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Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic

Regional analysis report

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Acronyms

AmFAR	American Foundation for AIDS Research
ART	Antiretroviral therapy or treatment
ARV	Antiretroviral
BSS	Behavioral Surveillance Survey
CBO	Community-based organization
CIS	Commonwealth of Independent States
COC Netherlands	<i>Cultuur en Ontspannings-Centrum</i> (Centre for Culture and Leisure)
CSW	Commercial sex workers
E&E countries	Europe & Eurasia countries*
GFATM	The Global Fund to fight AIDS, Malaria and Tuberculosis
HIV	Human immunodeficiency virus
HSS	HIV Sentinel Surveillance
ICF	International Charitable Foundation
IDU	injecting drug user
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
LGBT	lesbians, gays, bisexuals and transgender people
M&E	monitoring and evaluation
MOH	Ministry of Health
MSM	Men who have sex with men
MSW	male sex workers, who provide commercial sex services
NAP	National AIDS Program
NGO	non-governmental organization
NSP	National Strategic Plan
PLHA /PLHIV	People living with AIDS/People living with HIV
PLWHA	People living with HIV/AIDS)
RDS	Respondent driven sampling
STI	Sexually transmitted infections.
TLS	Time location sampling
TG	Transgender
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WSW	Women having sex with women

**For UNAIDS, the Eastern Europe and Central Asia region includes Armenia, Belarus, Bulgaria, Estonia, Kazakhstan, Latvia, Republic of Moldova, Russian Federation, Ukraine, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, Kyrgyzstan, Lithuania, Romania, Tajikistan, and Uzbekistan. They are considered together because of their physical proximity and their common epidemiological characteristics. In this report, "Men having sex with men in Eastern Europe," countries covered include countries within USAID's Bureau for Europe and Eurasia in Washington DC: Armenia, Albania, Azerbaijan, Belarus, Georgia, Moldova, Russian Federation and Ukraine.*

Executive summary and key findings

Men having sex with men and transgender people are recognized as key vulnerable groups in the context of concentrated HIV epidemics in Eastern Europe and Asia.¹ Unfortunately there is no comprehensive data to fully identify the role of this population in the HIV epidemic, and studies by major international AIDS organizations estimate that official studies in these countries underestimate the infected population. For example, according to UNAIDS, “various organizations, including UNAIDS, WHO and the International HIV/AIDS Alliance in Ukraine estimated that in 2006 there were between 177,000 and 430,000 MSM in Ukraine, of whom between 3 and 15 percent lived with HIV, which is several hundred times the figure reflected in the official studies.”²

Available data on MSM in low-income countries show a lifetime occurrence of men having sex with men as 6% to 15% in Eastern Europe, compared with 3% to 5% in East Asian countries, 6% to 12% in South and Southeast Asia, and 6% to 20% in Latin America. Approximately half of these men had sex with another man in the previous year, and among these, 40% to 60% engaged in unprotected anal sex or commercial sex in all these regions except South Asia (where figures were higher).³

Consensus among an expanding group of stakeholders is that significant risk and HIV infection among MSM is likely in Eastern Europe & Eurasia. WHO’s technical consultation in 2008 concluded that in Eastern and Central Europe, “among MSM, preventive behavior is minimal, knowledge is poor and HIV prevalence is high and rising.”⁴ This is reinforced by local examples of evidence that, while raising the issue of the need for further investigation, are worrying:

In Russia, Population Services International’s 2006 survey of nearly 3,700 MSM indicated that only 31% of those in a monogamous relationship always used condoms, and just 61% of those with non-monogamous sexual partners always used condoms. Less than half considered taking care of their sexual health to be a priority.⁵ Armenia’s main NGO for MSM has assessed behavior and attitudes; one survey found two-thirds of MSM had unprotected anal intercourse during their last sexual encounter. Another survey found only about half of younger Armenian MSM (18–30 years old) identified unprotected sex as a transmission route for HIV, although 82% identified injecting drug use as a transmission risk.⁶

Epidemiological, behavioral, and attitudinal indicators from these survey results are reminiscent of the early days of the MSM HIV epidemic in North America and Western Europe. Inappropriate reactions and

¹ UNAIDS Action Framework “Universal Access for the Men who have Sex with Men and Transgender People”/ UNAIDS/09.22E/JC1720E

² ‘Hidden HIV epidemic amongst MSM in Eastern Europe and Central Asia’, UNAIDS (January 2009), (http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090126_MSMUkraine.asp accessed 17 July 2009).

³ C Careres, et al. ‘Estimating the number of men who have sex with men in low and middle income countries.’ *Sexually Transmitted Infections* 2006; 82 (Supplement 3): iii3-iii9.

⁴ World Health Organization (2008), op.cit.

⁵ Russian Federation (2006): HIV/AIDS TRaC Study among Men who have Sex with Men. Population Services International (2006).

⁶ ‘MSM’s attitude towards HIV infected people in Armenia’. We For Civil Equality (Armenia). (<http://wfce.am/index.html>, accessed July 17 2009).

a lack of prevention in local populations led to a 20% annual incidence of HIV infections being reported, resulting in up to 50% prevalence among MSM in some US cities.⁷ This was accompanied by — with a few notable exceptions — strong resistance of public officials to address a health issue among gay men.

Despite the fact that MSM programs exist to a certain extent in most E&E countries, there is a lack of political will and a common strategy for the development of such programs at regional and national levels. Without a systematic approach at both levels, funding and technical support provided by GFATM and USAID for MSM targeted programs will not have a significant impact on the epidemic among MSM.

The AIDSTAR-Two project conducted an assessment of eight selected Eastern European countries – Albania, Azerbaijan, Armenia, Georgia, Russian Federation, Belarus, Moldova and Ukraine – to identify gaps in data and the needs for development of programs for MSM. The assessment included a review of existing surveillance and other data, and studies on HIV prevalence and risks of HIV-infection in the MSM community, including political documents, and best practices informing responses to the epidemic among this group. The eight countries that were included have active support from USAID missions to public health programs, in order to support networking and collaboration in the development of a regional strategy. Following the data aggregation process, a workshop was held to discuss assessment findings and formulate recommendations. The findings of these assessments are contained within this report, “Men having sex with men in Eastern Europe: implications of a hidden epidemic.”

Following is a summary of the key findings:

Key findings

1. Homosexual male behavior is largely decriminalized in Eastern Europe. However, according to the assessment, homosexuality is not socially acceptable. The resulting stigmatization of MSM is the largest barrier to developing HIV response programs for this population. Given the high stigma against MSM in the region, the access to this group is extremely challenging, which negatively influences development of HIV prevention and care programs for this target group.
2. In the region, there is a lack of population research and size estimations for MSM. Existing population descriptions are not systematic and use methodologies that are not standardized and sometimes unclear. There is a strong need for national MSM population size estimation research as well as national behavior surveillance surveys to be conducted at regular intervals (at least once every four years). It is important to define (in line with UNAIDS and international technical support providers) a common regional methodology for such surveys, as well as for surveys of the MSM sub-groups and sub-populations.
3. According to routine epidemiological data and sentinel surveillance of Eastern European concentrated HIV epidemics, MSM populations take third or fourth place as the main driving force of the epidemic, after injecting drug users, female sex workers and prison populations. However, with no consistent or accurate reporting, official figures underestimate the numbers of MSM living with and acquiring HIV infection.
4. HIV and STI epidemics among MSM in Eastern Europe are being driven by comparatively high numbers of male and female sex partners and low rates of consistent condom use. Among

⁷ Cited by Grulich A. ‘HIV risk behavior in gay men: on the rise? Monitoring risk behavior and incidence of infection is essential.’ BMJ 2000, 320: 1487-1488.

specific behavioral risk factors several should be listed: low level of the condom use with incident partners; in some countries, high levels of injecting drug usage among MSM (more than 9% in Georgia, 12% in Azerbaijan), especially in the Caucasus region; high levels of MSM having regular sex with female partners and having sex with commercial partners.

5. A comprehensive approach to HIV and sexual health among MSM includes foundational activities to create an enabling environment, supportive interventions needed for the effective operation of the prevention and care package (e.g. capacity building of NGOs and CBOs), and a complete prevention and care package. Current MSM programming in Eastern Europe includes pilot and short term programs for delivering prevention services, and much less emphasis is placed on creating an enabling environment, providing supportive interventions, and providing treatment and care for MSM.
6. MSM are now considered one of the key populations at higher risk of HIV in the prevention strategies of national programs in most of the assessment countries. They are also included in the national goals for scaling up towards universal access to HIV prevention, treatment, care and support for groups at high risk of HIV. The level of prioritization for this group, however, is low in all countries. Commitments to MSM programming in national strategic plans have generally not resulted in any level of state funding. For external and international donors, MSM are generally accorded a lower priority than the other key populations at risk of HIV (IDUs, FSWs, imprisoned population). National responses to HIV need to effectively respond to all key populations to bring HIV epidemics under control.
7. Funding and coverage levels for MSM prevention programs are low and insufficient to halt HIV epidemics in this population. This political commitment has been only partly supported by resources for program development. There are no state-funded HIV prevention programs for MSM in the assessed Eastern European countries. HIV prevention activities are mostly carried out by NGOs with financial backing from international donors, with the main funding sources for MSM programs being the GFATM, with some additional funding provided by USAID (Ukraine, Georgia) and COC Netherlands in cooperation with ILGA-Europe. The scale and scope of prevention services for MSM have improved, but remain significantly inadequate to make a sustainable impact on behavior and reduce HIV transmission among MSM. No MSM programs are large enough to be considered at scale, and most could be classified as small scale boutique or pilot projects. Insufficient government commitment to provide resources, support and services for MSM and address legal, financial and administrative barriers to MSM's access to services, indicates that governments throughout the region are still not fully prepared to address the HIV epidemic among MSM.

Reviews and evaluations of MSM programs are uncommon. There is insufficient available data to come to conclusions regarding the quality of MSM prevention programs, although most key informants are of the view that there is room for significant improvement.

8. Since 2004, LGBT community activists have begun more professional HIV advocacy and response work in Ukraine, the Russian Federation, Belarus, Moldova and Caucasus countries. LGBT community mobilization and empowerment was supported by a regional COC program and partly by USAID funds for civil society development, as well as by the GFATM in the framework of prevention activities. However LGBT/MSM groups are severely under resourced and have capacity gaps that make it difficult for them to manage and implement large scale projects.

There are no national or regional mechanisms for MSM projects and organizations to meet, discuss and form strategies on best practice approaches to HIV.

9. A summary of existing program gaps and needs of the MSM population in the selected Eastern European countries reveals key problematic areas common to most countries. The most urgent findings can be structured as follows, in accordance to the Action Framework⁸ suggested by UNAIDS globally:
 - i. The human rights situation for MSM and TG people as the cornerstone to an effective response to HIV:
 - There are extremely high levels of stigma and discrimination against MSM in the region. Despite the fact that most countries have signed the European Covenant on Human Rights there is no protection for MSM as anti-discrimination legislation does not exist (except in Albania), and recourse to the courts is not possible in cases of human rights violations.
 - Significant levels of discrimination occur in health care settings, making accessing services even more difficult for MSM.
 - Stigma and discrimination in the region make it extremely difficult for MSM to organize and form groups and as a result very few groups exist, particularly outside of the capital cities. Where MSM and LGBT organizations do exist, they are severely under-resourced and lack the capacity to design and implement large scale HIV projects.
 - ii. The evidence base on MSM, TG people and HIV:
 - There are significant gaps in data relating to MSM in the region. There are no consistent way in which MSM are defined or reported on in sentinel or surveillance data, meaning that MSM size estimation is ill defined and unreliable. As a result, there is significant under-reporting of HIV prevalence amongst MSM.
 - iii. Capacity building and partnerships to ensure broader and better responses for men who have sex with men, transgender people and HIV:
 - No state resources are allocated to support programs targeting MSM. The only resources available have come from international agencies. With only limited resources, projects cannot move beyond small scale boutique or pilot projects.
 - Projects that do exist focus exclusively on prevention for MSM, and there are no MSM+ prevention, care or support programs.
 - There is no consensus at either the regional or national level as to what should constitute a comprehensive package of services for MSM, nor a clear definition of what those services actually are.

⁸ UNAIDS Action Framework “Universal Access for Men who have Sex with Men and Transgender People”/
UNAIDS/09.22E/JC1720E

- MSM have very few opportunities to network and exchange ideas/issues at either the country or regional level. This has led to programs developing in isolation of each other with inconsistencies in their approaches and interventions.

