underground for fear of being ostracized and imprisoned. “We have so many gays in Malawi – from all social groupings, and some of them are high-profile people. We have very educated gays, including those with university qualification as well as those who are not educated at all. [5]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Other than at CEDEP, there are no organised or specific places where gay people can meet, and the majority of MSM are closeted. Many MSM are married to women. [8]

Homosexuality is said to be rampant along the lake resorts of Malawi where the local inhabitants meet foreigners who introduce the same to them. The tourists are said to be splashing money on young Malawians in order to indulge with them in this practice. [9] In 2006, Blantyre Minister of Information and Tourism Patricia Kaliati said she visited the lakeshore resort of Chintheche Inn where she complained that homosexual tendencies are “infecting areas around the country’s lake resorts”. [9] She said tourists coming into the country are introducing the malpractice to innocent Malawians by promising them money.

3. Presence of an organized LGBT or MSM community

The Center for the Development of People (CEDEP), a Malawian human rights organization in Blantyre, advocates for LGBTI rights. It is funded by HIVOS, AmFar and the Open Society, and holds meetings for LGBTI people twice a month; it seems only men come to the meetings. It also has men’s netball and basketball. [8]

4. What is known about stigma and discrimination of male same-sex sexuality

In Malawi, sex between men is socially, culturally, legally and religiously prohibited creating room for stigma and discrimination which results in the prevention of homosexuals to access STIs and HTC services due to fear of sexual orientation disclosure, In May 2010, Blantyre chief resident magistrate Nyakwawa Usiwa Usiwa sentenced the two men to 14 years hard labour for “unnatural acts” and “gross indecency”. The magistrate said he was giving the gay couple the maximum sentence permitted under the country’s colonial-era penal code because he wanted to protect Malawians and their children from homosexuality. [17] In Malawi, homosexuality has almost always been discussed in relation to sexually transmitted infections, criminality, and unsafe prison conditions. [14] Arguing on the basis of “divine creation,” culture and morality, an officer of the Malawi Classification Board (previously the Censorship Board) wrote that a homosexual marriage is a foreign concept and practice and is against the cultural values, norms, and dignity of Malawians. The practice of homosexuality is against the creation of man and woman as God designed them to be. Other opponents of homosexuality claimed that homosexuality was in a way promoted by the white race. [14]

The executive director of CEDEP, an organisation addressing the needs and challenges of the most at risk populations in the context of HIV and AIDS, human rights and social wellbeing, said the lives of homosexuals in Malawi were characterized by rejection, verbal and physical abuse so much that stigma and discrimination drives them under the ground and where they can hardly be reached with HIV related information. In Malawi, sex between men is socially, culturally, legally and religiously prohibited creating room for stigma and discrimination which results in the prevention of homosexuals to access STIs and HTC services due to fear of sexual orientation disclosure, and that it was important that the government and NGOs create awareness among stakeholders, the general public including the media of HIV issues affecting homosexuals so that the policy environment encourages funding of gay-HIV related programs. [13]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

According to a study conducted by the Centre for the Development of People (CEDEP) in collaboration with the Malawi College of Medicine in 2008, HIV prevalence in homosexuals in Malawi, which is mostly urban centred, stands at 21 per cent, higher than the national prevalence rate which is at 12 per cent and the national productive adult male rate which is at 11 per cent. Eric Umar, a psychologist in the department of community health at the Malawi College of Medicine attributed the HIV high prevalence rate in homosexuals to unprotected anal intercourse and high frequency of male partners among other reasons. The study findings showed that interviewees had more than three sexual contacts per week and averaged more than ten sexual encounters in their lives and that another study indicated a maximum of 51 homosexual encounters in six months. Umar said that the studies revealed that most people practicing homosexual are educated with 82 per cent of the interviewees saying they had gone through tertiary education and 100 per cent being secondary school graduates. This shows that these are people who know what they are doing; however, their situation is now a public health issue and needs to be looked into seriously. The psychologist noted that one of the reasons the country is having more unstable marriages and divorces is because homosexuals are forced to marry people of the opposite sex because of societal pressures. [1]

#### 6. Any on-going activities to counteract stigma and discrimination?

Organisations and individuals have called for repeal of laws stigmatizing homosexuality. The Center for Development of People (CEDEP) in Blantyre continues its efforts to revise laws against homosexuality. CEDEP urged the Malawi Law Commission to conduct a comprehensive review of penal statutes to determine whether the criminal offences they create are consistent with constitutional and international human rights standards. By criminalizing sexual practices between two consenting adults in private, it threatens a citizen's constitutional rights to privacy, dignity and freedom of association. [1]

Reinghard Kaweta Chavula, a Local Government and Rural Development officer under the Blantyre District Assembly supported this notion. He said that in the wake of HIV and AIDS, Malawians have to change their attitudes towards homosexuals as some are forced into heterosexual relations to be in line with societal expectations yet they do not have access to homosexual related health care services. It is important that the nation finds a legal address to their situation so that they can come out in the open and be accepted by the society without fear of stigma otherwise as the situation is, this is a dangerous hidden society that can infect their unsuspecting wives because of lack of health care services. [13]

Human rights lawyer Crispin Sibande said it was necessary that the government and the private

sector accommodate homosexuals in their efforts to fight HIV and AIDS. He said homosexuality in Malawi is not recognized, not accepted but seen and known, and the first step to change the situation in the country was to challenge the provision in the penal code which criminalizes homosexuality and bestiality. [13]

On May 18, 2010, a Malawian couple, a transwoman and a man, were convicted by the Malawian courts for having committed "unnatural offenses" and "indecent practices between males" under sections 153 and 156 of Malawi's criminal code, following arrest at their home in Blantyre. The trial and sentences were condemned by regional human rights organizations including AIDS and Rights Alliance for Southern Africa (Arasa) the Southern Africa Litigation Centre (Salc), the Centre for the Development of People (CEDEP) and the Centre for Human Rights and Rehabilitation (CHRR). In addition, international human rights organizations such as Amnesty International and IGLHRC reacted with condemnation, as did donor entities and governments such as the UK government, Germany, the African Development Bank (AfDB), Norway, the European Union and the World Bank, who operate under the Common Approach to Budget Support (CABS). Following pressure from civil rights groups, President Jacob Zuma of South Africa also condemned the imprisonment and discrimination against gay men and women.[13] The singers Madonna and Elton John have also been vocal in their condemnation. However, the Malawi Council of Churches (a grouping of Anglican, Baptist, Evangelical and Presbyterian churches) advised the Malawi government to retain current laws against homosexuality in the criminal code and to disregard the pressure from donor countries, advising the countries to respect Malawi's cultural and religious values and refrain from using aid as a means of forcing the country to legalise sinful acts like homosexuality in the name of human rights. The International Women's Health Coalition,[14] OSISA, and Gender Dynamix, identified the imprisonment of Tiwonge, in particular, as an issue of transphobia due to the fact that Tiwonge identifies as a woman and dresses in women's clothing. On May 29, 2010, President Bingu wa Mutharika pardoned both individuals, during a visit by Ban Ki-Moon the UN Secretary General. [25]

#### 7. Existence of homosexuality-related barriers to health care

Malawi has one of the highest national HIV prevalence rates in the world. Most notably it revealed that 56% of men who have sex with men also have sex with female partners, whether they are wives, casual or anonymous partners. Very disturbing also was the fact that 95.3% of the men were unaware of their HIV status. The majority of about 76.5 % indicated that no health professional had ever recommended that they be tested for HIV. An important hidden issue here is that advising a man to get tested or use condoms suggests an accusation that he is promiscuous or unfaithful, which virtually all men will deny and may elicit defensive hostility. If a wife wants her husband to use a condom the implied accusation can cause serious marital problems [8]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Homosexual acts are illegal in Malawi. Section 153 prohibits "unnatural offences". Section 156 concerning "public decency" is used to punish homosexual acts.[2] Tourists who commit acts of homosexuality with locals can be prosecuted under article 156 and expelled as "undesirable aliens". Homosexual acts are proscribed under the Malawi Penal Code of 1930, drafted when Malawi was under British colonial rule and retained after independence. No specific laws against homosexuality were in place before British rule. Homosexuality remains largely a taboo subject in the generally conservative country. In 2007 the Anglican Church sent a pro-gay rights



Bishop, Nick Henderson, to head a diocese in rural Malawi. However, the congregation did not accept him and protests led to the death of a church member. [25]

Section 156 concerning "public decency" is used to punish homosexual acts. Tourists who commit acts of homosexuality with locals can be prosecuted under article 156 and expelled as "undesirable aliens".

Malawi has some of the harshest laws in all of Africa criminalizing homosexuality. Sex between men is punishable by up to 14 years imprisonment, although it appears that female-to-female sexual relations are legal. [21]

It is reported that, in the past, Europeans who committed homosexual acts with Malawians were prosecuted under Article 156 and expelled as undesirable aliens. Some call homosexuality "bad culture", "malpractice", "satanic", and an "insult to a family's honor". [8]

The Constitution of the Republic of Malawi gives everybody the freedom of association. In 2006 Malawi's Health Minister spoke publicly about homosexuality and MSM. However, Malawi's National Policy on HIV/Aids (2003) does not mention MSM. [8]

#### 9. Any action under way to change legal status of homosexuality

Malawi Human Rights Resources Centre (MHRRC) proposed to Malawi Law Commission to legalise homosexuality in the country, currently an offence under the penal code. [15] UN and gay rights activists are working against impediments to changing attitudes and laws on homosexuality in Malawi however have not been successful as yet.

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

Homophobia is rife in Malawi and the general consensus is that homosexuality is wrong. Because of these attitudes both the UN and gay rights activists are working against a impediments to changing attitudes and laws on homosexuality in Malawi. The Centre for the Development of People (Cedep), Malawi's Human Rights Consultative Committee (HRCC), Malawi Human Rights Resources Centre (MHRRC), and the Student Law Society of Malawi (SLS), are advocating for sections in the Penal Code to be repealed so that homosexuality is legalised. In July 2009, the country's Constitution Amendment Bill banning homosexual marriages was passed by parliament.

Local NGO, Centre for the Development of People (Cedep), is concerned about sections in the Penal Code of Malawi that criminalise homosexuality and wants them repealed. Cedep says sections 153 and 156 of the Penal Code target any conduct or forms of behaviour that are not heterosexual. The issue of homosexuality was never discussed at the national constitutional conference. Cedep recommends to the Malawi Law Commission conducts a comprehensive review of penal statutes to determine whether the criminal offences they create are consistent with constitutional and international human rights standards.

A few years ago Malawi Human Rights Resource Centre (MHRRC) urged Malawians to debate whether to legalise homosexuality or not, citing the same reasons that it impedes on the citizens' human rights, but their call was met with condemnation from the general public and religious community. [16]

A proposal to incorporate homosexuality into the Malawian Constitution was strongly repudiated by that country's Legal Affairs Committee. Malawi's Human Rights Consultative Committee (HRCC) together with Student Law Society of Malawi (SLS) submitted the proposal during a meeting aimed at getting the public's input on the country's constitution. These two social and legal consortia pleaded to legislators to also endorse laws that could represent homosexuals. Benjamin Banda, a Member of Parliament (MP), emphasized that there was no evidence to prove that homosexuality was practiced in Malawi, and continued that it could not therefore be legalized for the mere reason that it has been made legal elsewhere in the world. Also speaking against homosexuality, MP Adden Mbowani Nkhotakota said that homosexuality could not be legalized in Malawi because it is evil, and stands for everything that is immoral in the country. [18]

Mary Shawa, secretary for nutrition, HIV and AIDS in the president's office, advocates for a human rights approach to the delivery of services for people living with HIV/AIDs. Her opinion that the fight against HIV will not be won without a change in attitude towards risk groups, such as men who have sex with men. This unsurprisingly sparked controversy in the conservative African country. [21]

The Opposition Peoples' Transformation Party (Petra) says it is against legalising homosexuality and has urged Malawians to reject any external pressure to embrace the practice. Petra President Kamuzu Chibambo says a debate on homosexuality or any sexual relationship between same sex should be done openly and urgently by all Malawians who are concerned with the well being of the country. He argues that the country's laws must not be tampered with so as to accommodate other sexual orientations. [19]

#### 11. HIV prevalence/incidence data for MSM and general population

The first figures released from a series of systematic surveys of men who have sex with men in southern Africa has revealed, at least in the first site analysed in Malawi, very high levels of behaviours likely to enhance the spread of HIV. These figures were presented at the meeting of the Global Forum on Men who have Sex with Men and HIV, a satellite conference on gay men and MSM attended by nearly 500 people in the two days preceding the World AIDS Conference. Nearly two-thirds of the men surveyed had had sex with women as well as men in the last six months and nearly half had a steady female partner; only a third consistently used condoms in casual sex with other men and only a quarter with women; and although the average number of male partners amongst the group as a whole in the previous six months was four, amongst those with HIV it was 14. HIV prevalence among MSM was 21%, nearly twice the general-population prevalence of 12%; in early results from the South African survey HIV prevalence was similarly about double that in the general population. The Malawi survey was the first in a series conducted by the Johns Hopkins School of Public Health, in partnership with local LGBT and sexual rights organizations. Because of the survey methodology, this was a well-educated urban population. Their mean age was 26, 91% had been in secondary education and 70% were of urban origin, in this overwhelmingly rural country. In one indication of rapidly-changing sexual opportunity and mores, 44% had met sexual partners on the internet; in another, 12% had at any time injected drugs, though the survey does not say which ones. Being 'out' as gay or bisexual was rare; only 6% had told immediate family members about their sexuality and only 14% a member of their extended family. Fifty-five per cent said they currently had a boyfriend, 47% a girlfriend and 26% said they had both male and female steady partners. Only 40% defined themselves as gay or homosexual, 53% as bisexual and 7% heterosexual. Forty-five per cent only had casual partners. The mean number of male partners men had had in the last

six months was 3.9 and 1.5 female partners; 17.5% had had six or more male partners. Sixty-three per cent had also had at least one sexual contact with a woman in the six months. HIV status was related to self-defined sexuality; 15% of the 106 men who defined as bisexual had HIV, 26% of the 79 men who defined as gay, but none of the 15 men who defined as straight. In a multivariate model, the only significant risk factors for HIV were meeting partners on the internet, not always using condoms and being over 25. Thirty-five per cent said they always used condoms with casual male partners and 25% with any partner. With casual female partners 26% always used condoms and with any partner 19.5%. With casual male partners 22% 'sometimes' used them, 2.5% rarely and 10% never, with the remainder not having casual partners; with casual female partners 12.5% 'sometimes' used them, 5% 'rarely' and 3.5% 'never', with the remaining 53% not having casual female partners. Only a third regularly used water-based lubricant for anal sex and only 2.6% said they 'always' used both condoms and a water-based lubricant. In an indication of the human rights context in which these men live, 18% said they had been afraid to seek health services because of their sexuality, 18% had been blackmailed because of their sexuality, 8% had been beaten up by the police or government officials, and 11% had been raped. [6]

Malawi has one of the highest HIV prevalence rates in the world. Estimates range from an 11.8 per cent adult prevalence rate found in the 2004 Demographic and Health Survey to a 14.1 per cent prevalence rate estimated by UNAIDS in 2005. Yet, a study released in Copenhagen in July at the World Outgames, involving 200 Malawi men, 75 per cent of whom had multiple male sexual partners, revealed a prevalence rate among respondents of around 21 per cent, an obvious difference with the national rate. Among respondents, only 1.5 per cent had ever been told by a health professional that they were HIV positive, with 77 per cent never having been asked by a health professional to undergo an HIV test. The impact of criminality and stigmatisation is also revealed by the fact that only 10 per cent has informed a health professional that they have sex with men. The 2007 study also revealed that politicians and leaders in Malawi prefer to promote the idea that homosexuality does not exist in Malawi. [21]

In 2008, CEDEP [8] conducted an HIV sero-prevalence study among men who have sex with other men (MSM) in Malawi. The research was conducted in collaboration with the John Hopkins Centre for Public Health and Human Rights, Open Society Institute of Southern Africa (OSISA) and the University Of Malawi College Of Medicine. The report found that the HIV infection rate in the sample was 21% (as opposed to 12% in the national population). An alarming 95.4% of the men were unaware of their HIV status. The report argues that the criminalization of same sex behavior and the stigmatization of MSM contribute to their HIV risk. [8]

Other research reveals that of the men who have ever had anal sex with another man, 6.5% of the sample self-identified as heterosexual, 40.5% as gay/homosexual, and 53% as bisexual. None self-identified as transgender. 17% had disclosed sexual orientation to a family member and 8.9% to a health care worker (Baral). 4% of the sample claimed that they had been denied health care because of their sexuality, 17.59% were afraid to seek health services and 18.0% had been blackmailed because of sexuality. The threat of blackmail may result in MSM not going for an HIV test or seeking health care. [8]

Research conducted by Chibwezo (et al) found that 33% of the sample reported not always using a condom. Only 18% had ever received HIV prevention messages targeted at MSM and 40% had ever gone for VCT. 70% said they would not disclose their sexuality to non MSM members. 90% had not disclosed to non MSM and family while 30% did not disclose their

sexual orientation to a health worker when they had to. 95% said they would prefer to attend MSM gatherings in private and 85% of these would not mind the presence of non-MSM professionals. 65% would not prefer to go to a MSM-only health care centre for treatment unless discreet (70%) and 95% of all would prefer being attended to by a gay-friendly health worker. [8]

Research also indicates that homosexuality is rampant in the prisons. [8]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

In 2006, Malawi's health minister Marjorie Ngaunje, speaking at the opening of the third annual forum of national Aids authorities from the 14 member nations of the Southern African Development Community (SADC), said that to make advances in HIV AIDS prevention, Malawi must begin to tackle honestly the difficult questions that the epidemic raises addressing positively the needs of sex workers and of men who have sex with men. [3]

The National AIDS Commission is concerned with the needs of MSM. The director has attended workshops on MSM organized by the Center for the Development of People. In Earlier in 2009, she said publicly that it is important to involve gay people in HIV and AIDS Programs.

## 13. Current status of prevention, treatment and care for MSM

HIV is still a taboo subject in many communities within Malawi and discrimination is common. As a result, few people living with HIV make their status known, many have difficulty discussing the subject with their families, and some support groups do not meet openly.

Homosexuality is illegal in Malawi and punishable by up to 14 years in prison (rarely imposed but always threatening), which has prevented the development of an open gay community or even public discussion of this lifestyle and associated health issues. As a result, human rights abuses on the basis of sexual orientation have been high with about 39% of the research MSM's being victims of crimes or being denied healthcare and/or housing. Eighteen percent of the sample said they had been afraid to seek health services because of their sexuality; 18% had been blackmailed; 8% had been beaten up by the police or government officials, and 11% had been raped. [1]

A 2004 report emanating from the University of Pretoria "HIV/Aids and Human Rights in Malawi", in relation to homosexuality the report highlights that the National Policy document, in section 4.9, provides for the drafting of guidelines for an effective response to promoting prevention and care in terms of HIV infection for people in same sex relationships. In section 7.1.2 the National Policy also addresses the involvement of traditional leaders in the issue. "Traditional leaders should be sensitised with a view that, in the long term, prostitution, sodomy and same-sex sexual practises may be decriminalised for proper management of the HIV/Aids epidemic. The report emphasises that the National Policy also states that government shall promote the empowerment of commercial sex workers and same-sex sexual partners to enable them to make informed decisions about their sexual life. While there seem to be many positive elements to the National Policy, as pointed out in the report, there are discernable cracks in the veneer. For example, in relation to condom distribution, free condoms are supposed to be made available in prisons. The Department of Home Affairs has however kept true to its promise not to segregate HIV + prisoners from the rest of the prison population, which is in accordance with the National Policy. [2]

#### 14. MSM related UNGASS indicators

In terms of the UNGASS indicators, Malawi did not report on any of the MSM indicators. [8]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Homophobia is rife in Malawi and the general consensus is that homosexuality is wrong. Because of these attitudes both the UN and gay rights activists are working against an impediments to changing attitudes and laws on homosexuality in Malawi.

In 2007 Malawi admitted that *AIDS was one of its biggest challenges*". Homophobia in Malawi may be rooted in the role of the west, religion, history and politics.[20] AIDS is commonly perceived as being related to homosexuality in Malawi, hence the stigmatization of homosexual people and extensive objections to tolerating same-sex couples. Although in reality, in Africa as a whole there is a general prejudice against wearing a condom, which essentially stems from men wanting to be 'masculine', which is arguably an underlying result of the "emasculatation" of men in Africa during years of colonialism and exploitation from the west. Consequently both women and men are exposed to great risk of contracting HIV, and this reluctance to practice safe sex is breeding grounds for the disease to spread. The Guardian newspaper summed the situation in Africa up well by stating, "*A crisis of masculinity underlies much of the hysterical rhetoric around homosexuality*". [20]

Furthering the complex issues surrounding the 'masculinity' of men influencing an intolerance towards homosexuality, is that fathering a child, not just in Malawi, but in many other African nations, is seen as an expression of a man's 'manliness'. It deepens the alienation towards gay couples whose '*unnatural*' sexual exploits can obviously not produce a child. [20]

Religion also plays an imperative role in understanding the roots of Malawi's homophobia, whose doctrine is to view homosexuality negatively and to regard it as a sin. [20]

Ironically stigmatizing and punishing gays and lesbians will only push homosexuality underground, which instead of proactively helping the fight against HIV in Malawi it is likely to worsen the situation.

#### 16. Whether and how MSM are included in National Strategic Plans

The Constitution of the Republic of Malawi gives everybody the freedom of association. In 2006 Malawi's Health Minister spoke publicly about homosexuality and MSM. However, Malawi's National Policy on HIV/Aids (2003) does not mention MSM.

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

The scope of the HIV/AIDS epidemic in Malawi presents many challenges to treatment. One of the greatest challenges is building the capacity of Malawi's health care system – especially in the rural areas – to cope with the enormous needs of the people. Other serious constraints include: the severe lack of trained health care professionals and para-professionals; limited access to health services, especially in rural areas and among the poor; an inefficient supply chain for drugs and other supplies; inadequate physical infrastructure; and limited laboratory capacity. These critical barriers make it particularly difficult to provide treatment and care. The

high levels of HIV infection have resulted in an unprecedented increase in the number of tuberculosis cases, which rose to over 27,000 cases annually in recent years. The disease burden is also exacerbated by endemic malaria, which affects up to four million people annually, the majority of whom are women and children. [26]

Recognizing the global HIV/AIDS pandemic as one of the greatest health challenges of our time, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003. To address the HIV/AIDS epidemic in Malawi, the U.S. Government (USG) through PEPFAR is working in partnership with the National AIDS Commission and the Ministry of Health to support Malawi's National HIV/AIDS Action Framework. In Malawi, USG collaborates with the Government of Malawi and other stakeholders to develop and support critical interventions for HIV/AIDS prevention, treatment and care. Intervention strategies of PEPFAR involve: Strengthening government and private health systems to scale up counseling and testing, antiretroviral treatment, and prevention of mother-to-child HIV transmission services; Building capacity to support strengthening of critical areas, including laboratory infrastructure and strategic information; Filling the critical gaps in HIV prevention and behavior change interventions; Strengthening care services provided by the public sector and indigenous organizations; Expanding and strengthening services for orphans and vulnerable children in urban and rural areas; and Supporting coordination between HIV/AIDS efforts of PEPFAR, the Government of Malawi, and other partner organizations.

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## **Mauritius**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Although Mauritian law does not explicitly outlaw homosexuality, gays here complain of rampant social discrimination despite provisions in the constitution designed to prevent such bias. [11]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

There is no specific place to meet for gay. Usually, they do meet in clubs and in public places like shopping malls or seaside to know each or date for the first time. The meetings are very “straight looking” meetings just for drink and share some information. [7] According to the internet, there are a few discreet gay beaches [10]. MSM also use the internet to arrange rendezvous. However, there are a few discreet gay beaches, Trou aux Biches, Mont Choisy, Grand Baie and Pereybere, on the north coast, though check local news groups on the internet as the exact locations shift monthly. In fact, the whole gay community use the internet to arrange meetings and get-togethers. Rendezvous are very discreet, which can make attending them adventurous affairs. Most guys who make it onto the tiny scene are under 25. According to anecdotal information older gays either leave, or settle down with a wife and kids. There’s so much pressure to study, marry and have a family. Many young gays who “enjoy” a gay life until it’s time to marry. [2]

Contradictory anecdotal reports are that Men dressing up as women seem quite common on the island. Other report state that if someone is gay here, he may be regarded as a freak, and made fun of, no matter how straight he may look!” Blending in seems to be the only way to get through the day, “You may not care what others think, but many gay people in Mauritius are afraid someone may recognise them as a gay. The island is too small. Many gay guys plan to leave the island at some point, and many go to South Africa or Europe as soon as they can afford the journey. There’s little appetite for fighting public attitudes. It’s an unfortunate belief that coming out as gay brings shame on the family, which too many Mauritian gay men aren’t willing to do. [2]

3. Presence of an organized LGBT or MSM community

There is a Mauritian LGBTI organisation called Collectif Arc-en-ciel (CAC) which organises annual pride parades and works towards increasing LGBT visibility. CAC has highlighted the importance of setting up facilities to support the transgender and transsexual community. However, other organisations working on the SRH field also cares for people with diverse sexuality and they are PILS, Mauritius Family Planning and Welfare Association. [7]

4. What is known about stigma and discrimination of male same-sex sexuality

Anecdotal information states that Mauritian society is not yet open as in Europe and USA. The stigma and discrimination are still present. These include giving nick names -making fun of you- if one gay is too feminine, he will have difficulty in getting jobs either in governmental offices or firms. It is still thought that gays are responsible for HIVs though the problem in Mauritius for the rise in HIV is related to IDU [7]

Much remains to be done in Mauritius to ensure equal rights for all citizens. The questionnaire one has to fill before giving one’s blood is an example of discrimination against gays. Danielle



who is gay did not hesitate to tell it to the person present in the blood donors' caravan in Port-Louis when she went for blood donation, but was astonished when she was told that she could not give her blood because she was homosexual. [6]]

The fight for rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) people in Mauritius is finally bearing fruits. The country's government has, for the first time, included sexual orientation in its discrimination bill. Employment Rights Bill, states that nobody should be discriminated against based on sexual orientation while applying for a job. Parallel to this provision, the Bill also indicates that nobody can be dismissed from the job on the basis on sexual orientation. For the Mauritian LGBTI organisation, Collectif Arc-en-ciel, this move shows great victory for the LGBTI people, and constitutes a step towards recognition of all rights. With no legal basis supporting their rights to employment or protecting them from discrimination before, LGBTI individuals were either finding it difficult to get a job or were at the mercy of abuse from employers. They were silently suffering prejudice. [16]

In 2007, the Sexual Offences Bill tabled at the Mauritian Parliament brought much heated debate from both sides of the house, as well as protests from religious leaders and professionals. The bill could also decriminalise consensual anal sex. Such debate and delay about putting sexual offences firmly on the legal agenda are not unique to Mauritius. Only a handful of countries in the Southern African region have such laws in place, including Lesotho, Namibia and Tanzania. In Mauritius, the bill would not only mean stronger legal protections, but it has already meant a greater openness on gender violence issues. But activists hold some points still need clarification, such as sex trafficking of children and adults; offences covering commercial sexual exploitation related to pimps and others who force children and adults into prostitution; indecent exposure, etc. It is also seen as unfortunate that the voices of those most concerned: victims, survivors, youth, sex workers, gays and lesbians, were largely absent from the debates.

The bill is very much in line with the draft National Action Plan (NAP) to end Gender Violence, approved at an October 2006 workshop organised by the activist group Gender Links of South Africa and Mauritius' Media Watch Organisation, with various representatives of ministries, police, civil society and non-governmental organisations.

The Mauritius NAP recommends that the Sexual Offences Bill encompass a wider definition of rape, including marital rape, as well as protection against human trafficking and harsher penalties. It recommends provisions for comprehensive treatment and empowerment of victims, and video recording of complaints to reduce distress of survivors. [15]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

Mauritius has a population of 1.2 million made up of Hindus, Catholics and Muslims. The gay community, which activists say makes up about 10 percent of the population, is mostly underground as many face persecution and discrimination. Little is known of the social position and needs of MSM living with HIV/AIDS

#### 6. Any on-going activities to counteract stigma and discrimination?

Many NGO are working and helping as well as addressing the stigmatisation but like marches, articles on press and radio programmes. LGTB community is being consulted to involve them into decision making with NGO's for a better serving their needs. [7]

#### 7. Existence of homosexuality-related barriers to health care

However, Mauritius also acknowledges that the country has laws which do present obstacles to effective HIV prevention, treatment and care for MSM. For example, there are criminal codes against anal sex

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

There is no section in the Mauritian Constitution dealing with sexual orientation. The Sections of the Penal Code Penal which may be of interest are as follows: Section 250 Sodomy and bestiality: Any person who is guilty of the crime of sodomy or bestiality shall be liable to penal servitude for a term not exceeding 5 years. Section 251 Debauching Youth(1) Any person who offends against morality, by habitually exciting, encouraging, or facilitating the debauchery or corruption of youth of either sex under the age of 18 shall be punished by imprisonment for a term not exceeding one year and by a fine not exceeding 2,000 rupees. (2) Where such prostitution or corruption has been excited, encouraged or facilitated by the father, mother, guardian or other person entrusted with the care of youth so debauched, the punishment shall be imprisonment and a fine not exceeding 5,000 rupees.

The Sexual Offences Bill includes forced anal sex and oral sex in its definition of rape, with a possible penal servitude not exceeding 45 years.

The country recognizes that stigma and discrimination are a challenge, and maintains that there are non-discrimination laws which protect MSM. [11]

The country's Employment Rights Bill (adopted in December 2008) states that job applicants should not be subjected to discrimination because of sexual orientation; nor can anyone be dismissed from a job because of his or her sexual orientation. [11]

It is still illegal in Mauritius for a gay couple to get married. As far as I know, there is nothing being done to change the law. However, many gay couples are cohabiting and living together without any problem. [7]

#### 9. Any action under way to change legal status of homosexuality

Gay and lesbian people of Mauritius they want protection against discrimination built into new human rights legislation. The homosexual community felt that sexual orientation must be included in the law to be debated by Parliament in July. Currently there is a gap in the law concerning homophobia in Mauritius. Homosexuality is neither legal nor illegal, so if a victim of sexual discrimination complains to the police, they have no legal reference. They want the Equal Opportunity Bill has provisions on discrimination based on sex, race or religion. There should be no second-class citizens in this country. It is time discrimination ended in this country. Although Mauritian law does not explicitly outlaw homosexuality, gay people here complain of rampant social discrimination despite provisions in the Constitution designed to prevent such bias." [10] Employment Rights Bill, as it is known, states that nobody should be discriminated against based on sexual orientation while applying for a job. Parallel to this provision, the Bill also indicates that nobody can be dismissed from the job on the basis on sexual orientation. [16]

The Sexual Offences Bill tabled in 2007 at the Mauritian Parliament brought much heated debate from both sides of the house, as well as protests from religious leaders and professionals. The bill could also decriminalise consensual anal sex. Amid the outcry, the speaker has tasked a Select Committee to look into the bill in detail. [14] The HIV and AIDS Act (2007) provides for a rights-based approach to HIV and AIDS-related issues.

10. Any human rights based organizations active in this country that does or should address MSM issues?

The Arc-en-Ciel, The Human Right Commission, The Ministry of Justice and Human Rights, the Ombudsperson offer their support to LGBT community. [7]

11. HIV prevalence/incidence data for MSM and general population

It is estimated that 51-75% of HIV prevention programs for MSM are provided by civil society (UNAIDS).

According to anecdotal information, those who have been found infected with HIV/Aids, the government are providing all the services necessary for them like medical drugs for free. Few of them are given state pension etc. However, PLWHA, especially MSM needs additional help like more information. Though the state is giving pension but this is insufficient. [7]

The majority of MSM are discreet. If someone comes out, his family will suppress it or have recourse to direct services like counselling etc. Condoms and lubricants are easily available through the island in Pharmacies. In State ran medical centres, only condoms are available. [7]

In Mauritius like in many countries, men who have sex with men are less visible and are most difficult to reach. Sex between men is stigmatized and officially denied. This adds to the vulnerability of men who have sex with men, and it is challenging to carry out relevant HIV prevention campaigns. In Mauritius although homosexuality is tolerated, men who have sex with men often hide their same-sex relations from their friends and families to avoid persecution. Many are bisexual and married, and this means that they may transmit HIV to their female partners if they become infected.

Addressing the lack of services for marginalized groups in the global HIV epidemic, including men who have sex with men, Ban Ki - moon, the UN Secretary - General remarked, "not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us". [13]

In Mauritius there is growing evidence that transmission through MSM is a significant problem. Though data from Mauritius is severely lacking, studies of African men who have sex with men have shown that unprotected anal sex is common place and HIV prevalence among men who have sex with men is as high as 25.3% in some African countries. To address this situation the AIDS Unit, MOH and QL, have developed a network of LGBT in 2000 (lesbian, Gay, Bisexual, and Transgender), where regular awareness sessions, HIV testing and condom distribution were organized. In 2006, in spite of opposition from various segments of the Mauritian Society, an NGO for LGBT "Collectif Arc en Ciel" was launched. UNAIDS had a regional project in its 2008 - 2009 biennium and because of varied issues, the project has finally been postponed to 2010.

The Republic of Mauritius had very few HIV positive HIV and AIDS cases prior to 2000, with a range of 20 to 30 new HIV positive cases reported yearly till the end of 2000. During the period 2001 - 2005 there was a drastic change in the HIV situation, with an exponential rise in the number of detected cases to reach a peak of 921 cases in 2005. The majority (92%) of all new HIV infections in Mauritius by 2005 were injecting drug users. It can be surmised that this change was most likely due to increased HIV testing, particularly among IDUs in various

institutions including the prisons and might not necessarily represent a sharp rise of new IV infection. This situation characterises the epidemic as a 'concentrated' one, with HIV prevalence estimates among ANC women to be below 1% and above 5% among Most at Risk Populations (MARPs),<sup>1</sup> comprising Injecting Drug Users (IDUs), Female Sex Workers (FSWs), and Men having Sex with Men (MSM). The status of the MARPs is as follows:

Table 1: HIV Prevalence of High Risk Groups

Most at Risk Populations	%
Injecting Drug Users (IDUs)	47.4 (IBBS □ 2009)
Female Sex Workers (FSWs)	Unknown
Men having Sex with Men (MSM)	Unknown
Prison inmates	Unknown

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

In Mauritius there is growing evidence that transmission through MSM is a significant problem. Though data from Mauritius is severely lacking, studies of African men who have sex with men have shown that unprotected anal sex is common place and HIV prevalence among men who have sex with men is as high as 25.3% in some African countries. To address this situation the AIDS Unit, MOH and QL, have developed a network of LGBT in 2000 (lesbian, Gay, Bisexual, and Transgender), where regular awareness session, HIV testing and condom distribution were organized. In 2006, in spite of opposition from various segment of the Mauritian Society, an NGO for LGBT Collectif Arc en Ciel was launched. UNAIDS had a regional project in its 2008 □ 2009 biennium and because of varied issues, the project was finally been postponed to 2010. [13]

#### 13. Current status of prevention, treatment and care for MSM

There are some grants available to NGOs who are working on the field to address the issue of HIV/AIDS with regards to PLWHA including MSM.

The country has a National AIDS Secretariat and a national multisectoral strategy to combat HIV/Aids for the period 2007-2011. MSM are recognized as a target population, as are prison inmates, youth, and women and girls. The country claims that MSM are recipients of targeted information on risk reduction, stigma and discrimination reduction, condom promotion, HIV testing and counseling, and reproductive health (including STI prevention and treatment).

NGO's and the Health Ministry through sensitisation campaign are targeting MSM. [7]

There some grants available to NGOs who are working on the field to address the issue of HIV/AIDS, PLWHA, LGTB and others. [7]

#### 14. MSM related UNGASS indicators

In 2008 Mauritius did report against some of the UNGASS indicators relating to MSM. It reported that the HIV testing rate among MSM was less than 40%, that 40-59% of MSM know how to prevent HIV; that 40-59% of MSM used a condom the last time they had sex, and that 40-59% of MSM are being reached by HIV prevention programs. It did not report on the percentage of MSM who are living with HIV. [11]

15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Barriers derive from religious bodies to adequate prevention, treatment and care for MSM, however, the government is doing its best by providing grants to NGO's to handle the matter. [7]

16. Whether and how MSM are included in National Strategic Plans

Though not specifically relating to MSM, in 2001, Honourable Ashock Jugnauth Minister of Health & Quality of Life of the Republic of Mauritius at the 26th Special Session of the United Nations General Assembly on HIV/AIDS 25-27 June 2001 in New York reported that the Government of Mauritius was proposing to set up an inter ministerial committee on HIV/AIDS to be chaired by the Prime Minister or Deputy Prime Minister and Minister of Finance for the implementation of a National Strategic Plan which has already been drafted according to their needs. [17]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

There is no separate infrastructure that can be used for the delivery of adequate HIV prevention, treatment and care to MSM [7]

UNAIDS and the UN Family support a variety of HIV/AIDS activities in Mauritius, including the Indian Ocean Partnership Initiative Against HIV/AIDS, a regional partnership which includes Mauritius, Madagascar, Seychelles, Comoros and Reunion Island.

In 2008, given the fact that the HIV/AIDS epidemic in Mauritius is now mainly driven through injected drugs use, the UN System will concentrate its support on the inter-connected issues of HIV/AIDS and substance abuse among Most At Risk Populations (MARPs, i.e. sex workers, detainees). A Joint Programme is currently being formulated between UNODC, UNDP, WHO and UNAIDS to address this specific nexus. Technical assistance from UNAIDS, and WHO and the Office of the UNRC will also be combined to assist Mauritius in its preparation / submission of a proposal to the eighth call of the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFTAM). Support will also be lent to Rodrigues, whose migrant population transiting to and from Mauritius constitutes an increasingly vulnerable group which will require close monitoring and tailored preventive/response strategies. Targeted capacity-building assistance, already provided last year by UNFPA and UNAIDS in the form of Training of Trainers sessions, will be renewed again in 2008. UN inter-agency expertise was mobilised in 2007 to evaluate the Rodrigues Action Plan and will be again this year to support the elaboration of the next Strategic Plan and the setting up of a Rodriguan sub-national AIDS Unit [9]

Mauritius has not been spared from the deadly scourge of HIV/AIDS. Although the prevalence of HIV/AIDS infection is low among the population, vigilance is required and one must be on guard, for the prevalence can increase in the future, said the Minister of Health and Quality of Life, Mr. S. Faugoo, official launching of the National Multisectoral HIV/AIDS Strategic Framework 2007-2011. The aim of this framework is to identify the critical constraints to halt and reverse the HIV/AIDS epidemic in line with the Millennium Development Goal 6 and to get commitment at the national level.

The Minister recalled that AIDS is not merely a health issue but also a national issue concerning various sectors such as education, youth, women, civil society and NGOs. He underlined the

impact of HIV/AIDS, its contribution to the reversal of health, social and economic gains of past decades, reduction in life expectancy, worsening poverty levels in AIDS affected families and its toll on women and girls.

The National Multisectoral HIV/AIDS Strategic Framework is based on a “Three Ones Principle” encompassing five key areas namely; prevention and social mobilisation; care, treatment and support; development and mitigation of the impact; resource mobilisation and monitoring and evaluation of HIV and AIDS.

In a view to fight against the HIV/AIDS epidemic, the HIV/AIDS Act was enacted in December 2006. Besides ensuring an effective legal framework to implement the Needle Exchange Programme, it eliminates all forms of discrimination and assures the full enjoyment of Human Rights by people living with HIV/AIDS.

Achieving the Millennium Development Goal 6, that is halting and reversing the HIV/AIDS epidemic by 2015 remains the overall aim of successive national strategic plans. The National Strategic Framework (NSF) 2007-2011 has been therefore conceived to respond to the findings of the Biennial UNGASS report 2005, the Universal Access consultative meeting in February 2006 and the evaluation of the National Strategic plan 2001-2005 by Pr. Juergen Freers in May-July 2006.

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## **Mozambique (Maputo)**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Mozambique is a large country with a small LGBT representation. Despite the absence of aggressive anti-gay action by authorities, gay citizens keep their secrets and make no showing of Pride in public. Unlike many British and French colonies around Africa where the 19th century brought demeaning and deadly criminal laws against same-sex behavior, in Mozambique the ruling class did not act with the same abhorrence.

Homosexuals exist in different layers of Mozambican society, although society at large disapproves of homosexual behavior. This, is due to conflicts with religious beliefs, masculinity values, reproduction and continuity of family, among others factors. Society still does not act peacefully towards homosexuality, leading to discrimination in the family, at school and at work. Few Mozambican gays are open about their sexuality - but that the number is growing. Many lead a semi-open (or semi-closed) life, while the majority keep their sexual orientation completely clandestine, or even deny it. One often finds homosexuals married to members of the opposite sex, merely to please their family and society, but they're unhappy and often lead a double life". [4] However, compared to most Southern and East African nations, homosexuality is still treated light-handedly in Mozambique. [14]. Gay men are referred to in Portuguese as: Bicha, paneleiro, maricas, biba. [9]

There are numerous long-term gay and lesbian couples in Maputo. [1] LGBT people have an open social life when in a LGBT event. But people are afraid of being stigmatized or discriminated when around non-LGBTI. There are no gay-only bars or clubs, no publications, no big social events other than friendship networks. [1] Peace Corps/**Mozambique** has open **gay**, lesbian, and bisexual Volunteers who are presently serving [10]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

LAMDA hosts monthly gay parties; these are advertised among 'the gays', through emails and text messages. LAMDA hosts barbeques at which gels and condoms are given out freely. In 2008, LAMDA, with support from Pathfinder International and UNFPA, implemented an HIV prevention program focused on the promotion of health and human rights for MSM. The program also focuses on strengthening LAMDA's institutional capacity through technical assistance so that it can do research, reach a wider number of MSM, and encourage the government to provide essential services for MSM. [12]

There are various gay dating websites, Mozambique gay dating no longer is it taboo. The impact the Internet has had on the Mozambique gay community dating is significant. Websites advertise that "No longer are homosexual men forced to hide their sexual orientation; No longer is it taboo to see two people of the same sex holding hands in public, dancing together at clubs or just enjoying a quiet dinner in a restaurant together; You can now celebrate your diversity with millions of others around the world" [13]

Some favorite places in the area for socializing including Inhaca Island, Marracuene Lodge, Ponta D'ouro Beach, Namaacha Village, Pequenos Libombos Dam and Costa do Sol Beach. There are some mixed nightclubs like Coconuts, Lounge, 4U, Mafalala Libre (offering gays night every Thursday) and also Sheik and Havana clubs. There is the occasional general reference to homosexuality in health/HIV seminars presented by LAMBDA to government organizations,



health care workers and schools. [1]

### 3. Presence of an organized LGBT or MSM community

LAMBDA is a gay organisation in Mozambique LAMBDA's vision is stated on their website: to work toward a society where sexual orientation and diversity are recognized by the state, respected by citizens and protected by law. LAMBDA promotes civic, human and legal rights of the LGBTI community through public awareness and education as well as advocacy and social dialogue. Their mission with LAMBDA is to focus on lobbying for the repeal of homophobic legislation whilst the public awareness campaign will raise the profile on the rights of the LGBTI community in Mozambique. The objective is to enhance the numbers of LGBTI people coming out of the closet and celebrating their sexuality. With the help of the Dutch charity Hivos, LAMBDA is able to offer informal education seminars about HIV issues, gay sensitivity, condom and lube use and other health issues, and provide in trainings in human rights, sexuality and peer education. In 2009 it was reported that LAMBDA currently counts about 50 activists in its membership.[11]

The Mozambican Human Rights League is also actively concerned with researching homosexuality. [9]

### 4. What is known about stigma and discrimination of male same-sex sexuality

Although there appears to be a high number of MSM in Mozambique, they still tend to live invisible lives because of the taboos around homosexuality. However, homosexuality is still handled somewhat 'lightly'—certainly not openly accepted but also not cruelly or vengefully persecuted as currently done in Nigeria, Rwanda, Tanzania, Congo and across most of this continent of 54 countries where gay people face harassment, jail and violence. [1] A 2009 survey on attitudes towards gays, in which 700 people, aged between 18 and 56, were interviewed in four Mozambican cities (Maputo, Beira, Nampula and Quelimane). Only 16 per cent of this sample considered homosexuality a disease. Virtually everybody (96 per cent) said they knew gay people, and no less than 80 per cent said they had gay friends. [10]

Anecdotal information in on the website Manjam, states that Mozambique is still neutral regarding same-sex sexuality simply because there is no gay activity held "Some people don't even know what gay is; they don't even know that there are cases of men liking men, because that simply doesn't happen there. What happens the most are gay/bi men living double lives: married and having affairs with men. There are no hate crimes because here simply because there are no targets, otherwise I think there would be. [13]

However, anecdotal information refers to tension between personal desire and fear of ostracization through social, cultural, family, community and religious expectations. Homosexuality has also been referred to as Anti-African, brought in by Portuguese settlers and the West. Through social pressures, one often finds homosexuals married to members of the opposite sex, merely to please their family and society but they're unhappy and often lead a double life [1]

A Californian Peace Corps volunteer stationed in Mozambique however, found the country to be "unfortunately very homophobic". [15] In 2006, Prominent Radio Mozambique journalist Emilio Manhique took the issue up of gay marriage on his phone-in programme "Cafe de Manha". Some of the listeners who rang in to the programme were shocked - how could Manhique even

raise the subject? For them, homosexuality was so taboo that it should not even be discussed in Mozambican society.

However, gay activist Danilo de Sousa is optimistic - for there are signs that young Mozambicans are more tolerant towards gays than the older generations, and younger homosexuals are now posing openly the possibility of living their sexual orientation regardless of the wishes of their families. Amongst those who come into regular contacts with homosexuals, at home, or at work, or socially, there is a great level of acceptance, which shows that mutual knowledge is the main factor for overcoming intolerance, stigmatisation and discrimination [1]

South Africa's recent acceptance of gays and lesbians causes a discovery of national sexual minorities all over Africa. Homosexuality got a very positive debut in the Mozambican national press, as the state-owned news agency AIM interviewed the country's principal human rights group on its new campaign to stop discrimination against gays and lesbians. The dominant independent weekly 'Savana' went further by interviewing several gay men from a newly started organisation, talking about their experiences of discrimination and presenting their lifestyle in a non-scandalising manner. The principal national media of Mozambique seemed promoting an improved rights situation for the country's sexual minorities, and government representatives promised to look at the situation. Influence from neighbouring South Africa surely had made a rapid impact on the social dialogue in Mozambique, where the issue of homosexuality has been a no-go debate until recently. [20]

Although historically, homosexuality was not as highly stigmatized, condemned or made sinful by the Catholic Portuguese here as other Euro-imperialist colonies elsewhere in Africa, religious intolerance is still prevalent. As an example of religious intolerance, in 2004 at a public debate on strategies for preventing infection by HIV, Islamic cleric, Sheik Aminuddin Mahomed. attacked, what he called "the revolution of the gays", and implied that gay sexual practices were somehow responsible for Aids. He claimed that morality and ethics can only be exercised by religious believers, and lumped together "blasphemy, heresy, homosexuality and pornography" and attacked gay bars (even though no such institutions exist in Mozambique), claiming that these were nests of depravity where gay people took part in "disgusting practices". [1]

##### 5. What is known about social position and needs of MSM living with HIV/AIDS

There is a shortage of information on the composition of the social group of men who have sex with other men (MSM). Anecdotal information state that homosexuals exist in different layers of Mozambican society. Gay people live in all parts of the country, of all social strata, of all religions, of all ethnic groups, of all academic levels, and of both sexes. [14]

##### 7. Existence of homosexuality-related barriers to health care

There is a shortage of information on the sexual practices, perception of risk of infection and their conditions of access to health services of MSM. It is inferred that the fear of homophobia towards members of the homosexual community jeopardise efforts undertaken to combat HIV. Many men here are on the down-low. A major project being initiated in March 2009 by LAMBDA is a sex survey of men in Maputo to determine sexual patterns of behavior, with the intention of bringing the MSM population to the authorities' attention. It is estimated that 17% of men in Mozambique are HIV+ with most not knowing it. [1]

Unfortunately it is still a long way off that MSM will be specifically targeted as a high-risk group by the health ministry. Lamda cannot officially offer services to LGBT citizens, unless they are

registered. Despite its non-legal status LAMBDA does work with local authorities to lobby for HIV awareness.

A respondent on Manjam states that Mozambique has one of the highest AIDS rated countries, where about 1-2 people in every 5 people have AIDS, and the Gay community is the most vulnerable because there isn't much education regarding Gay sex, since it's something that barely exists.. [14]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

The legal status of same-sex sexual activity is ambiguous in Mozambique. While there are no explicit laws against homosexual sex, the Penal Code does contain an offence of "practices against nature". According to the ILGA, this clause could potentially be interpreted as including male and female same-sex sexual activity, even though it is unknown to what extent the law is enforced.<sup>[1]</sup> Indeed, reports state that the incidence of the statute being enforced against LGBT individuals has been slim to none.

Mozambique is frequently regarded as amongst the most tolerant states concerning gays and lesbians throughout Africa, if not the most. While the government has reported fairly little on LGBT rights, all of what has been said has been positive. It is one of the only three countries in Africa to offer any form of discrimination protections for gay, lesbians, and bisexuals, which have been in place since 2007. Protests for such legislation had been kick-started only a year before, signaling a reasonably swift response by the government. Mozambique does not provide any form of recognition of same-sex relationships, though protests for same-sex marriage and common-law marriage have been ongoing since 2006. [23]

Although Mozambique's constitution and legal framework establish safeguards for all citizens' civil rights and liberties, the treatment of individuals who are arrested or detained remains a concern. In addition, prison conditions are substandard, and trafficking of children and women has increased. [6]

#### 9. Any action under way to change legal status of homosexuality

LAMDA has called for removing any clause from the country's laws that might be used to criminalise gays, and to introduce measures that ban discrimination on the base of sexual orientation, just as discrimination on the grounds of race, sex, religion or ethnic group is already outlawed. [5]

The Mozambican Human Rights League (LDH) advocates for LGBT rights and in 2007, the government approved Labour Law that prohibits discrimination in employment on the basis of sexual orientation. [9]

In 2006, the new publication "Matinal", claimed that Mozambican gays intend to present a petition to the country's parliament seeking the approval of gay marriage. [9]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

There are many NGOs that deal with the diseases and the poverty in Mozambique. DFID, HIVOS, USAID and UNAIDS work in the country. The Mozambican Human Rights League (LDH) advocates for LGBT rights

The country has a National AIDS Council which has recognized in documentation that MSM are a most-at-risk population. There is also a National Council for the Fight against AIDS (CNCS).

#### 11. HIV prevalence/incidence data for MSM and general population

National HIV prevalence (in 2008) was estimated at between 12.5% (UNAIDS) and 16% (UNICEF). Mozambique, a nation of 21 million people, suffers one of the world's highest burdens of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). In 2007, HIV prevalence in the 36 antenatal clinic (ANC) sentinel surveillance sites ranged from 3% to 35% with a national estimate of 16% (plausibility bounds from 14-17%) in women ages 15-49 years. Provincial HIV prevalence estimates ranged from 8% to 27% and were highest in the central and southern provinces [3]

According to UNGAS, the shortage of information on the composition of the social group of men who have sex with other men (MSM), their sexual practices, their perception of risk of infection and their conditions of access to health services underlie the conduction of their research with view to contributing to the designing of prevention strategies and actions aiming specifically to reduce the vulnerability of MSM in the face of HIV.

The study was conducted in Maputo city, and qualitative methodologies were used for data collection and analysis. From the analysis of data produced in interviews with 45 MSM are highlighted the findings summarized as follows: Heterogeneous profile of the group, in terms of age, level of education, occupation, religion, place of residence, sociability, nature of affective and sexual relations practiced and role performed in these relations; Shortage of information on prevention and fight against HIV specifically formulated for MSM; Difficult access to public health services; discrimination and hostility from the side of health providers. General knowledge of the risk and measures of STI and HIV prevention; therefore, there was found a major inconsistency in the practice of this measures, and the following were pointed out to be the reasons: the alleged trust in the partner, the belief that oral sex and anal sex practices are safe and the belief that it is possible to see the signs of infection by HIV with naked eye and, consequently, decide to use or not the condom; General unawareness of the importance of water-based lubricant; Some sexual practices that increase the vulnerability of MSM to infection by STI and HIV: transactional sex; sex in group; and sex under the effect of alcohol and other drugs. Some MSM also have sex with women, which broadens the sexual intercourse network and, ultimately, the possible circulation of HIV for the general population. [21]

The general conclusion of the study is that MSM in Maputo city live in a context of multiple vulnerabilities that expose them to the risk of infection by HIV. The inefficiency of the current prevention and care programs to meet the specific needs of MSM and the social discrimination to which they are subject, cause them to remain hidden and therefore, deprived from demanding their right to information and health services that include their specificities

Main challenges identified include: Limited resources for interventions targeted to most-at-risk populations; The majority of the studies show a high level of knowledge of male condom, but its use is still inconsistent within most-at-risk populations, especially among partners of people involved in high risk behaviors; Need for addressing varied and concomitant behaviors of sexual and drug risks, including unprotected anal and vaginal sex, and sex with multiple partners. For instance, sex workers use alcohol and drugs (especially cannabis) to face their jobs and some drug users sell sex in order to get drugs; Inadequate provision of water-based lubricant gel for MSM and sex workers; need for increasing knowledge of the gel and correct forms of use;

Increase provision of health services, especially for diagnosis and treatment of STI. It is necessary to develop health services that are responsive to health specifications of the most-at-risk populations (e.g. attention to anal STI), and that offer care to these groups, free of discrimination and prejudice; Human Rights – violence and discrimination are effective barriers among most-at-risk populations, to access prevention and health care services. In this context, it's necessary to promote linkages between prevention programs targeted to these groups and the initiatives of defense and guarantee of human rights, so that the processes of collaboration will increase their effectiveness; Complexity in the implementation of ongoing and consistent interventions, both of prevention and care, targeted to mobile population groups like miners and truckers, among others. [21]

In Mozambique, data on the HIV sero-prevalence among most-at-risk populations is not yet available. One of the difficulties to obtain this data was related to the lack of definition of the most-at-risk populations in the country. This was however overtaken when, through an extensive consultation process, government approved the National Strategy for the Acceleration of Prevention whereby the following most-at-risk sub-populations were considered priority: Women, Children and Adolescents, Police and Military, Health workers, Teachers, Prisoners, High competition Athletes, Miners, Sailors and Sex workers. Considering that these groups are relatively extensive, government decided to focus its interventions in the following more restricted sub-groups: Women and Adolescents, Prisoners, Miners, and Sex workers.

The implementation of the National Strategy for the Acceleration of Prevention is very recent and it has not yet generated enough information to allow estimating the HIV sero-prevalence among most-at-risk populations. There is however, data derived from small scale and localized projects, implemented by the government and its partners. The Centre for Diseases Control and Prevention (CDC), in coordination with the Ministry of Health, implemented a qualitative research "International Rapid Assessment, Response and Evaluation – I-RARE" in three port cities of the country, namely Nacala-Porto, Beira e Maputo, on the risk behaviours for HIV among injecting and non-injecting drug users, sex workers and their clients, whereby it was possible to test for HIV a small proportion of the sample. Acceptability for testing was very low among these groups (24%). Among those tested the positive results for HIV were as follows: sex workers: 48% (30/63); drug users, 43% (13/30); sex workers clients, 42% (5/26) [21]

Research (2008) shows that the national HIV prevention strategy was not reaching the groups most at risk of infection. Funded by UNAIDS and the World Bank, the research found that in Mozambique an estimated 19% of new HIV infections were spread through commercial sex work, 3% from injection drug use and 5% among men who have sex with men. Despite the fact that LAMDA is a gay organisation in Mozambique, the research report also indicated that no programmes are tailored to MSM. Mozambique has subsequently been recognized for making significant progress in unifying HIV and AIDS research in the country. Even so, the National Strategic Plan for HIV/Aids does not include MSM as a priority for prevention efforts.

An evaluation of Mozambique's prevention response found that an estimated 19 percent of new HIV infections resulted from sex work, 3 percent from injecting drug use, and 5 percent from men who have sex with men (MSM), yet there are very few programmes targeting sex workers, and none aimed at drug users and MSM. The research also found that spending on HIV prevention was often simply too low: Lesotho spent just 13 percent of its national AIDS budget on prevention, whereas Uganda spent 34 percent, despite having an HIV infection rate of only 5.4 percent.

Sex between male prison inmates is also a reality. According to Elsa Thaibo, (then) director of the health department in Chimoio, the majority of HIV positive inmates were infected inside prison. The government has started to distribute condoms in prisons. Shinguirirai (an NGO) offers education and psychological services to inmates at the Maniza Provincial Prison, and helps them stick to their ARV treatment regimen.

[27 May 2009 - Plus News AFRICA: Prevention efforts and infection patterns mismatched <http://www.globalgayz.com/country/Mozambique/view/MOZ/gay-mozambique-news-and-reports>]

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

There is a shortage of information on the perception of risk of infection and their conditions within the MSM.

#### 13. Current status of prevention, treatment and care for MSM

Condoms are given out freely and for every person with AIDS, \$100 is increased in their salaries to have reinforced alimentation [13]

Research (2008) shows that the national HIV prevention strategy was not reaching the groups most at risk of infection. Funded by UNAIDS and the World Bank, the research found that in Mozambique an estimated 19% of new HIV infections were spread through commercial sex work, 3% from injection drug use and 5% among men who have sex with men. Despite the fact that LAMDA is a gay organisation in Mozambique, the research report also indicated that no programmes are tailored to MSM. Mozambique has subsequently been recognized for making significant progress in unifying HIV and AIDS research in the country. Even so, the National Strategic Plan for HIV/Aids does not include MSM as a priority for prevention efforts.

Within the National Reference Group for Prevention, a working subgroup was established to address, in a structured manner, the response to HIV within most-at-risk populations. The group comprises members of government institutions and international and local partners involved in the designing of policies, strategies and/or in implementation of interventions targeted to different groups of most-at risk populations.

In 2009, the Ministry of Justice, in coordination with the United Nations Office on Drugs and Crime (UNODC) and implementing partners, organized a National Workshop under the theme "Prison Health is Good Public Health" with the purpose of contributing for greater understanding and dialogue among government and non-government institutions, with view to improving the effectiveness and coordination among prison services and other public health services in the promotion of health, prevention and control of diseases in prison settings. [21]

To date, there have been few prevention programs targeted to most-at-risk populations. Prevention activities are primarily focused on sex workers, while neglecting addressing the major part of the most-at-risk populations with appropriate prevention strategies. The effectiveness of the small number of prevention activities related to most-at-risk populations is not yet visible, since many programs addressing these populations are run by small NGOs and CBOs, which, apart from their limited geographic scope, have little capacity to monitor the uptake and coverage of services and to assess the effectiveness of the prevention interventions. Therefore, there is an urgent need for scaling up and expanding the implementation of specific prevention activities related to most-at-risk populations. [21]

#### 14. MSM related UNGASS indicators

Mozambique did not report against any of the UNGASS indicators relating to MSM.

15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

According to UNGAS, the shortage of information on the composition of the social group of men who have sex with other men (MSM), their sexual practices, their perception of risk of infection and their conditions of access to health services underlie the conduction of their research with view to contributing to the designing of prevention strategies and actions aiming specifically to reduce the vulnerability of MSM in the face of HIV. [21]

16. Whether and how MSM are included in National Strategic Plans

National Strategic Plan for HIV/Aids does not include MSM as a priority for prevention efforts. [21]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

A legacy of colonial rule coupled with a devastating 16-year civil war through 1992 left Mozambique economically impoverished just as the human immunodeficiency virus (HIV) epidemic swept over southern Africa in the late 1980s. The crumbling Mozambican health care system was wholly inadequate to support the need for new chronic disease services for people with AIDS. [<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2891693/>]

For people living with HIV/AIDS on the islands of Inhaca and Catembe in Mozambique, decentralization of HIV/AIDS services from hospitals to health centers has had many benefits. Before their local health centers began offering such services, these individuals had to travel seven miles by boat to obtain care at two general hospitals in Maputo. In addition to incurring transportation costs, they typically had to wait for hours at these overcrowded facilities. Under a decentralization policy initially launched by the Ministry of Health in 2003, ICAP has been supporting the rapid expansion of HIV/AIDS services to health centers in Mozambique. The plan is designed to bring services closer to patients, especially in rural areas where most of the population lives, and to assist in decongesting hospitals where such services are typically delivered.

Currently, in Mozambique, ICAP supports 33 HIV/AIDS service sites of which 15 facilities are health centers. To facilitate the initiation of HIV/AIDS services at health centers, which typically offer only primary care services, a comprehensive assessment is conducted to identify infrastructure, staffing, and training needs. Based on this assessment, physical space is reorganized or renovated, additional personnel are hired, and existing staff are trained to perform HIV/AIDS services. Because HIV services are fully integrated in the primary care services provided at these health centers, all staff participates in the integration process and all patients gain from the infrastructure and service enhancements. ICAP clinical advisors provide close supportive supervision during and after the integration process. This includes helping to address challenges such as the integration of health centers into laboratory/supply networks and the adoption of new monitoring and evaluation tools for HIV services.

As more health centers in Mozambique provide HIV/AIDS services, they will increasingly serve as entry points for HIV care. ICAP is working with the Ministry of Health to develop new referral

mechanisms to ensure that patients who obtain their care at health centers can obtain specialized services at district hospitals.  
[<http://cumc.columbia.edu/dept/icap/news/icapnews/OctoberENews.html>]

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- <http://www.afrol.com/articles/22322>
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## **Namibia**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

In Namibia, gays said there was a relatively relaxed climate in large cities in the years before and after independence from South Africa in 1990, and gay couples in Windhoek could hold hands in the street. But, in the mid-'90s, they said a chilling change occurred.

"The first five years after independence it was like a utopia," Swartz said. "People were proud to be gay. But when Namibian leaders' promises fell through and poverty did not improve, the government became increasingly unpopular. . . . The leaders were looking for a smokescreen and someone to blame."

In 1996, the public campaign against homosexuals began, after a group of cross-dressing men used a women's restroom during a rally of the ruling party. At the time, unemployment was at 60 percent and opposition parties were on the attack.

Days later, then-President Sam Nujoma gave his first anti-gay speech, saying that "homosexuals must be condemned and rejected." Suddenly, many officials were bashing gays. One minister called homosexuality a "behavioral disorder which is alien to African culture." In response, the Rainbow Project was formed.

"LGBT Namibians live in fear of hate, discrimination, brutality and are regarded less human in an independent Namibia"

[1]Emily Wax Washington Post Foreign Service Monday, October 24, 2005  
[http://www.washingtonpost.com/wp-dyn/content/article/2005/10/23/AR2005102301163\\_2.html](http://www.washingtonpost.com/wp-dyn/content/article/2005/10/23/AR2005102301163_2.html)

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Bars and clubs such as the Dansy's Inn does exist in Namibia.

Through the gaydar web site, I'd met a handful of gay men in Windhoek, all colors, and the unanimity of opinion was total: gay life in Namibia sucked. It's not completely non-existent, even though there's no gay bar; it's just weak, fearful, and fragmented. Only a handful of gay men are "out" in any sense of the word.

Namibia's semi-hidden gay organization is called The Rainbow Project, known among gays as TRP. The name expresses the hopeless desire to unite Namibia's races under the banner of gay pride. There's precious little pride and even less racial tolerance. If the whites ever participated, they pulled out long ago, retreating to private parties and social cliques. The Rainbow Project is now a Black and Coloured organization. I'm told that there are tribal differences in the acceptance of homosexuality. Among the Ovambo and the Herero, it's absolutely verboten; the Coloured and Damara communities are much more tolerant.

[2]A Crisis Corps Assignment in Namibia -Robert Philipson, RPCV, Central African Republic  
[http://www.lgbrpcv.org/articles/05\\_05\\_namibia.htm](http://www.lgbrpcv.org/articles/05_05_namibia.htm)

3. Presence of an organized LGBT or MSM community

LGBTI organisations include The Rainbow Project, and Sister Namibia. The Rainbow Project has been funded by overseas gay-friendly countries. They do have gay parties and organized functions and even some gay cultural film festivals as well. The US President's Emergency Plan for AIDS Relief (PEPFAR) is active in the country.

#### 4. What is known about stigma and discrimination of male same-sex sexuality

There is also a tremendous amount of explicit homophobia, and gay and lesbian people have been accused of being responsible for the HIV/AIDS pandemic. Men wearing earrings have been attacked and beaten

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

The sexual health needs of the LGBT community have been excluded from wider public health discussions of HIV/AIDS.

#### 6. Any on-going activities to counteract stigma and discrimination?

In Namibia, a growing national debate about homosexuality has followed a period of harsh condemnation, and gay rights groups now operate openly in the capital, Windhoek.

The Rainbow Project has joined forces with other interest groups, including the women's movement, people with AIDS and progressive political parties, which have been lobbying for equal rights for all Africans. Unlike in many Western countries, gays have never been blamed for the AIDS pandemic in Africa, where the disease is largely transmitted through heterosexual sex and blood transfusions.

The continent's gay population, which is mostly youthful and active in cities, has also benefited from Africa's rapid urbanization. These days, TV programs such as "Queer Eye for the Straight Guy" are beamed via satellite from the West, and a smorgasbord of gay-oriented Web sites can be accessed at Internet cafes.

#### 7. Existence of homosexuality-related barriers to health care

The country has developed a multi-sectoral strategy to respond to HIV which covers the period 2004-2009. The budget mostly covers funds for the HIV/AIDS workplace programmes. The sectors are each responsible to budget for their respective HIV activities. Additionally, development partners support different MSM sectors to implement HIV programmes. All target populations are addressed except for MSM, sex workers and IDUs.

The status of homosexuality in Namibia has so far been disputed. Apart from the homophobic statements from the President and some prominent politicians, the gay and lesbian community has been allowed to exist openly. Legislation prohibiting homosexuality or protecting gay rights explicitly does not exist. [3] Namibian president announces purges against gays

[http://www.afrol.com/News2001/nam008\\_gay\\_purges.htm](http://www.afrol.com/News2001/nam008_gay_purges.htm)

President Sam Nujoma in 2001 warned about forthcoming purges against gays and lesbians in Namibia, saying "the Police must arrest, imprison and deport homosexuals and lesbians found in Namibia. Home Affairs Minister Jerry Ekandjo in 2007, when he told new Police recruits at Ondangwa to "eliminate" gays and lesbians - whose conduct he equated to "unnatural acts" such as murder - "from the face of Namibia". In November 1998 Ekandjo also stated in the National Assembly that legislation would be tabled in Parliament to combat homosexuality. Nothing has come of that - yet. [4] Namibian president announces purges against gays

[http://www.afrol.com/News2001/nam008\\_gay\\_purges.htm](http://www.afrol.com/News2001/nam008_gay_purges.htm)

### 3. Legal situation regarding same-sex sexuality plus extent of enforcement

Namibia has had a troubled history in regards to the protection of the rights and civil liberties of lesbian, gay, bisexual, and transgender (LGBT) citizens. Sodomy is illegal in Namibia, and is punishable with prison time. Furthermore, statements by government leaders, such as Sam Nujoma and Jerry Ekandjo, concerning gays and lesbians have drawn both domestic and international condemnation. However, LGBT rights groups, such as Sister Namibia and Rainbow Project, operate freely in Namibia's major cities, even though they have been frequented by anti-gay attacks since independence in 1990. There is no information on the history of the LGBT citizenry prior to 1990. [5][http://en.wikipedia.org/wiki/LGBT\\_rights\\_in\\_Namibia](http://en.wikipedia.org/wiki/LGBT_rights_in_Namibia)

Status of homosexuality: Male homosexuality / sodomy is illegal, based on the common law offence of committing "an unnatural sex crime". The last case was tried in the late 80's (IOC). It is not clear whether lesbian acts are an offence. Article 10 in the Namibian constitution explicitly prohibits discrimination on the grounds of sex and guarantees all persons equality before the law. In addition, Namibia's labour code explicitly prohibits discrimination in the workplace based on sexual orientation. However, the National Policy on HIV-AIDS (MTP3) that was adopted in Parliament in 2007 excludes gay, lesbian, bisexual and transsexual people. MSM are not recognized as an at risk population.

### 9. Any action under way to change legal status of homosexuality

In 2011, Justice Minister Pendukeni Iivula-Ithana, who represented the Government at the United Nations Human Rights Council (UNHRC) in Geneva in 2011, reiterated the stance that there are no plans to give to legal protection to gays. In the UN report, it was noted that "homosexuals were not prosecuted for practising same-sex activities in private, although this practice was not condoned, and was considered immoral and prohibited in public". Furthermore, Namibia does not recognise same-sex unions and "the Government has no intention of amending current laws".

[6]Constitution there for gays too – LAC, By: DENVER KISTING THE Namibian Constitution protects all human rights – irrespective of people's sexual preferences. <http://www.namibian.com.na/news/full-story/archive/2011/march/article/constitution-there-for-gays-too-lac/>

### 10. Any human rights based organizations active in this country that does or should address MSM issues?

OutRight Namibia (ORN) was formed in March 2010 by Namibian LGBTI, MSM and WSW activists. It prioritizes leadership development, human rights, emancipation of movement building as well as health and legal reform as its main strategic areas of focus.

Legally registered in November 2010, ORN seeks to respond to challenges facing the LGBTI community in Namibia such as exclusion in the National system and the general non recognition of LGBTI people in the Namibian social communities.

## 11. HIV prevalence/incidence data for MSM and general population

Research (Baral et al) shows that many MSM in Namibia also have sex with women. Of the sample of men who had ever had anal sex with another man, 19.4% self-identified as heterosexual, 48.6% self-identifies as gay, 29.1% self-identified as bisexual and 2.9% as transgender. 44.5% had disclosed their sexuality to at least one family member and 21.6% had disclosed to a health care worker. 18.3% indicated that they were afraid to seek health care services and 21.3% claimed to have been blackmailed because of sexuality. 8.3% said they had been denied health care because of sexuality. Although same sex activities occur in prisons, there is a dominant belief that condoms in prisons will “encourage sex” (to quote the Home Affairs and Immigration minister). 2008 research (Kupe) shows that HIV prevention work aimed at MSM has great potential and is needed.