Key Recommendations

Despite the challenges, an appropriate combination of action and investment by all relevant stakeholders can make a dramatic difference in HIV prevention, treatment, care and support. Indeed, many of the earliest and most dramatic HIV prevention successes around the world involved men who have sex with men.⁹ Most activities for MSM conducted by local CBOs and NGOs in the selected countries last year had no support from the state or local authorities, nor were MSM even mentioned as a vulnerable group in these countries' National AIDS programs (NAP); instead, programs were implemented thanks to the support from GFATM programs on prevention among MSM. Based on the data collected in the assessment and the gaps identified during the workshop conducted with research team and regional experts, there appear to be three main objectives on which international donors, national governments, LGBT networks and NGOs working in HIV prevention should focus to improve programming for MSM and thus have an impact on the epidemic:

Objective 1: Improve the human rights situation for MSM and TG people, as the cornerstone to an effective response to HIV

- Further research is needed into the types/depth of stigma and discrimination that MSM face in the region.
- MSM/LGBT organizations need advocacy skills to assist them in their efforts to challenge and change laws and attitudes.
- Specific interventions need to be developed to address discrimination against MSM and TG people by Health Care Workers

Objective 2: Strengthen and promote the evidence base on MSM, TG people and HIV

- A comprehensive and consistent regional approach to MSM size estimation needs to be developed and implemented
- A comprehensive and consistent approach to MSM data collection through sentinel and other surveillance mechanisms needs to be developed and implemented

Objective 3: Strengthen capacity and promote partnerships to ensure broader and better responses for MSM, TG people and HIV

- High-level intervention from UNAIDS, USAID, GFATM is needed to convince governments to commit funding to MSM-focused HIV programs.
- A comprehensive package of services for MSM needs to be developed that is adopted as standard practice in the region. This package should include specific programs/support for HIV positive MSM.

⁹ Merson H M et al. "The history and challenge of HIV prevention," The Lancet, HIV Prevention, August 2008, pp. 7–20.

- Capacity assessments need to be conducted and subsequent capacity building plans developed and implemented for the MSM groups that currently exist in the region.
- A mapping exercise of where groups exist in the region and where gaps exist is needed
- Opportunities need to be created for MSM groups to meet and discuss priority issues/strategies at both the national and regional level.

All recommendations discussed during the regional workshop were divided by potential key implementing agencies or responsible national/regional and local authorities. Recommendations were also divided by activities that could be achieved in the short-term, medium-term and long-term. Using this type of analysis, it appeared that most of the service recommendations should be addressed at the country and organizational level. There were also several regional level activities which could be addressed by regional technical support agencies and bilateral donor-supported programs.

The following priorities were chosen as the most urgent activities that could be supported and implemented on a regional basis and could be completed in the short to medium term:

- Develop a comprehensive package of services for MSM that is adopted as standard practice in the region. This package should include specific programs/support for HIV positive MSM
- Conduct capacity assessments and develop and implement subsequent capacity building plans for MSM organizations so that they can implement relevant components of the comprehensive package of services.
- Create opportunities for MSM groups to meet and discuss priority issues/strategies at both the national and regional level.

If additional funding is available AIDSTAR Two should also consider:

- Develop a consistent regional approach to MSM size estimation.

Introduction

It is estimated that at least 5.0% to 10.0% of all HIV infections worldwide are due to sexual transmission between men,¹⁰ and that this figure varies considerably within countries and between regions.¹¹ Men who have sex with men (MSM) are not a uniform group of people, nor are they necessarily an isolated social minority. They range from men who maintain conventional masculine identities to transgender (TG) men, those who do not accept their gender and self-identify as women, such as India's Hijras, Indonesia's Waria and Thailand's Katoey. Married men may also engage in male-to-male sex, and MSM may also have sex with women. Many men who sell sex to men have a wife or female partner; others also sell sex to, and buy it from, women. All these sub populations have different behaviors and their use of strategies to reduce risk varies with different sexual partners and situations. Much of the detail and analysis of the elements that contribute to HIV risk for MSM has only recently started to emerge and has immediate policy relevance for the prevention of HIV and sexually transmitted infections.

Male-to-male sex is a major route of HIV transmission in high-income countries, and the emerging data from low- and middle-income countries indicate that men who have sex with men bear a substantial burden of HIV epidemics there as well. A meta-analysis of 83 studies from 38 countries showed that overall, men who have sex with men were at 19 times greater risk of infection with HIV than the general population. The analysis, however, also showed significant variations between countries. In countries with a very low HIV prevalence (below 0.5%), men who have sex with men were 58 times more likely to have HIV. In low prevalence countries (prevalence between 0.5%–1%), the risk was 14 times higher. Men who have sex with men in medium and high prevalence countries (1.1%–5% adult HIV prevalence) were almost ten times more likely than the general population to have HIV¹².

Gender identity and sexual orientation continue to be used as justifications for serious human rights violations around the world. Lesbian, Gay, Bisexual and Transgender (LGBT) people constitute a vulnerable group and continue to fall victims of persecution, discrimination and gross ill-treatment. They are often subject to extreme forms of violence, and in several countries, sexual relations between consenting adults of the same sex are considered criminal and punished with imprisonment or with the death penalty.

The need to recognize MSM as a priority group within HIV responses was highlighted by the United Nations (UN) by Ban Ki-moon, Secretary-General of the UN, in August 2008: "In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to [HIV] prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us."

¹⁰ UNAIDS/WHO AIDS epidemic update. Geneva: UNAIDS; 2007. Available at:

<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>

¹¹ Caceres CF, Konda F, Pecheny M, Chatterjee A, Lyerla R. Estimating the number of men in low and middle income countries. *Sex Trans Infect* 2006;82 (Suppl III):iii3-iii9.

¹² Baral S et al. 2007, 'Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: a systematic review', *PLoS Medicine* Vol. 4, No. 12, e339 doi:10.1371/journal.pmed.0040339.

The Joint United Nations Programme on HIV and AIDS (UNAIDS) Action Framework, “Universal Access for Men who have Sex with Men and Transgender People,” issued in 2009,¹³ notes that ‘business as usual’ is no longer a viable response to the HIV-related risks of MSM and transgender people. Where data exist on HIV within these populations, they show that our collective responses are actually failing far more often than they are reaching scale or succeeding. It is equally disconcerting that, in many parts of the world few reliable data exist at all. The UN Secretary-General’s call of alarm thus comes at a critical moment. It is increasingly clear that commitment and resources allocated to HIV programming for men who have sex with men and transgender people fall far short of what is required to achieve universal access to appropriate HIV prevention, treatment, care and support services across the world. At the June 2008 United Nations General Assembly High-Level Meeting on AIDS, fewer countries reported on the implementation of services for MSM than for any other population at risk of HIV. Furthermore, those reports that were made available, on average reflected lower coverage levels for MSM than for the general population or for other most-at-risk populations.¹⁴

The failure to respond adequately to the human rights and public health needs of MSM and TG is reflected in epidemiological data. Almost universally, even in generalized HIV epidemics, men who have sex with men are more affected by HIV than the general population.¹⁵ Biologically, unprotected receptive anal sex poses a much higher risk than unprotected receptive vaginal sex, whether that anal sex is heterosexual or homosexual.

In addition, people with marginalized sexual or gender identities or behaviors sometimes lack the ability or desire to protect themselves from infection, due to structural factors including self stigmatization, discrimination and lack of access to information and services. In certain studies, HIV prevalence among men who have sex with men has been found to be as high as 25% in Ghana, 30% in Jamaica, 43% in coastal Kenya and 25% in Thailand. Among TG people, HIV prevalence is thought to be even higher. Data presented at the 2008 International AIDS Conference in Mexico showed overall HIV prevalence of over 25% among TG people in three Latin American countries, and prevalence ranging from 10% to 42% in five Asian countries.¹⁶

There is growing recognition that significant under-reporting masks the true picture of male-male sexual transmission of HIV in Eastern European epidemics.¹⁷ The WHO/Europe literature review released at a consultation in 2008, found that more than half of 27 countries in Central and Eastern Europe and Central Asia “had no reliable estimates of HIV prevalence among MSM, while STI data for MSM were nearly nonexistent.”¹⁸

Given the sheer number of people affected by the epidemic – roughly 1.5 million people were living with HIV in Russia, Eastern Europe and Central Asia in 2007 – some experienced stakeholders are increasingly questioning whether emphasis should be placed on risk groups that are usually affected within concentrated HIV epidemics, i.e. MSM as opposed to other groups of at-risk populations. Because of

¹³ UNAIDS Action Framework “Universal Access for Men who have Sex with Men and Transgender People”/ UNAIDS/09.22E/JC1720E

¹⁴ UNGASS 2008 country progress reports.

¹⁵ Baral S et al. 2007, ‘Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: a systematic review’, PLoS Medicine Vol. 4, No. 12, e339 doi:10.1371/journal.pmed.0040339.

¹⁶ Data presented by the International HIV/AIDS Alliance at “The hidden HIV epidemic: a new response to the HIV crisis among transgender people” press conference, 4 August 2008, Mexico City, Mexico.

¹⁷ HIV and other STIs among MSM in the European Region – Report on a consultation. World Health Organization (2008).

¹⁸ Ibid.

the stigmatization of the MSM population by medical doctors and social workers, routine monitoring of the registration of HIV cases does not accurately convey the number of HIV-infections resulting from MSM transmission. Ukraine's official statistics in 2007, for example, attributed only 48 of 18,000 new HIV infections to MSM transmission.

Despite the fact that MSM programs exist to a certain extent in most E&E countries, there is lack of political will and common strategy for the development of such programs at regional and national levels. Without a systematic approach at both levels, funding and technical support provided by GFATM and USAID for MSM targeted programs will not have a significant impact on the epidemic among MSM.

The AIDSTAR-Two project conducted an assessment of eight selected Eastern European countries – Albania, Azerbaijan, Armenia, Georgia, Russian Federation, Belarus, Moldova and Ukraine – to identify gaps in data and the needs for development of programs for MSM. The assessment included a review of existing surveillance and other data, and studies on HIV prevalence and risks of HIV-infection in the MSM community, including political documents, and best practices informing responses to the epidemic among this group. The country assessments also included interviews with key stakeholders. For the assessment of the situation in Ukraine, existing International HIV/AIDS Alliance documents and information sources were used without conducting additional interviews. The eight countries that were selected have active support from USAID missions to public health programs, in order to support networking and collaboration in the development of a regional strategy.

Methodology of assessment

Aim of the assessment

The objective was to conduct an assessment of existing surveillance and other data, studies in HIV prevalence and risks of HIV infection in the MSM community, existing political documents and best practices of the epidemic response among this group in eight selected Eastern European countries – Albania, Azerbaijan, Armenia, Georgia, Russian Federation, Belarus, Moldova and Ukraine – to identify gaps in data and the needs for development of programs for MSM. The assessment was performed in three main steps:

1. Development of methodology during a workshop with local experts and International HIV/AIDS Alliance (Secretariat) staff, September 2009.
2. Country data collection by consultants with coordination from ICF “International HIV/AIDS Alliance in Ukraine,” February–April 2010.
3. Assessment team meeting for finalization of key findings and recommendations, May 2010.

Objectives of the assessment

1. To provide detailed information on the HIV epidemics and responses among MSM in the selected countries to support further country-level planning of the response. The supplied information will also be instrumental in the development of country funding proposals to the GFATM and other bilateral and international donor agencies.
2. To analyze the existing effective practices and approaches in HIV prevention and care for MSM in the region. Identified best practices can be utilized for scale-up and dissemination of promising approaches across the region.

3. To identify and recognize gaps in the existing epidemiological data and programs. These will form the basis for advocacy activities aimed at overcoming data gaps and political barriers, and strengthening and improving national AIDS programs and strategies.
4. To identify needs in capacity building and networking which could be addressed during phase two of the project.

Identified target groups for assessment

The assessment targeted men having sex with men (gay, bisexual, transgender); if possible, female sexual partners of MSM; LGBT in the case of political and advocacy programs.

Analysis timeframe

The assessment was conducted between February and April 2010.

Methodology of data collection

1. Document review

Documents reviewed included national strategic plans, other national policy and programmatic documents, epidemiological data, project and program data and documentation (including coverage, descriptions of existing activities, evaluations and reviews), regional mappings and reviews, and peer review literature available in English, Russian or local languages published or available since 2004. The key focus of the document review was to identify information on the epidemiology of HIV and STIs, existing strategic and policy frameworks, existing and planned HIV and MSM services, including types of services, coverage, quality, lessons learned and financing, information on the efficacy of services, and the range of services that constitute a comprehensive approach. A reference list is at Annex 7.

2. Mapping

Information for mapping was obtained from the document review and key informant interviews. The purpose of the mapping was to identify current activities addressing HIV epidemics among MSM in order to identify gaps (geographic, programmatic and efficacy) in existing work when compared to a comprehensive approach.