HIV Prevalence rate among general population is estimated to be 15.3% (UNAIDS). Among MSM the estimate is 12.4% with 59.2% being aware of HIV status (Beyrer et al). Namibia has an HIV prevalence rate of 15.3 percent in adults ages 15 to 49 and shows signs of HIV epidemic stabilization. The primary mode of transmission is through sexual contact and mother-to-child transmission. Data compiled by the Ministry of Health and Social Services show that AIDS became the leading cause of death in Namibia in 1996. It is estimated that AIDS accounts for at least 50 percent of deaths among individuals ages 15 to 49. Other at-risk populations include migrant workers, people in prostitution, street children, and long distance DRIVERS.

According to the report ([8]DE LA TORRE ET AL, 2009), a number of factors are likely contributing to the high levels of HIV in Namibia. These various factors are often inter-related and operate in unison to create what these researchers consider to be one of the worst HIV epidemics in the world. The factors are outlined below.

Multiple and concurrent partnerships are likely contributing to the rapid spread of HIV throughout the country. In 2006, 16 percent of sexually active men and 3 percent of sexually active women reported more than one partner over the previous 12 months. Several local studies have also recorded high levels of concurrent partnerships throughout Namibia, although nationally representative data are not available. Having multiple partners is not common, nor apparently a major risk factor for HIV for the majority of women. However, the widespread practice among men of maintaining multiple relationships is contributing to the high levels of HIV infection among women, especially young women.

Intergenerational sex exposes adolescents and young adults to partners who, by virtue of their age and longer sexual history, are more likely to be HIV positive. Among women age 15 to 24, 7 percent of single women and 26 percent of married women have a partner 10 or more years older. Intergenerational sex in Namibia is associated with higher levels of sexually transmitted infections (STIs) and with a greater likelihood of having multiple partners. Intergenerational relationships introduce the virus into the younger cohort, where it quickly spreads as a result of rapid partner turnover and common concurrent partnerships (especially among young men). Pervasive alcohol abuse and low levels of HIV risk-perception serve to foster multiple and concurrent partnerships, and may discourage consistent condom use. Nationally, 78 percent of men and 62 percent of women used a condom at last sex with a non-marital non-cohabiting partner. In Caprivi and Kavango, regions facing the worst of the epidemic, condom use is the

lowest in the nation. Furthermore, low levels of male circumcision are reported in some of the areas with the highest HIV prevalence, namely Caprivi, Ohangwena, Omusati and Oshikoto.

Over the years there has been a steady decline in marital or cohabiting relationships. In 2006, approximately 1 in 3 Namibians ages 35 to 39 had never married or cohabitated with anyone. For women, never marrying or cohabiting was associated with having a greater number of sexual partners over one's lifetime. In most African countries one of the strongest predictors of HIV infection is the number of lifetime sexual partners. Transactional sex appears to be common, and even expected, in many sectors of Namibia, although research that quantifies this practice is lacking. In the context of widespread poverty and limited employment opportunities, sexual intercourse has become a commodity freely traded for goods and services by men and women. Women appear to be particularly vulnerable to transactional sex, possibly because their marital independence has not been matched with new income generating opportunities and many remain economically dependent on men.

High levels of population mobility also accelerate the spread of HIV. Namibia serves as a corridor for much traffic to and from Southern Africa, receiving migrants from the highest prevalence countries in the world. Furthermore, Namibia's reliance on the mining and fishing industry, as well as on seasonal agricultural production, requires regular internal population displacement. Travel away from home is associated with an increase in multiple partnerships in Namibia. Infections are passed on rapidly through a chain of interconnected sexual networks that can be distributed over various sections of the country. With multiple and concurrent partnerships relatively common in both rural and urban areas, the epidemic has spread to all regions of the country.

The evidence strongly suggests that young women are at highest risk of acquiring HIV. Recent projections estimate that nearly half (44%) of new infections over the next 5 years will occur among 15 to 24 year olds; 77 percent of these will occur in young women. These women are most likely infected early in their sexual life by their first or second partner. It appears that the risk for many women stems from their choice of partner rather from their own behaviour. Only 27 percent of women aged 15 to 49 reported more than two partners in their lifetime, and multiple partnerships were not a risk factor for HIV infection among female VCT clients.

[9]HIV/AIDS in Namibia: Behavioral and Contextual Factors Driving the Epidemic

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## 12. Is there understanding of specific risk factors for HIV transmission in MSM

The country has developed a multi-sectoral strategy to respond to HIV which covers the period 2004-2009. With the ending of MTP3 the country is in the process of developing the next five year National Strategic Framework for HIV. Namibia has had a multi-sectoral strategy for more than 15 years since 1990 which includes sectors for health, education, labor, transportation, military, police, women, and local government. The budget mostly covers funds for the HIV/AIDS workplace programmes. The sectors are each responsible to budget for their respective HIV activities. Additionally, development partners support different sectors to implement HIV programmes. All target populations are addressed except for MSM, sex workers and IDUs.

### 13. Current status of prevention, treatment and care for MSM

Namibian laws and policies protect and promote the rights of people living with HIV and pregnant women but omit other most at risk populations such as Men having Sex with Men and sex workers. Furthermore, organizations for MSM, sex workers and youth are poorly represented in the civil society sector.

Namibia has a strategy in place for promoting IEC on HIV to the general population. The messages include sexual debut, faithfulness, reduced number of sexual partners, consistent use of condoms, fight against violence against women, greater acceptance of PLWH, safe sex, involvement of men in reproductive health programmes, importance of knowing HIV status, prevention of mother-to-child transmission of HIV. Male circumcision is receiving considerable attention as a new initiative while abstinence is underemphasized. The country does not have a specific policy for IEC targeting most at risk or other vulnerable subpopulations. The policy for Reproductive and Sexual Health for young people particularly emphasizes education on HIV related reproductive and sexual health. HIV education is now part of the school curriculum both at primary and secondary level. Teachers' training also covers HIV education. The Reproductive and Sexual Health education is the same for both young men and women. The strategy also targets out-of-school youth. The development of policy efforts in support of HIV prevention has been generally good. The country has developed all major policies although they exclude specific most at risk populations such as sex workers and MSM. However, the country plans to do studies among most at risk populations.

[10]United Nations General Assembly Special Session (UNGASS) Country Report Reporting Period 2008 –2009, Directorate of Special Programmes, Division Expanded National HIV/AIDS Coordination Subdivision: Response Monitoring and Evaluation Private Bag 13198 Windhoek, Namibia Tel: +264-61-203-2833 Fax: +264-61-22-4155 Email: rm&e@nacop.net

Namibia has a Human Rights Organization. Namibian lawyer, Michaela Clayton, won the 2009 International Award for Action on HIV/Aids and Human Rights. She is the director of the regional AIDS and Rights Alliance for Southern Africa (ARASA) and is concerned with stigma relating to vulnerable groups such as MSM. She also concerns with the PITC model.

The United States Government, as represented by the United States Agency for International Development (USAID) Mission to Namibia, is seeking applications from qualified organizations to implement a three-year program to provide technical leadership and service delivery to most at risk populations (MARP) in Namibia. This program is funded through the President's Emergency Plan for AIDS Relief. Activities funded under this program fall under the U.S. Foreign Assistance Framework objective of Investing in People. The goal of this project is to strengthen the capacity of indigenous organizations to reduce HIV transmission among MARP through comprehensive HIV prevention services and linkages to care and treatment for the following MARP: Men who have Sex with Men (MSM), Sex Workers (SW), and clients of Sex Workers including truckers, seafarers, and miners. This will be accomplished by providing: direct support and technical assistance for the delivery of a comprehensive package of HIV prevention services for MARP; organizational capacity building for local MARP-led organizations serving the target populations; and capacity development for civil society to advocate for increased commitment by government and other stakeholders for improved HIV prevention, care and treatment services for the target populations

[11]Strengthening HIV/AIDS Prevention for Most at Risk Populations in Namibia <http://www.cdcnpin.org/Display/FundDisplay.asp?FundNbr=4035>

#### 14. MSM related UNGASS indicators

In 2008, Namibia did not report against any of the UNGASS indicators relating to MSM.

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

- Criminalization and stigma limit MSM access to HIV prevention, treatment and care
- MSM understudied in many emerging HIV epidemic contexts
- Not included in national HIV surveillance in majority of low and middle income countries
- As of 2009, relatively few countries have published data characterizing MSM risk and HIV rates
- Fewer than 1 in 10-20 MSM worldwide have access to necessary prevention services
- This is markedly lower in the African Context
  
- Men who reported blackmail
  - Much more likely to have disclosed sexual orientation to a family member
  - Less likely to have had HIV test in last 6 months
  - More likely to be afraid to seek health care
- Disclosing sexual orientation to health care workers
  - Highly associated with being denied health care
  - Much less likely to have had a HIV test in last 6 months

#### 16. Whether and how MSM are included in National Strategic Plans

Namibia plans to reduce its current HIV/AIDS prevalence rate of 22 percent by more than half over the next five years.

The ministry of health is hoping to achieve this national goal through the recently launched Third Medium Term Plan (MTP III), a multi-sectoral response to the epidemic."The objective of the MTP III is to reduce the incidence of HIV infection to below epidemic threshold. In epidemiological terms this implies less than one new infection for every existing person living with HIV/AIDS," Dr Norbert Forster, Under Secretary Health and Social Welfare Policy of the Namibian Ministry of Health, explained to PlusNews. The MTP III will run until 2009 and cost over Namibian \$3.7 billion (US \$575 million), of which The Global Fund to Fight AIDS, Tuberculosis and Malaria has committed about N \$800 million (US \$124 million), or just less than a quarter of the resources required for the five-year effort. [12]NAMIBIA: Namibia rolls out third National AIDS plan - Monday, April 19, 2004 <http://medilinkz.org/news/news2.asp?NewsID=6313>

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Agency for International Development, USAID, The goal of this project is to strengthen the capacity of indigenous organizations to reduce HIV transmission among MARP through comprehensive HIV prevention services and linkages to care and treatment for the following MARP:Men who have Sex with Men (MSM), Sex Workers (SW) and clients of Sex Workers including truckers, seafarers and miners. [13][Strengthening HIV/AIDS Prevention for Most at Risk Populations in Namibia](http://www.topgovernmentgrants.com/grants_gov_display.php?progra)[http://www.topgovernmentgrants.com/grants\\_gov\\_display.php?progra](http://www.topgovernmentgrants.com/grants_gov_display.php?progra)



Namibia is the second most sparsely populated country in the world. Providing comprehensive HIV/AIDS services to the mostly rural population requires a fully decentralized, community-based approach with strong policies and leadership from the central level. Insufficient numbers of skilled technical personnel and limited managerial capacity at all levels exacerbate the challenges of decentralization, and access to services remains limited for those living in sparsely populated areas. As the country with the highest level of income disparity in the world, poverty poses a major challenge. The United Nations reports that the poorest 20 percent of Namibia's population earns only 1.4 percent of the national income versus the richest 20 percent of the population that earns 78.7 percent of the national income. Household food security and access to services are limited for the vast majority of the population. There is a considerable need for expansion of health services in particular, including community- and home-based care programs, HIV testing and counseling services, and support for orphans and vulnerable children (OVCs). Trucking, shipping, mining and fishing industries generate labour migration that is contributing to the spread of the epidemic.

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## **Somalia**

(comprised Somaliland, Puntland and South Central Somalia)

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Although homosexuality is considered by many a mortal sin Arab and Muslim officials often turn a blind eye to homosexual practices as long as it stays in the dark. In parts of Somalia, gay men are expected to either remain in the closet or wear women's attire. [8]

Homosexuality in Somalian communities is as extensive as in any other ethnic community; the only difference is that it's done in private and secrecy thus not openly visible. Arab and Muslim governments turn a blind eye to homosexual practices as long as it stays in the dark. But conspicuous punishments await those who dare to test the limits of the law. In several occasions when gays came to the open and in case a gay marriage was conducted, they had to face the shame of the community and the hand of law.

Homosexuality in Somalia and Africa predates European colonisation, as sexual relations were said to be common in many cultures especially among young boys. Boys sleeping in the same bed and holding hands in public was a familiar sight. However when adults, they are expected to be married and have families. Wherever you are being gay does not stop anyone from having children or a family.

2. Existence of MSM/gay culture (meeting places, bars, etc.)

There is no MSM/gay culture meeting places in Somalia. The situation is very dangerous and Homosexuals live under a constant cloud of fear, as homosexuality is often punished with lashing, being ostracised from families and communities and even death. In February 2001 a lesbian couple was sentenced to death found guilty of "exercising unnatural behaviour". Somalia has no laws regulating homosexuality and its general legislation is loosely based on the Shari' a law. This brutal case shows that there often is little connection between legal status and legal practice, as the Muslim court in Somalia based its sentence on wide formulations, and to a big degree, on the cheering crowd outraged by the mere existence of homosexuality in Somalia. [1]

3. Presence of an organized LGBT or MSM community

In 2004, a group reportedly existed for LGBT Somalis. It cannot lobby the national government, which barely exists, and regional government is essentially in the hands of Islamic fundamentalists, pirates and other violent gangs. In 2005 a group of LGBT Somalis living in the United Kingdom was formed. [3]

The organisation Queer Somalia is a community based organisation based in Addis Ababa, Ethiopia. There is no law to protect or help queers in Somalia and Queer Somalia (a community based organisation) cannot be public or make demands on the government because there is no government with whom to talk. Without official recognition and without a government to lobby, Queer Somalia can do little more than report on the plights of individuals and to host meetings with small groups, acting as a link to the outside world. [5]

4. What is known about stigma and discrimination of male same-sex sexuality

Homosexuals in Somalia live in contexts where same-sex practices are criminalised where

heterosexism, homophobia and prejudice is strong: severe penal codes exist. Somalia has no legal system but has a cultural ban (there is no NSP) and a group called Queer Somalia operates out of the country. Its spokesperson: "My people don't understand what a homosexual is. They only know that through their religious law the solution is to kill" (Faro, a leader of Queer Somalia)

Gay and Lesbian Somalians who are in Somalia have no official recognition and live under a constant cloud of fear, as homosexuality is often punished with lashing, being ostracised from families and communities and even death! This is not an exaggeration as many of our brothers and sisters have been made to suffer inhumane reprimands or killed. Being Somali and gay is difficult. Living secret lives and not sharing your ideas and feelings with those you have close contact with in life is not an easy thing. Many flee their homes to escape possible torture or "honour killings". Some become accustomed with living double lives. Some are out to their families, not necessary by choice. Homosexuality is discussed in Somali households mainly in a negative way. Families tend to know or suspect their children but the problem arises when the son or daughter admits to his/her sexuality. [4]

Suicide is rife, following pressure from families or via loosely applied Islamic law that is uncontrolled due to the lack of a central government, their greatest fear is death - a sentence that can be brought upon them just for being homosexual, or for being perceived to be homosexual. [5]

If a person comes to know that another person is queer the children and women will kill them. There are secret houses where individuals meet at and rooms that they have rented. Sometimes they wear women's clothes, which is a veil (hijab).

Men may be rounded up simply because he was not married and was considered old enough to have married. "He will get at least 100 lashes for that, another man, who was married, will certainly be killed." [5]

The website for a group of gay Somalis in London ([www.somaligaycommunity.org](http://www.somaligaycommunity.org)) caused a stir with death threats. This is the first website of its kind anywhere in the world. It drew a lot of attention during its first week online with over 133,000 hits. Some of the major online news sites, including ones serving the mainly Somali Muslim community, covered the story and requested interviews from the Moderator of the website. Somali gays and lesbians worldwide have welcomed the site as long overdue and although it is only a web presence it will help to unite Somalis online where they can share experiences, learn from each other and at the same time knowing that there are others like themselves out there. The international Somali community is up in arms and the forums, weblogs, and sites dedicated to Somali news are awash with hate writers.

One individual calls for them to be "hunted down in the street and stoned like dogs" while another said, "Allah will punish them", another, "It's a western illness", and yet another, "... if I ever see you on the street, am gonna chop you to pieces then feed ur crap to dogs" – this last one from a Muslim woman. One Somali woman even mentioned that there was less than 100 gay people in all of Somalia. Then there is that old nemesis in African countries that seems to keep rearing its head throughout all this – the clan. North Somalis blames the south Somalis saying that is the part of the country where all the gay and lesbian people come from. Nevertheless the enormous amount of reactions to his project has indeed been mostly positive, documenting the great need among Somalis for a gay forum. During its first week online, the site registered over 133,000 hits. [11]

## 5. What is known about social position and needs of MSM living with HIV/AIDS

The study provides insufficient information about social position and needs of MSM living with HIV/AIDS. Reports suggest that LGBT Somali are typically pressured to conceal their orientation and, upon parental approval, marry someone of the opposite sex. People who are believed to be LGBT may become the victims of an honor killing.

The Boston Globe reported in 2006 that there may be no harder place in the world to fight AIDS than Somalia. For the United Nations and Western charities, some areas are off-limits because it is so risky. But even in places where they operate, the basic task of testing someone for the virus is widely considered too dangerous. If we tell someone that they are HIV positive, they might take revenge, according to Josef Prior Tio, general coordinator for Doctors without Borders in this central Somali town and in Mogadishu, the capital. 'You could get killed, said Halima Hasan Osmani, a supervisor at a Doctors Without Borders clinic that specializes in care for pregnant mothers. [14]

## 6. Any on-going activities to counteract stigma and discrimination?

A United Nations analyst has warned that peace will remain elusive in Somalia if the country's new government fails to ensure respect for human rights. [10]

## 7. Existence of homosexuality-related barriers to health care

The government & society refuse to acknowledge that homosexual communities exist in Somalia, which frustrates creating access to HIV prevention and awareness programmes.

This lack of structural and moral support leaves homosexual persons extremely vulnerable to HIV infection.

## 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Since its creation in 2000, Somalia's Transitional National/Federal Government has avoided most matters concerning human rights. As of 2009, there is no national constitution or legal system and the political parties who participate in the national parliament do not support LGBT rights. No national law exists, so there are no anti-discrimination laws, hate crime laws, or national family law. As of 2009, no Somali State or region has enacted such laws. No political party has called for such laws to be enacted. No Somali region recognizes a same-sex marriage or civil union.

The State of Puntland appears to be using the original Somali code, a combination of British colonialism and Islamic law. As such, homosexuality is a crime under both the penal code and the prevailing social mores derived from Islam.

Its transitional constitution stipulates that Islamic law shall be one of the legal foundations of the state and the only religion that may be promoted. Among its other relevant provisions are: Section 3. Article 17. Protection of the Family - Promise to defend the family, defined as a union between a man and a woman. Article 32. Personal freedom shall be limited by, among other things, Islam and morality.

Somaliland declared its independence from Somalia in 2001, and apparently decided to retain

the original Somalia criminal code, with some revisions. Hence, homosexuality is likely illegal in Somaliland under the same provisions as is the case in Puntland. The Press/Media Law of 2007 requires the Somaliland support good Islamic morality and not endorse immorality or corrupting practices. Several parts of its Constitution may impact LGBT rights. Article 5 - Islam is the official religion, the basis for all laws and no other faith may be promoted. The Government is charged with fighting immorality and promoting Islamic law. Article 8 - Equal rights regardless of, "colour, clan, birth, language, gender, property, status, opinion etc." Article 16 - Promotion of Arts and Culture that respect Islam and modesty.

Reports suggest that LGBT Somali are typically pressured to conceal their orientation and, upon parental approval, marry someone of the opposite sex. People who are believed to be LGBT may become the victims of an honor killing.

#### 9. Any action under way to change legal status of homosexuality

Qaniisiinta Soomaaliyeed (Queer Somalis) held talks with a newly-elected president of Somalia. The group's Executive Director, Hadiyo "Boston" Jimcale, said the new president promised to her that under his government all Somalis would be safe, over a telephone conversation she had with the president. She stated that the country's new laws (put in the books in 2000 by a worldwide recognized temporary national government in Mogadishu) call for all Somalis to be treated equal under the law, regardless of their sexualities or religious beliefs. But in 2001, a lesbian couple in northwest Somalia was executed after the local Islamic government found out they were to be married. "We are confident this government will help us as people of sexual minority," said Jimcale. Back in July, the group had its 4th international conference in London with more than 200 participants from all over the world. [9]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

No information available

#### 11. HIV prevalence/incidence data for MSM and general population

The International Organization for Migration (IOM) completed the first Somali HIV Hot-Spot Mapping of Most-at-Risk Populations. Populations sampled include MSM. Although MSM reported both receptive and active anal sex with condom use, the report indicates that many believe that using condoms with oil-based lubricants (hand lotion etc) is safe. [8]

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

Recent qualitative research (IOM 2008) reported high HIV risk behaviours among transactional sex workers and their clients and PLWH. [8]

Family planning services are hard to access as is fact based information on human sexuality. Humanitarian workers have stated that Islamic social mores often make it difficult to publicly talk about how the virus can be spread. Since 1999 most of the AIDS/HIV education and care comes from international organizations such as United Nations. Despite the apparent lack of information regarding HIV/AIDS, only 0.5% of the population have been infected by the virus. According to UNAIDS, the HIV prevalence rate for adults aged 15-49 years is 0.5%. However, PlusNews reports that HIV prevalence is 0.9%. Anecdotal evidence indicates that Somalia could be suffering from a concentrated epidemic in urban and cross-border regions, which host truck

drivers and sex workers who may be MSM.

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### 13. Current status of prevention, treatment and care for MSM

Officially MSM does not exist and condoms are not openly discussed in this Islamic country.

The UNDP is one international organization works closely with the three AIDS Commissions in Somalia, line ministries, networks of PLHAs as well as CSOs and other development partners to ensure a well coordinated and effective response to HIV & AIDS in Somalia. UNDP has been working on HIV & AIDS issues in Somalia for the last 5 years. UNDP will continue to support the implementation of the second National Strategic Framework for HIV & AIDS which covers the period 2009 – 2013.

Most recently, UNDP Somalia has been supporting the three zonal AIDS Commissions – the Somaliland AIDS Commission (SOLNAC), the South Central AIDS Commission (SCAC) and the Puntland AIDS Commission (PAC) - to finalize an HIV & AIDS Policy for each zone as well as an HIV/AIDS Bill in collaboration with Members of Parliament as well as each AIDS Commission.

Early November 2009, UNDP held a three-day meeting in Djibouti for 30 Members of Parliament drawn from South Central, Puntland and Somaliland to discuss Legislation in response to HIV & AIDS. The meeting provided an opportunity for Members of Parliament to review a Draft HIV & AIDS Policy and a HIV/AIDS Prevention, Control and Management Bill which will help in the fight against HIV & AIDS, reduce stigma and discrimination, and protect the rights of People Living with HIV & AIDS. In the month, UNDP also assisted the Puntland AIDS Commission (PAC) to organize a meeting for 65 Members of Parliament from Puntland to review a National Policy on HIV/AIDS and Sexually Transmitted Infections, as well as a Draft HIV/AIDS Prevention, Control and Management Bill. Similar meetings or MPs from Somaliland and South Central are scheduled to take place soon. [15]

### 14. MSM related UNGASS indicators

In 2008 Somalia did not report against any of the UNGASS indicators relating to MSM. [8]

### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Somalia has stringent religious, cultural and structural barriers to adequate prevention, treatment and care for MSM.

### 16. Whether and how MSM are included in National Strategic Plans

During the first half of 2003, a Strategic Framework for Prevention and Control of HIV/AIDS and STI within the Somali populations was developed. In 2004, action plans were developed.

Policies in place include: Somaliland National Policy on HIV/AIDS and STI Prevention and

Control; National Policy on HIV/AIDS and Sexually Transmitted Infections Control for the Puntland State.

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

The Joint UN Team on AIDS and AIDS Commissions compiled the Somali 2008 UNGASS Report with assistance from civil society and various other stakeholders. It reports that there is low awareness and access to information on HIV among all age groups; low risk perceptions, widespread sexual and gender-based violence, high illiteracy rates, poor infection control, and poverty. The three regions continue to work together on the Somali AIDS response despite political divisions and conflict. There are 3 multisectoral AIDS Commissions (with secretariats) and each region submits data separately.

In June 2007 the World Bank and Intergovernmental Authority on Development (IGAD) signed a USD 15 million grant to support the IGAD Regional HIV/AIDS Partnership Program (IRHAPP) to mitigate the impact of HIV among cross-border and mobile populations in IGAD's member states: Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan and Uganda. The four-year project will be the first financed by the Africa Catalytic Growth Fund (ACGF). The 2008 Consolidated Appeal for Somalia (CAP) does not contain an Early Recovery pillar (as in 2007). Emergency assistance and early recovery/development will be bridged through the CAP's complementarity with the United Nations Transition Plan. The 2008 CAP contains the following priorities: Save lives and provide assistance to 1.5 million people identified as being in a state of Humanitarian Emergency or Acute Food and Livelihood Crisis, or as internally displaced, including an estimated 400,000 protracted IDPs and approximately 450,000 newly displaced; Improve the protection of, and respect for, the human rights and dignity of vulnerable populations with a special focus on IDPs, women, children, victims of trafficking, and marginalised groups through effective advocacy and the application of a rights-based approach across all sectors; Strengthen local capacity for delivery of basic social services and for disaster preparedness and response [16]

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## **South Africa**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

South Africa stands apart when it comes to the legal status of gays and lesbians in Africa, and stands comparison with Western European countries. Not only is homosexuality legal and visible, but there exists a national legislation which bans discrimination on the basis of sexual orientation. Gay and lesbian office bearers are not unheard of. Annual gay pride parades are arranged, with substantial participation. [1]

According to the website Wikipedia, despite the occasional incidents of homophobia, gay people in major urban areas, such as Johannesburg, Pretoria, Durban and Cape Town, are fairly accepted, and all of these cities have a thriving gay nightlife. Cultural, arts, sports and outdoor activities play a major part in everyday South African gay life. Annual Gay pride events are held in both Johannesburg and Cape Town.

Smaller cities such as Bloemfontein, Port Elizabeth and East London, too, cater for gay people. Knysna hosts the yearly Pink Loerie Mardi Gras, which attracts gay people from all over the country. Locally produced television programmes also focus on gay life. The locally produced soap opera Egoli featured a long term gay relationship. South Africa, due to its reputation as African's most gay-friendly destination, attracts thousands of homosexual tourists annually.

The official South African Tourism site offers in depth travel tips for the gay traveller. Gay-friendly establishments are situated throughout South Africa and may be found on various gay travel websites.

Gay professionals are employed at major corporate companies throughout the country. Homosexuals are also targeted through various marketing campaigns, as the corporate world recognizes the value of the "Pink Rand".

Prominent religious leaders have voiced their support for the South African LGBT community. Archbishop Desmond Tutu and Dr. Allan Boesak are vocal supporters of gay rights in South Africa.

Even the conservative Dutch reformed church ruled that gay members should not be discriminated against and could hold certain positions within the church. However, much criticism of the church still exists; a court has ruled against a church congregation, for firing a gay musician; the issue provoked much uproar from the gay community and within liberal circles. [3]

## 2. Existence of MSM/gay culture (meeting places, bars, etc.)

In the past, same sex sexual activities were criminalized, but under the new constitution, homosexuals are specifically protected against discrimination. Now there are LGBT magazines, films, and places where MSM can meet. These places include support groups; gay pride events, bars, discos, and saunas. Many middle class MSM set up their meetings with each other via the internet (e.g. [www.gaydar.co.za](http://www.gaydar.co.za) and [www.queerlife.co.za](http://www.queerlife.co.za)), and one can easily organise 'rent boys'.

South Africa also attracts thousands of homosexual tourists to the country each year, as it is regarded as Africa's gay friendly destination. The official South African Tourism site offers in depth travel tips for the gay traveller. Gay friendly establishments are situated all over South Africa and could be found on one of the various gay travel websites.

In correctional centres (<http://www.csvr.org.za/wits/papers/papgear1.htm>), same sex boarding schools, and hostels for miners, homosexual relations seem to be quite common, but do not necessarily produce gay identities. Reaching lower income MSM can be quite difficult. Research suggests that many Black MSM if they are active in sex will not call themselves 'gay'; the word 'gay' may be used by more effeminate men who allow themselves to be penetrated anally.

## 3. Presence of an organized LGBT or MSM community

There are many organisations serving the LGBT communities. For example, there is an organisation called the Inkanyezi Project, which serves male rape survivors, provides male rape counselling, emotional awareness, lobbying and advocacy. Other helpful organizations in South Africa, include Planned Parenthood, Triangle Health Care (a gay and lesbian health project), the Department of National Health AIDS Program, SWEAT (Sex Workers Education and Advocacy Taskforce) and student groups at the universities who offer safe-sex workshops, HIV testing, self-esteem workshops, educational seminars, etc. The Joint Working Group is an alliance of LGBT organisations.

Activities to counter stigma and discrimination come mostly from activists and NGOs serving the LGBTI and MSM populations, and there are discrimination protections based on sexual orientation.

There are campaigns to address, criminalize and minimize Hate Crimes.

Human rights based organizations that do or should address MSM issues include organizations such as OUT LGBTI, Triangle, Behind The Mask, etc.

The Forum for the Empowerment of Women (FEW), established in January 2002, is a networking, empowerment and support organisation of and for black lesbians in and around Johannesburg, <http://www.gaycentre.org.za> The official website of the Durban Lesbian and Gay Community and Health Centre. The organisation empowers the LGBT community by providing services, support and training to enable them to claim their rights to equality, dignity and freedom within the context of transformation.

Gender DynamiX is a live and growing website with the aim to provide help, advice and information for those who seek to adjust their lives to live in the opposite gender role, as to that assigned to them at birth, or who are working to come to terms with their situation despite their genetic background. <http://dating.genderdynamix.co.za/> is a brand new site for transgender people and their admirers to meet each other in South Africa.

A website on OUT-Lesbian/Gay/Bisexual/Transgender Well Being provides health and mental health. Their services includes telephonic counselling and information online, psychotherapeutic support groups, HIV prevention work and an office in Mamelodi, Pretoria; Member Organisations of the Joint Working Group (JWG) - a collective network between LGBTI organisations in South Africa, working towards coordinating national approach to LGBTI issues in South Africa: ; The African Men for Sexual Health and Rights (AMSHeR), is an African coalition of LGBT/MSM led organizations working to improve access to HIV services for gay men and other MSM as well as the full realization of their human rights. ; Atlantic Tourist Information is the first official gay tourist information centre in South Africa. Although we specialise in the gay market, we are straight friendly and treat all our clients equally.; Boyzone is an Online gay magazine with pictures, personals, information reviews; Gaysouthafrica Provides links, articles of interest and a discussion forum for gay and lesbian South Africans; Johannesburg Gay and Lesbian Library Listings of available books and videos, operating hours, location and membership information.; SA Bears ( Men that Like Men ) SA Bears is an all-new gathering of men who represent a cross section of the men that South Africa has to offer. The formation of SA Bears is the culmination of a vision by a few like-minded men who wished to provide a well organised, safe, private, and welcoming gathering place for men who enjoy the company of men. ; The Johannesburg Gay and Lesbian Library List available books and videos

#### 4. What is known about stigma and discrimination of male same-sex sexuality

Gay women from smaller towns (especially the townships) are often victims of beating or rape. This has been posited, in part, to be because of the perceived threat they pose to traditional male authority. South Africa has no specific "hate crime" legislation; human rights organisations have criticised the South African police for failing to address the matter of bias motivated crimes. For example, the NGO *ActionAid* has condemned the continued impunity and accused governments of turning a blind eye to reported murders of lesbians in homophobic attacks in South Africa; as well as to so-called "corrective" rapes, including cases among pupils, in which cases the male rapists purport to raping the lesbian victim with the intent of thereby "curing" her of her sexual orientation.[1] [2] Human rights watchdogs believe that much of the sexism and homophobia that erupts is tied to male frustration with unemployment and poverty.

Despite the country's laws, there are reported (an often non-reported) cases of stigma, harassment and discrimination in South Africa, as well as hate crimes and bullying in schools. Homophobia remains a problem. 82% of the adult population of South Africa think that sex between two men or two women could be considered 'always wrong,' according to the latest South African Social Attitudes Survey. Just 8% thought it was never wrong. Gay and lesbian identities continue to be characterised as 'un-African' and 'immoral' and most HIV service providers are not trained, equipped, or willing to meet the specific prevention and treatment needs of LGBT people let alone MSM who may not call themselves gay or bisexual.

Fears about family rejection, loss of job, and public shunning, impede the effectiveness of HIV and AIDS prevention and care efforts. Stigma and discrimination discourage those who are infected with and affected by HIV and AIDS from seeking needed services because seeking services may reveal their HIV status to their families, workplace colleagues, or community. Ideas about the lifestyles of people living with HIV and AIDS contribute to a sense that HIV and AIDS are problems that affect "others," which may undermine individuals' estimation of their own risk and reduce their motivation to take preventive measures (Population Council).

Since anti-discrimination laws exist, many gay professionals are employed at major corporate companies throughout the country. Homosexuals are also targeted through various marketing

campaigns, as the corporate world recognizes the value of the "Pink Rand".

International non-governmental organisation (NGO) Action Aid recently stated that horrific crimes against South African lesbians were going on with neither recognition nor punishment. While South Africa's Constitution makes explicit provisions against discrimination based on sexual orientation, the first in the world to do so, law enforcement agents are still lax in their response to crimes committed against homosexuals. So even where there is Constitutional protection of homosexual persons, this 'protection' does not seem to translate into much human commitment and action. [7]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

Since the primary mode of HIV transmission in sub-Saharan Africa is heterosexual, research focusing on the sexual behaviour of men who have sex with men (MSM) is scant. Currently it is unknown how many people living with HIV in South Africa are MSM and there is even less known about the stigmatisation and discrimination of HIV-positive MSM. A 2008 study HSRC *Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town*, examined the stigma and discrimination experiences of MSM living with HIV/AIDS in South Africa. Anonymous venue-based surveys were collected from 92 HIV-positive MSM and 330 HIV-positive men who only reported sex with women (MSW). Internalised stigma was high among all HIV-positive men who took part in the survey, with 56% of men reporting that they concealed their HIV status from others. HIV-positive MSM reported experiencing greater social isolation and discrimination resulting from being HIV-positive, including loss of housing or employment due to their HIV status; however these differences were not significant. Mental health interventions, as well as structural changes for protection against discrimination, are needed for HIV-positive South African MSM. [2]

#### 6. Any on-going activities to counteract stigma and discrimination?

Results of a needs assessment by OUT LGBT-Wellbeing showed that many homosexual people feel uncomfortable talking about safer sex and they have opened a facility (The Prism Lifestyle Centre) that, according to the founders, aims to provide lesbian, gay, bisexual, transgender (LGBT) people an alternative LGBT affirming and health-promoting space with increased direct services such as face to face counseling, support groups, and primary healthcare services. It also aims to facilitate workshops that will encourage positive sexual behaviour, offer life skills, advice on risk reduction and a range of activities such as book clubs, interest groups and yoga.

With the hope to bridge the service delivery gap the centre will also offer LGBTI focused health services such as the primary health care services, including HIV testing, STI testing and diagnosis, selected lab work, general physical examinations, PAP smears, referral and follow-up and treatment literacy. Based on the results of the needs assessment it was highlighted that a range of individual and contextual determinants that influence sexual risk-taking among those sampled. Of these multiple determinants it became clear that a large portion of LGBT people feel isolated and disconnected from others. Many feel a sense of shame and guilt about their sexual orientation. Many feel pressured to take risks because of negative peer norms that exist in their social and sexual networks.

#### 7. Existence of homosexuality-related barriers to health care

Health workers often display negative and judgmental attitudes and tailor clinical management almost exclusively towards heterosexuals. This makes men very reluctant to use healthcare services, particularly public health services. And due to persistent stigmatization of

homosexuality, some MSM fear to disclose their sexual practices and sexual identity to health workers.

LGBTI organizations and researchers are collecting and sharing data. However, it would seem that the average gay man in South Africa doesn't know his HIV status. Numerous MSM told IRIN/PlusNews that part of the reason MSM do not go to be tested is because they are embarrassed to go to "normal" clinics. A safe-sex campaign, "Play Nice", targeting men who have sex with men (run by Health4Men, a program of the Perinatal HIV Research Unit (PHRU) of the Johannesburg-based Witwatersrand University) was launched in 2009 – and is aimed at men in underserved populations, including MSM and unemployed young men, and is the first large-scale campaign specifically geared to get HIV-related messaging to the MSM community. The Play Nice drive is using the internet, mobile phone technology, traditional media and direct campaigns, hopes to reach various groups of MSM in novel, pro-sex ways that will appeal to this target audience.

Health4Men has collected a database of phone numbers, and uses techniques like sending out a bulk text message on a Friday night, reminding guys who are "playing" to bring condoms and lubricant. Later in the evening another text message might be sent, informing recipients that if they have had unsafe sex, they have 48 hours to begin post-exposure prophylaxis (PEP), and giving a number they can contact to receive treatment. Health4Men has an office in Cape Town's "gay village" of De Waterkant, holds seminars at gay venues, posts articles in the gay newspaper, Pink Tongue, and distributes messages in the lockers at a steam bath frequented by MSM.

"For the gay community, people feel embarrassed to go to the local government clinic where they are known. To have sores in your mouth or down there ... if you can go to a special clinic where you're comfortable and won't be discriminated against, that's good," said Prosper Mandy at the Play Nice launch party. Health4Men will be opening a facility - described it as a "male friendly" space - at the Ivan Toms Centre for Men's Health in the Cape Town suburb of Woodstock in the coming months. Personnel are all male, though not necessarily all gay, and all services will be free, and will include HIV tests, CD4 counts to measure immune system strength, viral load testing to check the quantity of

South Africa is failing to protect its gay men from HIV adequately enough, according to research presented at an historic conference. Attendees of the African Congress on Sexual Health and Rights heard that the South African government is currently focusing purely on heterosexual people, and is failing to provide education or resources to gay men.

Health workers say it is increasingly up to them to ensure gay men – and MSM - are aware of the risks that could result in HIV. One group told BBC Online that the situation is fast reaching a level where gay men do not believe HIV affects them, because they fail to associate themselves with the government messages targeted at heterosexuals. This is the reverse of the situation across developed countries, where HIV is still considered a disease that affects gay men more than straight people, despite a sharp increase in heterosexual cases.

Of those that do know of the risks, most are failing to look after themselves properly. A lot of gay men are either absolutely terrified or in total denial.

According to De Swardt of the Play Nice campaign, various funding agencies have identified the need for MSM HIV interventions. "We have more resources for the new campaigns than we've had for the current one - we're investing quite heavily in this preventative thing," he added. "It's

the first time this kind of thing - MSM, multimedia, sex-positive kind of messaging - has been done in South Africa, and a lot more money will go into the next non-Eurocentric campaigns."

A UNAIDS published article describes the obstacles and opportunities to better address HIV prevalence among men who have sex with men (MSM) in Africa and the need for tailored HIV resources and programs. The article describes how the SHARP/Open Society Initiative for Southern Africa (OSISA) research project and related meeting in Southern Africa have contributed to these efforts:

Of course, the poorest suffer most and South Africa's black community has been the hardest hit and the most difficult to educate. The previous government did little to move actively against the disease and ignorance. With Mandela's election there has been a significant increase in funding and resources for education and care.

Stakeholders also want African governments to use their resources from their own coffers and from international donors to fund programs that address the issue of HIV prevention among gay and lesbian Africans.

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Same-sex marriage became legal in South Africa on 30 November 2006 when the *Civil Unions Bill* was enacted after having been passed by the South African Parliament earlier that month. A ruling by the Constitutional Court on 1 December 2005 had imposed a deadline of 1 December 2006 to make same-sex marriage legal.

South Africa's post-apartheid constitution was the first in the world to outlaw discrimination based on sexual orientation, and on 1 December 2006 South Africa made history by becoming the fifth country in the world, and the first in Africa to legalise same-sex marriage. It was also the only republic to provide non-heterosexual individuals with exactly the same rights, such as adoption and military service, as heterosexual individuals, until it was joined by Argentina on July 15, 2010. The only other countries to provide these are all constitutional monarchies, such as Canada and the Netherlands. One year later an equal age of consent was achieved; after lengthy debate and an overhaul of sexual offences legislation, age of consent was gender-neutralized at 16. [6]

#### 9. Any action under way to change legal status of homosexuality

South Africa's post-apartheid constitution was the first in the world to outlaw discrimination based on sexual orientation, and leads the way for other countries to follow suit.

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

There are many organisations serving the LGBT communities. Activities to counter stigma and discrimination come mostly from activists and NGOs serving the LGBTI and MSM populations, and there are discrimination protections based on sexual orientation.

There are campaigns to address, criminalize and minimize Hate Crimes.

#### 11. HIV prevalence/incidence data for MSM and general population

Currently it is unknown how many people living with HIV in South Africa are MSM and there is

even less known about the stigmatisation and discrimination of HIV-positive MSM. Research with 92 HIV-positive MSM and 330 HIV-positive men who only reported sex with women (MSW) was quite revealing; internalised stigma was high among all HIV-positive men who took part in the survey, with 56% of men reporting that they concealed their HIV status from others. HIV-positive MSM reported experiencing greater social isolation and discrimination resulting from being HIV-positive, including loss of housing or employment due to their HIV status; however these differences were not significant. [2]

In other research, in-depth interviews were held with a purposeful sample of 48 black MSM aged 18 to 52 from Johannesburg. Participants described their sexual identity and activities, HIV knowledge, risk behaviours, condom access and use, HIV testing history, and health services experiences.

Lessons learned: Forty-one men identified as gay, 7 acknowledged same-sex desire without identifying as gay, 2 had current female partners. Anal and oral intercourse was common. Forty-six had ever engaged in anal sex. Twenty-seven preferred receptive anal intercourse, either exclusively (22) or in addition to insertive anal intercourse (5). Twelve preferred insertive anal intercourse exclusively; 8 were not specific. Thirty-nine men reported having oral sex. Knowledge of HIV transmission risk through anal intercourse was high, but limited for oral sex. Participants reported high condom accessibility. All reported current regular condom use, but 14 reported past non-regular condom use. Nineteen gay-identified men reported having receptive anal intercourse with straight-identified men. Twenty-seven men reported ever testing for HIV. Sixteen participants experienced discrimination in public health clinics.

A study of LGBT teens in South Africa's KwaZulu-Natal province has sent shockwaves throughout the country. Focusing on young people in the municipalities of Pietermaritzburg and Durban researchers found that 20 percent of gay and bisexual teenage males and 19% of lesbian and bisexual female teens had been raped or sexually assaulted. They also found that one third of all LGBT students had been physically assaulted at school because of their sexuality. The study was conducted for Out LGBT Well-being and the Durban Lesbian and Gay Health and Community and Health Center. The researchers found that black and Indian students were more likely to be victimized because of their sexuality than were white students. "More alarming is the victimization by teachers and principals," said Pietermaritzburg Gay & Lesbian Network convener Anthony Waldhausen. "The network will go out of its way to protect the gay and lesbian community and is looking at ways to provide hope for the many that are victimized." The study found that homophobia was so severe in the province that many students refused health care because they did not trust medical staff. The researchers noted that this often had the added concern that HIV transmission to the victims was not determined. The situation in the province is so severe the researchers said in their report that almost one in five LGBT students said they had attempted suicide.

New research from UCSF examining HIV among men who have sex with men (MSM) in the township of Soweto in South Africa has found that a third of gay-identified men are infected with HIV (Tim Lane et al). Of the study's 378 participants, 34.1% identified as gay, 30.4% as bisexual and 31.7% as straight. All but one of the participants were black South Africans and all of South Africa's black African ethnic groups were represented in the sample.

The researchers found that the highest HIV rate was among gay identified men, at 33.9%. The researchers estimated the rate of HIV infection for bisexual MSM in Soweto to be 6.4% and 10% for straight identified MSM.



The study showed that MSM's sexual identities predicted their sexual behaviour with other men. Gay identity was highly correlated with the exclusive practice of receptive anal intercourse and straight and bisexual self-identification was highly correlated with the exclusive practice of insertive anal intercourse with male partners. As such, control of condom use in same-sex partnerships tends to be in the hands of bisexual and straight MSM. This finding demonstrates the pressing need to promote condom use among bisexual and straight-MSM for same-sex as well as heterosexual relationships.

The authors also looked at other risk factors and found that HIV infection was also associated with being older than 25, lower incomes, purchasing alcohol or drugs for a male partner in exchange for sex, having receptive anal intercourse and having any unprotected anal intercourse with a man.

HIV infection was significantly less likely among men who have sex with men who were circumcised, smoked marijuana, had a regular female partner or reported unprotected vaginal intercourse with women [2]

Recent research by the MRC (Jewkes et al) involving a representative sample of 1 738 men in the Eastern Cape and KwaZulu-Natal found that 28% of respondents said they had raped a woman or girl, and 3% said they had raped a man or boy. One in 10 men said they had been forced to have sex with another man. [6]

HSRC (CAROL METCALF and LAETITIA RISPEL) has also found that there exists a 'hidden epidemic' of HIV among MSM in South Africa. [8]

Keren Middelkoop of the Mother City Men's Health Project gave results for 79 men recruited so far out of the target of 200 from black townships around Cape Town. In South Africa sexuality is protected under the constitution, and men had relatively higher levels of awareness and condom use.

Eighty-eight per cent defined as gay or homosexual and 2.7% as transgender (compared with zero in Malawi), 50% 'always' used condoms and only 26% (compared with two-thirds in Malawi) used an oil-based lubricant with a condom. The HIV prevalence so far seen was 34% compared with 18-20% for the latest general-population estimate in South Africa, and 31.5% had a current acute STI (gonorrhoea, syphilis or trichomoniasis).

Despite legal protection, 12% said they had been assaulted due to their sexuality (7% by the police), 8% arrested for sexual offences and 13% had been raped.

#### 12. Is there understanding of specific risk factors for HIV transmission in MSM

Sexual risk factors account for most HIV infections in MSM. These factors include unprotected sex and sexually transmitted diseases (STDs).

Having anal sex without a condom continues to be a significant threat to the health of MSM. Unprotected anal sex (barebacking) with casual partners is an increasing concern. Not all the reasons for an apparent increase in unprotected anal intercourse are known, but research points to the following factors: optimism about improved HIV treatment, substance use, complex sexual decision making, seeking sex partners on the Internet, and failure to practice safer sex. Rape is also a significant factor.

Some of these men may be serosorting, or only having sex (or unprotected sex) with a partner

whose HIV serostatus, they believe, is the same as their own. Although serosorting between MSM who have tested HIV-positive is likely to prevent new HIV transmission to persons who are not infected, the effectiveness of serosorting between men who have tested HIV-negative has not been established. Serosorting with condom use may further reduce the risk of HIV transmission. However, for men with casual partners, serosorting alone is likely to be less effective than always using condoms because some men do not know or disclose their HIV serostatus.

STDs, which increase the risk for HIV infection, remain an important health issue for MSM. In addition to increasing susceptibility to HIV, STDs are markers for high-risk sexual practices, through which HIV infection can be transmitted. Research has shown that many people who learn that they are infected with HIV alter their behaviors to reduce their risk of transmitting the virus. Therefore, increasing the proportion of people who know their HIV serostatus can help decrease HIV transmission.

The use of alcohol and illegal drugs (substance use) continues to be prevalent among some MSM and is linked to risk factors for HIV infection and other STDs. Substance use can increase the risk for HIV transmission through the tendency toward risky sexual behaviors while under the influence and through sharing needles or other injection equipment. Reports of increased use of the stimulant drug methamphetamine are also a concern because methamphetamine use has been associated both with risky sexual behaviors for HIV infection and other STDs and with the sharing of injection equipment when the drug is injected. Methamphetamine and other “party” drugs (such as ecstasy, ketamine, and GHB [gamma hydroxybutyrate]) may be used to decrease social inhibitions and enhance sexual experiences. These drugs, along with alcohol and nitrate inhalants (“poppers”), have been strongly associated with risky sexual practices among MSM.

More than 25 years into the HIV epidemic, there is evidence of an underestimation and complacency of risk, of difficulty in maintaining safer sex practices, and of a need to sustain prevention efforts for all gay and bisexual men. The success of highly active antiretroviral therapy (HAART) may have had the unintended consequence of increasing the risk behaviors of some MSM. Some research suggests that the perceptions of the negative aspects of HIV infection have been minimized since the introduction of HAART, which has led to a false understanding of what living with HIV means and thus to an increase in risky sexual behaviors. For example, some MSM may mistakenly believe that they or their partners are not infectious when they take antiretroviral medication or when they have low or undetectable viral loads.

It would seem that the rates of risky behaviors are higher among young MSM than among older MSM. Not having seen firsthand the toll of AIDS in the early years of the epidemic, young MSM may be less motivated to practice safer sex. HAART has enabled HIV-infected MSM to live longer. However, HAART’s success means there are more MSM living with HIV who have the potential to transmit the virus to their sex partners. This emphasizes the importance of focusing prevention efforts on those who are living with HIV. More SA-based research is needed on this.

Although many MSM reduce their risk behaviors after learning that they have HIV, most remain sexually active. Most HIV-infected MSM believe that they have a personal responsibility to protect others from HIV, but some engage in risky sexual behaviors that may result in others’ contracting HIV.

During the past decade, the Internet has created new opportunities for (mostly middle-class) MSM to meet sex partners. Internet users can anonymously find partners with similar sexual

interests without having to leave their residence or having to risk face-to-face rejection if the behaviors they seek are not consistent with safer sex. The Internet may also normalize certain risky behaviors by making others aware of these behaviors and creating new connections between those who engage in them. At the same time, however, the Internet has the potential to be a powerful tool for use with HIV prevention interventions.

There is growing recognition that combinations of individual, sociocultural, and biomedical factors affect HIV risk behavior among MSM. Childhood sexual abuse, substance use, depression, and partner violence have been shown to increase the practice of risky sexual behaviors. Further research has shown that the combined effects of these problems may be greater than their individual effects. Therefore, MSM with more than 1 of these problems may have additional risk factors for HIV infection. The expansion and wider awareness of this type of research, which shows the additive effect of various psychosocial problems, will result in more precise prevention efforts.

Even though MSM constitute a group at risk for HIV, not all MSM are at risk for HIV. Analyzing the context within which individuals of the larger MSM community live and socialize may be a promising method for developing and focusing HIV interventions. The appreciation of differences within the MSM community will aid in the development of successful HIV prevention interventions.

### 13. Current status of prevention, treatment and care for MSM

While studies have indicated the widespread existence of MSM groups across Africa, little has been done to ensure their safe access to relevant HIV and AIDS information and services. The lack of focus on MSM is also evident in South Africa where one researcher, Earl Ryan Burrell of the Desmond Tutu HIV Foundation, said that “HIV programmes in South Africa are heavily heterosexual and female focused... more recognition of MSM as a risk group is needed.” (31) Speaking at the third national conference on peer education, HIV and AIDS, held in Nairobi, a prominent MSM activist, Peter Njoroge, noted that “There are no appropriate and sensitive counselling services and HIV and sexual health campaigns only talk about vaginal sex as a route of transmission.”

One challenge inherent in reaching MSM groups is that many MSM often do not regard themselves as homosexuals. These individuals are usually in serious relationships with women and do not classify themselves as homosexuals because of the heavy stigma that surrounds male-to-male sex. They may reject or disregard HIV prevention services that cater for the needs of homosexual men, thereby exposing themselves further to the risks of homosexual sexual behaviour, and the possibility of becoming infected with HIV. [4]

LGBTI organizations and researchers are collecting and sharing data. However, it would seem that the average gay man in South Africa doesn't know his HIV status. Numerous MSM told IRIN/PlusNews that part of the reason MSM do not go to be tested is because they are embarrassed to go to "normal" clinics.

A safe-sex campaign, "Play Nice", targeting men who have sex with men (run by Health4Men, a program of the Perinatal HIV Research Unit (PHRU) of the Johannesburg-based Witwatersrand University) was launched in 2009 – and is aimed at men in underserved populations, including MSM and unemployed young men, and is the first large-scale campaign specifically geared to get HIV-related messaging to the MSM community. The “Play Nice” drive is using the internet,

mobile phone technology, traditional media and direct campaigns, hopes to reach various groups of MSM in novel, pro-sex ways that will appeal to this target audience.

Health4Men has collected a database of phone numbers, and uses techniques like sending out a bulk text message on a Friday night, reminding guys who are "playing" to bring condoms and lubricant. Later in the evening another text message might be sent, informing recipients that if they have had unsafe sex, they have 48 hours to begin post-exposure prophylaxis (PEP), and giving a number they can contact to receive treatment. Health4Men has an office in Cape Town's "gay village" of De Waterkant, holds seminars at gay venues, posts articles in the gay newspaper, Pink Tongue, and distributes messages in the lockers at a steam bath frequented by MSM.

"For the gay community, people feel embarrassed to go to the local government clinic where they are known. To have sores in your mouth or down there ... if you can go to a special clinic where you're comfortable and won't be discriminated against, that's good," said Prosper Mandy at the Play Nice launch party. Health4Men will be opening a facility - described it as a "male friendly" space - at the Ivan Toms Centre for Men's Health in the Cape Town suburb of Woodstock in the coming months. Personnel are all male, though not necessarily all gay, and all services will be free, and will include HIV tests, CD4 counts to measure immune system strength, viral load testing to check the quantity of HI-virus in the body, screening for sexually transmitted infections, counselling, and antiretroviral and other treatments. Dr Kevin Rebe, an infectious disease specialist and HIV physician who will be the primary medical officer, said the clinic would adhere to all Department of Health guidelines, but would be "more holistic".

Health4Men has set up the process for research among the various socioeconomic groups in the black and coloured communities around Cape Town. Adiel Peters, the administrator of the Woodstock Clinic and an MSM from the Cape Flats who runs support groups for MSM in Manenberg and Bonteheuwel townships, believes that direct support to MSM in the townships is desperately needed.

"At the moment there are no services specifically around MSM in those communities. Discrimination also affects service delivery - people won't always give you the same level of service if they have preconceived thoughts about you being gay. Sometimes MSM are not taken seriously, or are chased away," Peters told IRIN/PlusNews. "MSM in my community mostly engage in spontaneous sex – it's about meeting a guy in the street at night and deciding to have sex for a number of reasons: enjoyment, financial gains ... most are reliant on substances, so it could be an exchange for drugs or alcohol. And because it's spontaneous they don't have condoms and engage in barebacking," he said. "They're usually intoxicated, can't even remember what they did the night before; they wake up the next morning on the side of the street or in someone's home they don't know, and have had sex with people they don't know or can't remember."

Hoping to reach those communities, De Swardt has suggested that the new campaigns attempt to avoid the stigma of being MSM by providing testing and messaging in places like pharmacies, or even hairdressing salons. "We have more resources for the new campaigns than we've had for the current one - we're investing quite heavily in this preventative thing," said De Swardt. "It's the first time this kind of thing - MSM, multimedia, sex-positive kind of messaging - has been done in South Africa, and a lot more money will go into the next non-Eurocentric campaigns."

"We're assessing sexual risk in greater detail; we are extra tailored to higher-risk populations." In addition to physical care, "we deal with psychosexual issues that really affect sexual activity,

like impulsivity, sexual addiction, and the use of drugs and alcohol." Health4Men distributes free lubricants along with condoms, a vital component of safe anal sex. De Swardt also runs support groups for HIV-positive men. "In the next three months I want to have three support groups running: one for people who have just found out their status, one for those with difficulty adjusting to it, and a third for those going into treatment."

Referring to the black and coloured townships around Cape Town, Prosper Mandy said: "The problem is getting the message out there to the communities. As you can see, most people here [at the fetish party] are middle- and upper-class, so the question is how to get the services out there, and how to get them to come here." De Swardt commented: "This campaign has been designed specifically for urban ... gay men. This campaign - the way it exists now - cannot be replicated in the Cape Flats [an area of large coloured townships] or the black townships. You can't just take a campaign from one community and drop it in another."

Condoms (and sometimes water-based lubricant) are distributed for free by certain LGBTI NGO's to some gay / MSM venues (clubs, bars and saunas / sex venues), etc. in South Africa, and awareness around the correct usage of water based lubricants with latex condoms is also promoted. VCT sites and Government ART sites also provide free condoms (but not necessarily water based lubricant). Pharmacies and supermarket stores also have condoms and water based lubricants available on the shelves or over the counter.

#### 14. MSM related UNGASS indicators

Out of the 52 countries reviewed, 35 countries did not report on any of the five UNGASS indicators relevant to MSM. South Africa was one of them.

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Health workers often display negative and judgmental attitudes and they tailor clinical management almost exclusively towards heterosexuals. This makes men very reluctant to use healthcare services, particularly public health services. And due to persistent stigmatization of homosexuality, some MSM fear to disclose their sexual practices and sexual identity to health workers.

#### 16. Whether and how MSM are included in National Strategic Plans

Whilst HIV infection amongst MSM was the focus in the early phases of the epidemic in South Africa, there is currently very little known about the epidemic amongst MSM in the country - National Strategic Plan on HIV and AIDS 2007-2011. This is changing.

Just like in most of the industrialised world, in South Africa in the early 1990's, HIV was associated with the visible gay male population, who, it was widely thought, were mostly white. The country was in denial about at least two things: 1) that HIV is not a problem in the general population, and 2) that men of all races were having sex with men. The reality of the epidemic among the general population proved too much to disguise, but as in much of the rest of Africa, MSM continue to be a marginalised, hard to reach and under studied population. However, in most of the developing world, the studies that have been conducted indicate that MSM are at a much higher risk of HIV infection than the general population. According to a review in *Plos Medicine*, the prevalence among MSM is about 9-fold higher than the general population in medium-high HIV prevalence countries, though only a couple sub-Saharan African countries

were included (Baral).

In South Africa, by 2007, the NSP finally called for more information on HIV among MSM and also for programmes to reach the most at risk populations, including MSM. There were so little reliable data that the country was unable to report on indicators for MSM for the UNGASS report submitted to the UN early 2008. Since that time, several studies have been launched.

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

There are existing healthcare insurances that include HIV, private practice and Government ART sites, including access to free ARV treatment in South Africa. However, according to Dr Carol Metcalf, it is clear, the current HIV response in South Africa does not meet the (Prevention, testing and treatment services) needs of MSM. Professor Rispel described some of the challenges MSM have in accessing services from the public sector: "Although the majority of survey participants, 57%, had used public health services in the past year (most had little choice because they had no private medical aid), only 7% of individuals said that they would prefer to receive HIV prevention services from a government health service rather than from other service providers," she said.

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## Sudan

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Gay life in Sudan is virtually non-existent from an observer's eye. Deeply Muslim (in the north) and very conservative, the laws against same-sex behavior are severe. A group African and Middle Eastern gays and lesbians who, in the face of hostility and repression, have come out online. There is a small, self-supporting network of people who have launched Web sites about their sexuality, while keeping their full identity secret. Caution is crucial; homosexual acts are illegal with penalties ranging from long-term imprisonment to execution. Beyond the blogging scene, the Internet's chat rooms and community sites have also become one of the safest ways to meet, away from the gaze of a hostile society. [8]

A gay-focused website was launched in December 2006 called Freedom Sudan-the Sudanese LGBT Association. On their website it says: "Freedom Sudan is the lesbian, gay, bisexual, and transgender (LGBT) organization in Sudan. The organization also has its own Twitter account here. [1]

Historically it is evident in Sudan's Nubian and Cushite societies that homosexuality was an intricate part of the society. In Sudan, there were "homosexual" tribes in Cush and Nubia before the invasion of the White and Arab religions. According to anecdotal information, Homosexuality has always been present in Africa. [14] Siegfried Frederick Nadel, writing in the 1940s and 50s noted that among the Otoro, a special transvestitic role existed whereby men dressed and lived as women. Transvestitic homosexuality also existed amongst the Moru, Nyima and Tira people, and reported marriages of Korongo londo and Mesakin tubele for the bride-price of one goat. In these tribes with "widespread homosexuality and tranvesticism", Nadel reported a fear of heterosexual intercourse as sapping virility and a common reluctance to abandon the pleasure of all-male camp life for the fetters of permanent settlement. "I have even met men of forty and fifty who spent most of their nights with the young folk in the cattle camps rather than at home in the village." In these pervasively homoerotic societies, the men who were wives were left at home with the women. Among the Mossi, pages chosen from among the most beautiful boys aged seven to fifteen were dressed and had the other attributes of women in relation to chiefs, for whom sexual intercourse was denied on Fridays. After the boy reaches maturity he was given a wife by the chief. The first child born to such couples belonged to the chief. Today, the issue has divided some religious communities. In 2006, Abraham Mayom Athiaan, a bishop in South Sudan, led a split from the Episcopal Church of Sudan for what he regarded as a failure by the church leadership to condemn homosexuality sufficiently strongly. [25]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

The media and the press in Sudan dare to talk about homosexuality. Homosexuality is illegal in Sudan, therefore gays remain subject to imprisonment, torture and in some cases the death penalty. [17] There is however, a small, self-supporting network of people who have launched Web sites about their sexuality, while keeping their full identity secret. The website: [www.black-gay-arab.blogspot.com](http://www.black-gay-arab.blogspot.com) is for men who are "Sudanese by birth, gay by nature, proud by choice".

According to unconfirmed reports from a Sudanese it is believed gay men meet anonymously at certain cafes. However, these café's are not safe as meeting places as it has been reported that

men have been jailed even on suspicion of their perceived sexual orientation.

### 3. Presence of an organized LGBT or MSM community

Freedom Sudan is the lesbian, gay, bisexual, and transgender (LGBT) organization in Sudan. The organization formed in December 2006 is considered illegal in Sudan. It was formed in secret and all activities are carried out secretly, hoping that one day they will get accepted by Sudanese communities and even by their families. This is an organization run by volunteers only. The organization also has its own Twitter account here. Main goals are: (1) Recognition of homosexuality in Sudan; (2) Social acceptance of homosexuality and acceptance of the rights of homosexuals in Sudan; (3) Abrogation of the death penalty for homosexuals (Articles 148, 151, 316 and 318); and (4) to work together with other LGBT organizations in the world for a better LGBT rights. [16]

### 4. What is known about stigma and discrimination of male same-sex sexuality

In Sudan it has been reported that even a kiss can get you killed. Same-sex sexuality is illegal: high instances of torture and death & imprisonment (Islamic law) and high rates of slavery is evident, while anecdotal evidence shows instances of rape of slave boys by older men. [17]

The Anglican Church of Sudan said preferring to establish its own hierarchy in the country in a manner to mark its distance from other reformist churches for tribalism and their practices of homosexuality and abortion. The Archbishop of Anglican Church of Sudan, in South Sudan Rt. Rev most Archbishop Abraham Mayom Athiaan told the Sudan Tribune “We, the bishops together with our congregation of the Anglican church of the Sudan (ACS) strongly condemn the practice of homosexuality, abortion which is being practiced in Episcopal Church of Sudan (ECS) leaderships. [18]

According to unconfirmed reports from a Sudanese source 2 men were arrested in 2003 at a cafe in Omdurman, called Ezzo, where it is believed gay men meet anonymously. According to the source, so far no charges have been brought against them, however they have been jailed on suspicion of their perceived sexual orientation. In Sudan the only way for gay people to communicate is through the Internet, unfortunately Internet is also reported to be risky nowadays, as gay men have been targeted over the Internet, but they continue to risk arrest and ill-treatment. According to accounts from anecdotal information, after being arrested, some of them disappear and it is assumed that they have been sentenced to death. [17]

### 5. What is known about social position and needs of MSM living with HIV/AIDS

Leaders across Africa claim that homosexuality is not within their culture, that it doesn't exist and where it is seen it's a result of Western influence. As a result, men who have sex with men (MSM) are less visible, stigmatised, officially denied and criminalised. This adds to the vulnerability of men who have sex with men, and makes it near impossible to know about the social position of these men, and especially to carry out relevant HIV prevention campaigns in some countries. In places where homosexuality is not tolerated, men who have sex with men often hide their same-sex relations from their friends and families to avoid persecution. Many have wives, or have sex with women as well as men, and this means that they may transmit HIV to their female partners if they become infected. The significant impact that HIV is having on men who have sex with men is therefore not an isolated problem in Sudan, but one that is very much linked to countries' wider HIV epidemics.



There are numerous anecdotal reports of men and soldiers raping young boys, and the existence of young slave boys in villages being raped. Young slaves from neighboring countries being captured and raped by the military and in villages, a situation exacerbated by migration and natural disasters. Sudan is known to suffer recurrent natural disasters including floods, drought, famine as well as epidemics consisting mainly of water borne diseases and meningitis. In addition, a protracted civil war in the southern region for the last two decades has created a massive movement of people from south to central Sudan affecting a large number of people.[22] British human rights organisation Waging Peace have reported that boys from the Darfur region of Sudan were kidnapped from refugee camps in Chad and sold as child soldiers to fight in Sudan with the silent approval of the Chad government. The United Nations estimated earlier that between 7,000 and 10,000 child soldiers have been recruited in eastern Chad.[3] Slavery exists in the country. Villagers have reported that young male slaves are raped while in captivity, it is not discussed because of the cultural prohibitions on all forms of homosexuality including rape. In fact, male-to-male sex is considered such an egregious act in South Sudan that if two males are found guilty of having consensual sex with each other they are killed by a firing squad, according to Aleu Akechak Jok, an appellate court judge for the South. Southern Sudan's punishment for consensual homosexual sex is not too different from the Muslim Sharia law in Northern Sudan, which imposes a death penalty on those found guilty of homosexuality. [19] "People are not coming out about men who have sex with men. We are learning that older people are infecting young boys. We want more information but most people are illiterate so we need materials that they can use. We need to do something specifically for men who have sex with men. There are so many sad stories." [23]

That limited form of coming out has earned the bloggers abuse or criticism via their blogs' comment pages or e-mails. "The fact that you are a gay Sudanese and proudly posting about it in itself is just not natural," a reader called 'sudani' posted. Some of the bloggers use the diary-style format to share the ups and downs of gay life -- the dilemma of whether to come out to friends and relatives, the risks of meeting in known gay bars, or, according to blogger "Others have turned their blogs into news outlets, focusing on reports of persecution in their region and beyond. "It is the rare soul who is willing to go up against such blind and violent ignorance and advocate for gay rights and respect," [1]

#### 6. Any on-going activities to counteract stigma and discrimination?

Freedom Sudan is the lesbian, gay, bisexual, and transgender (LGBT) organization in Sudan which, though it is illegal and operates secretly, aims to gain recognition, social acceptance and rights for homosexuals in Sudan, and to do away with the death penalty for homosexuals.

#### 7. Existence of homosexuality-related barriers to health care

Homophobia, imprisonment and condemnation exists, with some African leaders even calling for men who have sex with men to be beheaded. Fear prevents many from finding out their HIV status and accessing the help they need. The climate of homophobia tends to extend to African organisations involved in the response to HIV & AIDS. While in the early days of the epidemic, homosexuals in high-income countries were able to build strong community-based responses to HIV based on the community infrastructures that existed, those infrastructures remain weak in most low and middle-income countries, especially in settings where homosexuality remains highly stigmatised (24). This lack of structural and moral support leaves homosexual persons extremely vulnerable to HIV infection. [10]

Although the prevalence of HIV and AIDS appears relatively low in Sudan compared to other

sub-Saharan countries, it is increasingly becoming a major public health problem. The cross border movement of displaced persons and refugees from neighbouring countries known to have high HIV prevalence rates could form a ground for inevitably increased vulnerability to HIV transmission and sudden increase in HIV infection in Sudan. [10]

Men who have sex with men are less visible, stigmatised, officially denied and criminalised. This adds to the vulnerability of men who have sex with men, and makes it near impossible to carry out relevant HIV prevention campaigns in some countries. In places where homosexuality is not tolerated, men who have sex with men often hide their same-sex relations from their friends and families to avoid persecution. Many have wives, or have sex with women as well as men, and this means that they may transmit HIV to their female partners if they become infected. The significant impact that HIV is having on men who have sex with men is therefore not an isolated problem, but one that is very much linked to countries' wider HIV epidemics.

The hostile cultural and social climate prevents full and open involvement of MSM in planning and formulation of HIV/Aids activities and policies.

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Lesbian, gay, bisexual, and transgender (LGBT) persons in Sudan face legal challenges not experienced by non-LGBT residents. Both male and female same-sex sexual activity is illegal in Sudan. Same-sex sexual activity is illegal in Sudan. The judicial system is based on the Shari'a and according to Article 148; capital punishment applies should the offense be committed either by a man or a woman. For homosexual men, lashes are given for the first offence, with the death penalty following the third offence. 100 lashes are given to unmarried women who engage in homosexual acts. For lesbian women, stoning and thousands of lashes are the penalty for the first offence. [25]

#### 9. Any action under way to change legal status of homosexuality .

No information is provided

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

Organisations such as UNICEF, UNAIDS, WHO, UNFPA and the International Lesbian, Gay, Bisexual, Trans and Intersex Association address HIV/AIDS issues.

#### 11. HIV prevalence/incidence data for MSM and general population

Two studies (2007) indicated that 20% of MSM and 19.3% of prisoners in the sample had ever had an HIV test. UNAIDS is pleased that studies assessing HIV prevalence and risk behavior in MSM are being conducted.

There have been different reports on the prevalence of HIV/AIDS in Sudan. The 2004 National Aids Policy reports that regionally, Sudan has the highest HIV/AIDS prevalence of any country in the Middle East and the number of people living with HIV/AIDS (PLWHA) is estimated in 600000. 16 of every 1000 Sudanese are people now living with HIV/AIDS. [5]

According to UNAIDS (2008) the HIV epidemic in (Northern) Sudan is generalized across all

population groups and regions. The low prevalence is 1.6% of general population and 2.6% of the adult and productive population. However, there are increasing numbers of orphans, persons living with HIV, and increased strain on limited available resources. In addition, higher prevalence has been reported among MSM (9%) and small scale interventions have been started for them (van Griensven 2007).

The first study ever to address HIV/AIDS among MSM in Sudan aimed to measure HIV prevalence and generates information regarding knowledge HIV/AIDS, behavior and practices including condom use among MSM in Khartoum State, capital of Sudan. The study revealed that MSM are part of Khartoum State community, though marginalized and undignified. The recorded HIV prevalence was the highest compared to other at risk population. Having multiple sexual partners, exchanging sex for money and inconsistent use of condom risking MSM of contracting HIV/AIDS. [4]

In Khartoum, Sudan's capital, sex between men is a primary mode of HIV transmission ([www.globalhealth.org](http://www.globalhealth.org)). Research (Elrashied, S.) on the HIV risks of young receptive MSM in Khartoum was presented at the 16<sup>th</sup> International AIDS Conference in 2006. This hard to reach population was contacted through 'snowballing'. Of the 713 men surveyed, 9.3% had HIV, three-quarters were involved in commercial sex, and 53% did not know that anal sex was an HIV risk. Although 47% had used a condom at last sex, only one in 30 did so consistently.