3. Key informant interviews

Interviews were conducted with national stakeholders and specialists: USAID country missions; UNAIDS experts (social mobilization coordinator, M&E officer or head of the Country Office); representatives of the Country Coordination Mechanism or National Coordination Council (commitment, funding and response); representatives of key program implementers; other experts including community based organizations (CBOs) formed by MSM. Interviews had a strong focus on addressing the analytical aspects of this work in areas such as the extent of government commitment, the enabling environment, and the role of government in coordinating MSM programs, quality, efficacy, key gaps, and strategic priorities.

The situational assessment in Ukraine was conducted by IHAA staff based on existing data sources without conducting additional interviews.

4. Analysis

Following completion of the document review and key informant interviews an analysis of all information was undertaken to develop key findings and recommendations. The unified information structuring format for data analysis by countries was used (see the table on the following page).

Structure of data collected in countries:

1. Description of prevalence and risks of HIV infection in the MSM community:

- 1.1. Definition of the population
- 1.2. Social characteristics of the population
- 1.3. Risk factors of HIV infection
- 1.4. Epidemiological situation – HIV and STI prevalence
- 1.5. Group stigmatization

2. Epidemic response in the MSM community:

- 2.1. National commitments and official documents
- 2.2. Resource analysis
- 2.3. Existing HIV response programs and projects:
 - 1) HIV/STI prevention
 - 2) Care and support for PLHA-MSM
 - 3) Social and psychological support for homosexual men (community centers, work with parents, coming out, self-help groups, legal support)
 - 4) Advocacy, rights protection, stigma and discrimination
 - 5) Research, training and method guidance publications
 - 6) Mobilization, organization development, capacity building, leadership

3. Program gaps and recommended steps to improve services.

Analysis of regional findings

Eastern European countries have experienced major political, economic and social changes associated with declines in health and life expectancy, as well as growth in informal economies, including drugs and the sex trade, since the collapse of the Soviet Union in 1989.¹⁹ These transitions have been associated with the rapid increase of HIV epidemics in all parts of Eastern Europe.²⁰

HIV in the region is predominantly spread through the sharing of injection equipment and sexual contact with infected people who inject drugs.²¹ Data on other modes of transmission, such as male- to-male sex are limited. There is a growing, but limited, body of literature suggesting that men who have sex with men (MSM) form a population that is at risk of HIV and other sexually transmitted infections in Eastern Europe.²²

The following section provides an analysis of HIV prevalence, risk behavior and HIV-response programs for MSM in the selected eight countries of Eastern Europe. The assessment could not give a full regional picture for several reasons. According to their social, geographical and economic background, the eight selected countries belong to at least two different regions: Balkan countries (Albania) and post-Soviet countries.

Within the group of post-Soviet countries, there are deep cultural and social differences affecting the HIV-response:

- **regional differences** (the Caucasus region has specific social systems and attitudes which differ from those of Eastern European post-Soviet countries like Ukraine, Moldova and Belarus);
- **the influence of religion and traditions on behavior** (these are stronger in Azerbaijan, but less significant in Ukraine or the Russian Federation).

These factors influence the programs analyzed, as well as the political and social attitudes toward MSM as a group most at risk of HIV infection.

¹⁹ DeBell, D., & Carter, R. (2005). The impact of transition on public health in Ukraine: A case study of the HIV/AIDS epidemic. *British Medical Journal*, 331, 216–219; Hamers, F. F., & Downs, A. M. (2003). HIV in Central and Eastern Europe. *Lancet*, 361, 1035–1044; Rhodes, T., Ball, A., Stimson, G., Kobyschka, Y., Fitch, C., Pokrovsky, V., et al. (1999). HIV infection associated with drug injecting in the newly independent states, eastern Europe: the social and economic context of epidemics. *Addiction*, 94, 1323–1336; Rhodes, T., Lowndes, C., Judd, A., Mikhailova, L. A., Sarang, A., Rylkov, A., et al. (2002). Explosive spread and high prevalence of HIV infection among injecting drug users in Togliatti City, Russia. *AIDS*, 16(13), F25–F31.; Rhodes, T., Sarang, A., Bobrik, A., Bobkov, E., & Platt, L. (2004). HIV transmission and HIV prevention associated with injecting drug use in the Russian Federation. *International Journal of Drug Policy*, 15, 1–16; Rhodes, T., Stimson, G. V., Crofts, N., Ball, A., Dehne, K., & Khodakevich, L. (1999). Drug injecting, rapid HIV spread, and the ‘risk environment’: Implications for assessment and response. *AIDS*, 13 (Suppl. A), S259– S269.

²⁰ Donoghoe, M. C., Lazarus J. V., & Matic, S. (2005). HIV/AIDS in the transitional countries of Eastern Europe and central Asia. *Clinical Medicine*, 5, 487–490.;

²¹ Aceijas, C., Stimson, G. V., Hickman, M., & Rhodes, T. (2004). Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS*, 18, 2295–303.

²² Amirkhanian, Y. A., Kelly, J. A., Kukharsky, A. A., Borodkina, O. I., Granskaya, J.V., Dyatlov, R.V., et al. (2001). Predictors of AIDS risk behavior among Russian men who have sex with men: An emerging epidemic. *AIDS*, 15, 407–412.; Bozicevic, I., Rode, O., Zidovec-Lepej, S., Johnston, L. G., Stulhofer, A., Dominkovic, Z., et al. (2008). Prevalence of sexually transmitted infections among men who have sex with men in Zagreb, Croatia. *AIDS and Behavior*, 12, 502–512.

1. Description of prevalence and risks of HIV infection in the MSM community

During the reported period, since 2004, in most countries the first surveys were conducted as a component of second generation surveillance of behavior monitoring and HIV prevalence in the homosexual male population group.

1.1. Definition and social characteristics of the population

The behavior-based definition for MSM/LGBT-targeted programs that is mainly used in the region defines MSM as follows: Males (biological sex) who regularly (at least once every 12 months) have sexual relationships with males. In this case sexual contacts mean sexual practices that are characteristic for homosexual relationships: mutual masturbation, oral-genital and anal-genital sex.

In official documents from Azerbaijan this term is mostly avoided, instead using the general expression "vulnerable people."

In countries where qualitative surveys were conducted, a key indicator for population structuring could be defined as "open homosexual identity." The more open the identity, the easier the access of identified sub-populations to HIV/STI prevention programs. For example, in Belarus the following classification was widely used:

- i. Open groups. They identify themselves as gay, bisexual or transgender people. They do not conceal their sexual orientation from their close environment. They regularly visit meeting venues (on the streets, "specialized" clubs, friends etc.), and place their profiles with photos on social websites not only to find sexual partners but also to communicate with like-minded people. This group is easiest to reach with prevention interventions.
- ii. Semi-open group. More numerous than the previous group. The majority of its members identify themselves as gay, bisexual or transgender people. They reveal their sexual orientation only to a limited number of people, who in rare cases include parents and close relatives. Sometimes they visit meeting venues (on the streets, "specialized" clubs, friends etc.), and place their profiles (usually without photos) on websites as a rule to find a sexual partner. Typically they build Male+Male (M+M) couples. Sometimes they have fictitious heterosexual families. This group can be reached by peer educators.
- iii. Closed group. There was no specific research on this group, but using data from focus group discussions and expert interviews, we could assume that this group is the most numerous group of MSM. As a rule, they do not identify themselves as gay, bisexual or transgender. They conceal their sexual orientation from their close environment. They may visit street meeting venues to find a one-time sexual contact. They do not communicate with other MSM communities. They place announcements on websites ostensibly to find a heterosexual partner, but offer sexual contacts to other men. They may have one permanent partner from the same group, if he has a family and does not evoke suspicion about his sexual orientation among other people. Most of them have heterosexual families. Sometimes they engage in sexual relationships against their will (patronage relations in the work place, within closed male-only collectives, etc.). This is the most hard-to-reach group for HIV/AIDS/STI prevention.

Other criteria for classification of MSM populations are used in other countries: by social-economic status (in Georgia, for example: 1 – people in cruising areas who sell sex, 2 – people who have a job and

meet in nightclubs, 3 – top business, buying sex); by age group; by involvement in prostitution; by meeting places (in Armenia, for example: cruising areas, bars, Internet). Estimates of the share of each defined sub-population on a scientific basis, however, were not done in any country.

A general statement of the age structure of the MSM population is possible only after a representative national study. In all countries, the surveys could only give the age structure of the sample, which mostly fell between 20–40 years old, but not of the overall population. Older age groups (over age 45) in all countries examined in this report have limited representation in the surveys.

The only available data of the population size estimation are shown in Table 1 below, where it is possible to see the percentages of the male population used for MSM population estimates from 1.3% (Ukraine 2005 and 2009), to 2 % in Belarus and Armenia, and up to 2.5% or 4% in the Russian Federation, using two different estimates. In most publications, the estimated numbers only quote the source of an expert’s opinion (UNAIDS or AIDS Centers) without giving clear definitions of the methodology used to make these estimations. The only methodological publication on size estimation of MSM available is the report of the estimations done in Ukraine.²³

Table 1. MSM size estimation data from selected countries

Country	General population of the country	% of male population used for MSM population estimates	MSM population size
Albania	3,190,000	No data available	3,500 (only in Tirana)
Armenia	3,002,000	2%	13,500 (UNAIDS)
Azerbaijan	8,467,000	No data available	No data available
Belarus	9,689,000	2%	70,000
Georgia	4,395,000	No data available	No data available
Moldova	3,794,000	No data available	No data available
Russian Federation	141,927,296	2.5%	1,350,000–3,400,000
		4%	2,100,000 (Federal AIDS center)
Ukraine	46,205,000	1.3%	95,000–213,000

²³ Analytical report on Estimation of the Size of Populations at Risk for HIV (IDUs, WCs, MSMs)/ Balakireva O., Dovbakh G., Husak L., Salyuk T. and others - Kiev, International HIV/AIDS Alliance in Ukraine, 2005

Key finding

There is a lack of MSM population research and size estimation in the region. Existing population descriptions are not systematic and do not use a standardized or clear methodology. This suggests that there is a strong need to research national MSM population size estimation regularly (at least once every four years). It is important to define (in line with UNAIDS and international technical support providers) a common regional methodology for such surveys as well as for surveys of the MSM sub-groups and sub-populations.

1.2 Group stigma and legal environment

Stigmatization and discrimination toward MSM was named in all interviews as the most crucial barrier to social program development involving this target group.

There has been no criminal prosecution for homosexual behavior in the selected countries. However, homosexuality is not socially acceptable and men who have sex with men tend to gather in small circles, rarely exhibiting their sexual orientation outside their peer groups. Due to social stigma, there is no single stereotype of a typical MSM, and the MSM population can be difficult to identify: some members are married or do not identify themselves as gay, and many do not inform their families of their sexual orientation. Sex is often limited to small, insular groups, which increases the risk of HIV infection of the group as a whole. Isolation of MSM hinders their access to health and social services and makes it difficult for them to receive information and improve their awareness, thus increasing their risk of contracting HIV and other STIs.

In most of the selected countries there have been no specific surveys measuring stigmatization of the MSM population by the general public. In Belarus, nearly 12% of MSM reported facing serious stigma. A 2007 survey conducted in Ukraine at the behest of Nash Mir Center, using the Bogardus scale, found that only 15–17% of the general population treat gays and lesbians as ordinary individuals and do not have any stereotypes and preconceptions concerning them. Also in Ukraine, interviews conducted by GfK Ukraine showed that in a number of cities, attitudes towards different ethnic and religious minorities were significantly more tolerant than those towards gay people.

Over the last three years, well-established homophobic movements (religious, traditional or fascist) have actively prejudiced public opinion toward MSM in all countries assessed. In Armenia and Azerbaijan, even on the level of HIV-response stakeholders, prevention programs among MSM are designated “prevention among vulnerable youth” interventions to avoid police interest and public abuse.

Key finding

Homosexual male behavior is largely decriminalized in Eastern Europe. However, according to the assessment, homosexuality is not socially acceptable. The resulting stigmatization of men who have sex with men is the largest barrier to developing HIV response programs for this population.

1.3. Epidemiological situation – HIV and STI Prevalence

Experts interviewed from all the countries considered that routine HIV surveillance, due to several factors, could not provide a good basis in defining the role of MSM in the HIV epidemic. The official routine data shows extremely low levels of HIV-positive people registered by the Ministry of Health (MoH) in each country. Experts interviewed indicated that the surveillance data collection tools and stigmatization of MSM as a group are key factors in dissuading MSM to report this route of transmission in the AIDS center during registration.