HIV1 prevalence was found to be (9.3 %). Almost all (97.5%) of them were Muslims, (49.1%) were originally from Khartoum State, and around half (49.6%) were students either in secondary schools or at universities. The mean age at first sex was 11 years. Oral sex was practiced by almost all (98.3%) of MSM as standalone practice or as part of sexual act with insertive partners. Commercial sex was practiced by two third (75.5%) of them while vast majority (97.2%) were having more than one sexual partner at a time. Nearly half (47%) mentioned use of condom at last sex, while only (3.3%) reported consistent condom use. More than half (55.3%) did not perceive the link between anal sex and HIV infection. [4]

## 12. Is there understanding of specific risk factors for HIV

In 2006, it was also found that knowledge of HIV was extremely poor: only 2% of the men knew that condoms can prevent HIV transmission.

A Comprehensive Peace Agreement has led to increased migration of the population, which experts fear poses a threat to health and development. There is also a low level of understanding about HIV transmission among many Sudanese people. Only 9% of women aged between 15 and 49 years could identify the main causes of HIV transmission, according to the 2006 Sudan Household Health Survey. Results of another study demonstrated that less than 25% of Sudanese people aged 12 to 25 years knew that HIV could be transmitted through unprotected sex. [9]

## 13. Current status of prevention, treatment and care for MSM

Fifteen states in northern Sudan have implemented a new curriculum that focuses on HIV/AIDS, according to UNICEF sources. The curriculum was developed by the Ministry of General Education, the Sudan National AIDS Control Programme and UNICEF. The aim was to reduce the risks for HIV and AIDS among the 2.5 million children aged between 10 and 18 years who will participate. The program also includes lessons on how to reduce or prevent discrimination against people with HIV/AIDS. [9]

Sudan has a government of national unity and a National AIDS Control Program (SNAP) located within the Federal Ministry of Health. SNAP, is working hard to implement the commitment of the Government and to break the silence to prevent the spread of HIV/AIDS. UNAIDS, WHO, UNFPA, and non-governmental organizations and civil societies have made significant contribution with the Federal Ministry of Health to prevent the spread of HIV/AIDS in the country. SNAP organized a workshop to train trainees in Khartoum and presented many papers during the four days.

The AIDS epidemic has quickly become of the most serious health and development problem facing Sudan today. Efforts to combat AIDS in the country have so far been too little too late. Over half million people are currently infected with HIV in Sudan. In 2001, AIDS was responsible for about 23 thousand deaths in the country and leaving more than 63 thousand orphans. A supportive policy environment is crucial to the implementation of successful programmes that prevent the spread of the virus, deliver care to those infected, and mitigate the impacts of the epidemic. An appropriate policy environment is essential in supporting efforts to ensure that human rights are respected and eliminating stigmatization and discrimination associated with HIV/AIDS. This National policy, guidelines, and strategic plans are needed to guide the effective implementation of HIV prevention and care initiatives. At the same time, financial and other resources must be mobilized to build capacity to respond to the epidemic. The process of policy development The National AIDS Council will encourage all sectors, local government councils, faith groups, NGOs and CBOs to mobilize communities to plan and implement their community-based HIV/AIDS control activities. Special emphasis should be based on community support groups and services for those infected and affected by the epidemic. [5]

#### 14. MSM related UNGASS indicators

In 2008 the country did submit a country progress report in which it reports against one of the UNGASS indicators relating to MSM: it reported that less than 40% of MSM have taken an HIV test in the last year. It did not report on HIV seroprevalence of MSM living with HIV, the percentage of MSM who know about HIV, the percentage of MSM who used a condom the last time they had sex or the percentage of MSM being reached by HIV prevention programs.

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Globally, men who have sex with men (MSM) continue to bear a high burden of HIV infection. Same-sex behaviours have been largely neglected by HIV research up to now. The results from recent studies, however, indicate the widespread existence of MSM groups across Africa, and high rates of HIV infection, HIV risk behaviour, and evidence of behavioural links between MSM and heterosexual networks have been reported. Yet most Africa MSM have no safe access to relevant HIV/AIDS information and services, and many African states have not begun to recognise or address the needs of these men in the context of national HIV/AIDS prevention and control programmes. The HIV/AIDS community now has considerable challenges in clarifying and addressing the needs of MSM in Africa; homosexuality is illegal in most countries, and political and social hostility are endemic. An effective response to HIV/AIDS requires improved strategic information about all risk groups, including MSM. The belated response to MSM with HIV infection needs rapid and sustained national and international commitment to the development of appropriate interventions and action to reduce structural and social barriers to make these accessible.

## 16. Whether and how MSM are included in National Strategic Plans

Ironically: Sudan's NSP does not include MSM but they reported on one UNGASS indicator (HIV testing for MSM: less than 40 % of men tested for HIV in the last year).

Men who have sex with men lack universal access to HIV services. With laws banning homosexual activity, the government is unlikely to promote any sort of HIV interventions aimed at men who have sex with men. Groups or individuals who do try to carry out such campaigns, as much as men who have sex with men themselves, may face violence or arrest:

## 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

To address the HIV/AIDS situation in Sudan, UNDP, with the support of the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM), launched in April 2005 Fighting HIV/AIDS in Sudan project. [23] The project's ultimate objective is to contribute to reducing HIV/AIDS transmission and mortality in Sudan. With this in mind, the project's specific objectives are as follows: (1) To increase the prevalence of safe behaviour among vulnerable populations with a focus on female sex workers, tea sellers, long-distance truck drivers and jail inmates; (2) To establish Voluntary, Confidential Counseling and Testing (VCCT) services and quality Antiretroviral treatment (ART) and support centres for people living with AIDS; (3) To improve knowledge and practice of HIV/AIDS preventive measures by the general adult population during 2004/08, including the use of high quality care services for sexually transmitted infections (STI); (4) To improve screening of blood and blood products for HIV and other blood born infections; (5) To improve knowledge of HIV/AIDS transmission among in-school youth; (6) To monitor the trend of the HIV/AIDS epidemic through Second Generation Surveillance in selected high-risk population groups, by measuring behavioural and biological parameters and guide programme planners to realign the programme interventions in line with current and future epidemic trends. [23]

A total of 332,045 people from vulnerable groups were reached by community outreach activities. Free distribution of 3,130,721 condoms with GF resources. A total of 9,992 Sexually Transmitted Infections (STI) cases treated among vulnerable groups during outreach activities. A total of 728 lay and professional counselors trained in Voluntary Counseling and Testing Centers (VCT). A total of 75,275 people completed the testing and counseling process. A total of 410 service deliverers trained in ARV treatment and treatment of opportunistic infections. Antiretroviral combination therapy provided at 32 service delivery points. A total of 3,217 people with advanced HIV infection received ARV combination therapy. Diagnosis and treatment for opportunistic infections with GF Support (combined indicator) provided to 5,013 people with HIV infection. A total of 2,092 health/community workers received training on interpersonal communications. A total of 1,194 Health Community Professionals trained in syndromes approach to STIs. Global Fund supported points treated 76,184 STI cases. A total of 356 service deliverers trained (blood bank staff trained in screening of blood for HIV/HBV and HCV). Of 622,035 transfused blood units screened for HIV/HBV. A total of 3,373 individuals trained to deliver youth education including trainers, school teachers and counselors of drop-in-center. A total of 232 schools and drop-in centers providing life-based HIV/AIDS education. HIV/AIDS education in Out-of-School settings using GFATM resources was provided to 239,747 young people. HIV/AIDS education reached 84,059 young people in school settings. A total of 35 sentinel sites established. Second generation surveillance taught to 208 service deliverers. [23]

The Sudanese Red Crescent HIV Programme is part of the Eastern Africa Zone HIV Programme which is a component of the Red Cross and Red Crescent Global Alliance on HIV. The purpose of our programme is to reduce vulnerability to HIV and its impact in Sudan through achieving the following outputs: • Preventing further HIV infection • Expanding HIV care, treatment, and support • Reducing HIV stigma and discrimination Bolstered by a fourth output: • Strengthening Sudanese Red Crescent Society capacities to deliver and sustain scaled-up HIV programme. We work in accord with the established principles of the International Red Cross and Red Crescent Movement to support the country's national HIV policies and programmes.

The SRCS have a HIV program that has been running from 2006 in five states (Khartoum, Kassala, Central Equatoria, West Darfur and Elgazira). The programme targets the youth aged 10-24 with the aim of improving their knowledge, impart life skills and behaviour change. It is supported by the Netherlands Red Cross and the Global Fund through the UNDP and Planned Parenthood Federation of American.

The following have been achieved so far: • 65 Peer education facilitators have been trained – 3250 person have been reached by peer education program. • 226,000 out of the total target groups have been reached by information education and communication (IEC) material. • 453,000 people have benefited from the program. • 65 people have been referred to the VCT. • 43 PLHIV persons have been supported in positive prevention. Impact of HIV and AIDS programme This program has also observed: • Increased levels of HIV awareness and stigma reduction in targeted communities. • High numbers of volunteers/peer educators have been trained. This has enhanced the capacity of volunteers in information dissemination, built their self-confidence and leadership skills. • SRCS has made significant inroads with special groups including commercial sex workers, tea sellers, truck drivers, street children and men having sex with men (MSM) and conservative communities. • The NS has been able to implement programmes taking into consideration the varied context in Sudan: adapting the inter-agency standing committee (IASC) guideline in conflict areas (such as Darfur) and in post conflict area (Central Equatorial) and stable areas in northern part of Sudan.[22]

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## Swaziland

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

In Swaziland male same-sex sexual acts are illegal although as of May 2008 the legal status of female same-sex sexual acts was unclear according to the International Lesbian and Gay Association's 2008 "State sponsored homophobia" report. According to the Prime Minister homosexuality is an "abnormality and sickness". According to Swazi tradition however, two women can lawfully marry. [11]

The situation regarding homosexuality in Swaziland can sometimes be confusing, but it is generally understood that homosexuality is de facto illegal, and local community is generally intolerant of same sex relationships. There is pressure from the family on Swazi men to marry and especially to also sire sons. Anecdotal evidence from a homosexual man from Swaziland [12] recounts how after agonizing whether to give in to his family and take a wife, going to the extent of even assembling a small herd of cattle to use as a bridal dowry, Ruby's dilemma was solved by Swazi custom. When his brother died of Aids he inherited his brother's wife and kids - Homosexuality may not be legal in Swaziland, but polygamy is. "She came to live with me with her two children. Now I am a married man with kids. My family loves me for accepting my responsibility as a Swazi man. Ruby and his wife agreed to have separate partners, however to keep up appearances at home to honour custom.

The publication Emajaha Ekuluseni meaning, 'boys in the field looking after the cattle', focuses on same sex sexuality, "amantanyula" or, sex between boy's while looking after the cattle. Amantanyula is a culturally acceptable African word which can be translated as sodomy. Swaziland boys who looked after the cattle in the forest would have sexual intercourse with each other. This was only for boys over the age of 16 to prove their "man-hood" before they slept with any woman. The BTM correspondent reports that it is okay that both parents and the community would know about it and they would be happy that their boy is becoming a man. Though they never understood, what they were promoting was homosexuality, they respected it as traditional behaviour. "They praised it and loved it - so much that some never stopped." In some African countries, culture includes same sex behaviour but not gay identity or a gay community as like in western culture. The reporter states that most of the communities in Swaziland have not accepted homosexuality like other people have in South Africa and other developing countries. "It is much better for the community to identify one or two gay people but it becomes a problem when they discover that there is a group because it becomes an embarrassment hence not acceptable in their culture, this is according to the Ekuluseni book's view." [7]

It is reported that in 2005, five gay people went public about their sexuality appealing for public acceptance, and to be regarded as members of society. They said that their coming out was to be a means of appealing for public acceptance and not as a way to carry them to their crucifixion.[9]

Anecdotal information is provided about local tour operators have discreetly tapped into the lucrative world gay tourism market and offer holiday packages to game parks. [12]

Although there is much denial of this, it seems that there is significant MSM in prisons, with much of the sexual activity involving rape. In 2009 Swaziland started setting up HIV testing and



counselling centres in jails. The goal has been to set up centres in all prisons and to encourage VCT. The United Nations Joint Programme on AIDS (UNAIDS) says many governments refuse to provide condoms in prisons because they fear it would encourage homosexuality among inmates. However, governments' refusal to acknowledge the problem means that inmates are forced by circumstances into same-sex relationships and are denied the right to safe sex. The report, based on studies by the Family Life Association of Swaziland (FLAS), the Southern Africa AIDS Information Dissemination Service (SAfAIDS) and Panos says homosexuality in prison is either consensual or the result of rape or forms of exploitation. In Swaziland, the government acknowledged the fact that homosexuality in prisons enhances the spread of HIV/AIDS, but has not provided condoms to inmates, concentrating instead of efforts to curb prison sex [23]

In 2007 a situation analysis on commercial sex work, conducted in collaboration with the Swaziland Gay and Lesbian Committee with funding from UNAIDS and UNFPA, found that male sex workers in Swaziland are a distinct population. [17]

## 2. Existence of MSM/gay culture (meeting places, bars, etc.)

In 2005, there were reports of the gay community getting their first same-sex club in the Swazi kingdom. In announcing the establishment of the gay bar, Pholile Hlatjwako, an Mbabane entrepreneur, said it would call itself the Laughing Club. The club members who will populate his bar will come predominantly from the nation's most affluent stratum, Government officials and company heads are expected to visit the club with their privacy guaranteed by management [12]

## 3. Presence of an organized LGBT or MSM community

The Gays and lesbians in Swaziland formed an association, GALESWA, defying abuse from traditionalists who say that homosexuality is "ungodly, unSwazi and unacceptable". The association had been formed by 21 year-old Mangosutho Dlamini, who went public on national television about his homosexuality. [10]

## 4. What is known about stigma and discrimination of male same-sex sexuality

Local media frequently portrays homosexuality in a very negative light. [17] The Peace Corps warns gay, lesbian, and bisexual Volunteers that Swaziland has a very conservative society. It states on its website: "Because of Swazi cultural norms, you will not be able to be open about your sexual orientation in your community. You may serve for two years without meeting another homosexual or bisexual Volunteer, and there may be little support for your sexual orientation within the Volunteer social scene. Lesbians, like all American women, may have to deal with constant questions about boyfriends, marriage, and sex, while gay men may have to deal with machismo: talk of sexual conquests, girl watching, and dirty jokes". [17]

Religious groups have also promoted homophobic stances. In 2007, Chairman of the League of Swaziland Churches Bishop Samson Hlatjwako appealed to His Majesty King Mswati III that Swaziland should not join the African Union organisation because it is evil. He said they had witnessed in the other continents where gays and lesbians were allowed to marry other people of the same sex. In turn, King Mswati, speaking at a national prayer meeting on the one occasion when he mentioned same- sex relations, said gay people were possessed of Satanic notions, and out of charity the nation should pray for them. However, Deputy Prime Minister Albert Shabangu was reported to have told Swazis they should prepare for the "inevitability" of

same-sex marriages. [12]

It was reported that during the drafting process of the constitution there was strong opposition against gays and lesbians to the extent such subject could not even be tolerated in any forum, be it parliament or anywhere else. [9]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

Because of a largely homophobic society, homosexuals have largely pursued their orientation in secret to avoid oppression from the government or people in general. Anecdotal information however refer to all strata of society, from the club who target predominantly the nation's most affluent stratum, government officials and company heads, homosexual middle class men who feel pressurized to marry, and even herdsmen.

Few people living with HIV/AIDS, particularly prominent people such as religious and traditional leaders and media/sports personalities, have come out publicly and revealed their status. Stigma hinders the flow of information to communities, hampers prevention efforts, and reduces utilization of services.[2]

#### 6. Any on-going activities to counteract stigma and discrimination?

Various organizations are trying to counteract stigma and discrimination, for example, the International Gay and Lesbian Human Rights Commission in Africa, and Swaziland Aids Support Organisation (SASO), and the Sex Worker Education and Advocacy Taskforce (SWEAT) who called for conducting a study to look at the role prostitutes play in the spread of HIV/AIDS. The Male Circumcision Project, supported by PSI, the Gates Foundation, Jhpiego, and the Population Council, is launching a massive scale-up of voluntary male circumcision services in Swaziland. Peace Corps has had a strong presence in Swaziland for many years. Almost all volunteers there are involved in some form of education or community development that involves AIDS prevention, education, or provision of information and resources.

#### 7. Existence of homosexuality-related barriers to health care

The stigma associated with HIV and AIDS prevents many Swazis from being tested or declaring their HIV positive status if they are positive. [17]

HIV and gay activists in Swaziland are calling for the legalisation of prostitution and gay marriages to bring the spread of the HIV epidemic under control. Swaziland Aids Support Organisation (SASO) spokesperson, Vusi Matsebula, said it was necessary to conduct a study to look at the role prostitutes can play in preventing the spread of the disease. The Sex Worker Education and Advocacy Taskforce (SWEAT) director, Eric Harper, also recommended the decriminalisation of sex work alongside a new prostitution law that addresses potential harm and HIV infections. Swaziland Aids Support Organisation (SASO) spokesperson, Vusi Matsebula, said people cheat on their spouses because they are not allowed to marry partners of the same sex. [1].

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Swaziland Government warns homosexuals or sodomy are liable to imprisonment. Even though such practices are fully legal in some African states like neighbouring South Africa, where practitioners are even protected by that country's constitution and openly hold gay pride

marches, the local Bill prohibits such practices and proposes very stiff fines for those found to have contravened such laws. According to the Bill, any person, be it a male or a female, who intentionally, with or without consent, commits or continues to commit a sexual act with another person of the same sex, or causes another person of the same sex to commit a sexual act with another person of the same sex or with a third person of the same sex, is guilty of an offence of homosexuality. Any person convicted of an offence of homosexuality, be it lesbianism or sodomy (sex between two men), is liable to imprisonment for a minimum period of two years, or to a minimum fine of E5 000 or to both. If the persons convicted are two consenting adults, they will be liable to imprisonment. If a person commits either sodomy or lesbianism to a child under the age of 16 years, such a person is guilty of rape and will be punished in terms applicable to the rape crime, which can include the death penalty if the victim ended up contracting HIV and Aids during the ordeal. [17]

#### 9. Any action under way to change legal status of homosexuality

In 2006, it was reported that the gay community in Swaziland was worried that the new constitution does not address their rights. They believe it is too general about their rights as it only addresses freedom of expression and opinion.

In March 16, 2006 it was reported that Gays and lesbians may be considered for inclusion in the country's constitution. This was disclosed by the Deputy Attorney General Mzwandile Fakudze at King Sobhuza II Memorial Park during the capacity building workshop for Members of Parliament. They were discussing about the rights of people. [2]

HIV and gay activists in Swaziland are calling for the legalisation of prostitution and gay marriages to bring the spread of the HIV epidemic under control. [2]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

The Family Life Association of Swaziland, an NGO that leads a campaign for safe sex practices, offered to provide prisoners with free condoms. However, the prisons department said it would not allow it because "it is against the country's policy on the use of condoms". [23]

The United Nations Children's Fund (UNICEF) has extended the lives of many Swazi women with its PMTCT programme, in which more than two-thirds of pregnant women receive medication to protect their unborn infants from HIV

#### 11. HIV prevalence/incidence data for MSM and general population

The first survey to provide population-based prevalence estimates for HIV, showed that HIV adult prevalence was 26% (31% in adult women and 20% in adult men). High reported levels of stigma and discrimination were confirmed by the Demographic and Health Survey, which found that only 43% of adult women and 47% of adult men expressed accepting attitudes towards people living with HIV (PLHIV). The recent modes of transmission study, led by World Bank GAMET, found higher HIV prevalence among men and women in urban areas, wealthier and employed men and women, and men and women with ulcerative STI. It also noted that 72% of all new infections in adults were in those aged over 25 and that the prevalence in younger antenatal clinic clients appeared to have started to fall. It concludes that transmission is mainly heterosexual and between longer term and older partners and suggests that only a small proportion of new infections are the result of casual and commercial sex. It also notes that there

is a lack of evidence to determine the extent to which injecting drug use and men who have sex with men (MSM) play a part and that the extent of transactional sex is unclear. Mobility, gender and sexual violence are believed to be important factors in the epidemiology of HIV in Swaziland.

There does not seem to be HIV prevalence/incidence data for MSM, however in the general population, Swaziland is confronted by a human disaster of epic proportions in the form of one of the highest - and possibly the highest - HIV/AIDS prevalence rates in the world. According to the Swazi Ministry of Health, the rate in 2002 for adults aged between 15 and 49 years was 38.6%. For those in the age brackets 20-24 and 25-29, the rates were 45.4% and 47.7% respectively. By 2004, it was estimated that one in two Swazis in their twenties would be HIV positive. In the period 1980-2005, life expectancy for Swazis almost halved from 60 years of age to 34. By 2010, it is projected that it will have fallen to 27 years of age. Furthermore, by then it is estimated that 12 percent of the population - some 120,000 children - will have been orphaned. [10]. UNAIDS estimates that the HIV prevalence rate for adults aged 15-49 is 26.1%. [17]

HIV/AIDS remains one of the major challenges to Swaziland's socioeconomic development. The epidemic has spread relentlessly in all the parts of the country since 1986. The Human Development Index of the UN Development Programme reports that as a consequence of HIV/AIDS, life expectancy in Swaziland has fallen from 61 years in 2000, to 32 years in 2009. From another perspective, the last available World Health Organization data (2002) shows that 61% of all deaths in the country were caused by HIV/AIDS.. With a record crude death rate of 30 per 1000, this means that about 2% of the Swazi population dies from HIV every year. The United Nations Development Program has written that if the spread of the epidemic in the country continues unabated, the "longer term existence of Swaziland as a country will be seriously threatened" In February 2010, UNAIDS Executive Director Michel Sidibe visited Swaziland where he presented a report estimating that three in every 100 people in Swaziland will be infected with HIV every year leading to an expected 18,000 new infections each year by 2012. [24]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

An Anecdotal report from Manjam state that "Swaziland is a fairly closed book... I gets a little rough around the edges on a drunken Friday night..... Condoms do not form a part of that reality... most gays cross the borders to safety of sex. No organizations have been successful in having chapters here...People refuse to be tested , avoid condoms will not go and collect drugs.. and swap and change cocktails... Cultural barriers and the way the drugs are distributed thorough one source that creates even more stigma..[20]

Another obstacle to the provision of effective treatment in Swaziland is the pervasive belief in witchcraft and the trust placed in traditional health practitioners of which there are more than 8,000 in Swaziland. According to a 2008 government report, some people are tempted to replace ARVs with medicines provided by these health practitioners, reducing levels of treatment adherence. HIV & AIDS in Swaziland [15]

Homosexuality, rape and other forms of sexual violence in prisons have been cited as the main factors causing the high HIV infection rate in African prisons. However, a study conducted by UNAIDS reveals that despite this status quo, African prisons still provide very little anti-retroviral treatment to prisoners despite the high HIV infection rate. A UNAIDS study has revealed that while most of the sex in prisons was consensual, rape and sexual abuse were often used to exercise dominance in the culture of violence that is typical of prison life. According to UNAIDS, attitudes that inadvertently expose homosexuals to HIV-infection, are not unique to Swaziland:

"Most governments in the region will not provide condoms in prisons because they believe that would be encouraging homosexuality," [4]

### 13. Current status of prevention, treatment and care for MSM

The country has a National Emergency Response Council on HIV and AIDS. It has tried to reduce the common Swazi practice of multiple partners.[17]

Free condoms have been made available at key locations designed to target female sex workers, migrant workers, and truck drivers who could be MSM. [17]

The Male Circumcision Project, supported by PSI, the Gates Foundation, Jhpiego, and the Population Council, is launching a massive scale-up of voluntary male circumcision services in Swaziland. The Partnership is establishing a network of providers across the public, private, and NGO sectors to deliver quality male circumcision services. These providers could target MSM who are predominantly closeted.[17]

The Swazi government has introduced a number of initiatives for HIV prevention, such as condom distribution, behaviour change campaigns and prevention of mother-to-child transmission of HIV. <http://www.avert.org/aids-swaziland.htm> [17]

By the end of 2009, antiretroviral therapy had become available at 89 health facilities across the country and just over 47,000 people were receiving ARVs. This means that more than 70 percent of those in need are currently receiving antiretroviral treatment. Despite these successes and the high level of funding for HIV treatment in Swaziland, limited infrastructure and human resources hinder the delivery of effective treatment. Around 80 percent of the population lives within 8 kilometres of a facility that provides at least antenatal care, however access for rural communities is limited. There are only 2 physicians available for every 10,000 people, and one nurse for every 356 people in Swaziland. The recruitment and retention of staff is constrained by poor working conditions, few incentives and low pay, and the availability of health staff is declining further due to HIV related illness and deaths. In addition, the government have been slow to implement 'task-shifting' programmes. These programmes increase the distribution of antiretroviral drugs as they allow nurses to carry out routine prescription duties that would normally be carried out by doctors. [15]

UNAIDS secretariat and UNFPA have started to engage with sexual minorities including MSM, but the focus of engagement is on access to services rather than broader rights or representational issues. The UCC reports that UNAIDS Swaziland is developing an MSM proposal in response to the recent request for proposals from UNDP HQ. UNAIDS has provided limited leadership on human rights issues affecting key populations, due largely to the sensitivity of these issues in Swaziland. Groups working with or representing key populations such as sex workers, MSM or IDU are not involved in policymaking, implementation or M&E. Visible participation is a challenge, since sex work, drug use and MSM behaviour are illegal. Representatives of key populations or groups working with key populations stated that UNAIDS could use its comparative advantage to raise sensitive issues and sensitise NERCHA and others in government in a way that they cannot. However, the draft JUNPS does not include any specific action or milestones related to empowering vulnerable or key populations to participate in policy, implementation or M&E. It is anticipated that improving the evidence base, e.g. through the action research project commissioned by UNAIDS secretariat, UNFPA and WHO, will support advocacy with government and other stakeholders.

In 2003, the National Emergency Response Committee on HIV/AIDS (NERCHA) was established to coordinate and facilitate the national multisectoral response to HIV/AIDS, while the Ministry of Health and Social Welfare (MOHSW) was to implement activities. The previous national HIV/AIDS strategic plan covered the period 2000–2005; a new national HIV/AIDS strategic plan and a national HIV/AIDS action plan for the 2006–2008 period are currently being developed by a broad group of national stakeholders. To date, the six key areas of the plan are prevention, care and support, impact mitigation, communications, monitoring and evaluation, and management/coordination. Despite the widespread nature of the epidemic in Swaziland, HIV/AIDS is still heavily stigmatized. Few people living with HIV/AIDS, particularly prominent people such as religious and traditional leaders and media/sports personalities, have come out publicly and revealed their status. Stigma hinders the flow of information to communities, hampers prevention efforts, and reduces utilization of services.[2]

On June 4, 2009, the USA and Swaziland signed the Swaziland Partnership Framework on HIV and AIDS for 2009-2013. The President's Emergency Plan for AIDS Relief will contribute to the implementation of Swaziland's multi-sectoral National Strategic Framework on HIV/AIDS. [24]

#### 14. MSM related UNGASS indicators

In terms of the UNGASS indicators Swaziland did not report on any relating to MSM.

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Despite the widespread nature of the epidemic in Swaziland, HIV/AIDS is still heavily stigmatized. Few people living with HIV/AIDS, particularly prominent people such as religious and traditional leaders and media/sports personalities, have come out publicly and revealed their status. Stigma hinders the flow of information to communities, hampers prevention efforts, and reduces utilization of services.[2]

Sex work, IDU and MSM are illegal in Swaziland, hence making it difficult to reach these population groups. The provision of condoms to young people in schools and prisons for inmates is still prohibited. [6]

Peace Corps volunteer, Vincent D'Agostino, in venting his frustrations in an entry on his personal blog referred to the lack of a comprehensive strategy, stating: Even in a country where ARVs (antiretroviral) drugs are free, it is still difficult for people to get to them, take them like they should, and continue to take them. There are too many helping hands, too many players, too many fighters, too many NGO's, too many messages, too many mixed messages, too many everything. There's no cohesion, no communication. There is constantly a breakdown of all these things wherever you go. No one knows how to work together, and I'm guilty of that too. It really is a land of confusion out there. [8]

#### 16. Whether and how MSM are included in National Strategic Plans

In 2008 Swaziland submitted a 120 page country report on its HIV/Aids work. This report indicates clearly that the country does not target MSM in its programmes – because they are illegal. It also indicates that the provision of condoms to young people and prison inmates remains prohibited. [17]

The national response was initiated in 1987 through the establishment of the Swaziland National HIV/AIDS Programme (SNAP) under the Ministry of Health and Social Welfare (MOHSW). The first National HIV/AIDS Policy was launched in 1998 and the King declared HIV and AIDS a national disaster in 1999. The national coordinating body, the National Emergency Response Council on HIV and AIDS (NERCHA) was established through an Act of Parliament in 2002, with a mandate to coordinate and mobilise resources for an expanded, scaled up, coordinated national multisectoral response to HIV and AIDS. This mandate is carried out through a National Directorate and structures at regional and local levels (REMSHACCs and COMSHACCs). NERCHA reports directly to the Prime Minister. The National Decentralisation Policy has equally facilitated the formation of decentralised institutions including Regional Multi-Sectoral HIV and AIDS Committee (REMSHACC), Tinkhundla Multi-Sectoral HIV and AIDS Committee (TIMSHACC), Chief's Multi-Sectoral HIV and AIDS Committee (CHISHACC). [15]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

There is no specific infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM. However, various programmes target treatment of HIV/AIDS. Since January 2006, the International Center for AIDS Care and Treatment Programs (ICAP) at Columbia University's Mailman School of Public Health has been supporting activities in Swaziland to provide care and treatment for pregnant women, children, and their families, including services to prevent mother-to-child transmission (PMTCT) of HIV and reduce HIV-related morbidity and mortality. In addition, ICAP provides technical and clinical assistance to the Ministry of Health and health facilities in the development of family-focused, multidisciplinary HIV/AIDS prevention, care, and treatment programs. In 2009, ICAP was awarded a new five-year grant from the U.S. Centers for Disease Control and Prevention to support the rapid scale up of decentralized HIV care and treatment services in the Kingdom of Swaziland. Support for Programmatic Activities ICAP-supported activities in Swaziland include: Support to develop systems and services to provide de-centralized HIV care and treatment in three regions (Hhohho, Manzini, Lubombo); Enhanced PMTCT/MTCT-Plus services for HIV-infected pregnant women, including provision of antiretroviral therapy (ART); Family-centered HIV/AIDS prevention, care, and treatment, including provision of ART; Pediatric HIV/AIDS care and treatment, including early infant diagnosis and ART provision; Linkages to tuberculosis (TB) control programs for TB/HIV co-infected patients; Ongoing clinical training, mentoring, and quality improvement in delivering HIV/AIDS care and treatment, ART, and monitoring and evaluation; Strengthening medical records systems; Adherence and psychosocial support, and the development of follow-up systems; Enhancing laboratory and pharmacy services; Community linkages for care and treatment programs; Development of managerial and technical capacity to administer HIV/AIDS programs. Support for improved nursing capacity, including pre-service education support, in-service training support and nursing wellness and retention strategies. [14]

As of Sept. 30, 2009, ICAP Swaziland supported 31 sites delivering HIV/AIDS care and treatment to more than 42,000 people, including antiretroviral therapy to nearly 38,000 individuals. In 2009, ICAP staff conducted more than 600 site visits providing mentoring support to health care providers. [14]

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## **Tanzania/United Republic of Tanzania (and Zanzibar)**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

In Tanzania as homosexuality is illegal and there is no gay scene as such reported. Because of a largely homophobic society, and publically homophobic religious groups, homosexuals are not able to have much in way of a social life. This has influenced society bat large. According to the 2007 Pew Global Attitudes Project, a strong 95% of Tanzania residents said that homosexuality should be *rejected* by society, making it among the highest rejection of homosexuality in the 44 countries surveyed [24]

The traditional view of homosexuality is that of one man playing the woman's role in sexual intercourse known as a msenge. The msenge is usually expected to be younger and consents to be used by another man for money or because he is impotent. The other man (the basha) is assumed to sleep with women as well as men. There is more stigma attached to the role of msenge. Although, many men would in certain circumstances have sex with a msenge there is nonetheless a prevalent hostility to gays. There is a term for "lesbian": msagaji, literally, one who grinds. The verb for lesbian lovemaking, sagana, means "grind together". In Tanzania lesbians are even less visible than gay men Dar es Salaam being a large city has a gay network. Whilst there are no gay bars as such, there are places where gays tend to meet. There is no gay movement or organisation in Tanzania. On the coastal areas and offshore islands where there is more Arab influence people are more tolerant of homosexuality. In particular, the island of Zanzibar is much more gay-friendly than the mainland. Having said that the government in Zanzibar in 2004 made homosexuality illegal, claiming it to be an attempt to stem the acceptance of lesbians and gays. In 2003 a gay tour group from the United States had their arrival in Tanzania marked with a demonstration by over 300 anti-gay protestors. All in all probably Tanzania does not make the ideal gay tourist destination.

Despite this homophobia reported, according to Ammon, it is claimed that 40% of Tanzanian men engage in sex with other men, with 100% denial. [1] Research suggests that if MSM are discreet and don't make a public scene or act inappropriately, they can have a moderately comfortable and safe life with a same-sex partner and gay friends in Dar, Zanzibar City, Arusha or Mwanza, Tanzania's major cities. However, research suggests that most MSM are married to women and live "double lives". Some gay men actually prefer to conduct affairs with married men because they are afraid of being found out. [13]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

There are no gay bars on the mainland, although there are places where gay men meet, and lesbians are even less visible than gay men. There have been gay marriages. Tanzania has no organized gay community. Inside the city limits of Dar there is a quietly thriving LGB community with interconnecting circles of friends meeting privately in homes or in the half dozen venues that are gay or gay friendly, such as Ma Chain Club (mixed gay/straight), Mama's Club (women), Q Bar (mixed, including sex workers) or Club Oasis in trendy Oyster Bay district popular with men. [1]

3. Presence of an organized LGBT or MSM community

There are LGBTI organisations. 'The Association' is a pseudonym for the one and only lesbian

organization in the country - TELESA. The Association focuses quietly on health care workers who deal with HIV testing and Counselling, including health workers involved with MSM and WSW.

Community Peer Support Services (CPSS) is the men's organization. The CPSS educates people about HIV preventions and care. They use code words to identify among themselves. [13] Like many gay organizations in repressive homophobic countries, CPSS does not present itself as gay but rather as an HIV education and awareness program offering community-based activities and information as a means of helping others and becoming a familiar local helping hand—not unlike the women's Association. As well as serving others such charitable activity also helps qualify CPSS to receive some limited funding from international donors who must, in turn, be sensitive to the laws of recipient countries.

In Tanzania homosexuality is a criminal offense which forces funders from liberal pro-gay countries such as Holland and Norway to find ways of spiriting money to groups without offending authorities. As part of their protective guise, CPSS has established a 'cover' organization with a different name through which foreign donations can be received—a common tactic throughout homophobic Africa [1]

The LGBT organizations are based in Dar es Salaam but have members and activities in other parts of the country. In Dar es Salaam there is a quiet but vivid LGBT community. People find places to meet in private homes or a handful of venues that cater to LGBT clientele.