Information on the prevalence of HIV among MSM in the selected countries is available only for the last three years, when the first sentinel surveillance surveys were conducted (see table 2). Unfortunately, for most of the assessment countries there are no data for analyzing prevalence dynamics. HIV prevalence rates among MSM identified by these studies include: Ukraine, 8.6% (2009); Moldova, 4.8% (2008); Georgia, 3.7% (2008); Russian Federation, 3.5% (2007); Belarus, 3.1% (2008) and 2.1% (2009); Armenia, 2% (2007); Azerbaijan 1.1% (2008); and Albania, less than 1% (2007).

STI prevalence rates are higher than HIV prevalence rates among MSM, ranging from 4 to 41% in Moldova, Russian Federation, Georgia and Belarus. STI prevalence is an indicator of risky sexual behavior. The highest data for Syphilis prevalence was found in Belarus (41%) and Georgia (31.4%). Collected data shows high risk of STI infections, including Hepatitis B (HBV) and Hepatitis C (HCV) among MSM in the E&E countries. While there is no specific regional data that links STI prevalence to HIV prevalence, we can assume from other global research that high rates of STI are associated with higher rates of HIV.

Table 2. Data on HIV/STI prevalence among MSM

Country	Prevalence of infections (%)			
	HIV	Syphilis	HBV	HCV
Albania	0.8	0.6	15	
Armenia	2			
Azerbaijan	1.1	High prevalence, 12 out of 15 MSW.		
Belarus	2.1±0.7	41% for any STI		
Georgia	3.7	31.4	10	15
Moldova	4.8	8	4	14
Russian Federation	3.5	9% (5-23%)		
Ukraine	8.6			

The available data on the dynamics of HIV prevalence among MSM in the region are shown in Table 3, below. Unfortunately, this is not sufficient to give a basis for comparison. Data from Belarus on the prevalence rate among MSM has shown a significant increase from 0.2% in 2006 to 3.1% in 2008 and 2.1% in 2009. Data from Moldova shows the same tendency, with significant growth from 1.7% in 2003 to 2.4% in 2006 and 4.8% in 2008. Sample for routine surveillance as well as behavioral sentinel surveillance (BSS) in selected countries is rather low, so this data may indicate the tendency of a significant HIV epidemic among MSM in this region.

Table 3. The dynamics of HIV prevalence among MSM in the region.

Country	HIV prevalence (%)						
	2003	2004	2005	2006	2007	2008	2009
Albania	-	-	-	-	0.8	-	-
Armenia	-	-	-	-	2	-	-
Azerbaijan	-	-	-	-	-	1.1	-
Belarus	-	-	-	0.2	-	3.1	2.1
Georgia	-	-	-	-	-	3.7	-
Moldova	1.7	-	-	2.4	-	4.8	-
Russian Federation	-	-	-	-	3.5	-	-
Ukraine					4.4 (4-23.2)	10.6	8.6

The data shows the highest level of prevalence in Ukraine, because several large scale behavior and surveillance surveys were conducted in 2004, 2006, 2007 and 2009, and during these years, the population became more open to and transparent about biodata collection. In 2009, the sentinel surveillance data shows the HIV prevalence at 8.6%, but official registration of HIV cases reports only 0.5% prevalence (94 MSM out of 19,840 people registered as HIV positive in the country).²⁴

A study published in 2007 entitled “The Elevated Risk for HIV Infection among MSM in Low and Middle Income Countries 2000-2006: A Systematic Review”²⁵ shows the lowest level of HIV prevalence among

²⁴ UKRAINE. National Report on Monitoring Progress towards The UNGASS Declaration Of Commitment On HIV/Aids. Reporting period: January 2008–December 2009. Kyiv 2010

²⁵ Baral et al, 2007, PLOS Medicine, Dec. 1, 2007

MSM in the E&E region, as compared with other regions which include low and middle income countries (see Table 4). For example, data on the concentrated epidemic among MSM seems far more developed in the Asia Pacific region.

As discussed during the Regional Consensus Meeting on Developing a Comprehensive Package of Services to Reduce HIV among MSM and TG Populations in Asia Pacific, held June 29-July 1, 2009, highly concentrated and severe HIV epidemics among MSM in urban areas across the region are already well documented, showing the following prevalence rates for Bangkok, 30.7%; Mumbai, 9.6%; and Beijing, 5.8%. These figures are much higher than those produced in the analysis of Eastern European regions. It is likely, however, that the available data on prevalence rates for regions in Eastern Europe is significantly lower than in other regions because of the later start of HIV epidemics in E&E countries, and a lack of quality surveillance data for the review.

Table 4. The Systematic Review of HIV among MSM in Low and Middle Income Countries.²⁶

	Number of Countries	Odds Ratios	95% Confidence Interval
Region			
Americas	15	33.3	32.3-34.2
Asia	7	18.7	17.7-19.7
Eastern Europe	12	1.3	1.06-1.6
Africa	4	3.8	3.3-4.3
Prevalence Level			
Very Low Prevalence Countries	23	58.4	56.3-60.6
Low Prevalence	8	14.1	13.9-14.9
Medium/High Prevalence	7	9.6	9.0-10.2

Key finding

According to routine epidemiological and sentinel surveillance data of Eastern European concentrated HIV epidemics, MSM populations take third or fourth place after injecting drug users, female sex workers and prison populations as the main driving force of the epidemic. However, with no consistent or accurate reporting, it is expected that official figures underestimate the numbers of MSM living with and acquiring HIV infection in Caucasus countries, Moldova, Ukraine, the Russian Federation and elsewhere in the Eastern European region. Since 2004, sentinel surveillance that has included MSM reporting (though inconsistent) has been conducted mainly with support from the GFATM. Data from sentinel surveillance so far shows a significant HIV epidemic among MSM in this region. High levels of STI prevalence indicates that HIV prevalence is also likely to be high, and spreading among this population.

²⁶ Baral. *et al*, 2007, *PLOS Medicine*

1.4. Risk factors for HIV infection

Among key risk factors for HIV and STI infections transmission, the level of condom usage, injecting drug usage and level of knowledge on HIV were analyzed. Risk factors for HIV/STI infection transmission were analyzed in behavior monitoring surveys conducted in all selected countries during recent years. In the selected countries, 60–70% of surveyed MSM have only male sexual partners; 30–40% have both male and female partners. Unfortunately, sampling methods used in different countries as well as the set of questions were not standardized to enable an accurate comparison.

As illustrated in Table 5 below, which shows behavior monitoring data for each country, the level of knowledge of how HIV is transmitted (indicated by the number of people answering correctly four recommended questions from UNAIDS) varies from 24.3% in Georgia, 26.4% in the Russian Federation, 71% percent in Ukraine, and 86% in Albania, to more than 90% in Armenia and Belarus.

Table 5. Level of knowledge of HIV-transmission and safe behavior among MSM

Country	Knowing how HIV is transmitted (UNGASS definition ²⁷)	Using a condom during last anal sexual contact	Injecting drug use
Albania	86%	61%	34% ²⁸
Armenia	92.9%	74.3%	No data available
Azerbaijan	No data available	42.6 %	12%
Belarus	98%	53.6%	2% currently, 12% during the lifetime
Georgia	24.3%	61.7%	9.3%
Moldova	No data available	38%	No data available
Russian Federation	26.38%	78.7%	4%
Ukraine	71%	82.1%	1.3%

A comparatively high level of safe sexual behavior is estimated among MSM respondents from Albania (61% reported using condoms), Georgia (61.7%), Armenia (74.3%), Russian Federation (78.7%) and Ukraine (82.1%). In detailed country reports, it is seen that level of condom usage during last anal sexual contact is correlated with the coverage by prevention programs for MSM in focused countries.

²⁷ Using recommended question from Monitoring the Declaration of Commitment on HIV/AIDS GUIDELINES ON CONSTRUCTION OF CORE INDICATORS, http://data.unaids.org/pub/manual/2009/jc1676_core_indicators_2009_en.pdf

²⁸ This figure caused a lot of doubt in the assessment team, and needs to be further clarified with national Albanian experts.

As the epidemic in Eastern Europe is driven in large part by injecting drug use, in most of the countries there were special questions on this risky behavior of the MSM population. The level of injecting drug use in the countries of the region shows something different. Comparatively low levels of injecting drug use among MSM is seen in Ukraine (1.3% of MSM reported injecting drugs during last six month), in Belarus (2%) and in Russian Federation (4%). Much higher levels of injecting drug behavior are shown among MSM in Caucasus countries: Georgia (9.3%) and Azerbaijan (12%). The only available data from Albania needs additional clarification and research using RDS sampling to verify the data on injecting drug use. Unfortunately, there was no specific research or analysis in the assessed countries on the range of all behavioral risks for HIV transmission among MSM. Existing Behavioral Surveillance Surveys provided some facts which could indicate additional behavioral risks in several countries. There is strong need for the further research in this area. Based on anecdotal evidence from in-country key informants possible behavioral aspects which could be connected with HIV/STI risks are following:

- Internal migration from the countryside to the capital city could create higher risks for bisexual men and MSM without an open homosexual identity (e.g. Azerbaijan, Moldova, Armenia);
- International migration – including both work-related migration and sex trafficking (Albania, Armenia) – could be recognized as an additional risk factor for MSM as a bridging population to other vulnerable groups;
- Alcohol abuse in all countries and having sexual intercourse while intoxicated (in Belarus, for example, 58.2% of MSM have sexual contacts while intoxicated) can possibly lead to high-risk sexual behaviors.

To see the potential influence of the MSM population on the general HIV epidemiological situation in these countries, we suggest using behavioral data on possible bridging to other populations, such as heterosexual women and sex workers as well as their clients. The collected data shows that 21.2 % of MSM respondents had sex with women during the last 12 month in Belarus, 30% in Armenia, 34% in the Russian Federation, 37% in Ukraine, 40% in Albania, 41% in Azerbaijan and more than 47% in Georgia. The percentage of MSM who have sex with commercial sex workers in the region varies from 3 percent in Ukraine to 39 percent in Albania (illustrated in Table 6, on the following page). The wide range of the results for these two behaviors could be connected with differing levels of stigmatization of MSM group and/or ability to access closed subgroups during research.

Table 6. Level of risk of MSM as a bridging population to the general population through sexual contact with women and commercial sex workers during the last six months

Country	Have sex with women	Have sex with commercial sex workers
Albania	40%	39%
Armenia	30%	17.2%
Azerbaijan	41%	N/A
Belarus	21.2%	11.5 ²⁹ %
Georgia	47.1% ³⁰	17.9%
Moldova	N/A	6%
Russian Federation	34%	13%
Ukraine	37%	3%

Key finding

HIV and STI epidemics among MSM in EE are being driven by high numbers of male and female sex partners and low rates of consistent condom use. More research is needed to determine the level of concurrent partnerships. A comparison with data from the South East Asia and Pacific shows that consistent condom use with casual male partners in the last month is much higher than in Eastern Europe (ranging from 23 to 55% in Cambodia, 29 to 37% in Vietnam, 13 to 26% for receptive anal intercourse in Indonesia and 45% for last sexual intercourse in the Philippines). Among specific behavioral risk factors, several should be listed: low levels of condom use, high levels of injecting drug usage among MSM, especially in the Caucasus region; high levels of MSM having sex with female partners and commercial partners.

²⁹ BSS, 2007

³⁰ In Georgia BSS 2007 47.1% of MSM respondents reported having female occasional sex partner.

2. Responding to the epidemic in the MSM community

To analyze the current provision of prevention, care and support services for MSM in Eastern Europe, existing examples of comprehensive packages of services were used.

2.1. Comprehensive approach toward the programs

A summary of the key elements of effective prevention programs for MSM could be developed from a series of articles in *The Lancet* in 2008, which reviewed evidence for efficacy in a broad range of HIV prevention programs, including those for most vulnerable populations, including MSM.³¹ Key findings from the reviews were:

- Combined, multiple approaches to prevention are essential since HIV prevention is neither simple nor simplistic. To achieve significant reduction in HIV transmission, widespread and sustained efforts and a mix of communication channels is needed to disseminate messages to motivate people to engage in a range of options to reduce risk. Success in HIV prevention results from a complex combination of strategies and several risk-reduction options, with strong leadership and community engagement that is sustained over a long period of time.
- Interventions derived from behavioral science have a role in HIV prevention, but are insufficient when used by themselves to provide substantial and lasting reductions in HIV transmission between individuals or in communities. Behavioral strategies need to be combinations of approaches at multiple levels of influence. Behavioral HIV prevention also needs to be integrated with biomedical (including condom promotion) and structural approaches, promotion of social justice and human rights, and treatment for HIV and STI infections. Top-down approaches can be adept at packaging and branding replicable strategies such as behavior change communication and social marketing, while bottom-up approaches are useful for supporting local innovation and ownership. Both approaches have experienced successes and limitations.
- Local engagement, using the creativity and energy of the people who are most affected to develop messages and strategies to motivate behavior change, is important. It is necessary to create an enabling environment that allows members of a community to act on their own behalf in response to their perceived needs.
- Peer education is especially effective if it involves participation and collaboration with vulnerable groups who are often alienated from formal service providers and government structures. Peer education has been demonstrated to be effective in increasing condom use and reducing STIs in Asia. Peer education can be successfully coupled with network-based interventions which involve gaining access to social and sexual networks through key individuals, identifying members of the networks, training network leaders as peer educators, disseminating risk reduction messages, and assessing effects.