The self-identified challenges faced by CPSS and TALESA are: unprotective legislation, lack of support from media institutions, unequal access to health care and HIV/STI prevention and lack of support from other civil society organizations. For both organizations, the focus is rather on social activities than on strategic, political work. Neither can be said to have substantial capacities when it comes to organizational and project management. In part this is due to the lack of networks that both organizations suffer from. This in turn is an effect of social marginalization caused by homophobia, that leaves them with few alternatives for allies, but also works as a factor that may hold them back from making contacts and initiating partnerships. CPSS and TALESA have previously had funding from Hivos a Dutch NGO. A youth group called Cool Brain Family has recently been formed within TALESA, a group which may have the capacity to grow, should they be given the proper networks. The Tanzanian LGBT movement would benefit greatly from the emergence of "new blood". The primary support geared at these initiatives should be to help establish relations and support networks, rather than direct funding. [10]

#### 4. What is known about stigma and discrimination of male same-sex sexuality

Peace Corps Volunteers have reported that Tanzania is a very conservative society. Some Tanzanians deny that homosexuality exists in their culture, while others note that it is against the law. A law in Zanzibar makes homosexuality illegal, with prison sentences of 8-15 years. Thus, any display of your sexual orientation will be severely frowned upon and may affect your acceptance at work and possibly even your legal status. While physical contact between two men or two women is not uncommon, it is not likely to be sexual in nature and you should not misinterpret its meaning.

There are many reports of religious groups homophobic stances against the homosexual community. Gays and lesbians in Tanzania are persecuted, mistreated, hated and ostracized according to Tanzanian Bishop Mdimi Mhogolo in a letter he sent to the Anglican Diocese of Central Tanganyika (AI 8 Feb. 2007; *Church Times* 2 Feb. 2007) [12]. Bishop Mhogolo's letter expressed disagreement with the Diocese's decision to refuse donations from any United States

(US) Episcopal Church group that either fails to censure homosexual acts or that blesses same sex unions (ibid; AI 8 Feb. 2007). A World Bank-supported working paper entitled *Sexual Minorities, Violence and AIDS in Africa* (Anyamele et al July 2005, i) – written by a medical doctor based in Nigeria, the co-founder of an international development non-governmental organization (NGO) in Uganda and two World Bank professionals, reports that homosexuals in Tanzania run a high risk of experiencing violence and intolerance. The paper surveys relevant literature and reports on the results of an assessment done at the 2004 All Africa Symposium on HIV/AIDS and Human Rights. The findings reported in the working paper indicate that social risks – such as the risk of being evicted or losing a job were "especially high" in Tanzania. In addition, the paper reported that "adverse comments" against homosexuals in Tanzania were regularly made by senior politicians, including the head of state. [12]

In November 2003, responding to the consecration of Bishop Gene Robinson, Archbishop Donald Mtetemela said homosexuality is against biblical teaching. Mtetemela declared that the church of Tanzania was no longer in communion with ECUSA bishops who participated in the consecration of Gene Robinson, and those who permit the blessing of same-sex unions. Auxiliary Bishop Method Kilaini of the Dar es Salaam Roman Catholic Archdiocese said lesbians and gays habits were unlawful and harmful to the society and that the practices should not be tolerated. [20]

Since the UNHRC Concluding Observations have been publicized by the media and the Tanzania Human Rights Commission, there has been a considerable backlash against lesbian, gay, bisexual and transgender (LGBT) people. Tanzania criminalizes homosexuality under Section 154 of the Penal Code, and LGBT people already suffer persecution and violence at the hands of state and non-state actors. Attacks have reportedly become more direct and aggressive following media coverage of the UNHRC's recommendations, particularly by individuals acting with the encouragement of the police. Targets have included those perceived to have given information to the UNHRC – especially those who reported human rights violations against sexual minorities for the shadow report that the Centre for Human Rights Promotion, IGLHRC and Global Rights submitted for review. [9]

In 2003, it was reported that hundreds of Muslims in Dar es Salaam participated in a peaceful demonstration organised to protest the visit of gay tourists from the United States of America which has, however, been cancelled. A group, identifying itself as the committee to curb immorality in Muslim organisations, pinned notices in various areas of the city centre, instructing its members to picket and harass the visiting gay tourists. The Archbishop of the Full Gospel Bible Fellowship, Zakaria Kakobe, had also threatened to lead a demonstration to protest the visit. He said the coming of the gay tourists to Tanzania would damage the reputation of this country. [15]

Previous gay, lesbian, and bisexual Volunteers have had to be very discreet about their orientation to prevent adverse effects on their relationships with their community and co-workers. [13]

##### 5. What is known about social position and needs of MSM living with HIV/AIDS

Homosexuals pursue their orientation discreetly, There is a shortage of information on the composition of the social group of men who have sex with other men (MSM). Anecdotal information state that homosexuals exist in different layers of society, as is evident through the network of intersecting friendship circles in private homes, gay-friendly venues and at CPSS meetings. The entire network is virtually invisible from the outside as homophobia always

threatens to unmask or arrest people. The consequences for being 'outed' are dire. Jobs, reputations and family honor are at stake. This may be attributed to poor education, the conservative culture, narrow-minded religion and rigid adherence to heterosexual traditions, all which inhibit personal freedom and cast a shadow on the progress of pro-gay efforts. [1]

#### 6. Any on-going activities to counteract stigma and discrimination?

In 2009, it was reported that Human rights campaigners filed a report with the United Nations, complaining against Tanzania's violation of the rights of lesbians, gays, bisexuals and transgender (LGBT) persons. The report submitted sought to highlight the social and legal obstacles that hinder the freedom of the groups with this type of social relations. The report was filed by three non-governmental organisations: the Centre for Human Rights Promotion in East Africa, International Gay and Lesbian Human Rights Commission, and the Global Rights. [20]

The LGBTI support unit in Tanzania; IGLHRC; and LGBTI Initiative for Global Rights, were behind the effort. They hoped the release of the report would raise their plight and inspire Government attention. The three NGOs argue that Tanzania still maintained laws that invade their privacy and create inequality. [20]

#### 7. Existence of homosexuality-related barriers to health care

Stigma and homophobia may have a profound impact on the lives of MSM, especially their mental and sexual health. Internalized homophobia may impact men's ability to make healthy choices, including decisions around sex and substance use. Stigma and homophobia may limit the willingness of MSM to access HIV prevention and care, isolate them from family and community support, and create cultural barriers that inhibit integration into social networks.

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

In Tanzania, sexual acts between men are illegal. In particular, sections 154 to 157 of the Penal Code criminalize sexual activity between men, stipulating a maximum sentence of 14 years in prison. Sexual acts between women are not mentioned in the Penal Code (AI 2005). The Penal Code is applicable on the Tanzanian mainland but not on the semi-autonomous island of Zanzibar, which is part of Tanzania's territory. In fact, in 2004 Zanzibar enacted a law criminalizing female homosexual acts. Sexual acts between women are punishable by a maximum prison term of five years – the same prison term that men face for homosexual acts in Zanzibar, according to Amnesty International. *The Guardian* reports a maximum prison sentence of five years for homosexual acts, adding that "contrary to earlier press reports men convicted of gay sex will not risk being jailed for life". However, gay or lesbian couples who celebrate their union in a manner that approximates a marriage ceremony – or who live together as spouses – are reportedly subject to seven years in prison. Of note is the fact that *Country Reports on Human Rights Practices for 2005* states that the law in Zanzibar, "establishes a penalty of up to 25 years of imprisonment for men who engage in homosexual relationships, and 7 years for women in lesbian relationships". *The Gay Times* reports that the laws against homosexuality in Tanzania are "rarely enforced" [12]

#### 9. Any action under way to change legal status of homosexuality

The Centre for Human Rights Promotion in East Africa, International Gay and Lesbian Human Rights Commission, and the Global Rights, have among many petitions, pushed for amendment of the Penal Code decriminalising private, consensual, adult same-sex sexual

activity as well as reviewing the HIV and Aids (Prevention and Control) Act, 2008, to provide "access to HIV preventive information and services" to LGBT. [20]

10. Any human rights based organizations active in this country that does or should address MSM issues?

PEPFAR and HIVOS fund projects. [13] There are also reports of the Muhimbili University of Health and Allied Sciences together with the University of Oslo hosting the HIV and most at risk populations (MARPS) short course in Dar es Salaam, Tanzania on 18-29 October 2010, to create awareness about HIV infections amongst vulnerable groups. According to organisers, the aim of the course is to provide participants with insight into and knowledge about the lives and circumstances of Men who have sex with Men (MSM) and injecting drug users (IDU) in Africa, the challenges posed by HIV among them, and approaches to intervention strategies for HIV prevention and care." The short course is scheduled to unravel topics such as same sex attractions, practices, risks, vulnerabilities and approaches to HIV programming that includes and involves MSM and IDU amongst others. [14]

11. HIV prevalence/incidence data for MSM and general population

The only accessible study on rates of HIV among MSM in Tanzania suggest a prevalence rate of 12,4% (Baral et al [10]). This corresponds with other figures from the region that points at disproportionate high rates among MSM compared to the general population. [10] Research shows that IDUs could be worsening the spread of HIV among MSM. [13]

The 2004 Tanzania HIV Indicator Survey (THIS) carried out on the mainland indicated a generalized epidemic of 7% in the sexually active population (15 to 49 age group), with infections higher in women (8%) than men (6%). According to the HIV validation survey (2002), Zanzibar has a low prevalence in the general population at 0.6% However, HIV is more concentrated in high-risk sub population groups namely, drug users, men having sex with men (MSM), and sex workers. A survey of HIV infection among substance users showed a prevalence of 28% in Injecting Drug Users (IDU). It was reported that unless appropriate strategies are put in place to contain the high HIV infections in these groups, Zanzibar is in danger of developing into a generalized epidemic. [13]

12. Is there understanding of specific risk factors for HIV transmission in MSM

Research suggests that there are high rates of unprotected anal intercourse among MSM (Baral). [13]

It is reported that many Tanzanian men engage in same-sex sexual relations, despite the criminalization and without identifying as gay. [10] Without proper prevention strategies, MSM risk being at the forefront of further spreading the epidemic. Hard facts and figures are a useful tool to spread the awareness needed to develop programmes that successfully targets MSM. But since HIV in relation to MSM is an underresearched field in Tanzania, as in most other countries in Africa, reliable statistics are hard to obtain. A Norwegian study was conducted by researcher Kåre Moen, under the heading "HIV vulnerability and HIV prevention needs among men who have sex with men in Tanzania". Another study with a similar scope, but investigating Women who have sex with women (WSW - an even more underresearched field) in Tanzania is being reviewed by the Research Council of Norway. The stigma that is culturally imposed on LGBT people creates marginalisation and social exclusion and also prevents participation in society on equal terms. This leads to limited opportunities for earning a livelihood and providing

for themselves and in many countries there is a wide spread poverty among LGBT people. [10]

### 13. Current status of prevention, treatment and care for MSM

Even though Tanzania's National HIV/AIDS Policy recognises the role of most-at-risk Populations (MARPs) in HIV transmission, little has been done to reach such groups as Commercial Sex Workers (CSWs), Men having Sex Men (MSM), and Drug Abusers (DAs) with comprehensive HIV/ AIDS prevention interventions. Instead, these groups have been highly stigmatised, discriminated against, and even criminalized. TAWIF has tried to reach out to these groups, to break the silence about their rights to comprehensive HIV/AIDS care, and increase their access to services and alternatives for economic livelihood. With a grant of Tsh.236, 800,800 from the Rapid Funding Envelop (RFE), the organisation was able to implement a comprehensive HIV/AIDS prevention project targeting the MARPs in Kinondoni District of Dar es Salaam Region. Various strategies were used to reach the groups. Among them was to approach sex workers at social events and clubs, then engaging them in serious discussions about HIV prevention. The project also established a drop-in centre for dissemination of HIV/AIDS information, delivery of voluntary counselling and testing services, and referrals for clients found to be HIV positive. Leaders of the CSWs, MSM, and Das networks were also identify, trained as peer educators, and used by the project to reach their members. Likewise, other members of the networks were trained as peer educators on HIV/AIDS and life skills. In addition, the project rolled out a powerful poster campaign titled "Tuzungumze" (Let's talk). [16]

The Swedish country strategy for Tanzania 2006-2010 does not explicitly mention LGBT people. There are however some entry points in the strategy, where LGBT issues could be highlighted namely: The democracy and human rights perspective is to be mainstreamed into the different sectors and reform programmes. In order to make the LGBT group visible and acknowledged, Sida could work with other donors to have this group explicitly mentioned in plans and monitoring indicators for reform and sector programs; Direct support will be channelled to civil society organisations (CSOs) and media. Sida could make a deliberate effort to inspire human rights organisations and media representatives to take on board LGBT issues; and the conflict situation in Zanzibar calls for ambitious support to organisations advocating respect for human rights and conflict resolution. Violence against LGBT persons could be brought up as one specific issue in these general efforts. [10]

### 14. MSM related UNGASS indicators

Tanzania did not report against any of the UNGASS indicators relating to MSM. According to USAID, Tanzania will need to harmonise the National HIV/Aids Policy with legal provisions relating to MSM. [13]

### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Reports show that stigma and homophobia may have a profound impact on the lives of MSM, especially their mental and sexual health. Internalized homophobia may impact men's ability to make healthy choices, including decisions around sex and substance use. Stigma and homophobia may limit the willingness of MSM to access HIV prevention and care, isolate them from family and community support, and create cultural barriers that inhibit integration into social networks.

### 16. Whether and how MSM are included in National Strategic Plans

Since 2007, the country's multi-sectoral strategic framework on HIV/AIDS includes MSM (men who have sex with men) as a vulnerable group. It has advised increased efforts to develop services, interventions and studies, but it seems that little or no action has actually been taken in regards to MSM. The inclusion of MSM into a national AIDS plan is usually a great window of opportunity for LGBT organizations. In Tanzania, so far, no known work has been done to use this opportunity to strengthen LGBT organizing or HIV prevention in the LGBT community. [10]

Tanzania has a National AIDS Control program (NACP), a Tanzanian Commission for AIDS (TACAIDS) in the Prime Minister's Office, and a Monitoring and Evaluation framework for HIV/Aids. The broad national response is guided by the National Multi-Sectoral Strategic Framework on HIV/Aids (2008-2012) which is based on 2001 National HIV/Aids policy. In 2008 the parliament passed the HIV and AIDS (Prevention and Control) Act which provides for HIV prevention, care and treatment and protects the rights of people living with HIV. The law prohibits discrimination against HIV-positive people. [10]

The defense force has taken various measures for the care, support and treatment of uniformed service personnel affected by, or infected with, HIV/Aids. This includes awareness raising, condom provision, and VCT provision for personnel who are believed to engage more than most in risky sexual behaviour. It is estimated that about half of the country's hospital beds are occupied by HIV/Aids patients. [13]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

There are no specific infrastructures present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM, and it is reported that stigma and homophobia may limit the willingness of MSM to access HIV prevention and care.

Tanzania declared HIV & AIDS a national disaster at the end of 1999. As a result Tanzania Commission for AIDS (TACAIDS) and Zanzibar AIDS Commission were established to lead and coordinate partners and actors involved in the national multisectoral responses. Also the health and non-health sectors and actors were all directed to integrated HIV/AIDS in their strategies and to initiate workplace programmes. In addition efforts were taken to integrate HIV/AIDS in the first generation PRSPs for mainland and Zanzibar in 2001. However, it is within the current NSGRP ("MKUKUTA") and MKUZA for Zanzibar that significant achievement has been realized in mainstreaming HIV/AIDS together with Gender, environment and other crosscutting issues. Another step was the adoption of the "Three Ones" - One Coordinating Body, One national strategy and One M&E framework - that are now in place and being implemented by Governments, CSO/NGOs, Faith Based Organizations and with support from Development Partners. [22]

Despite all the efforts by the Government and other stakeholders to contain the epidemic in this country, new infections are reported to be on the increase, particularly among young people, women and young girls, high risk groups and in urban and rural areas, thus putting in danger the attainment of the MDG goals and national development targets. Also, stigma and discrimination particularly against people living with HIV and AIDS is still prevalent in the society. In order to address these challenges the Government has decided to review and develop a new national multisectoral strategy framework (2007 to 2012) by engaging all stakeholders and with technical support from the UN and other development partners. [22]



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## Uganda

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

In Uganda, homosexuality is illegal and persecuted. Uganda has been the last country where gay and lesbian rights groups have been attacked by the Government. In September 1999 President Yoweri Museveni instructed Ugandan police to lock up and charge homosexuals. In October 1999 five members of the newly formed organisation, Right Companion, were arrested and deported to so-called 'safe houses.' One of the activists was raped twice, all were beaten, the recognised South African gay Internet site The Mask reports. Gay activists since then have continued to be persecuted and in June 2000, Ugandan police was covering up the murder of a member of Lesgabix, a lesbian and gay grouping in Kampala. [1]

Anecdotal information relates that the few gay men seem resigned to the lack of gay rights crusades, closeted, and local homosexuals remain completely without rights, despite the fact that gay organizations claim to have more 160 different members in Kampala. Gay men and women mainly keep to themselves, presenting different faces among their peers than they do in mixed company. Male friends hold hands while walking, sharing triumphs and pains in relationships seemingly void of sexual tension, but full of genuine concern and interest. Effeminate behaviour seemed to be completely acceptable to the men of Uganda. Men in Uganda present a wide range of feminine and masculine traits, having elaborate hissy fits over small matters one moment and posturing toughly the next. There are vast variations in men's behaviour — some more feminine, some more masculine — presenting the perfect cover for any gay behaviour. [15] However many gay men living in Uganda avoid trouble by using a woman as a "beard" both to avoid awkward questions from Ugandan friends and any possible violently homophobic encounters, which word of mouth threatens is a real occurrence.[16]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

According to anecdotal information there are gay bars which have gay nights once a week – these are heavily guarded. The internet speaks of an underground gay movement in Uganda but it seems to exist online.

3. Presence of an organized LGBT or MSM community

The country has groups representing the LGBT communities. SMUG (Sexual Minorities Uganda) is an alliance of FARUG (Freedom and Roam Uganda), Integrity Uganda, Spectrum Uganda and Icebreakers Uganda. Another group, Queer Youth Uganda, may possibly join the coalition. SMUG is supported by charity organizations and concerned individuals inside and outside Uganda. In 2008 SMUG's projects included dialoguing with police to establish a non-confrontation alliance in an effort raise their awareness of LGBT issues and nature. A major intention is to have MSM included in the National Strategic Plan for health care and AIDS prevention activity. [13]

Treasure Uganda gay and lesbian youth association (TREASURE-LGBT UGANDA) was conceived as a realization that within Africa and particularly Uganda there are many organizations targeting various interventions rather than LGBT concern. There is a disconnect from the national level strengthening programs and district/lower level concern. TREASURE-LGBT UGANDA has been established to support the LGBT both public and individual to

strengthen their equality, to ensure constant availability and full access to resources. The LGBT youth leaving rural areas and small towns, they are faced with a difficulty of finding relevant information about their sexuality, at the same time they are facing discrimination in their communities, families, schools and work places. TREASURE-LGBT UGANDA through its services helps a number of school dropout, and homeless. [23]

LGBT youth in this geographical area are a marginalized group, often living within marginalized communities in which poverty, unemployment, HIV and AIDS, crime, substance abuse and other social problems are epidemic. Youth in general (whether in school/students/unemployed) have few positive options, and LGBT youth have no safe space aside from TREASURE-LGBT UGANDA. Therefore TREASURE-LGBT provides this space as well as confidential support with the challenges and problems facing LGBT youth, practical skills training, information and the opportunity to build supportive social networks in the LGBT youth community and beyond. [23]

#### 4. What is known about stigma and discrimination of male same-sex sexuality

MSM face widespread discrimination and homophobia. A radio station was even fined for hosting gay men on a talk-show and a dominant belief is that LGB people “recruit” and are “child predators”. The government is also openly anti-gay. [13]

Society is largely homophobic. The Minister of State for Ethics, Nsaba Buturo, for example, has said: "We don't believe in homosexuality. We love the gays and homosexuals but we hate their activities. We want to help them to get rehabilitated." He has also has accused United Nations member countries of being involved in a covert mission to 'impose' homosexuality' on other nations. More recently he responded to threats from aid-donating nations who object to his moving ahead with plans to criminalize same-sex sex ([www.queerty.com](http://www.queerty.com)) by saying: "I have been receiving a number of friends from outside Uganda telling me that we should go slow on the rights of people who promote anal sex. And I'm telling them, 'Well, if you in your countries you've chosen to promote anal sex that is your business but leave us alone.'" In 2005, the president signed into law a constitutional amendment proscribing same-sex marriages. [11]

Homophobia and heterosexism are also perpetuated in the media. The News Editor of the Red Pepper, Ben Byarabaha, has vowed that the tabloid, infamous for outing alleged homosexuals in Uganda by publishing their names, photographs and addresses each year, will continue its campaign against homosexuals for as long as the conduct is illegal in the country. [11]

The Kampala-based "moral watchdog," Family Life Network, promotes healing of homosexuality. The Anti-Gay Task Force, the Uganda Joint Christian Council, The Interfaith Coalition Against Homosexuality, and the Inter-Faith Rainbow Coalition against Homosexuality, based at Makerere University Kampala, also fight against the spread of homosexuality and lesbianism in the country. They support gays and lesbians being arrested. In March 2008 these groups hosted the Anti-homosexuality conference which called for Uganda's laws against homosexuality — which currently call for a life sentence — to be “strengthened” with an option to force those convicted into ex-gay therapy. [11]

It was reported that the Uganda AIDS Commission chief, Kihumuro Apuuli, said that schools are a breeding ground for “the vice” of homosexuality, which targets youth aged between 15 and 24. "Gays are one of the drivers of HIV in Uganda, but because of meagre resources we cannot direct our programmes at them at this time,"

People have been arrested for being gay, lesbian or transgender. Wasikira Fred, a transgender

person also known as Namboozo Margaret, and Pande Brian, were charged with carnal knowledge against the order of nature. [11]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

No information is provided. There is a lack of information on the composition of the social group of men who have sex with other men (MSM).

#### 6. Any on-going activities to counteract stigma and discrimination?

Global Fund, PEPFAR, UNAIDS are active in the country. Irish Aid has been working in Uganda since 1994 when an Embassy was established.

#### 7. Existence of homosexuality-related barriers to health care

According to Reuters, Human Rights Watch in a statement said that Ugandan President Yoweri Museveni's promotion of homophobia and violence against men who have sex with men, hinders the country's efforts to fight HIV/AIDS. HRW urged Museveni to repeal a law against sodomy and to end his "long record of harassing" lesbian, gay, bisexual and transgender people (Cawthorne, Reuters, 8/24) [8]. In addition, HRW called on the government to integrate sexual orientation and gender identity issues into Uganda's HIV prevention and treatment programs (HRW statement, 8/23) [8]. Juliana Cano Nieto, a researcher in HRW's LGBT program, said that the government's promotion of homophobia is "undermining Uganda's efforts to combat the spread of HIV/AIDS." HRW said that the government harasses gay organizations, promotes discrimination and raids the homes of advocates, according to Reuters (Reuters, 8/24) [8]. Scott Long, director of HRW's LGBT program, said that the government's actions against MSM and WSW place the "health of all Ugandans" at risk "amid the HIV/AIDS pandemic." Long added that the government's "determination to silence any discussion of sexual orientation" is "devastating" to the fight against HIV/AIDS (Letter text, 8/23) [8].

The epidemic among MSM remains largely hidden due to the under-reporting of sexual transmission of HIV among MSM in official statistics. This paucity of research on HIV and same-sex practices in Africa is the result of a multiplicity of factors that include but not limited to: Hesitancy of those who engage in same-sex practices to expose themselves to potentially judgmental researchers.; Resistance by African review panels to approve research on homosexuality; A general unwillingness among otherwise rigorous scientists to address same-sex transmission due to their discomfort with homosexuality; Homophobic stigma faced by HIV researchers themselves when addressing issues of homosexuality; Denial of the frequency of same-sex behavior in Africa. [5]

More than a million of Uganda's 27 million people are already HIV+. Uganda was one of the first African countries to respond aggressively to the HIV/AIDS epidemic, moving rapidly to introduce measures to prevent HIV transmission. Thus, in Uganda HIV prevalence rates that once hovered around 30%, have declined to under 10 % over the last two decades (Okero et al, 2004). Nevertheless, there is presently some concern that HIV prevalence rates may once again be on the rise or at best reached a plateau where the numbers of new HIV infections match AIDS-related deaths. Reasons advanced for this state of affairs include the government's shift towards abstinence-based prevention programmes, general complacency ('AIDS-fatigue') and the changes in the perception of AIDS as a treatable and manageable disease with the availability of ART. Though the constitution of Uganda calls for the establishment of rights and freedoms, the LGBTI community in particular has not been able to enjoy their freedoms as a

minority group. · Section 140 of the constitution of the republic of Uganda *criminalizes “carnal knowledge against the order of nature” with maximum penalty of life imprisonment. Also, Section 141 prohibits “attempts at Carnal knowledge” with maximum penalty of 7 years’ imprisonment. Section 143, punishes acts of procurement of or attempts to procure acts of gross indecency” between men in public or private with up to 5 years imprisonment* While attempts have been made to mainstream MSM issues by activists regularly coming out to let the world know that they exist and are normal; it remains a matter of conjecture whether this greater participation of LGBTI activists leads to outcomes where LGBTI health concerns and needs more so in the HIV arena are better addressed. In the context of this initiative, the implication is that mainstreaming MSM HIV issues in community participatory processes cannot, *a priori*, be expected to lead to positive outcomes for the LGBTI community at all levels, and whether or not this is so, is an entirely empirical question. Focusing in on those key functions human rights and LGBTI activists have assigned on themselves, and bearing in mind the fact that individuals in the LGBTI community undergo challenging issues of stigma and discrimination every day, this project therefore aims at closely dealing with MSM HIV/AIDS issues since most people do not seem to understand them. This initiative is motivated by the fact that greater participation of human rights and LGBTI activists in speaking out for the community has not created a process that sees MSM health concerns and needs increasingly prioritized, promoted and addressed at all levels. [12]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

In Uganda, the Anti-Homosexuality Bill, if enacted, would broaden the criminalisation of homosexuality by introducing the death penalty for people who have previous convictions, are HIV-positive, or engage in same sex acts with people under 18 years of age. The bill also includes provisions for Ugandans who engage in same-sex sexual relations outside of Uganda, asserting that they may be extradited for punishment back to Uganda, and includes penalties for individuals, companies, media organisations, or non-governmental organisations that support LGBT rights. The private member's bill was submitted by MP David Bahati in Uganda on 13 October 2009. Homosexuality is currently illegal in Uganda—as it is in many sub-Saharan African countries—punishable by incarceration in prison for up to 14 years. The proposed legislation in Uganda, however, has been noted by several news agencies to be inspired by American evangelical Christians. A special motion to introduce the legislation was passed a month after a two-day conference was held where three American Christians asserted that homosexuality was a direct threat to the cohesion of African families. The bill, the government of Uganda, and the evangelicals involved have received significant international media attention and criticism from Western governments, some of whom have threatened to cut off financial aid to Uganda. In response to the attention, a revision was introduced to soften the strongest penalties for the most egregious offenses to life imprisonment.

Uganda's parliament was predicted to enter discussions about passing the bill in late February or March 2010. However, intense international reaction to the bill caused President Yoweri Museveni to form a commission to investigate the implications of passing the bill. In May 2010 the committee recommended withdrawing it. In April 2009, the Ugandan Parliament passed a resolution allowing Member of Parliament (MP) David Bahati to submit a private member's bill in October to strengthen laws against homosexuality. The bill was proposed on 13 October 2009 by Bahati and is based on the foundations of "strengthening the nation's capacity to deal with emerging internal and external threats to the traditional heterosexual family", that "same sex attraction is not an innate and immutable characteristic", and "protecting the cherished culture of the people of Uganda, legal, religious, and traditional family values of the people of Uganda against the attempts of sexual rights activists seeking to impose their values of sexual

promiscuity on the people of Uganda". The legislation strengthens the criminalisation of homosexuality in Uganda by introducing the death penalty for people who are considered serial offenders, are suspected of "aggravated homosexuality" and are HIV-positive, or who engage in sexual acts with those under 18 years of age. People who are caught or suspected of homosexual activity will be forced to undergo HIV tests; Ugandans who engage in same-sex sexual relations outside Uganda will likewise fall under the jurisdiction of this law, and may be extradited and charged with a felony. Furthermore, if passed, the bill will require anyone who is aware of an offense or an offender, including individuals, companies, media organisations, or non-governmental organisations that support LGBT rights, to report the offender within 24 hours. If an individual does not do so he or she is also considered an offender and is liable on conviction to a fine not exceeding 250 "currency points" or imprisonment up to three years. [25]

#### 9. Any action under way to change legal status of homosexuality

Uganda is planning new legislation that will violate the fundamental human rights of sexual minorities, compound their exclusion from access to services and exacerbate the stigma experienced by people living with HIV and AIDS. The Anti-Homosexuality Bill criminalises gay sex - rendering those accused of this 'crime' liable to life imprisonment. For those who prove to be HIV positive, the penalty is death. Stigma and discrimination have long been recognized the world over as one of the main obstacles to the prevention, HIV testing and counselling, care and treatment of AIDS (Malcolm et al. 1998; Busza 1999; Maluwa et al. 2002; Bond et al. 2003; Parker and Aggleton 2002; 2003; and others). Since the onset of HIV&AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic nearly world over (Fredriksson and Kanabus, 2008). From early in the AIDS epidemic a series of powerful images (HIV&AIDS as punishment for sin, as a crime, as war, as horror or as otherness) were used that reinforced and legitimized stigmatization (Hadjipateras Angela 2004). The fear of possible stigmatization promotes secrecy that increases HIV vulnerability and poor uptake of HIV&AIDS prevention, care and treatment services (ACORD,2008). [18]

In December 2008 a court declared that it is unconstitutional to discriminate against homosexuals and that they should enjoy the same rights as enjoyed by other Ugandans. Despite this, Uganda's "ethics minister" is about to table an "anti-gay" bill in parliament which will outlaw LGBT human rights activism by banning literature and public speaking on LGBT issues. Uganda LGBT activist Victor Juliet Mukasa reported this at the 2009 World Outgames. On September 29, 2005, President Museveni signed into law a constitutional amendment proscribing same-sex marriages, making Uganda the second country in the world to do so. According to the amendment, "marriage is lawful only if entered into between a man and a woman," and "it is unlawful for same-sex couples to marry [13]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

Global Fund, PEPFAR, UNAIDS are active in the country. SMUG is at the forefront of efforts to defeat the anti-homosexuality bill. In early March, SMUG leaders were part of a delegation, including AIDS service providers, human rights activists, and clergy members, who presented a petition signed by more than 450,000 people to the speaker of Uganda's Parliament. Faced with intense pressure from around the world, Uganda may remove some of the bill's harshest provisions, including the death penalty. But opponents point out that passing the legislation in any form will cripple efforts to combat HIV/AIDS among Uganda's MSM. By driving them

underground and denying them access to lifesaving prevention and treatment, Uganda will—no matter what the law says—be handing these men a death sentence. [6]

Even apart from the legislation to punish homosexuals, Ugandan human rights have been a concern for Amnesty International, who highlighted issues such as threats to freedom of expression and association, and the use of torture by law enforcement, among their major concerns in their 2009 report.[22] American evangelists active in Africa are being criticised for being responsible for inspiring the legislation by inciting hatred with excessive speech by comparing homosexuality to paedophilia and influencing public policy with donations from American religious organisations. [25]

Icebreakers Uganda MSM Initiative (IMSMI) is basically a project aiming to specifically look at MSM health issues and specifically in relation to HIV/AIDS and STIs. It aims at providing support and care for MSM infected or affected by HIV/AIDS to achieve this, we have three main categories of activities to lead us to our expected out comes. These include but not limited to: Social Wellbeing · Safe Spaces for mobilization, organizing and networking through activities, movie, discussions, debates, etc. this kind of space is available at our resource centre which is very secure; Open forum discussions guided covering issues i.e. healthy relationships; Psychosocial support through peer education services and counseling referrals by qualified LGBTI friendly medical practitioners and counselors; Production and distribution of information education and communication (IEC) materials; Voluntary counseling and testing services at our resource centre by qualified LGBTI friendly medical practitioners and counselors; Referrals to MSM friendly service providers to access CT services and STI treatment ; Post Test Clubs to provide psychosocial support and share experiences ; Safer Sex awareness workshops ; Online peer education and information sharing through our website ; Community outreach to the different MSM groups i.e. Male sex workers, Youths, Trans, Married, Bi-sexual men and other non identified MSM ; · Research ; Condom and Lubricant Distribution; Practical skills dissemination through referrals, networking and establishment of partnerships; Personal development and ongoing skills development with our volunteers i.e. on leadership and competence. The entire initiative is so designed and conducted that as a result of the process the, MSM are able to achieve a level of sexual health that is equal to or better than that of the general population. ; · Cut down on the levels of MSM HIV/AIDS infections in their communities. ; Evolve a rights-based perspective with regard to social change and an approach of youth-centered advocacy to organize the marginalized and influence public policies and programs; Make safer sex a part of their daily lives

#### 11. HIV prevalence/incidence data for MSM and general population

Uganda is a country of approximately 30 million people; with an estimated HIV prevalence rate of 5.4 percent—roughly five times the HIV prevalence in the U.S. The most recent UNAIDS data estimates 940,000 people living with HIV in Uganda. More than a million Ugandans have died of AIDS and 1.2 million children have been orphaned by the disease. Prevalence of HIV infection among women in Uganda is even higher: 7.5%. [15]

There is evidence to suggest that there is an increase in risky sexual behaviours especially among men in the period since 2001. Individuals reporting multiple sexual partners increased among age group 15-24, from 25% to 29% in men and from 2% to 4% in women while those reporting extra-marital sex increased from 14% to 29% among men but remained stable at 3% among women. Condom use at last sex with casual sex partners increased from 39% to 48% among women, but decreased from 61% to 53% among men during the period 2001 to 2005. It is projected that unless there are significant changes in sexual behaviour and other population



parameters such as the fertility and population growth rates, the increasing trend in HIV prevalence is unlikely to have changed by 2010. Moreover, with increasing access to ART, HIV-related mortality will decrease leading to a further increase in HIV prevalence. Incidence modeling reveals that 43% of new HIV infections are among monogamous relationships while 46% are among persons reporting multiple partnerships and their partners (see Odiit, 2008; Wabwire-Mangeni et al, 2008). Commercial sex workers (CSWs), their clients and partners of clients contribute about 10% of new infections. Men who have sex with men (MSM) and intravenous drug users (IDUs) contribute less than 1%. There has also been a shift in concentration of the epidemic from younger to older individuals with the highest prevalence for men (9.9%) being among 35 – 39 year olds while for women (12.1%) it is among 30 – 34 year olds [18]

In December 2001, 1.05 million Ugandans were living with HIV/AIDS. Among them, 945,500 were adults, of whom 56.3 percent were women. Nearly 80 percent of those infected with HIV were between ages 15-45. Since the beginning of the epidemic through 2001, 2 million Ugandan children had been orphaned by AIDS. Among reported AIDS cases through December 2001, 92.6 percent were adults. The overall mean age for adults with AIDS was 30.9 years; for men, this figure was 33.0, for women, 29.1. AIDS is responsible for 12 percent of annual deaths and is the leading cause of death among those ages 15-49. By 2000, there had been 1.3 million AIDS deaths in Uganda. [4]

Uganda has recorded declining rates of HIV infection since 1993. Although HIV prevalence among pregnant women rose from 24 per cent in 1989 to 30 per cent in 1992, by 1999 it had dropped to 10 per cent, according to the latest figures from the AIDS Control Programme (ACP) in the Ministry of Health. Among patients suffering from sexually transmitted diseases at Uganda's leading hospital, Mulago, HIV infection rates fell from 44.2 per cent in 1989 to 23 per cent in 1999. [14]

The current HIV prevalence in Uganda is estimated at 6.4% among adults and 0.7% among children. HIV prevalence is higher in urban areas (10% prevalence) than rural areas (6%). Perhaps as a result of earlier prevention programmes targeting young, single adults, the number of new HIV infections among those in monogamous relationships is now significantly higher than those with multiple partners (43 percent compared to 24 percent in 2008). Women are disproportionately affected, accounting for 57% of all adults living with HIV. Ugandan women tend to marry and become sexually active at a younger age than their male counterparts, and often have older and more sexually experienced partners. This (plus various biological and social factors) puts young women at greater risk of infection. AVERT.org has more about women and HIV. The number of new infections (an estimated 111,000 in 2008) exceeds the number of annual AIDS deaths (61,000 in 2008), and it is feared HIV prevalence in Uganda may be rising again. There are many theories as to why this may be happening, including the government's shift towards abstinence-only prevention programmes, and a general complacency or 'AIDS-fatigue'. It has been suggested that antiretroviral drugs have changed the perception of AIDS from a death sentence to a treatable, manageable disease; this may have reduced the fear surrounding HIV, and in turn have led to an increase in risky behaviour [13]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

Policy and programme challenges exist which hinder the development and implementation of effective national HIV responses based on appropriate, comprehensive interventions, and leaves MSM even more vulnerable to HIV infection. Strengthening the knowledge base and implementing capacity for the prevention and treatment of HIV among MSM and transgender

populations should be considered a priority for all countries and regions as part of a comprehensive effort to ensure universal access to HIV prevention, care and treatment. Men who have sex with men (MSM) still face severe problems of stigma and discrimination throughout the world. Experiencing discrimination not only affects physical and mental well-being, but also impedes access to HIV prevention, testing and treatment. Openness and improved national HIV surveillance is crucial and only attainable through societal and personal acceptance and disclosure of sexual behavior. Restrictive legislative environments in some countries hinder effective HIV service provision to MSM. In fact, sexual acts in private between consensual adults of the same sex are still criminalized in most of Africa. Effectively addressing MSM in HIV prevention and treatment is essential for an effective overall HIV response. [12]

Seen through the lens of HIV/AIDS, legislation is places at risk a comprehensive program of HIV prevention, care and treatment. Uganda had been held up as a model for real progress against AIDS by demonstrating serious, high-level political leadership and a willingness to engage in straight talk about HIV risk reduction and to mount a concerted condom distribution campaign. The proposed bill not only criminalizes homosexuality but by extension demonizes persons with HIV by labeling same-gender sexual activity by HIV-infected people “aggravated homosexuality,” punishable by death. Furthermore, the bill’s sponsor dangerously and incorrectly asserts that by criminalizing homosexual behavior, the country’s AIDS epidemic will be ameliorated. Stigma already poses a formidable barrier to HIV services for persons living with or at risk of HIV in Uganda and elsewhere in southern Africa. This law, if enacted, would render every person with HIV a potential criminal, subject to scrutiny about their sexual behavior and threatened with life in prison or even death. Moreover, this proposed law would essentially criminalize not only the activities of all organizations working in the LGBT communities, but also potentially all organizations delivering HIV prevention, care and treatment services, by calling for imprisonment of anyone who fails to report individuals who engage in homosexual acts. From the perspective of the HIV clinicians, researchers and educators who are represented by IDSA and HIVMA, this law would cripple the provider-patient relationship, making it virtually impossible for physicians and other caregivers to provide quality comprehensive medical care and risk-reduction counseling. It would also raise new barriers to enrollment in HIV clinical trials and the conduct of epidemiological research. [15]

It was reported to be especially troubling that the proposal has emerged at a time when there is finally a concerted effort underway to evaluate the impact of the HIV/AIDS epidemic on MSM in developing countries, and to ensure that targeted, human rights based programming is available to address the needs of this and other vulnerable populations. It is reported that while there exists no good data on the incidence of HIV infection among MSM in Uganda, studies conducted in neighboring countries would suggest that the level of HIV risk for this population is higher than the general population. UNAIDS has now embraced a clear agenda of ensuring that the needs of at-risk populations, including MSM are met. The enactment of this law would make efforts to assess the size and the needs of this population in Uganda essentially illegal, while casting an additional shadow of bigotry, discrimination and stigma on all persons in the LGBT community and all persons with HIV/AIDS regardless of their particular risk factors. [15]

Substantial unmet needs remain for HIV treatment among both adults and children in Uganda, as poor management of some funding and flat funding from PEPFAR have taken their toll. Passage of this law will make the continuing AIDS crisis in Uganda even worse. If draconian penalties drive homosexual activity even further underground, bisexual men may avoid HIV and STI screening and might be more likely to transmit to partners, particularly wives who would perceive themselves to be at low risk if they were monogamous. A study recently published online in the Journal of AIDS by Kumta et al showed that MSM married to women in Mumbai

were more likely to be HIV-infected than men who exclusively had male partners. Knowledge of HIV serostatus is one of the foundations of HIV prevention, but this law will make Ugandans even more reticent to be tested for HIV infection, to ask candid questions about their HIV risks, or to access HIV care if they do discover they are infected.