³¹ Coates, T.J. et. al., Behavioural strategies to reduce HIV transmission: how to make them work better. *Lancet* 2008; 372: 669-84. Gupta, G.R. et. al., Structural approaches to HIV prevention. *Lancet* 2008; 372: 764-75. Imrie, J. et. al., Biomedical HIV prevention – and social science. *Lancet* 2008; 370: 10-11. Merson, M.H., The history and challenge of HIV prevention. *Lancet* 2008; 372: 475-88.

- Community mobilization is an essential component of effective HIV prevention. A United States Centers for Disease Control and Prevention (US CDC) assessment of well-received HIV prevention programs in the USA demonstrated that community-based programs succeeded only if there was strong institutional support through organizational development, and capacity to implement and sustain the program.
- HIV prevention programs cannot succeed in the long-term without addressing the drivers of HIV risk and vulnerability in different settings. Structural approaches therefore need to be incorporated into HIV prevention. Structural factors include the physical, social, organizational, cultural, community, economic, legal and policy features of the environment that affect HIV vulnerability. The defining aspects of structural approaches is that they aim to change the social, economic, political, or environmental factors that determine HIV risk and vulnerability in specific contexts. Structural approaches can result in activities or services being delivered to individuals. However, the approach is different from individually oriented behavior change because it addresses the factors affecting individual behavior, rather than targeting the behavior itself.
- There is increasing evidence, including among sex workers and MSM, that community structures and systems (e.g. social support networks) can make populations less vulnerable to HIV.
- Investments in HIV prevention should be integrated with health system strengthening and training of community health workers who can generate and respond to community responses that are essential to HIV prevention.
- National level prevention successes have been associated with government leadership and community activism. Leadership and activism are also essential for sustaining and renewing prevention responses.

Defining key interventions, when informed by the key findings above, makes it possible to identify gaps in current responses to HIV and STI epidemics among MSM³² and provides a basis from which regional stakeholders can determine opportunities to address these gaps. It is possible to outline two broad categories of interventions and services, as described below:

1. Enabling environment and supportive interventions:

Enabling environment interventions include stigma and discrimination programs, policy and legal frameworks, advocacy, community development and mobilization, relations with gatekeepers and structural interventions. Supportive interventions include strategic information, capacity building and organizational development.

Key documents supporting this work were developed to enhance regional and national HIV responses and LGBT human rights protection activities:

- ***UNAIDS Action Framework “Universal Access for Men who have Sex with Men and Transgender People”*** The goal of this framework is to enable UNAIDS to facilitate and support the achievement of universal access to appropriate HIV prevention, care, treatment and support for men who have sex with men and transgender people. The UNAIDS Secretariat and the

³² David Lowe Scoping exercise: Options for AusAID support for comprehensive approaches to address HIV infection among men who have sex with men in the Asia Pacific Region, 3 June 2009

UNAIDS cosponsors recognize that universal access to appropriate HIV programs for men who have sex with men and transgender people is a crucial part of achieving universal access to HIV prevention, treatment, care and support as a whole. This approach aims to reduce the incidence of HIV everywhere, while protecting the health and rights of not only these marginalized groups but also their female sexual partners and the rest of the population. The Global Fund to Fight AIDS, Tuberculosis and Malaria in its Gender Equality Strategy supports the UNAIDS approach: “Towards a comprehensive package³³ of measures to address HIV-related issues among men who have sex with men and transgender people.” UNAIDS’ recommended conducive legal, policy and social environment requires:

- The promotion and guarantee of the human rights of men who have sex with men and transgender people, including protection from discrimination and the removal of legal barriers to access to appropriate HIV-related prevention, treatment, care and support services for them, such as laws that criminalize sex between males;
- An assessment and understanding of the numbers, characteristics and needs of men who have sex with men and transgender people regarding HIV and related issues, including risks associated with injecting drug use, sex work, prison confinement, etc.;
- Ensuring that men who have sex with men and transgender people are appropriately addressed in national and local AIDS plans, that sufficient funding is budgeted for work, and that this work is planned and undertaken by suitably qualified and appropriate staff;
- The empowerment of men who have sex with men and transgender communities to participate equally in social and political life;
- Ensuring the participation of men who have sex with men and transgender people in the planning, implementation and review of HIV-related responses, including the support of nongovernmental and community-based organizations, including organizations of people living with HIV;
- Public campaigns to address homophobia and transgender discrimination;
- Training and sensitization of health-care providers to avoid discriminating against, and ensure the provision of appropriate HIV-related services for, men who have sex with men and transgender people;
- Access to medical and legal assistance for boys, men and transgender people who experience sexual abuse;
- The promotion of multisectoral links and coordinated policy-making, planning and programming, including health, justice (including the police), home, social welfare, similar and related ministries, at the national, regional and local levels.

³³ UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People “UNAIDS/09.22E / JC1720E”. Based on the recommendations from the WHO consultation meeting on men who have sex with men, HIV and other STIs, held in Geneva, 15–17 September 2008, WHO’s.

- ***Yogyakarta Principles*** is the document developed on the basis of the Universal Declaration of Human Rights in 2006. It establishes international principles regarding the application of human rights to sexual orientation and gender identity. These address issues of extrajudicial executions, rape, torture, access to justice, integrity of private life, non-discrimination, denial of free speech and assembly, as well as a range of discriminatory actions in work, health, education, housing, immigration and status of refugees, participation in the state administration and other human rights issues related to LGBT.
- ***United Nations General Assembly (UNGA) Statement on human rights, sexual orientation and gender identity*** supported by 68 countries from five continents and unanimously supported by EU December 2008. The Statement reaffirms the principle of non-discrimination and condemns executions, arbitrary arrest or violations of human rights on the basis of sexual orientation or gender identity.
- ***Toolkit to Promote and Protect the Enjoyment of all Human Rights by Lesbian, Gay, Bisexual and Transgender (LGBT) People***. This document, prepared by the intergovernmental EU body in consultation with civil society organizations, outlines what the European Union should be doing abroad to defend the human rights of LGBT people. Among other recommendations, the toolkit calls on EU diplomats, the future European External Action Service (EEAS) and EU Member States to actively work towards the decriminalization of same-sex relations throughout the world; to further denounce discrimination on grounds of sexual orientation and gender identity; and to support human rights defenders in repressive areas. The toolkit is a welcome development in the European Union's external action. Although not binding, it provides the European Union's institutions with a blueprint for positive action in favor of LGBT people's human rights abroad.

2. Prevention and care package

UNAIDS recommend all interventions should be evidence-informed, developed with, and protect the rights of men who have sex with men and transgender people and should include safe access to:

- Information and education about HIV, other sexually transmitted infections, and safer sex and safer drug use, provided through appropriate service delivery models (including peer-led, -managed and -provided services);
- Condoms and water-based lubricants;
- Confidential, voluntary HIV counseling and testing;
- Detection and management of sexually transmitted infections through the provision of clinical services (by staff members trained to deal with sexually transmitted infections as they affect men who have sex with men and transgender people);
- Referral systems for legal, welfare and health services, and access to appropriate services;
- Safer drug-use commodities and services;
- Appropriate antiretroviral and related treatments, where necessary, together with HIV care and support;

- Prevention and treatment of viral hepatitis;
- Referrals between prevention, care and treatment services;
- Services that address the HIV-related risks and needs of the female sexual partners of men who have sex with men and transgender people.

Key finding

A comprehensive approach to HIV and sexual health among MSM requires foundational activities to create an enabling environment, supportive interventions for the effective operation of the prevention and care package (e.g. capacity building), and a complete prevention and care package. Given the unique needs of MSM in the post-Soviet/Eastern European social and cultural environment it is necessary to adapt a package of services for this region that focuses on stigma/discrimination, drug/alcohol use, care for HIV-positive MSM and organizational networking.

2.2. Existing programs in the region

1. Enabling environment and supportive interventions

In most of the countries covered by the report there were some pilot activities implemented by NGOs to create enabling environments and advocate for LGBT human rights. Country profiles in Annexes 1-8 of this report show that the only regional five-year project which systematically provided capacity building and support to create an enabling environment was the Dutch-funded COC project. Good methodological bases and a practical background for effective advocacy, media, and combating homophobia has been developed with USAID funding in Ukraine (the SUNRISE project) and has been compiled into methodological guidance available in Russian and English.³⁴ In several countries of the region AmFAR supported advocacy and innovation development projects.

2. Prevention and care package

According to the country analyses, most programs for MSM in the region are supported in the framework of prevention among vulnerable groups. In most countries, such programs were started or significantly developed and scaled up geographically with support from the GFATM since 2004. USAID funding for HIV response programs with this population is significant in Ukraine and Georgia. Table 7 summarizes the organizational and financial capacity of the HIV prevention and care projects in each country. The table shows that the majority of the countries include MSM prevention into NSPs and NAPs. At the same time, there is no state or municipal funding for such programs in any of the assessment countries. As most of the activities are dependent on external donor support, they are less sustainable and short term. It is seen from the table that in most of the countries, recognizing MSM as one of the groups vulnerable to HIV, there is some financial support and capacity building from GFATM. Among other donors supporting prevention and care programs for MSM, the COC Netherlands, USAID, and AmFAR should be named.

³⁴ Social Work with People Practicing Same-Sex Relationships. Theory. Methodology. Best Practice. International HIV/AIDS Alliance in Ukraine, K. – 2009

Table 7. Mapping of donor support to HIV prevention and care programs by countries

Countries	MSM are mentioned in NSP or NAP	Number of MSM services and LGBT organizations	State financial support for MSM Programs	GFATM supported programs	USAID support	COC Netherland support	Other donor support
Albania	yes	2	no	No	-	no	
Armenia	yes	3	no	yes until 2014	-	yes until 2011	AmFAR, Norwegian government 2008-2009
Azerbaijan	no	1	no	No		yes until 2014	AmFAR 2010
Belarus	yes	1	no	yes until 2015	-	No	AmFAR 2010
Georgia	yes	1	no	yes until 2014	yes 2010-2015	yes until 2010	-
Moldova	yes	1	no	Yes R6, R8	-	yes until 2011	Yes
Russian Federation	yes	10	no	yes R4 (2010)	yes until 2007	no	Yes
Ukraine	yes	22	no	yes R1 until 2009, R6 until 2012	yes until 2011	yes 2006-2010	Yes – Elton John Foundation, AmFAR and others

Prevention programs vary between the selected countries. There is no joint definition of the minimum service package. MSM prevention projects funded by the GFATM in selected countries usually include: condom distribution; lubricant distribution; counseling from social or outreach workers; and BCC material.

In some countries this package is supported by a range of additional services including social support, medical services, social mobilization events, psychological and legal counseling, etc. In some countries rapid tests for HIV, VCT services, rapid tests for STI and treatment are available for MSM clients (Ukraine, Belarus and Russian Federation). Rapid HIV tests are not registered and thus not allowed for use in Moldova and Azerbaijan. There is no access to condoms and lubricants in small packs in several countries (Georgia, Azerbaijan).

The coverage by HIV prevention programs is very low in most of the assessed countries. As seen in Table 8, only four countries have data on the percentage of the covered MSM population. Programs on HIV prevention in Armenia cover 12% of MSM population; in the Russian Federation, 16.8% of MSM population from 10 prioritized regions is covered; in Ukraine, 16% (using annual coverage data); and in Belarus, 23% (using cumulative data). To compare with other regions, a 2006 survey of the coverage of HIV interventions in 15 Asia-Pacific countries estimated that targeted prevention programs reached less than 8%.

Table 8. Data on HIV/STI prevention program coverage

Country	HIV-prevention program coverage as a % of all MSM population	HIV program coverage in absolute numbers (cumulative by all organization starting from year)	HIV program coverage during the last 12 months
Albania	No data available	<500	No data available
Armenia	12%	700 (since 2003) + 958 (since 2007)	No data available
Azerbaijan	No data available	No data available	1,944
Belarus	23%	16,355	No data available
Georgia	No data available	650 (since 2004)	No data available
Moldova	No data available	829	No data available
Russian Federation	16.8%	22,673	No data available
Ukraine	16%		13,000

No countries have significant prevention program coverage of MSM (current size estimations upon which coverage is based are unreliable and inconsistent, and do not give an accurate picture).

In most of the assessed countries, programs for care and support, psychological support and advocacy are pilot programs or cover only a small region. There are no care and support programs specifically targeting MSM at a country level. Most of the selected countries have several HIV-positive MSM self-help groups. Yet there is a lack of policy guidance for HIV interventions for MSM that comprehensively focus on prevention, treatment, care and support on the regional level.

Key findings

A comprehensive approach to HIV and sexual health among MSM includes foundational activities to create an enabling environment, supportive interventions needed for the effective operation of the prevention and care package (e.g. capacity building), and a complete prevention and care package. Current MSM programming in Eastern Europe includes only pilot and short term programs on delivering prevention services and little emphasis on creating an enabling environment, supportive interventions, and treatment and care.

MSM have now been included as one of the key populations at higher risk of HIV in the prevention strategies of national programs and national goals for scaling up towards universal access to HIV prevention, treatment, care and support for groups at high risk of HIV in most of the focus countries, although the level of prioritization is low in all of them. Commitments to MSM programming in national strategic plans have generally not resulted in any level of state funding. For the external and international donors, MSM are generally accorded a lower priority than the other key populations at higher risk of HIV (IDUs, FSWs, imprisoned population). National responses to HIV need to effectively respond to all key populations to bring HIV epidemics under control.

Funding and coverage levels for MSM prevention programs are low and insufficient to halt HIV epidemics in this population, which would require a 60% level of coverage. Political commitment has been only partly supported by resources for program development. There are no state-funded HIV prevention programs for MSM in Eastern European countries. HIV prevention activities are mostly carried out by NGOs with financial backing from international donors. The main funding source for MSM targeted services in all selected countries is GFATM. HIV-prevention programs targeting MSM are also supported by USAID (Ukraine, Georgia) and COC Netherlands in cooperation with ILGA-Europe as well as by AmFar. The scale and scope of prevention services for MSM has improved, but remain significantly inadequate to make a sustainable impact on behavior and reduce HIV transmission among MSM. No MSM programs are large enough to be considered at scale and most could be classified as small scale boutique or pilot projects. Insufficient government commitment to provide resources, support and services for MSM and to address legal, financial and administrative barriers to MSM's access to services indicates that governments throughout the region are still not fully prepared to address the HIV epidemic among MSM.

Reviews and evaluations of MSM programs are uncommon. There is insufficient available data to come to conclusions regarding the quality of MSM prevention programs, although most key informants are of the view that there is room for significant improvement.

Since 2004, LGBT community activists have begun more professional HIV advocacy and response work in Ukraine, the Russian Federation, Belarus, Moldova and the Caucasus countries. LGBT community mobilization and empowerment was supported by a regional COC program and partly by USAID funds for civil society development, as well as by the GFATM in the framework of prevention activities. However LGBT/MSM groups are severely under-resourced and have capacity gaps that make it difficult for them to manage and implement large scale projects. There are no sustainable and functional national or regional coalitions or networks for MSM projects and LGBT organizations to meet, discuss strategies, share best practices approaches to HIV and develop partnerships.

Key Recommendations

Despite the challenges, an appropriate combination of action and investment by all relevant stakeholders can make a dramatic difference in HIV prevention, treatment, care and support. Indeed, many of the earliest and most dramatic HIV prevention successes around the world involved men who have sex with men.³⁵ Most activities for MSM conducted by local CBOs and NGOs in the selected countries last year had no support from the state or local authorities, nor were MSM even mentioned as a vulnerable group in these countries' National AIDS programs (NAP); instead, programs were

³⁵ Merson H M et al., "The history and challenge of HIV prevention," *The Lancet*, HIV Prevention, August 2008, pp. 7–20.

implemented thanks to the support from GFATM programs on prevention among MSM. Based on the data collected in the assessment and the gaps identified during the workshop conducted with research team and regional experts, there appear to be three main objectives towards which international donors, national governments, LGBT networks and NGOs working in HIV prevention should focus to improve programming for MSM and thus have an impact on the epidemic:

Objective 1: Improve the human rights situation for MSM and TG people, as the cornerstone to an effective response to HIV

- Further research is needed into the types/depth of stigma and discrimination that MSM face in the region.
- MSM/LGBT organizations need advocacy skills to assist them in their efforts to challenge and change laws and attitudes.
- Specific interventions need to be developed to address discrimination against MSM and TG people by Health Care Workers.

Objective 2: Strengthen and promote the evidence base on MSM, TG people and HIV

- A comprehensive and consistent regional approach to MSM size estimation needs to be developed and implemented.
- A comprehensive and consistent approach to MSM data collection through sentinel and other surveillance mechanisms needs to be developed and implemented.

Objective 3: Strengthen capacity and promote partnerships to ensure broader and better responses for MSM, TG people and HIV

- High-level intervention from UNAIDS, USAID, GFATM is needed to convince governments to commit funding to MSM-focused HIV programs.
- A comprehensive package of services for MSM needs to be developed that is adopted as standard practice in the region. This package should include specific programs/support for HIV positive MSM.
- Capacity assessments need to be conducted and subsequent capacity building plans developed and implemented for MSM groups that currently exist in the region.
- A mapping exercise of where groups exist in the region and where gaps exist is needed.
- Opportunities need to be created for MSM groups to meet and discuss priority issues/strategies at both the national and regional level.

Annex 1. Armenia country profile

1. Description of HIV prevalence and related risks among MSM

1.1. Group identification

Definition (accepted in the country)*: no available data.

Structure (identity, subgroups): according to specialists' observation, homosexuality is not considered socially acceptable, and men who have sex with men tend to cluster in small circles, rarely exhibiting their sexual orientation outside peer groups. Due to social stigma, there is no single stereotype of a typical MSM, and the MSM population can be difficult to identify: some members are married or do not identify as gay, and many do not inform their families of their sexual orientation. Sex is often limited to small, insular groups, which increases the risk of HIV infection of the group as a whole.

Because MSM are socially isolated and often engage in risk behaviors in locations that are hidden from the mainstream, ensuring access to information and services is challenging, and increases their vulnerability. This combination of social and physical isolation makes the MSM population highly vulnerable and among the most hard-to-reach populations [1].

MSM comprise a closed group which can be divided into the following sub-groups according to level of self-identification:

- **Open.** They identify themselves as gay, bisexual or transgender. They do not hide their sexual preferences within their close environment. They visit meeting points regularly (street, "specialized" clubs and friends' communities, etc.); they create profiles with photos on relevant web-sites not only to find a sexual partner but to communicate with peers. This group is the most accessible to prevention interventions.
- **Semi-open.** This group is larger than the previous group. The majority identify themselves as gay, bisexual or transgender. They reveal their sexual preferences to their close environment only, and rarely to parents and relatives. Sometimes they visit meeting points (street, "specialized" clubs and friends' communities, etc.); they create profiles on websites without photos, usually to find a sexual partner. Typically they establish M+M unions. Sometimes they have heterosexual pro forma marriages. This group is accessible to HIV/AIDS and STI prevention with peer support.
- **Closed.** The largest MSM group. As a rule, they do not identify themselves as gay, bisexual or transgender. They hide their sexual preferences from their close environment. They may visit meeting points to seek for a one-off sexual partner. They do not communicate with other MSM communities. They create profiles on dating web-sites ostensibly looking for a heterosexual relationship, but in fact make one-off sexual offers to other men. They may have a regular partner, if he comes from the same group, has a family and does not provoke suspicion related to his sexual orientation. The majority have heterosexual families. Sometimes they may be involved in forced sexual relationships (patronage at work, within closed male communities, etc.). This group is the most inaccessible in terms of HIV/AIDS and STI prevention.

Size estimation: in accordance with USAID estimates, 2–5% of men aged 15–49 engage in homosexual or same sex relations. Taken to scale, there are an estimated 17,000–65,000 men having sex with men in the Republic of Armenia [1].

According to data from an interview with the USAID Mission together with UNAIDS and GFATM representatives, the general number of the MSM population is 13,500; less than 5% of them are covered with prevention programs.

Legal status, homosexual partnerships: homosexuality was decriminalized by the new Penal Code of the Republic of Armenia adopted on 18 April 2003. Decriminalization refers only to voluntary homosexual relations. The RA Penal Code defines as a criminal offense, “Violent actions of a sexual nature,” according to which homosexuality or other actions of a sexual nature against the will of the victim, by the application or threat of force towards the latter or to another person or by taking advantage of the victim’s helpless state, is punishable by three to six years imprisonment [2].

Homosexual men are discharged from military service, which is legally justified by article 12 of the law of RA “On Military Service.” According to the relevant article, citizens considered unfit for military service on health grounds are discharged from compulsory military service by the republican drafting commission and taken off military books [3]. An internal decree of the RA Defense Ministry based on this article stipulates discharge of gay people from compulsory military service by characterizing the latter’s sexual orientation as illness.

Case study:

People who are openly gay are exempt from military service, purportedly because of concern that they will be abused by fellow servicemen. However, the legal pretext for exemption is predicated on a medical diagnosis of mental disorder, which is stamped in the person’s documents and could affect his future. During the year there was at least one reported case of a young man whose homosexuality was revealed during military service being diagnosed and hospitalized with "homosexuality disease." [4]

According to the RA Family Code, marriages between Armenian citizens and those of other countries, or those without citizenship, registered outside Armenia, in compliance with the legislation of the country where the marriage took place, are valid in Armenia together with consular validation. Marriages between foreign citizens registered outside the Republic of Armenia are valid in Armenia together with consular validation if the legislation of the country where the marriage was registered remains unchanged [5]. This would permit recognition of same sex marriages in Armenia if they are registered in another country where the law allows it. However, another article of the RA Family Code prohibits the use of foreign country norms of familial rights if they contradict the legal framework of the Republic of Armenia (public framework). In this case the legislation of the Republic of Armenia is applied [6].

Stigma and discrimination: there is no special legislation on discrimination based on sexual orientation. According to the RA Constitution, everyone is equal before the law. Any discrimination based on grounds of sex, race, color, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or other personal or social circumstances is prohibited [7]. This article does not specifically prohibit discrimination on the grounds of sexual orientation; nevertheless, it can be interpreted to also cover such discrimination. A person thus discriminated against may also refer to the case law of the European Court of Human Rights, which is mandatory for courts investigating a case with similar factual circumstances as an interpretation of the European Convention on Human Rights (ECHR).

Case studies

General social attitudes towards homosexuality remain highly unfavorable and homosexuality is largely viewed as an affliction. The country's endorsement of the UN's December 2008 statement against discrimination on the basis of sexual orientation and gender identity caused a public outcry and increased negative media coverage of homosexuality.

Homosexuality has not been a criminal offense in Armenia since 2003. Two years ago the country signed the United Nations Declaration on Sexual Orientation and Gender Identity, which asserts the right to equal treatment regardless of sexual orientation or gender. It has also ratified a protocol to the Council of Europe's Convention for the Protection of Human Rights and Fundamental Freedoms that bans all forms of discrimination.

Nevertheless gay Armenians are still often the targets of discrimination. Aside from the risk of losing their jobs, homosexuals face becoming social outcasts, a heavy burden in Armenia's communal, family-centric culture. Some families have been known to emigrate to escape the stigma of having a gay family member. Similar social prejudices prevail in neighboring Georgia and Azerbaijan [10].

20-year old Ruben (the names of our interviewees have been changed to protect their privacy) is a bartender at the only gay bar in Yerevan and also one of only three men employed as strip dancers in the capital's nightclubs. Ruben has not told his family about the nature of his work, only a few of his friends know. Those few friends are also aware that Ruben is in love with a boy.

"My parents were suspicious of my sexual orientation during my last years of school, and we had a lot of fights about it at home. Now we don't talk about it anymore; they think I've changed. As for my work, they know I'm a bartender in a club, but they don't know that it's for gays. The mere mention of the striptease job is out of the question," says Ruben.

Ruben is a student and future economist. He says he hardly makes any money dancing, because male strip shows are held very rarely. But he also says that making money is not his biggest problem. His greatest problem has been to overcome the period of dispute with his parents and resign himself to his current situation.

"When my parents found out, they cut me off. They wouldn't talk to me and kept being really hard on me. I was in a very bad state psychologically. I was aggressive and badly behaved: imagine what you would do if the world you lived in did not accept you," Ruben says.