More must be done to ensure that the needs of vulnerable populations, including MSM, are met in all PEPFAR-funded countries and that must begin with a rejection of laws and policies that violate the fundamental human rights of individuals. A study by Carlos Caceres, MD, PhD, commissioned by UNAIDS, found that in those countries where same-sex relationships are criminalized, “adequate provision for HIV prevention, treatment and care among sexual minority populations remains unthinkable. In other cases, while there is no criminalization, protection against hate crimes or other forms of discrimination does not exist, and the risk of occurrence of such crimes hampers the implementation of HIV prevention and treatment and care for such groups.”<sup>ii</sup>

Uganda already has regressive laws on the books regarding homosexuality, as do the majority of PEPFAR focus countries. [15]

The country faces daunting challenges to mobilize adequate funding for the national HIV response especially for treatment, care and support. Although the relationship between effective ART care and prevention of new infections is recognized, starting people on ARTs early enough when their CD4 count is still high continues to elude the country response. It has to be pointed out that Uganda is yet to develop an adequate human, logistical, supply and other systems resource base to cope with the demands of the HIV&AIDS epidemic to effectively manage the National HIV&AIDS response. As a result, provision of treatment is largely donor-driven and evidently this makes it unsustainable. Faith communities have the potential to do more in this area as well; to mobilize local and international faith communities for further support of the response. The amount of resources needed to reach all in need of support services—i.e., PHAs, OVCs and their families poses a serious challenge to all actors involved in the provision of support services. There are numerous pressing demands and an overstretched national budget for a resource poor country such as Uganda. Thus, whereas funding is limited, the scope and magnitude of needs of OVCs, PHAs, affected families and whole communities is increasing. This is further exacerbated by the inadequacy of human resource capacity to provide services. Whereas considerable work is evident among faith communities in mitigation of the impact of HIV&AIDS, a lot more is possible, given further strategic planning and resource mobilization for the needy flock. Similarly, further spiritual and psychosocial counseling and support is possible as part and partial of the cardinal work of faith communities. [18]

### 13. Current status of prevention, treatment and care for MSM

Several studies, conducted in Uganda and its neighbors, indicate that adult male circumcision may be a cost-effective means of reducing HIV infection. A review on the acceptability of adult male circumcision indicated across studies, the median proportion of uncircumcised men willing to become circumcised was 65% (range 29-87%). Sixty nine percent (47-79%) of women favored circumcision for their partners, and 71% (50-90%) of men and 81% (70-90%) of women were willing to circumcise their sons. [25]

The provision of all health services in Uganda is shared between three groups: the government staffed and funded medical facilities; private for profit or self-employed medics including midwives and traditional birth attendants; and, NGO or philanthropic medical services. The international health funding and research community, such as the Global Fund for Aids, TB and Malaria, or bilateral donors are very active in Uganda. Part of the success in managing

HIV/AIDS in Uganda has been due to the cooperation between the government and the non-government service providers and these international bodies. Public Private Partnerships in Health are often mentioned in Europe and North America to fund construction or research. In Uganda, it is more practical being the recognition by the public government and public donor that a private philanthropic health facility can receive free test kits for HIV screening, free mosquito nets and water purification to reduce opportunistic infections and free testing and treatment for basic infections of great danger to PLHA. [25]

The very high rate of HIV infection experienced in Uganda during the 80's and early 90's created an urgent need for people to know their HIV status. The only option available to them was offered by the National Blood Transfusion Service, which carries out routine HIV tests on all the blood that is donated for transfusion purposes. Because the need for testing and counseling was great, a group of local NGOs together with the Ministry of Health established the AIDS Information Centre in 1990 to provide HIV testing and counseling services with the knowledge and consent of the client involved.

In Uganda, HIV/AIDS has been approached as more than a 'health' issue and in 1992 a "Multi-sectoral AIDS Control Approach" was adopted. In addition, the Uganda AIDS Commission, also founded in 1992, has helped develop a national HIV/AIDS policy. A variety of approaches to AIDS education have been employed, ranging from the promotion of condom use to 'abstinence only' programmes.

Uganda was the first country to open a Voluntary Counselling and Testing (VCT) clinic in Africa called AIDS Information Centre and pioneered the concept of voluntary HIV testing centers in Sub-Saharan Africa. The Ugandan government, through President Yoweri Museveni, has promoted this as a success story in the fight against HIV and AIDS, arguing it has been the most effective national response to the pandemic in sub-Saharan Africa. Though equally there has in recent years been growing criticism that these claims are exaggerated, and that the HIV infection rate in Uganda is on the rise, perhaps linked to over-emphasis on abstinence at the expense of condom use

#### 14. MSM related UNGASS indicators

Uganda did not report against any of the UNGASS indicators relating to MSM. However, research (Baral) suggests that there are high rates of unprotected anal intercourse among the MSM. [13]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Wave of homophobic rhetoric and violence undermine efforts to combat high rates of HIV/AIDS among MSM. Human rights activists, AIDS advocates, and grassroots MSM organizations say that the progress that had been made over the past several years in reaching MSM is being threatened by a new climate of fear and repression that is sweeping parts of the country. Same-sex sexual behavior has long been outlawed in Uganda, but the country's war on homosexuality began to escalate in the spring of 2009, when several evangelical clergymen from the U.S. visited to give a series of talks opposing the "gay agenda." Amidst the ensuing anti-gay fervor, in October MP David Bahati introduced new anti-homosexuality legislation in Parliament. The proposed law would impose the death penalty for "aggravated homosexuality," which includes any same-sex sexual activity by HIV-positive people. It mandates up to life in prison for anyone convicted of homosexuality or attempted homosexuality. It would also imprison anyone who

knows of homosexual conduct and fails to report it—effectively criminalizing the efforts of anyone providing HIV/AIDS services to members of the LGBT community. Pepe Julian Onziema is the HIV/AIDS program coordinator at Sexual Minorities Uganda (SMUG), which received a community award from amfAR's MSM Initiative for advocacy and outreach aimed at curbing the spread of HIV among MSM. SMUG's vocal opposition to the bill has made it the target of sensational media coverage and has raised fears that anyone associated with the organization will be subject to violence or arrest. Providing HIV services has become nearly impossible. [6]

#### 16. Whether and how MSM are included in National Strategic Plans

MSM is not specifically included in National Strategic Plans however, in line with global and national development requirements, Uganda has launched a universal access to HIV/AIDS prevention, treatment, care and support services drive. This is enshrined in the recently developed National Strategic Plan for HIV/AIDS Activities 2007/8-2011/12. The universal access spirit is also embedded in the Country Road Map towards Accelerated HIV Prevention. The universal access vision acknowledges challenges in infrastructure and resource constraints. Implementation of the NSP takes on a phased approach ingrained in the indicators at mid-term and end of term periods as highlighted in the Performance Measurement and Management Plan 2007/8-2011/12.

The Uganda AIDS Commission spearheads joint planning for and monitoring and evaluation of the national response. Key stakeholders are periodically brought together to identify key priority areas for the national program and for particular areas of the response. This enhances shared perspectives and focuses on common problems, and promotes ownership of the national program by the various stakeholders. UAC spearheaded the development of the Multisectoral Approach to the Control of HIV/AIDS (MACA) in 1992, a national policy that has served as the basis for developing periodic national program priorities and implementation mechanisms. The National Operational Plan (NOP) for STI/HIV/AIDS Activities 1994-1998 guided the response for that period. This was succeeded by the National Strategic Framework (NSF) for HIV/AIDS Activities 1998-2000 which was revised in 1999/2000 into the NSF 2000/1-2005/6. The Mid Term Review (MTR) of the NSF 2000/1-2005/6 was conducted between October and December 2003. The findings of the MTR informed the revision of the NSF to reflect priorities for the remaining period of implementation. The revised NSF 2004-2006 was disseminated to stakeholders at national and lower levels. The revision took into account environments in terms of changes in the epidemic; changes brought about by increasing availability of prevention, care and treatment services including antiretroviral therapy; reviewed policy, planning and coordination frameworks; and an expanded funding base. The NSF came to an end in June 2006. UAC initiated the process for the new 5-year planning framework in December 2005. The comprehensive consultation process was concluded in November 2007. The final draft of the National Strategic Plan for HIV/AIDS Activities 2007/8-2011/12 will be present to Cabinet for endorsement before official dissemination to stakeholders. For more information on the process download NSP development process.

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Uganda has launched a universal access to HIV/AIDS prevention, treatment, care and support services drive. This is enshrined in the recently developed National Strategic Plan for HIV/AIDS Activities 2007/8-2011/12. The universal access spirit is also embedded in the Country Road Map towards Accelerated HIV Prevention.

The universal access vision however acknowledges challenges in infrastructure and resource constraints. Implementation of the NSP takes on a phased approach ingrained in the indicators at mid-term and end of term periods as highlighted in the Performance Measurement and Management Plan 2007/8-2011/12. [2]

Uganda was the setting for one of the first test programmers in Africa distributing life-saving antiretroviral medication (ARVs). The programme began in 1998 with the aim of assessing the feasibility of setting up and running an antiretroviral drug clinic in a resource-poor country. The patients involved had to pay for their medication, although at reduced prices. After the study was complete, the Ugandan Ministry of Health used the lessons it had learned to set up its National Strategic Framework for HIV/AIDS. [26]

It was not until June 2004 that Uganda began to offer free ARV medication to people living with HIV as part of a five-year pilot programme. The initial consignment was funded by the World Bank, with future drugs to be paid for by a Global Fund grant of US\$70 million and large grants from America's PEPFAR initiative. Initial drug roll out was fairly slow; by 2006 only 24% of adults in need of antiretroviral treatment were receiving it. The momentum of scaling up HIV treatment in Uganda was put in jeopardy following the suspension of funds from one of the country's key donors. In August 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria suspended the disbursement of money to Uganda after financial irregularities were discovered. It was found that management of Uganda's grants was generally poor, and that significant sums of money had been diverted to activities not related to combating HIV/AIDS. Grant disbursement was restarted in November 2005, and in 2008 the Global Fund signed Round Seven of funds pledging \$254m for HIV/AIDS over the next decade [25]

Currently just over 200,000 people in Uganda are receiving antiretroviral treatment, an estimated 39% of those in need, according to the latest WHO guidelines (2010). The latest guidelines recommend starting treatment earlier and have therefore increased the number of people estimated to be in need of treatment. Under the previous guidelines, treatment coverage in Uganda would be 53%. Targets have been set of 240,000 people on treatment by 2012, and 342,200 by 2020. When setting treatment targets Uganda must think about sustainability, as 95% of the ARV programme is currently donor funded, mainly by PEPFAR. This support is under threat; PEPFAR funding has flatlined, and the US government plans to cap funds to Uganda until at least 2011. [25]

In 2009, HIV activists in Uganda protested against the diversion of earmarked funds from the purchase of antiretroviral drugs.<sup>73</sup> This was closely followed by a recommendation by parliamentarians that Ministry of Health spending on HIV/AIDS increase from 6 percent to 15 percent of the national budget in order to effectively deal with the epidemic.<sup>74</sup> A few months later, announcements made by the head of HIV programming in the Ministry of Health committed to delivering 60 billion Ugandan shillings (approximately 26.5 million dollars) each year to HIV treatment.<sup>75</sup> However, increasing demand and reduced donor funding are already having an adverse effect on the provision of HIV treatment. In March 2010 Peter Mugenyi, the Director of the Joint Medical Research Centre in Uganda, spoke of turning away 'desperate patients' on a daily basis due to funding shortages.<sup>76</sup> Such difficulties in providing treatment are echoed by other health facilities in Uganda who have placed an informal ban on the enrollment of new patients [2]

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## Zambia

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Most LGBT people in Zambia are closeted due to fear of targeting and victimisation. Little is known about how male same-sex sexuality is organized and expressed on an individual level.

In general, Zambians view homosexuality as immoral and as something that has been "imported" from Europe. Homosexuality is against the law in Zambia and although few cases are brought before the courts, it still requires that homosexuals be mindful that anti-gay laws and sentiment exist. While there are certainly homosexuals, the level of tolerance will probably not be what it was in the States. Due to cultural norms, homosexuals may discover that they cannot be open about their sexual preference in their community. Most Zambian homosexuals have usually migrated to the larger cities. [10]

According to a report submitted to the United Nations Human Rights Committee by Global Rights and the International Gay and Lesbian Human Rights Commission, the criminalization of consensual homosexual sex in Zambia "has a devastating impact on same-sex practicing people in Zambia". The report asserts that LGBT people are subject to arbitrary arrest and detention, "discrimination in education, employment, housing, and access to services", and extortion—often with the knowledge or participation of law enforcement authorities. [6] According to a report by Behind the Mask, a non-profit organisation dedicated to LGBT affairs in Africa, most LGBT people in Zambia are closeted due to fear of targeting and victimisation. Lesbians are especially vulnerable, according to the report, due to the patriarchal structure of Zambian society. [14]

2. Existence of MSM/gay culture (meeting places, bars, etc.)

Despite high levels of homophobia, gay-friendly bars do exist and gay life can be quite comfortable, sociable and fun. There are two stories to describe gay Zambia: about an oppressed criminalized minority hiding in the shadows of a highly homophobic country and about a playful cruise subculture that parties, drinks and talks politics in the evenings at half a dozen clubs in Lusaka. [14]

3. Presence of an organized LGBT or MSM community

Rainka has replaced LEGATRA which was the LGBT organisation. [14]

4. What is known about stigma and discrimination of male same-sex sexuality

In Zambia the public attitude is that not only is it morally wrong since, Zambia has been declared a Christian nation, but that it is insane, madness and likened to the behaviour of dogs and animals. [6] Few are sympathetic, except for two NGOs [ZIMT and AFRONET] [6] the politicians, in particular the Vice President and the President have instructed the police to arrest anybody who support LGBT people or anyone who say that they are gay. The National Parliament has spoken strongly against the LGBT community and says that such abnormal people should be arrested. In the last quarter of 1999 an NGO calling itself Zambia Against People with Abnormal Sexual Acts [ZAPASA] was formed to fight against homosexuals. [8]

At least two religious leaders have recently criticized donor countries for speaking out in defense of the lesbian, gay, bisexual and transgender population. Bishop J.H.K. Banda, chairman of the National AIDS Council, described the donor's efforts as being "against the traditional values of the country." Zambia's Anglican Council presiding bishop Robert Mumbi also recently described homosexuality as un-African – an oft-repeated refrain. [15] According to the deputy president, —Zambia is a Christian nation and it shall continue to be so because it is part of our constitution. And acts such as homosexuality are not part of the Christian norm. In 2005, this house passed stiff laws against homosexuality. For people having carnal knowledge of each other against the order of nature the punishment is a minimum of 15 years imprisonment. If you have carnal knowledge of an animal you serve a minimum of 25 years. In 1998, in a statement to the National Assembly of Zambia, Vice President Christon Tembo called for the arrest of individuals who promote gay rights, citing a need to "protect public morality". President Frederick Chiluba described homosexuality as "unbiblical" and "against human nature". Later, Home Affairs Minister Peter Machungwa ordered the arrest of any individual or group attempting to formally register a gay rights advocacy group. Herbert Nyendwa, the Registrar of Societies, stated that he would refuse to register any LGBT organisation or civic group. [14]

According to anecdotal information the president of LEGATRA has been very badly attacked twice. There have been numerous occasions when gay men have been set upon by people and just attacked. Transgendered people are also targeted. Some transgendered people have been publicly undressed to ascertain their gender. They are beaten, made fun of and generally ridiculed and there is nothing that we can do about it. Zambians are generally not very militant people and faced with multiple hostilities the LGBT community closes rank. LEGATRA finds it very difficult to organise the LGBT community, as they live in perpetual fear of their lives. [8]

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

The majorities of LGBT people are "in the closet" and refuse to be associated with the LGBT movement for fear of victimisation in their homes, schools, colleges or places of work once they are identified as homosexuals. The majority of LEGATRA members are men. [8]

#### 6. Any on-going activities to counteract stigma and discrimination?

In Zambia, Public Health Watch is partnering with Neo Simutanyi, a lecturer at the University of Zambia, and Kaumbu Mwendela, the chairman and co-founder of Zambia AIDS Law Research and Advocacy Network (ZARAN). Launched in October 2000 as a student organization to address the legal, ethical and human rights issues around HIV/AIDS, ZARAN's principal aim is to champion the rights of people living with and/or affected by HIV/AIDS through advocacy, education, research, and policy development. [8]

#### 7. Existence of homosexuality-related barriers to health care

Human Rights Watch warned that homophobic statements by religious leaders and government authorities in Zambia. Zambia has a strong track record on addressing HIV/AIDS, however, promoting intolerance and creating a climate of fear will only sabotage efforts to ensure access to HIV prevention and treatment by driving men underground.[16] Human Rights Watch called on government authorities to condemn statements that could discourage men who have sex with men from seeking health care and erode their fundamental human rights, and to reaffirm the importance of HIV testing and treatment for these men. The letter also called on the Zambian Parliament to amend the Penal Code to decriminalize consensual sexual conduct among adults. [17]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Homosexuality is illegal in Zambia and there is no recognition of legal rights for same-sex couples. Section 157 applies to "any act of gross indecency" committed between males, "whether in public or in private", and classifies such acts as felonies punishable by imprisonment for five years. It seems that it the act of sodomy has to be witnessed in order for people to be prosecuted by the law. The law also includes lesbian homosexuality. [8]

Lesbian, gay, bisexual, and transgender persons in Zambia face legal challenges not faced by non-LGBT citizens. Same-sex sexual activity is illegal for both males and females in Zambia. Zambia inherited the laws and legal system of its colonial master upon independence in 1964 and laws concerning homosexuality have largely remained unchanged since then, and homosexuality is covered by sodomy laws that also proscribe bestiality. Social attitudes toward LGBT people are mostly negative and coloured by perceptions that homosexuality is immoral and a form of insanity. [8]

In 1999, the non-governmental organisation Zambia Against People with Abnormal Sexual Acts (ZAPASA) formed to combat homosexuality and homosexuals in Zambia. Arguably the largest recipient of Fundamentalist Evangelical missionaries during British colonial times, societal attitudes towards homosexuality heavily mirror these influences. A 2010 survey revealed that only 2% of Zambians find homosexuality to be morally acceptable; nine points below the figure recorded in Uganda (11% acceptance). Same-sex sexual activity is proscribed by Cap. 87, Sections 155 through 157 of Zambia's penal code. Section 155 ("Unnatural Offences") classifies homosexual sex (in the vague description "carnal knowledge of any person against the order of nature") as a felony punishable by imprisonment for 14 years. Any person who- (a) has carnal knowledge of any person against the order of nature; or (b) has carnal knowledge of an animal; or (c) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony and is liable to imprisonment for fourteen years. Section 156 imposes imprisonment for seven years for any "attempt to commit unnatural offences". Finally, Section 157 applies to "any act of gross indecency" committed between males, "whether in public or in private", and classifies such acts as felonies punishable by imprisonment for five years. The provision also extends to "attempts to procure the commission of any such act [of gross indecency]". Any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years. [16]

There is no explicit legal protection against discrimination based on sexual orientation in Zambia. The Constitution of 1991, as amended by Act no. 17 of 1996, contains an anti-discrimination clause, present in Article 23 of the document. According to Article 23(1), "no law shall make any provision that is discriminatory either of itself or in its effect". Article 23(2) further prohibits discrimination "by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority", and Article 23(3) defines discrimination as extending to differential treatment of persons on the basis of "race, tribe, sex, place of origin, marital status, political opinions, color or creed" [16]

#### 9. Any action under way to change legal status of homosexuality

There does not seem to be any action under way to change legal status of homosexuality

In 2006, Home Affairs Minister Ronnie Shikapwasha stated that Zambia would never legalise same-sex marriage, claiming that it is a sin that goes against the country's Christian status (see *Religion in Zambia*). In February 2010, the National Constitutional Conference (NCC) unanimously agreed to adopt a clause that expressly forbids marriage between people of the same sex. [16]

The Zambian registrar of societies has refused to register LGBT organisations. LEGATRA (Zambia) has been refused registration several times. LGBT organisations have continued to operate as social gatherings. They are failing to raise money for public awareness campaigns, or to start a National campaign or fund test cases to challenge the Penal Code and defend the LGBT community. At the moment we are at an impasse.

Human Rights Watch have stated that Zambia's laws criminalizing homosexual conduct also directly violate regional and international human rights standards. International protections of the right to privacy and against discrimination guaranteed by the International Covenant on Civil and Political Rights, to which Zambia is party, have been authoritatively interpreted to prohibit laws criminalizing consensual homosexual conduct among adults. Regional obligations such as the African Charter on Human and Peoples' Rights prohibit discrimination, require the promotion of and respect for "mutual respect and tolerance" among all individuals, and specifically guarantee the right to physical and mental health. All of these rights are threatened by laws criminalizing consensual sexual conduct and by homophobic statements by religious and government leaders. [16]

10. Any human rights based organizations active in this country that does or should address MSM issues?

The major responders to HIV Aids emergency were western government and non-government organizations bringing health care, technology and medications. Many of the personnel in these hundreds of organizations (NGO's)—religious, social, charitable, medical—were dedicated LGBT workers driven in part by compassion for their own community, even more so since homosexuals were not at first included in national strategic HIV plans in Africa. In 2007 the American-based Centers for Disease Control in Zambia (the CDC functions around the globe) proposed a research study of MSM in Zambia, a first in that country; since homosexually active men are not officially acknowledged as part of society here they have been ignored by HIV education programs emerging from the Health Ministry in Lusaka, Zambia's capital of 1.5 million people. The study of course has to be done by gays who can network within the community to gather valid data on sexual behavior of MSM, even though a significant percent of these men do not identify as gay and often make contact in secretive places that only other MSM's know about. African men, mostly straight and married, are known to have porous sexual boundaries and will engage with another man—or woman—just for the pleasure of the moment without connecting to (in total denial of) the gay/homosexual 'syndrome'. So Friends of Rainka was born as a research advisory group [2]

In 2007 the Human Rights Committee noted with concern that the Penal Code criminalizes *same-sex sexual activities* between consenting adults and urged Zambia to repeal the relevant provisions in the Penal Code. In 2008 the Human Rights Council also recommended that the Penal Code be amended to decriminalize same-sex activities between consenting adults. One of the few recommendations of the Universal Periodic Review opposed by the Zambian government (CCPR/C/ZMB/CO/3/CRP.1, para. 24, A/HRC/8/43 para 60). The Committee on Economic, Social and Cultural Rights in its General Comments No 18 on "The right to work", No 15 on "The right to water" and No 14 on "The right to the highest attainable standard of health"

has indicated that the Covenant on Economic, Social and Cultural Rights proscribes any discrimination on the basis of sex and sexual orientation that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of specific rights. In 2009 the UN High Commissioner for Human Rights has spoken out against discrimination directed at lesbian, gay, bisexual and transgender groups stating that the criminalization of different sexual orientation cannot be justified either as a matter of law or as a matter of morality. [7]

The Zambian National AIDS Council (NAC) was established as a statutory body through an Act of Parliament in 2002 and functions as the sole national AIDS coordinating authority accountable to the Cabinet Committee on HIV/AIDS. NAC manages and coordinates the country's multisectoral National AIDS Strategic Framework 2006-2010. The NASF has 6 themes, namely: Intensifying Prevention of HIV Expanding Treatment, Care and Support for people affected by HIV/AIDS; Mitigating the socio-economic impact of HIV/AIDS; Strengthening the Decentralised Response and Mainstreaming HIV/AIDS; Improving the Monitoring of the Multisectoral Response; Integrating Advocacy and Coordination of the Multisectoral Response.

The Churches Health Association of Zambia (CHAZ) was created in 1970 as an umbrella organization to represent work done by Church-based health institutions in Zambia. Altogether, these institutions are responsible for over 50% of health services in the rural areas and about 30% of health care in the country at large. CHAZ complements government efforts in the delivery of quality healthcare by bringing to the health sector professional human, material, and financial resources. The overall goal for the CHAZ AIDS Care and Prevention Programme is to contribute to the prevention of HIV incidence and mitigate the social-economic impact of HIV/AIDS epidemic in rural Zambia. This is contained in the CHAZ HIV/AIDS Strategic Plan 2006-2010. This goal is achieved through six main purposes: Prevent further transmission of HIV infections particularly in the youth and women; Improve quality of life of people infected by HIV; Reduce the socio-economic impact of HIV/AIDS on individuals and families; Strengthen capacities and increase the number of communities responding to the epidemic; Promote Human Rights and Gender Advocacy

The Zambia National AIDS Network (ZNAV) was established in 1994 to promote liaison, collaboration and co-ordination among non-governmental organizations and community based organizations involved in the fight against HIV/AIDS. ZNAV is a member of the NAC, and it works closely together with the CHAZ. Its Executive Director is also Vice-Chair of the Global Fund and Special Envoy of the United Nations' Secretary General for HIV/AIDS in Africa. ZNAV evolved from a network organisation into a sub-granting agency and is a well respected principal recipient of the Global Fund. The Embassy support forms part of a Joint Financing Arrangement between ZNAV, STARZ/DFID, the Embassy of Denmark and Open Society Initiative. The JFA over the period 2008-2010 aims to contribute to the strengthening of the civil society response to the HIV /AIDS epidemic in Zambia, in line with the National AIDS Strategic Framework 2006-2010. This will be achieved through the following purposes: To intensify civil society HIV/AIDS programmes country-wide ; To strengthening the advocacy roles of its 200 members ; To strengthen the capacity of the ZNAV Secretariat ; To provide a platform for civil society to lobby and advocate on HIV/AIDS interventions; To strengthen and expand ZNAV's sub-granting activities ; To strengthen the institutional and technical capacity to manage network plans ; To strengthen ZNAV's monitoring and evaluation system to measure the response [20]

#### 11. HIV prevalence/incidence data for MSM and general population

There are few if any HIV prevention programmes aimed at reaching MSM in Zambia. MSM who lack accurate prevention strategies and information, engage in unsafe sex practices and thus

risk being at the forefront of further spreading the epidemic. One common misapprehension is that HIV cannot be transmitted through anal intercourse; this was also reported in a small scale study from Zambia.[8]

Research (Zulu, 19) found that 50% of the sample of participants reported having sex with both men and women in the last twelve months, 20% of these reported having had an STI, but blamed women for it. 37% reported having sex with men only. 73% said anal sex is safer than having vaginal sex with a woman. 80% of self identified MSM reported initiation through peers and by choice. 41% reported to be doing it for money. No MSM prevention or advocacy programs were reported. 94% did not use a condom at last anal sex. 90% to 94% do not know condoms are used in anal sex. Below 1% attempted to seek VCT services. Although research shows high rates of unprotected anal intercourse among MSM, national AIDS Control Program does not address same-sex relationships. Other research has found that male truck drivers and uniformed personnel used condoms in over 80% of encounters with sex workers but virtually never with their wives. It is therefore easy for a married woman who has only ever had sex with her husband to acquire HIV ([www.aidsmap.com](http://www.aidsmap.com)). [7]

Although HIV prevalence for MSM is proportionally higher in low prevalence countries, than in countries with high prevalence, it is safe to assume that HIV rates are significantly higher among MSM than among the general population in Zambia. Studies in other countries in the region point to the fact that MSM are at least 3.8 times more likely to be infected than the general population. HIV among MSM in Zambia has not been extensively examined in any research, but one Zambian study is now ongoing.

Zambia is experiencing a generalized HIV/AIDS epidemic, with a national HIV prevalence rate of 17 percent among adults ages 15 to 49. The primary modes of HIV transmission are through heterosexual sex and mother-to-child transmission. HIV prevalence rates vary considerably within the country. Infection rates are highest in cities and towns along major transportation routes and lower in rural areas with low population density. HIV prevalence among pregnant women can range from less than 10 percent in some areas to 30 percent in others. In general, however, young women ages 25 to 34 are at much higher risk of being infected by HIV than young men in the same age group. The prevalence rates are 12.7 and 3.8 percent, respectively. Other at-risk populations include military personnel, people in prostitution, truck drivers, and people who work in fisheries. While Zambia's national prevalence rate remains high and shows no sign of declining, the country has been noted for its significant increases in antiretroviral treatment (ART) access [15]

HIV prevalence in the general population is high, with 16% of the population aged 15-49 years being HIV positive (ZDHS, 2001-2002). Prevalence rates are higher in urban than rural populations, estimated at 23% and 11% respectively. Prevalence rates also vary among geographical areas, the highest at 22% was Lusaka and the lowest at 8% was the Northern Province. Women were more vulnerable than men, with prevalence rates of 18% and 13% respectively, which calls for gender sensitive interventions. About 8% of boys and 17% of girls aged 15-24 are living with HIV and approximately 39.5% of babies born to HIV positive mothers are infected with the virus. Over 10% of the reported outpatient attendance to clinics is due to STIs (CBoH Syndromic Guidelines). The 2001-2002 ZDHS shows that 7 % of women and 8% of men in the 15-49 age group have Syphilis. [7]

12. Is there understanding of specific risk factors for HIV transmission in MSM

In June 2007, the Zambian Ministry of Health agreed to conduct, together with the Centers for Disease Control and Prevention and Society for Family Health under Population Services International, an assessment to evaluate HIV and AIDS prevalence and transmission among gay men [15] As of July 2007, no public or private programmes provide HIV-related counselling to homosexual men in Zambia, where the HIV seroprevalence rate among adults is approximately 17%. Although men involved in same-sex sexual relationships have a higher risk of HIV transmission, the government-operated National AIDS Control Program does not address same-sex relationships. [15]

Zulu (2009) conducted a study with the objectives to examine the existence of Men who have Sex with Men (MSM) and the frequency with which bisexuals engage in unprotected anal sex. Analyze factors propelling HIV transmission and assess vulnerability of MSM to HIV/AIDS in Zambia. 40% of self identified MSM reported initiation through peers and by choice. 35% reported having sex with both men and women in the last twelve months. 55% said rectal sex is safer than having vaginal sex with a woman. 20% of these reported having had syphilis, but blamed workers for it. 30% reported to be doing it for money. 83% do not know condoms are used in anal sex. No MSM prevention or advocacy programs were reported. Data analyzed from the study suggests that sex between men exists and is at the peak of HIV transmission in many Zambian contexts. It may be instrumental to argue for MSM's sexual rights in order to avoid a further escalation of the HIV/AIDS pandemic. No single AIDS service organisation (ASO) has programs targeting men who have sex with men in Zambia. it would be prudent not look at men who have sex with men (MSM) as a problem but must be part of the solution to HIV/AIDS prevention hence the need to have programs targeting MSM in order to achieve the much needed zero new HIV/AIDS infection rate. [19]

The Director Health and Human Rights Division of Human Rights Watch wrote an open letter to the President of Zambia Regarding the Marginalization of Men Who Have Sex with Men in the Fight Against HIV/AIDS, stating that the letter aims to draw attention to the risk posed to the continuing success of Zambia's HIV prevention, testing and treatment campaigns by recent statements first by religious leaders and then government authorities condemning homosexuality. The National HIV/AIDS/STI/TB Council (NAC) of Zambia acknowledged in 2009 that men who have sex with men (MSM) constitute a particularly vulnerable risk group for HIV and AIDS<sup>[i]</sup> and recognized the "urgent need" to include them in national AIDS strategies.<sup>[ii]</sup> Zambian activists have informed us, though, that homophobic statements by prominent leaders are already creating a climate of fear among men who have sex with men and threaten to drive this population underground, as activists fear a government crackdown on individuals suspected of being homosexual in Zambia. In the light of the threat that homophobic statements pose both to public health and to human rights in Zambia, we urge you to immediately revisit the criminalization and marginalization of the MSM community and to publicly condemn all statements that adversely affect health-seeking behaviour of men who have sex with men and other vulnerable populations. We call on you to make public statements acknowledging the importance of HIV testing, treatment and prevention for men who have sex with men, and to urge the Zambian Parliament to amend the Penal Code in order to decriminalize consensual sexual conduct among adults. Only by doing so will Zambia pave the way for HIV testing and treatment programs which serve all vulnerable populations. [1]

Prison sex is common (unprotected), and the government recently registered an MSM organization called PRISSCA (Prison Sexual Counseling Association) which deals with same-sex behavior among incarcerated men. [6]

### 13. Current status of prevention, treatment and care for MSM

There are few if any HIV prevention programmes aimed at reaching MSM in Zambia. MSM who lack accurate prevention strategies and information, engage in unsafe sex practices and thus risk being at the forefront of further spreading the epidemic. One common misapprehension is that HIV cannot be transmitted through anal intercourse; this was also reported in a small scale study from Zambia. [8]

The Zambian Ministry for Health has endorsed a study proposed by the American Center for disease control (CDC) on MSM and HIV. The study was scheduled to be completed in 2008, but sources reveal that the process has been stalled due to the controversial subject matter. The study is now reported to be in progress. The fact that the government is willing to endorse such research can be seen as a positive development. Zambian LGBT activists say that it could "give some sort of identity for MSM in Zambia". The results of the study and the measures taken after the study is completed are highly relevant for anyone working with health and HIV programmes in Zambia.

Zambia is hard hit by the AIDS epidemic, as is the rest of Africa. There are few counselling centres. KARA Counselling Centre has been approached to ask if they would counsel MSM members. They refused. They said that lesbians and gay men should be counselled by other gay people. They seem to have the idea that homosexuality is catching, a view shared by the majority of Zambian society. [8]

#### 14. MSM related UNGASS indicators

In terms of the UNGASS indicators, Zambia did not report on the percentage of MSM living with HIV, the percentage of MSM who took an HIV test in the last 12 months and who know the result, the percentage of MSM who know how to prevent HIV or the percentage of MSM being reached by HIV programs. However it did report that 60-79% of MSM used a condom the last time they had sex, leaving one to wonder how it knows this. Public Health Watch (working with Soros) partners with civil society organizations in Zambia to monitor and evaluate national efforts to comply with the UNGASS Declaration of Commitment (DoC) and other international and regional HIV/AIDS commitments, with a particular focus on vulnerable and marginalized populations. [8]

#### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

Human Rights Watch called on government authorities to condemn statements that could discourage men who have sex with men from seeking health care and erode their fundamental human rights, and to reaffirm the importance of HIV testing and treatment for these men. The letter also called on the Zambian Parliament to amend the Penal Code to decriminalize consensual sexual conduct among adults. [17]

#### 16. Whether and how MSM are included in National Strategic Plans

Mallard (2010) reported that Zambia has launched a ten-year program to circumcise more than 2.5 million men in an effort to curb HIV, the virus that causes AIDS. But the effort faces challenges from religious groups and others who say there's not enough evidence to support that circumcision curbs AIDS. 14% of all Zambians are infected, and less than 20% of all males are circumcised. Male circumcision is not unknown in Zambia, and some ethnic groups in the northwest practice it widely including the Luvale and Luanda. But many are opposed to it on religious or traditional grounds, and others say as a way to prevent HIV, it just does not work.



They say there is no scientific evidence that male circumcision is reliable in slowing the spread of HIV/AIDS. More than 200 doctors, clinical officers and nurses have been trained to perform the procedure, says Dr. Mukonka of the Ministry of Health. Zambia has scaled up male circumcision in 36 out of 73 districts, and health specialists hope to have more than 2.5 million males circumcised over the next 10 years. The United Nations' report last year indicated that universal male circumcision in sub-Saharan Africa could prevent 5.7 million new infections and three million deaths over 20 years. [8]

17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

Funding for MSM research comes through TALC (Treatment Advisory Literacy Campaign), which targets HIV+ people. [8]

The Zambian government and its expanded multi-sector network of partners, including faith-based organizations, community-based organizations, and other private and public groups, coordinated through the National AIDS Council and guided by the National AIDS Strategic Framework, seek to close the human resource and technical capacity gap and build a network of health systems managers and prevention, treatment, and care providers that can efficiently utilize donor funding and domestic revenue to produce health and quality of life gains for people living with HIV and AIDS (PLHIV), orphans and vulnerable children (OVC), and the general population. This requires not only an adequate stock and flow of health workers into the health system, but also a high level of Institutional, programmatic, and financial management capacity of these organizations. In order to strengthen the health system's management capacity, HIV/AIDS program planners and policymakers need analytical tools to assist with estimating the recurrent costs and non-pecuniary resources required to support an HIV/AIDS program. It is important that these tools help policymakers quantify and plan for the medium- to long-term implications of current policy decisions.

Zambia has experienced a remarkable scale-up of HIV/AIDS services over the past five years. More than 123, 000 Zambians have started on antiretroviral therapy (ART). Prevention of mother-to-child transmission (PMTCT), and voluntary counseling and testing (VCT) have been expanded to more than 250 and 600 sites, respectively, throughout the country. However, the resources required to sustain the current level of HIV/AIDS services in Zambia over the next decade have not been secured. With the upcoming conclusion in 2008 of currently authorized funding from the President's Emergency Plan for AIDS Relief (PEPFAR) and World Bank Multi-country AIDS Program (MAP), as well as uncertainty about future grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), Zambia will need to assess the sustainability of its current portfolio of HIV/AIDS activities. [13]

With about one million Zambians living with HIV/AIDS and 200,000 of these persons requiring ART, the Government of the Republic of Zambia has prioritized making ART available to all Zambians in need. A recent rapid assessment of the Zambian ART program identified several important constraints including: inadequate human resources for counseling, testing, and treatment-related care; gaps in supply of drugs in the public sector; increase in value of the Zambian Kwacha; lack of adequate logistic/supply chain systems; stigma that hinders people from seeking treatment and care; lack of information on the availability of treatment services; a high level of misinformation about ART; need for a continuous funding stream as an accumulation of patients on ART results in a growing need for support; high cost of ART to patients, despite subsidies from the public sector; lack of referral between counseling and

testing services and ART; and lack of referral between home-based care services, testing and ART [15]

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## **Zimbabwe**

1. How male same-sex sexuality is organized and expressed on an individual level (including presence of transgendered men, male sex workers, down low men, etc.).

Zimbabwe is more known for its homophobia and extreme statements made by President Robert Mugabe, including various claims that homosexuality is not an African phenomenon but rather a Western decadency. Homosexuality is illegal in Zimbabwe, and some individuals have been prosecuted and convicted for their sexual orientation, including the country's first president, Robert Mugabe. On the other hand, there are very active and very visible gay and lesbian organisations in Zimbabwe that have succeeded in creating a public debate on the issue. Even if homosexuality remains illegal and condemned by state officials, these organisations have won several law suits against the Government, trying to silence them, and the matter of homosexuality is coming out of the taboo closet. [1]

Gay and lesbian couples who manage to move to, or live in, Harare have the ability to live together quietly as 'roommates'. Most gay and lesbian people in Zimbabwe are married with kids. [2]

Many MSM have moved to South Africa. [2]

Traditionally, in some Shona tribes, there is a belief that a man having sex with another man, particularly a younger one, can bring good fortune to the senior partner. [17]

Gay life in the countryside has for generations meant getting married and having children despite secret feelings of being different. For many who have not been exposed to any information about sexuality there is little understanding of what this difference is. It has been reported [2] that in small villages and towns, there may be an occasional furtive experiment with homosexual activity but it's unlikely to develop into a relationship although such things are known to occur under certain isolated circumstances. An effeminate man or masculine woman is considered 'funny', at variance with most others who don't understand such behavior. The result is a lonely isolated individual who may feel 'possessed' by a spirit from an opposite-sex ancestor since they don't feel the same heterosexual urge to produce descendants. Children are believed to carry the spirit of their ancestors and not having offspring breaks this spiritual lineage. [2] Long-term relationships do happen but they are not common. Internal homophobia (within the individual) as well as public depreciation of LGB love creates a low expectation of lengthy ties, so dating is thought of as a short term deal as people move on to another trick after one or a few dates

Same-sex activity commonly and knowingly happened among poorly educated miners in their arduous work circumstances. Younger workers were chosen by older miners as conjugal wife substitutes--called 'mine marriages'. [2]

Most miners are reported to be essentially straight, some bi-sexual while others leaned toward a homosexual orientation. Other labor conditions such as for herdsmen, migrant farm laborers or railroad workers that kept countless men away from their wives and prostitutes left the drive for sexual release open to various furtive experimentations. So much for the myth that homosexuality is a colonial import. For the miners' wives back home there is testimony that female-female intimacies were formed as 'co-wives' were brought into the family unit. Other female-only relationships, called 'mummy-baby', were found even in middle class populations. [2]

## 2. Existence of MSM/gay culture (meeting places, bars, etc.)

GALZ sponsors social events such as parties where members can come and be relaxed and authentic with others. A few nightclubs in urban areas such as Harare and Bulawayo are tolerant of gay customers. Gay prostitution is known to be solicited in some Harare clubs. [17] According to anecdotal information, a few nightclubs in urban areas such as Harare and Bulawayo are tolerant of gay customers. Gay prostitution is known to be solicited in some Harare clubs. [8]

## 3. Presence of an organized LGBT or MSM community

Gays and Lesbians of Zimbabwe (GALZ) were formed in 1989 to provide gay men and lesbians in Zimbabwe with a network to facilitate communication within the gay community. Primarily concerned with providing the community with social events, the organisation kept a low profile at its onset. However, with the growing awareness of the needs of the gay community as a whole within the country, GALZ initiated a programme of outreach which inevitably led to the organisation's "outing". Presently GALZ' aim is to network broadly with other human rights organisations, the womens' movement, AIDS initiatives and regional associates. The primary objective is to increase awareness of gay rights in as broad a forum as possible thereby integrating these rights with the other basic human rights for which civil society is currently battling. GALZ has been the target of infiltration by government spies and extortion attempts by both strangers and casual acquaintances. [17] Galz' Objectives are to: to encourage civil, social and economic educational, sporting, political and other related opportunities and activities for gay men and lesbians; to act on behalf of and to represent gay men and lesbians, generally and individually, who reside in Zimbabwe ; to promote an awareness of issues which affect gay and lesbian communities ; to make known to the gay and lesbian community and to a broader community generally the aims and objectives of GALZ and the services which GALZ can provide to the gay and lesbian community ; to establish, maintain and administer in a democratic collective and accountable manner, a Gay and Lesbian Community Centre which will provide a venue for social, recreational, educational and other related activities ; to collect materials and resources on the issues related to gay men and lesbians and to establish or co-operate with other organisations whose object is to establish such a centre, a resource centre to make such resources and materials easily available ; any other subsidiary objectives which are consistent with the carrying out of the aims and objectives listed above; for example, to work towards and campaign for the adoption of a Charter of Gay and Lesbian Rights

Through all the suffering and government mismanagement and corruption GALZ has continued to stay the course and provide a beacon of hope for homosexuals throughout the country. Running a viable LGBT organization in Zimbabwe goes beyond the usual human rights and HIV education purposes, which GALZ does well. GALZ also is a means of personal survival for its staff. Without funding from abroad, the organizers could well be destitute like most others.

IN 2009, Gay rights activists in Zimbabwe have demanded to be recognised in the country's new Constitution which is currently being drafted. In a statement to the Zimbabwe Times, the Gays and Lesbians Association of Zimbabwe, GALZ, said: "The purpose of a Constitution is to protect vulnerable and marginalised minorities.

## 4. What is known about stigma and discrimination of male same-sex sexuality

Homosexuality is highly taboo in the socially conservative country and Mugabe's anti-gay

stance resonates with many Zimbabweans. Gays and lesbians in Zimbabwe are threatened by violence and suicide attempts are common among the gay community. [2]

The homophobia promoted by ZANU-PF is not divorced from the oppression of women, the exploitation of workers and the gross violation of human rights that the same government has been responsible for. Beyond majority numbers, democracy is also about progressive values of equality, freedom, human rights and non-discrimination. In Africa, homosexuality remains largely feared, misunderstood, illegal and heavily punishable. Various African leaders have made acerbic comments and statements against homosexuality that reflect the continent's general reluctance to promulgate legislation to stop discrimination against homosexual persons.

Rambling, vocal rhetoric against gay people does not constitute a policy. Government also cannot outlaw rights in Zimbabwe. Human rights are inalienable and cannot be given or withdrawn. Being gay or lesbian is not a crime in Zimbabwe: only sexual acts between men are illegal although government has made the definition of a sexual act very broad indeed and it could even be extended to hugging or holding hands in public.

The vast majority of gay and lesbian people are in the closet given the general prevailing attitude of disapproval and the attitude of powerful members of government. [9]

Zimbabwe is a country opposed to homosexuality. President Mugabe has called gays worse than pigs and dogs, and laws passed in 2006 make any actions perceived as homosexual a criminal offense. Laws are enforced by police in the form of routine harassment of gays and lesbians. The LGBT organization called GALZ's offices has been raided. [10] Homosexuals have been repeatedly bribed, detained, beaten and sometimes raped by the authorities. The Central Intelligence Organisation has reportedly been used to beat and arrest homosexuals. In 1996, former President Canaan Banana was arrested based on accusations made during the murder trial of his former bodyguard, Jeffa Dube. Banana was found guilty of eleven charges of sodomy, attempted sodomy and indecent assault in 1998. He was sentenced to 10 years in prison, defrocked, and served 6 months in an open prison. In 1999, British gay rights activists, led by Peter Tatchell, attempted a citizen's arrest of Mugabe for the crime of torture.<sup>[13]</sup> In 2001, Tatchell again tried to arrest the president in Brussels but was beaten unconscious by Mugabe's security guards. [17]

Although there is growing tolerance, most of Galz members still fear to tell their families and friends that they are gay. Galz reports that there is a small but growing number who are coming out of the closet. Gay and lesbian people face the same challenges as heterosexual counterparts when it comes to economic opportunities, education, health, housing etc. Although when it comes to housing, there have been times when a landlord has evicted or tried to evict a tenant because he or she is gay. [15]

Despite a high level of awareness, HIV and AIDS remain highly stigmatised in Zimbabwe. People living with HIV are often perceived as having done something wrong, and discrimination is frequently directed at both them and their families. Many people are afraid to get tested for HIV for fear of being socially alienated, losing their partner or losing their job. Those who do know their status rarely make it publicly known, which often means they do not have access to sufficient care and support.

Men who have sex with men (MSM) are a group who are particularly marginalised within society. As homosexuality is illegal in Zimbabwe, it is difficult for prevention programmes to reach MSM and MSM who are living with HIV are often unable to access HIV treatment, care

and support. The Zimbabwean government has been instrumental in discriminating against MSM; President Mugabe once reportedly described MSM as "worse than pigs and dogs".

There is a feeling in Zimbabwe that the stigma surrounding HIV is gradually diminishing, although it remains a significant problem. Various attempts have been made to improve the situation, such as the 2005 "Don't be negative about being positive" campaign. Organised by PSI-Zimbabwe, this campaign encouraged people to reveal their HIV-positive status and to share their stories. The organisers won the 2005 Global Media Award for their work.

#### 5. What is known about social position and needs of MSM living with HIV/AIDS

The vast majority of gay and lesbian people are obviously in the closet given the general prevailing attitude of disapproval and the attitude of powerful members of government, therefore, little is known about the MSM community and especially those living with HIV/AIDS. [17]

#### 6. Any on-going activities to counteract stigma and discrimination?

For the LGBT organization called GALZ, an important shift in recent months has been the recognition of MSM (men who have sex with men: gay, bi or straight) as a target population to receive HIV health education funding from the state. For years both non-governmental organizations (many of which are Christian-based NGOs) and the Zimbabwe National AIDS Council have tried to deny MSM people exist due to homophobia and the criminal status of sodomy. (In this country sodomy does not mean homosexuality per se; oddly, sodomy as described in the statutes has a loose definition that means intimacies like intercourse but may also be interpreted to mean kissing and holding hands in public places.) [17]

A positive twist towards human rights for Zimbabwean citizens, including lesbian, gay, bisexual, transgender and intersex (LGBTI) community, seemed imminent if elections favoured the Movement for Democratic Change (MDC). MDC spokesperson Nelson Chamisa revealed that the his organisation would build a new Zimbabwe for all its citizens irrespective of their social associations or even sexual orientation. Chamisa, however, included that individual choices should be defined by societal norms, consideration and the national feelings of the country. [12]

#### 7. Existence of homosexuality-related barriers to health care

Clearly, homosexual persons and MSM in Africa struggle with institutionalised and non-institutionalised discrimination on a daily basis. This discrimination extends especially to their human rights, specifically the right to equitable access to health care services. In an ideal world, there would be general acceptance of the fact that sexual identity is a fluid construct and that all persons are entitled to free expression thereof. But many changes need to occur first. In order to achieve this transformation, some important considerations need to be acknowledged. First, there is a need for commitment from all African states to repeal homophobic laws and enshrine diversity in sexual orientation within their Constitutions. Second, civil society actors in the field of HIV and AIDS need to tailor programmes for the inclusion and recognition of the sexual and reproductive health rights of gays, lesbians and MSM. Finally, the media must play its role in disseminating unbiased accurate information on homosexuality so as to initiate informed dialogues and debates among communities and within societies. [8]

Matsikure (2008) reports that in HIV and AIDS prevention information, protective barriers, psycho- social support, care and treatment among MSM is nonexistent among major stakeholders in HIV and AIDS including government intervention. There is no research or sero-

prevalence rate among MSM due to the denial of stake holders on the existence of MSM/WSWS in Zimbabwe. [11]

State-led homophobia in the country is holding back the potential positive impact on interventions related to curtailing the spread of the HIV/AIDS pandemic. In general, health service providers, including those in the counseling field, are not willing to address the issues faced by MSM and WSW. There are no clinics or hospitals providing services for MSM to check on STI's and other sexually transmitted diseases. [11]

Religious and cultural beliefs play a great role in Zimbabwe in encouraging MSM and WSW to go underground and not access information of sexual and reproductive health issues which affect them including HIV. Some people even believe anal sex does not cause transmission of HIV and engage in risk behaviours. MSM hide their sexual problems and pretend all is well to friends, relatives and family, due to fear of being ridiculed and stigmatize. [11]

A large number of MSM are dying without disclosing their HIV status for fear of rejection and being ridiculed by other members in the gay community and their families of origin. Forced marriages have also led much older gay men to live double lives. How much responsibility do they have towards the relationships they have outside marriage and towards their families in HIV and AIDS prevention? Not all MSM access HIV and AIDS prevention, care and management information as there is a large underground network of MSM. Double disclosure of one's sexuality and HIV status is such a challenge MSM are dying in silence. KY Jelly is not easily available and is now very expensive for an ordinary man to buy. What alternatives are available for MSM now and much risk are they putting themselves using these alternative lubes. Due to economic decline in country many people cannot afford to come for education workshops. NGOs working with HIV and AIDS are not including information and researches on MSM and WSW. Most of the information is heterosexualised and may not be relevant for MSM/WSW. [11]

Human rights groups dismiss LGBTI issues on the grounds that Zimbabwe has no consensus on the issue of Homosexuality and the President is against it. Homophobia among the subordinates in some institutions also affects delivering of services to people who identify as gay, bisexual or other. There is need for research to assess the prevalence rate of HIV among MSM and WSW as we do not know how much transference of HIV is taking between MSM and also with the 'straight world' [11]

The situation is not clear as to the status of people in the LGBTI community as to whether one is married, in an extra marital affair, bisexual, gay, lesbian etc and their access to preventive materials and lubes. There is need to involve marginalized groups if we are to fight HIV. [11]

Ignorance is the major obstacle among people working and advocating for prevention of new infection among the population, care. Support and access treatment as they sideline LGBTI issues. Therefore there is need to decriminalize same sex relations in Zimbabwe if we are to fight and eradicate HIV in Zimbabwe and Africa as a whole. [11]

The National HIV and AIDS Strategic Plan argues that punitive measures serve only to drive MSM underground, making intervention efforts more difficult. It also breaks the automatic link between homosexuals and prostitution which characterized the interpretation of homosexuality in the original 1999 version [13]

Zimbabwean researchers in HIV&AIDS are afraid of including the homosexual and drug injection communities in the national HIV&AIDS priority research document they are working on because of the criminalization of these areas by the country's government. These two areas among other minority groups are key drivers of HIV&AIDS and researchers said they need for the nation to prioritize them and have national campaign programs targeted at them. Zimbabwe AIDS Network National Director Lindiwe Chaza-Jangira said the gay and lesbians as well as the drug injectors are HIV&AIDS drivers who should not be ignored in the research. [13]

Research Advisory Committee (RAC) Chair Professor S Rusakaniko said the homosexual community was one of the vulnerable groups whose data needed to be included in the national HIV&AIDS policy document although its contribution to the risk was not all that serious. [3]

#### 8. Legal situation regarding same-sex sexuality plus extent of enforcement

Laws passed in 2006 make any actions perceived as homosexual a criminal offense. The Zimbabwean government has made it a criminal offense for two people of the same sex to hold hands, hug, or kiss. The "sexual deviancy" law is one of 15 additions to Zimbabwe's Criminal Code quietly passed in Parliament. The sections involving gays and lesbians are part of an overhaul of the country's sodomy laws. Before then, laws against sodomy were limited to sexual activity. The revised law now states that sodomy is any "act involving contact between two males that would be regarded by a reasonable person as an indecent act." [8]

Whilst there is no Statutory legislation prohibiting homosexual activities in Zimbabwe, there are criminal offences under Common law which effectively make homosexuality illegal in Zimbabwe. Common Law prohibitions include Sodomy defined as the "unlawful and intentional sexual relations per anum between two human males" and Unnatural Offences defined as the unlawful and intentional commission of an unnatural sexual act by one person with another person. The meaning of "Unnatural" involves a value judgement which can be interpreted how you will. These offences are particularly repressive. Zimbabwean law therefore criminalises sex and even the display of affection between men and criminalises unnatural sexual acts between two persons which in theory could be applied to two women though in practice never has. Although these outdated laws are not always applied, the threat of being caught still hangs over the gay and lesbian community in Zimbabwe. S11 of The Censorship and Entertainments has also been used to harass gay people in Zimbabwe. This provides that no person shall import, print, publish, distribute, or keep for sale any publication which is undesirable. A publication is undesirable if it is "indecent or obscene or is offensive or harmful to public morals or is likely to be contrary to public health." LGBT rights in Zimbabwe are dominated by the fact that male homosexuality is illegal in Zimbabwe, under laws which date to the Rhodesian and British colonial eras, and, since 1995, the government has carried out campaigns against homosexuality in both men and women. Robert Mugabe, president of Zimbabwe since 1987, has actively carried out actions against LGBT people and spoken out in public against homosexuality. Mugabe has blamed gays for many of Zimbabwe's problems, and views homosexuality as an "un-African" and immoral culture brought by colonists and practiced by only "a few whites" in his country.<sup>[8]</sup> During his 82nd birthday celebrations, Mugabe told supporters to "leave whites to do that."<sup>[9]</sup> Mugabe has informed journalists, most of who work for state-owned institutions, to report negatively on gay relationships. Some critics believe that Mugabe's anti-gay campaign is meant to deflect attention from Zimbabwe's economic problems by using gays as a scapegoat. [17]

LGBT rights in Zimbabwe are dominated by the fact that male same-sex sexual activity is illegal in Zimbabwe, under laws which date to the Rhodesian and British colonial eras, and, since 1995, the government has carried out campaigns against homosexuality in both men and



women. Common law prohibitions include sodomy defined as the "unlawful and intentional sexual relations per anum between two human males." An unnatural offence is defined as the unlawful and intentional commission of an unnatural sexual act by one person with another person. [17]

#### 9. Any action under way to change legal status of homosexuality

In 2008, it was reported that a positive twist towards human rights for Zimbabwean citizens, including lesbian, gay, bisexual, transgender and intersex (LGBTI) community, seemed imminent if elections favour the Movement for Democratic Change (MDC). While President Robert Mugabe has over the years condemned homosexuality in Zimbabwe, MDC spokesperson Nelson Chamisa revealed that the organisation would build a new Zimbabwe for all its citizens irrespective of their social associations or even sexual orientation. [12] However, in 2009, it was reported that President Mugabe increased the political repression of homosexuals under Zimbabwe's sodomy law. Mugabe blamed gays for many of Zimbabwe's problems, and views homosexuality as an "un-African" and immoral culture brought by colonists and practiced by only "a few whites" in his country. During his 82nd birthday celebrations, Mugabe told supporters to "leave whites to do that." Mugabe has informed journalists, most of who work for state-owned institutions, to report negatively on gay relationships. Some critics believe that Mugabe's anti-gay campaign is meant to deflect attention from Zimbabwe's economic problems by using gays as a scapegoat. [15]

#### 10. Any human rights based organizations active in this country that does or should address MSM issues?

At present, GALZ is one of the few lobby groups in Zimbabwe that has got a treatment plan up-and-running for people with full-blown AIDS. [10] Other human rights organizations such as Amnesty International, Zimbabwe Human Rights NGO Forum (also known as the "Human Rights Forum") and Zimbabwe Association of Doctors for Human Rights (ZADHR) are amongst others operating in Zimbabwe, though not specifically addressing MSM issues.

In 2008, it was hoped that with the Government of National Unity, and with a number of people in parliament who are gay-friendly. This could be an opportunity to engage with the government on issues affecting marginalised groups such as GALZ and ensure that government supports our call for specific mention of sexual orientation in Zimbabwe's next constitution.

#### 11. HIV prevalence/incidence data for MSM and general population

MSM specific data is lacking, however, the UNAIDS reports that the HIV/AIDS prevalence rates among adults between the age of 15 and 49 has been reduced to 24.6 percent. The most recent estimates suggest that between 3,000 and 3,500 die every week from HIV-related diseases although some people believe the numbers are significantly higher (Richard Tren et al) [8]. Reports of reductions in prevalence could be due to increased migration of young sexually active people out of Zimbabwe as well as men reporting fewer sexual partners. With high unemployment and dramatically increased levels of poverty, epidemiologists report that on average men have fewer sexual partners and are not sustaining extra martial relationships.

Efforts to prevent the spread of HIV in Zimbabwe have been spearheaded by the NAC, non-governmental, religious and academic organisations. Prevention schemes have been significantly expanded since the turn of the millennium, but remain critically under-funded. In addition to the impact of mortality, it is believed prevention programmes aimed at behaviour

change and the prevention of mother to child transmission have also been instrumental in bringing about a decline in HIV prevalence.

According to the Zimbabwe National HIV and Aids Strategic Plan 2006-2010 the previous framework highlighted the needs of specific groups at high risk, such as young People, sex workers, and prisoners. Recent reviews have further stressed the particular vulnerability of married women, orphans, the disabled and mobile populations. Mobile populations in Zimbabwe include sex workers, cross-border traders, uniformed personnel (soldiers, police, game rangers, and the militia, customs and immigration officials), truck drivers, the internally displaced and the farming community. The vulnerability and risk factors of mobile populations are caused by long periods of separation from regular partners and social settings, which may result in casual and commercial sex and/or irregular access to HIV prevention and care services.

Other groups that have been identified as particularly vulnerable to infection include the disabled (including the mentally challenged), prisoners, illegal immigrants, men who have sex with men (MSM), and survivors of rape and sexual abuse. While the mainstay of prevention efforts will be aimed at unmarried young people and married couples generally, specific programmes will be developed targeting such at-risk and minority groups as young people who start having sexual relations below the age of 17, adolescent orphans and street children, sex workers, injecting drug users (IDU), MSM, prisoners, among others.

Recent estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicate that approximately 1.6 million adults 15 years and older were living with HIV/AIDS in 2005. Despite the severity of the epidemic, prevalence rates in Zimbabwe have begun to show signs of decline, from 22.1 percent prevalence among adults ages 15 to 19 in 2003 to 20.1 percent prevalence in the same age group in 2005. Dr. Peter Piot, head of UNAIDS, said that in Zimbabwe, "The declines in HIV rates have been due to changes in behaviour, including increased use of condoms, people delaying the first time they have sexual intercourse, and people having fewer sexual partners." [16]

Zimbabwe has a generalized HIV/AIDS epidemic with HIV transmitted primarily through heterosexual contact and mother-to-child transmission. High risk groups, including migrant laborers, people in prostitution, girls involved in intergenerational sexual relationships, discordant couples, and members of the uniformed services warrant special attention in the fight against HIV/AIDS. Young adults and women are hardest hit by the epidemic. In 2005, approximately 930,000 women over the age of 14 were estimated to be living with HIV/AIDS in Zimbabwe. [16]

## 12. Is there understanding of specific risk factors for HIV transmission in MSM

Social norms, including stigma associated with HIV/AIDS, excessive alcohol consumption, and a reluctance to talk about HIV status or sexual relations also create barriers to behavior change [16]

HIV and AIDS have plagued homosexuals in Zimbabwe, and many cannot afford antiretroviral drugs. GALZ is one of the few lobby groups in Zimbabwe that has a treatment plan up and running for people with full-blown AIDS. The association intends to have all its registered members take an HIV test. It also distributes posters warning people about the ways in which gays are vulnerable to AIDS. [17]

Zimbabwe continues to suffer a severe socioeconomic and political crisis, including unprecedented rates of inflation and a severe 'brain drain' of Zimbabwe's health care professionals. Elements of a previously well-maintained health care infrastructure are crumbling. Zimbabwe's HIV crisis is exacerbated by chronic food insecurity. Sub-optimal nutrition increases the vulnerability of individuals with compromised immune systems to life-threatening opportunistic infections, such as tuberculosis. Gender inequality and widespread practices of multiple and concurrent sexual relationships, and cross-generational sex, fuel Zimbabwe's epidemic, particularly among youth. [16]

### 13. Current status of prevention, treatment and care for MSM

The Zimbabwe National AIDS Council has tried to deny MSM people exist due to homophobia and the criminal status of sodomy. However, the National AIDS Council Strategic Plan for 2006-10 mentions MSM, as urged by GALZ, and describes the risks of continued criminalization that can only drive this group underground and isolated them from HIV education and care. After 18 years the GALZ has made numerous calculated connections within the government health ministry, at lower political levels, that enable them to express some influence in HIV policy. Additional funding for this work has come from UNDP this past year.

Another project of GALZ is the 'Positive Image Scheme' that has provided access to care for HIV infected members by ensuring that HIV positive members have affordable access to health care including anti-retro-viral medications. But with soaring costs and the increased number of people, and it has become difficult to sustain the program. [2]

### 14. MSM related UNGASS indicators

Zimbabwe did not report against any of the UNGASS indicators relating to MSM. [8]

### 15. Perceived cultural and structural barriers to adequate prevention, treatment and care for MSM

With an unemployment rate of over 95 percent, Zimbabwe is suffering from a severe lack of human resources. In many cases this problem is a direct result of the HIV epidemic, as workers are either caring for family members with AIDS or suffering from it themselves. In the healthcare sector, the deficiency of workers has hindered efforts to treat and care for people living with HIV. Estimates suggest there is only one doctor for every 12,000 people, and in the public sector there are no functioning critical care beds. Additionally, large numbers of health personnel migrate to other countries once they are trained, and many of those who remain in the country are affected by HIV themselves. [8]

Not all MSM access HIV and AIDS prevention, care and management information as there is a large underground network of MSM. Double disclosure of one's sexuality and HIV status is such a challenge MSM are dying in silence [11]

NGOs working with HIV and AIDS are not including information and researches on MSM and WSW. Most of the information is heterosexualised and may not be relevant for MSM/WSW [11]

Human rights groups dismiss LGBTI issues on the grounds that Zimbabwe has no consensus on the issue of Homosexuality and the President is against it. Homophobia among the subordinates in some institutions also affects delivering of services to people who identify as

gay bisexual or other [11]

#### 16. Whether and how MSM are included in National Strategic Plans

The Zimbabwe National AIDS Council has tried to deny MSM people exist due to homophobia and the criminal status of sodomy. However, the National AIDS Council Strategic Plan for 2006-10 mentions MSM.

However, just when Gays and Lesbians of Zimbabwe (*GALZ*) celebrated what it thought was a breakthrough for men who have sex with men (*MSM*) in that country-the inclusion of MSM in the National HIV and Aids Strategic Plan (*ZNASP*) 2006-2010-Zimbabwe National Aids Council (*NAC*) denied that it plans to intervene in this regard. [14]

#### 17. Whether is there an infrastructure present that can be used for the delivery of adequate HIV prevention, treatment and care to MSM

*GALZ* is one of the few organizations focusing on MSM and has outreach buddy groups each with five men and five women who are trained in health education to visit members in their home areas. The staff engages with them in casual conversation about health and sexuality issues such as HIV prevention and testing, condom usage and STI treatments. Free condoms are provided through UNAIDS and the Zimbabwe Family Planning Association.

Zimbabwe's population is now approximately 9 million, and nearly a quarter of its population is HIV-positive. Zimbabwe receives the lowest donor support for people living with HIV in the southern region of Africa, just \$4 per person per year, while neighboring countries such as Zambia receive as much as \$184 per person per year. Even as development assistance programs focus on driving down costs for HIV tests and antiretroviral (ARV) drugs to treat HIV-positive individuals, research suggests that people don't always appear to use health technologies to their maximum benefit. [7]

Zimbabwe continues to suffer a severe socioeconomic and political crisis, including unprecedented rates of inflation and a severe 'brain drain' of Zimbabwe's health care professionals. Elements of a previously well-maintained health care infrastructure are crumbling. Zimbabwe's HIV crisis is exacerbated by chronic food insecurity. Sub-optimal nutrition increases the vulnerability of individuals with compromised immune systems to life-threatening opportunistic infections, such as tuberculosis. Gender inequality and widespread practices of multiple and concurrent sexual relationships, and cross-generational sex, fuel Zimbabwe's epidemic, particularly among youth. Social norms, including stigma associated with HIV/AIDS, excessive alcohol consumption, and a reluctance to talk about HIV status or sexual relations also create barriers to behavior change. [16]

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