Mistreatment and intolerance of homosexuals, which often turns into animosity, are typical in Armenian society. A survey we conducted among 100 people of different ages in the center of Yerevan provided further support of this fact.

According to the results, 53% of respondents felt animosity towards homosexuals, 40% were tolerant, 4% treated them well, and 3% were undecided. When asked, "What would you do if your child were homosexual?" 73 respondents said that they would disown the child [10].

According to local human rights activists, lesbian, gay, bisexual and transgender people experience some of the most humiliating discrimination in prisons, where they are forced to do the most degrading jobs and are separated from the rest of the prison population.

Discrimination based on sexual orientation continues to be a problem with respect to employment, family relations, and access to education and health care for sexual minorities [4].

1.2. Group description

Age: The majority of surveyed MSM had their first sexual intercourse at the age of 10–14. Their mean age at first sexual intercourse was 12.8 [9].

Urban/rural group concentration: it is complicated to identify MSM geographical allocation in Armenia. It is logical to assume that in highly populated cities a larger number of MSM may be found. Yerevan is the only city with a leisure structure for MSM, which is why many MSM from different regions of the country visit Yerevan regularly or try to move there. However, there are no studies related to this topic.

Family status: no clear data. The Rapid Assessment and Response of HIV/AIDS among Especially Vulnerable Young People in the Republic of Armenia showed that 5.7% of MSM are married [1]. According to 2007 epidemiological surveillance, 9% of MSM are married and 14% are divorced [9]. Among surveyed young MSM, 17% live alone, 37.1% with their father, 54.3% with their mother, 2.9% with their stepmother, 20% with siblings, 8.6% with grandparents, 20% with other relatives, and 2.95 with other people who are not relatives (multiple answers were permitted) [1].

Social status: surveyed MSM had a fairly high educational level, including 24% with secondary education, 22% with specialized secondary education, 13% university undergraduates and 41% with higher university education [9]. No other data is available.

Profession: no available data.

Income: only 11.4% of the surveyed young MSM consider their family to be very well-off, 11.4% consider them to be quite well-off, 28.6% indicate that they live well, 40% think their living conditions are average, 8.6 think they are lower than average. No one considers their family condition to be worse than average or extremely poor [1].

Karen Badalyan, director, “We are for Civil Equality” NGO: *“Many MSM come to Yerevan from other regions of Armenia. They do not have any skills. No prevention work has been done with them because all prevention activities take place in Yerevan.”*

1.3. Risk factors

Prevalence of injecting drug use, other drugs and alcohol: only 11 (11%) of those surveyed reported that they had ever used drugs, of whom 6 (6%) had injected drugs. The mean age of first drug use experience of those surveyed is 18.4. Seven percent of the surveyed MSM have had sexual intercourse under the influence of drugs [9]. The survey results show that those young MSM who had used drugs had used cannabis, marijuana, diazepam or other benzodiazepams (apaurin), ecstasy, heroin, cocaine, or other drugs. No one reported using glue or other inhaled drugs, amphetamines or opium tea. Young MSM using drugs indicated that they usually use drugs in bars, cafes, clubs, nightclubs, discos, in their own homes, at their friends' places or at parties [1].

No data on alcohol is available.

Case studies

During individual interviews drug-using young MSM indicated that they use drugs because "it's interesting to feel what it's like". For others, fear was cited as a reason for not using drugs. Among those using drugs, 66, or 7% reported having had sexual contact under the influence of drugs. Two of three young MSM using drugs injected heroin or morphine.

One young MSM who used injecting drugs reported sharing injecting equipment during the month prior to the interview. He also reported using drugs prepared by someone else. Usually he obtains injecting equipment from a drug supplier, always disinfects it himself and always uses disposable syringes. He also reported having skin problems at the site of injection (rash, pain, infection) in the month preceding the survey.

One of the two young MSM who inject drugs visited a physician to obtain treatment to quit injecting drugs. He was provided with socio-therapy (social group therapy) during the year preceding the survey [1].

Sex work (prevalence): it is impossible to evaluate the size of this subgroup. According to research, 17.2% of those surveyed have ever had sex for money. Of those, 5.9% started to provide commercial sex at the age of 14–15, 35.3% at the age of 15–19, 41.2% at the age of 20–24, and 17.6% aged 25 and over [9]. Twelve young MSM (35.3%) have had sex in exchange for money, drugs or a job, of whom 25% had been providing paid sexual services for 1–4 years prior to the survey, 33.3% for 5–9 years, 8.4% for 10–14 years and 33.3% did not indicate the period. The mean age of first paid sex is 17.5 [1].

Frequency and quantity of partners (per month, per three months and per six months), 0–1, 2–5, 5–10, 10+: according to behavioral surveillance among MSM performed in 2007, 14.2% of participating MSM practice only active sex and 33.3% receptive, 52.5% practice both active and receptive. 37% of those surveyed have sexual intercourse with their regular partners, 58% both with regular and non-regular sexual partners. 56% of those surveyed have one or more sexual partners per day, 41.1% have one sexual partner per day and 58.9% have two or more sexual partners per day.

Sex with women (frequency and number of female partners): the sexual partners of 62.9% of surveyed young MSM are men, 8.6% have female partners, and 28.6% have both male and female partners, i.e. nearly one third of the surveyed MSM are bisexual [1]. No other data is available.

Condom use with men, women, regular and sporadic partners: data from a behavioral survey among MSM performed in 2007 indicate that this group still practices behavior that can result in HIV/STI infection. In 2007, the number of MSM regularly using condoms increased by 14% in comparison with

2005 to 44%; the number of respondents who used a condom during their last sexual contact with sporadic partners increased by 25.8% to 80.8%. In addition, 34.7% of MSM interviewed in 2007 used a condom during their last oral sex contact, while in 2005 the percentage was 5.4%. 83.5% of respondents used a condom during anal sex in 2007, while in 2005 the figure was 60% of those interviewed [11]. 55% of those surveyed noted that they did not always use a condom in the last year [9].

Studies among young MSM show more risky behaviors, which could be seen from the data on consistent condom use:

- 74.3% used a condom the last time they had sex;
- 82.8% of young MSM used a condom the last time they had sex with a non-regular partner;
- 34.2% consistently used condoms;
- 62.9% used condoms inconsistently;
- 2.9% never used condoms in the year preceding the survey [1].

Request for STI testing: 40% of those surveyed had a history of STIs, of whom 22.5% had had STIs in the last six months [9].

HIV knowledge: in general, the basic level of knowledge about HIV/AIDS among target group representatives (behavioral survey) is fairly high. The overwhelming majority of surveyed MSM (92.9%) believe that it is possible to reduce the risk of HIV transmission by having one faithful uninfected sexual partner. 95.9% of those surveyed think that condom use can reduce the risk of HIV transmission. The overwhelming majority of surveyed MSM (87.9%) know that a healthy-looking person can have HIV. 87.7% of surveyed MSM know that it is impossible to get HIV from mosquito bites, and 91.7% of those surveyed consider it to be impossible to get HIV by sharing a meal with an HIV-infected person [9]. The survey found that young MSM are the most knowledgeable risk group, with 48.5% able to demonstrate a basic understanding of HIV prevention.

All surveyed young MSM had heard of HIV/AIDS and 97.1% had heard about STIs. For 51.4%, information about HIV/AIDS and STIs comes from friends and peers, suggesting that an increased focus on peer education would be effective in raising awareness among young MSM [1].

1.4. Epidemiological situation

HIV prevalence among MSM (official statistics according to registration): Armenia started to record HIV infection cases in 1988. The first case of homosexual transmission of HIV was recorded in 2000. As of 28 February 2010, Armenia had reported 831 HIV cases, with 149 cases (18%) in 2009.

The majority of PLHA (608 people, or 73.2% of all cases) are male, with 60% of infection cases being recorded among young people aged between 25 and 39. HIV has been detected among 16 MSM community members (1.9% of all cases).

Quantitative approach statistics show that 2300 PLHA are currently living in Armenia.

HIV prevalence among MSM according to epidemiological surveillance: behavioral survey data among MSM performed in 2007: a total of 100 MSM were tested for HIV, of whom two tested seropositive. Therefore, estimates made in the 90% confidence interval show that HIV prevalence among MSM is lower than 6%, which makes an average of 2%. All registered HIV cases were found in MSM older than 50 [9].

STI prevalence: epidemiological surveillance, project data, rapid tests: no available data.

2. Epidemic response in the MSM group

2.1. National documents and adherence

National HIV/AIDS Program: prevention work among MSM, as well as among IDU and FSW, is included in the National HIV Prevention Program for 2007–2011.

In 2007 the HIV/AIDS National Response Program was approved by a RA Government decree. Based on the HIV/AIDS strategic response plan of 2006, the HIV/AIDS National Response Program was developed, the main purpose of which is to form an effective response to HIV/AIDS in 2007–2011 [12]. Strategies and activities include six main directions:

1. Development of the inter-departmental response to HIV/AIDS
2. Prevention of HIV
3. Treatment, care and support
4. Monitoring and evaluation
5. Administration, coordination and cooperation
6. Funding and fundraising

One of the purposes of the strategy is prevention of HIV/AIDS among homosexual men. The capacity of NGOs implementing HIV/AIDS prevention projects among homosexual men will be developed to ensure effective project implementation.

Expected results:

1. Projects for HIV/AIDS prevention among MSM will be implemented in the capital city and two regions of Armenia (2007–2011).
2. A network of organizations implementing HIV/AIDS prevention projects among MSM will be created (2007).
3. The involvement of MSM in HIV/AIDS prevention projects will be increased to at least 1500 people who will have corresponding access to voluntary HIV counseling and testing, social-psychological and legal services, treatment of STIs and other services offered in the framework of projects (2007–2011).
4. Increased use of condoms by MSM during their last sexual intercourse with men to 80% (2010–2011).
5. At least 80% of MSM will have knowledge of HIV/AIDS prevention (2010–2011).

Among different MSM-service organizations, there is no consensus on the evaluation of GFATM supported program results for the moment. Most of the planned services such as development of outreach programs, rapid tests for HIV and STI, behavior change communications are available for the target group. Unfortunately there are no data of any external evaluation of GFATM program.

As Karen Badalyan, director of the “We are for civil equality” NGO notes, there is still a lack of a national MSM prevention network, training for the NGO staff, and commitment from the highest country authorities [to provide prevention projects or other services].

National Strategy, National Plan – HIV, reproductive health, demographic security: No available data.

2.2. Resource analysis

State allocation for the program: no available data.

Local resources: no available data.

Donors: according to interviews with the USAID Mission and UNAIDS and GFATM representatives and Mamikon Hovsepyan, project director "Public Information and Need of Knowledge" NGO, there are only a few sources of financing for MSM programs in Armenia:

1. GFATM component (Round 2 – 2003-2009)/ RCC Phase 1 (Jan 2010 – Dec 2011) addresses prevention activities for most at risk populations, including MSM. The amount of the current grant is approximately \$6 million.
2. COC Netherlands for HIV prevention services and empowerment (30,000 USD for two years);
3. Other international sources, such as Norwegian government support in 2008-2009 (\$11,645).

There are no specific USAID funds available for the HIV response. Different UN agencies are supporting HIV prevention programs among uniformed services and migrants without special provision for MSM.

2.3. Current programs and projects in service delivery areas

HIV/STI transmission: support to the National Program on HIV/AIDS Prevention," supported by the Global Fund to fight AIDS, Tuberculosis and Malaria (Round 2), 1 November 2003–30 September 2009.

"Scaling up HIV Prevention, Treatment, Care and Support in Armenia," supported by the Global Fund to fight AIDS, Tuberculosis and Malaria. There is no clear data on MSM.

Care and support for MSM-PLHA: no available data.

Social and psychological support for LGBT (community centers, work with parents, coming-out, self-help groups, legal support): no available data.

Advocacy, rights protection, stigma and discrimination: no target programs have been implemented.

Studies, technical support and method guidelines: no available data.

Mobilization, organization development, capacity building, and leadership: For now there are three civil society organizations addressing HIV and MSM issues and providing different services:

- "Education for Health Protection," providing most of the HIV prevention services with support from GFATM and in cooperation with National AIDS Centre and other medical facilities;
- "Public Information and Need of Knowledge" NGO
- "We are For Civil Equality" NGO

As seen from interviews with all three organizations listed above, these organizations are developing programs for community capacity building, leadership and reducing stigma in the country. There are no data on coalition or networking building available for the moment.

3. Program gaps and recommended steps to develop services

UNAIDS and USAID interview participants say that a key obstacle for program development and research is the high level of stigmatization of MSM.

3.1. Data gaps relating to group, risks and HIV prevalence

Comprehensive studies on MSM needs related to HIV and MSM risk behaviors are required.

A quality and quantity assessment of the following MSM sub-groups is needed:

- male commercial sex workers;
- young MSM;
- MSM in closed communities (prison, armed forces);
- MSM/drug users;
- bisexuals;
- transgender;
- men over 50.

3.2. Gaps in political decision-making and budget allocation

There is no state support for creating a supportive environment to scale up access to HIV/AIDS and STI prevention and treatment. Advocacy activities are needed to ensure that national programs on HIV response include systematic stigma reduction activities as well as development of community centers, work with MSM close environment, supporting long-term programs and interventions for MSM.

3.3. Gaps in programs according to service delivery areas

- No legal counseling for MSM;
- Programs of free and anonymous STI diagnosis for MSM are implemented, but only among a limited target group, as it is not implemented in all territories and regions of Armenia, and in Yerevan the procedure for obtaining referral coupons is flawed which leads to time consuming process for the client to access service;
- Psychological counseling for MSM is implemented, but the target group is insufficiently informed about the availability of this service;
- No target programs for MSM-PLHA;
- Programs for advocacy, rights protection, and overcoming stigma and discrimination towards MSM are implemented. But they are aimed at providing support for MSM rather than informing the general population.

4. Expert recommendations to develop this activity area in the country

- Geographically expand current HIV/AIDS and STI prevention services;
- conduct rapid HIV tests at MSM meeting points with support of trained outreach workers;
- improve information and education including training for target groups;
- ensure education of medical workers to reduce stigma and discrimination against MSM;
- develop a network of friendly medical services including health care centers for MSM in cities where prevention work takes place;
- develop programs for MSM-PLHA, young MSM and MSM over 50;
- implement programs in advocacy, rights protection, reducing stigma and discrimination;

- build capacity of functioning NGOs and MSM self-organizations, support initiative groups including study visits, motivational packages for volunteers, leadership development;
- expand study topics among MSM;
- scale up activities to prevent alcohol abuse and address problems in families and the close environment of MSM which may aggravate vulnerability to HIV;
- introduce and develop a drop-in center network providing MSM with a safe area for anonymous STI testing and HIV prevention activities;
- scale up on-line counseling;
- expand hotline counseling including topics related to discrimination, family problems, depression and alcohol abuse;
- provide anonymous STI and HIV testing for male and female MSM partners;
- conduct size estimation of the MSM group considering geographical location;
- support volunteers, develop training and an evaluation system for their work;
- conduct an expanded evaluation of MSM needs and increase funding for HIV response accordingly;
- implement projects and campaigns aimed at socialization of gays and lesbians, reducing homophobia in society.

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Annex 2. Albania country profile

1. Description of the situation with HIV prevalence and HIV infection risk among MSM

1.1. Definition of the population

Definition (accepted in the country): there is no specific definition of this population in the reviewed documents. In common with many developing countries, the term “gay” is not generally used in Albania. Instead the term “men who have sex with men” is used. Although homosexuality exists in Albania, few individuals have a “gay” identity similar to that found in the United States or other developed countries [17].

Structure (identity, subgroups): no available data. The LGBT community in Albania is very underground and there are no gay bars in any city including the capital, Tirana. It is very difficult to find any information about the LGBT community there.

Estimation of size: estimation of the size of the group size was apparently not performed [11]. The only known figures are related to all PLHA (not only MSM), and there is only one very approximate figure. In 2008 WHO/UNAIDS conducted an estimation of the number of people living with HIV/AIDS in Albania using the Spectrum model. Based on this it was estimated that there are currently 400–700 PLHA [16]. “From what we know, the data that we have, there is a community of nearly 3500 in Tirana alone,” says Genci Terpo, a lawyer with the Albanian Human Rights Group (AHRG) [9].

Legal status, same-sex partnership: Albania decriminalized homosexuality in 1995 (previously homosexuality was punishable by Albanian law by up to ten years imprisonment) [5, 12, 13]. Since 2001 the age of consent is 14 for all, regardless of gender and/or sexual orientation [2, 12, 13].

From Thomas Hammarberg's report to the Committee of Ministers and the Parliamentary Assembly of the Council of Europe [13]: *‘Same-sex consensual relations have been decriminalized by the Albanian Parliament but an open discussion regarding homosexuality remains taboo in Albania. Since 2001 the age of consent for heterosexual and homosexuals is 14... LGBT persons are routinely subject to intolerance, physical and psychological violence and seen by many as persons suffering from an “illness”. There were reports from the OSCE Mission, human rights NGOs and LGBT groups whom the Commissioner met that the LGBT community suffers abuses not only from the general public, but that there have also been cases of mistreatment by the police. The recent Naser Muhed Saidik Almalak case (relating to the arrest of five individuals in Tirana) highlighted shortcomings in police arrest and detention procedures when dealing with LGBT persons, but also discrimination, arbitrariness, maltreatment and public disclosure of the health status of some of the arrested persons. The People’s Advocate holds the mandate to receive complaints from individuals on cases such as discrimination or mistreatment by state authorities including the police. However, there is no single competent body that may accept complaints on the grounds of discrimination on the basis of sexual orientation in Albania in the context of employment. This lacuna results in victims being dissuaded or discouraged entirely from seeking just satisfaction. The Commissioner would welcome efforts by the Albanian authorities to ensure that any victims of discrimination are firstly made aware of their rights, and have access to a fully independent competent authority to receive their complaint. Although for the past decade same sex acts have been legal, attitudes have not changed much. This lacking public acceptance of LGBT may be attributable to the Communist heritage and patriarchal*

attitudes which have perpetuated a discriminatory and repressive attitude towards certain groups within society. To sensitize people on diversity of sexuality requires education. This could take the form of a combination of public campaigns, integration of further sexual education within school curricula and further training of state professionals including law enforcement, judicial and medical personnel.'

Situation with stigma and discrimination: LGBT people in Albania are protected by anti-discrimination legislation [7]. On 4 February 2010 the Albanian Parliament unanimously adopted a comprehensive anti-discrimination law which bans discrimination on the grounds of sexual orientation and gender identity. The law bans discrimination in all areas, including employment, the provision of goods and services, education, health care and housing. Albania is one of few European countries to explicitly ban discrimination on the basis of gender identity. The law also goes beyond EU minimum standards, which only require that discrimination on the basis of sexual orientation be prohibited in employment, and does not cover gender identity.

At the same time, Albania remains a country with strong traditional and patriarchal foundations and widespread stigma and discrimination against homosexuals. Generally Albanians are deeply homophobic and generally never discuss the topic [17]. NGOs claim that police target the country's homosexual community for abuse. According to the Albanian Gay and Lesbian Association, the police often arbitrarily arrest homosexuals and then physically and verbally abuse them in detention. In August, police arrested the secretary general of Gay Albania, a gay rights NGO, and three others on prostitution charges. The AHRG carried out an investigation and reported that while in detention the four were mistreated by other prisoners and insulted by prison authorities. The AHRG also reported that media coverage of this arrest did not respect the privacy of the arrested, including their HIV status, and was manipulated to propagate homophobic stereotypes and further discrimination.

A 2006 UN Development Program report on HIV/AIDS in the country stated that citizens perceived little confidentiality in their HIV test results. Social stigmatization and severe discrimination against people with HIV/AIDS were also common. According to the ombudsman's office, in 2005 police at the Tirana police commissariat detained, insulted, and physically mistreated a member of the Gay Albania association. Medical experts verified the mistreatment, and the ombudsman's office started an investigation. No action had been taken against the police by year's end [12].

Case studies

Local community police officers do not support LGBT in any way. Instead they beat them up and if they are out they will not be able to work, have friends or go to the shop without being shouted at and pushed aside.

"When I was 15 one guy I cannot name found out I was gay and tried to rape me twice with another guy. I was very lucky to get out of Tirana. If my family knew I was gay my brothers would try to kill me and I would no longer have a family. I would lose my beautiful sisters and my mum because of my brothers. I get so tired and I feel so hopeless that there is absolutely nothing to support us." Fatos, "I left my home country seven years ago when I was 15," commentary from 6 July 2008, 12:56 pm) [9].

According to the AHRG, Albanian homosexuals face "intolerance, physical and psychological violence — often from the police — and discrimination in the workplace" [9].

"We were sitting in a park when two police vans pulled over. The officers got out of the van and dragged us away. One of the drivers came over to me and kicked me repeatedly, his boot hitting my stomach. When I begged him to stop, he just shouted 'Shut up you faggot,' and continued kicking me," says S.L., recalling the incident [9].

1.2. Social characteristics of the population

Age, urban/rural concentration, family and social status, occupation, economic status: Albanian MSM are a poorly studied social group [14]. Knowledge about them is based on a single piece of research performed in 2005 with the use of RDS method (further — BSS2005) in Tirana [3].

On the basis of existing data this group can be characterized as predominantly young (the age of half the respondents is 24 and under), poorly educated (13% have not finished primary school), predominantly Muslim (81%) and geographically mobile (35% of them spent a month and more outside Tirana in the year preceding the survey). Around 40% of the questioned MSM were married at some time, but at the time of the survey only 0.5% of respondents were married or cohabiting with a sexual partner of a different sex.

Case studies: Family status, stigma, sex work, violence

“Being homosexual in Albania is an acute drama, both for the individual involved and for his or her family and society. Common reactions range from surprise and disgust to maltreatment, but mostly just silence. The present situation of our members (about 60 individuals) can only be described as extremely difficult. Almost all of us live with our families and are dependent on them in one way or another. It is virtually impossible to live alone because of the housing situation in the country. Most of us are unemployed and without any income or social assistance. Many are forced into questionable activities in order to survive. Employers react very negatively towards homosexuals in view of public opinion, so most of our members hide their homosexuality from the public” [15a].

“Could I tell my mother that I am gay? She is nearly eighty years old. I would never want to cause her so much trauma at her stage of life. My father – when he was alive – asked me, but I could not admit it to him either” [9, from readers’ comments].

“Repeated cases in the past have taught the homosexual community that, in a traditional society like Albania, going public with their sexual orientation means losing their jobs, risking threats and possible rejection by their families” [9, from readers’ comments].

1.3. HIV infection risk factors

The first and most significant risk factor for HIV throughout Albania is the high level of migration [14]. In the last 10 years, the mobility of the Albanian population has dramatically increased. According to estimates made by INSTAT (the National Statistical Institute of Albania), the number of migrants reached approximately 600,000 people, about 18% of the population. Most are men aged 20–30 [4a]. In relation to MSM, only some assumptions can be made in addition to the above figures from BSS2005.

Sex work (prevalence): sex work has emerged as a survival strategy for many Albanian male emigrants and many refer to learning about homosexuality when they were abroad. The confusion around sex between men is connected to the fact that it often happens in the context of illegal emigration to Western countries. A low risk perception towards HIV/AIDS is very common among Albanian homosexuals. Active partners do not consider themselves at risk of HIV/AIDS or other STIs [14].

Prevalence of injecting drug use, other drugs and alcohol use: the second important risk behavior factor is a high level of alcohol consumption (28% used alcohol every day in the month preceding the

survey) and drug use, including hard drugs (34% of MSM used heroin and 48% used marijuana in the month preceding the survey) [3].

Frequency and number of sexual partners: no available data.

Sex with women (frequency, number of female partners): no available data.

Condom use with both permanent and casual, male and female partners: 18% never used condoms for oral sex in the six months preceding the survey, and almost half of respondents (47%) had oral sex with ejaculation in the mouth. Only 61% used condoms during the last episode of anal sex (with a non-commercial partner) within the six months preceding the survey. 39% of respondents had anal sex with a commercial partner in the six months preceding the survey and half of them had sex with 2–4 such partners [3]. Overall, the data indicate a very high prevalence of risky sexual behavior among Albanian MSM and the existence of a number of other unfavorable epidemiological factors.

Seeking STI testing: no available data.

General level of awareness of HIV: national indicators for the beginning of 2008 [3, 4] for the percentage of most-at-risk populations who both correctly identify ways of preventing HIV/AIDS and major misconceptions about HIV transmission: an estimated 86% of MSM know that HIV can be transmitted by using previously-used needles, and 80% know that a pregnant mother can transmit the virus to her unborn child. Only one-fourth of MSM know that HIV is not transmitted through mosquito bites or by sharing a meal with someone living with HIV.

General level of awareness of STI (from behavioral survey data): no available data.

1.4. Epidemiological situation

HIV and STI prevalence among MSM: according to [3], HIV prevalence among MSM in Tirana is 0.8%, Hepatitis B is 15%, and syphilis is 0.6%. There are no data about the prevalence of other STIs.

2. HIV response in the MSM group

2.1. National documents and commitment

National HIV/AIDS Program: no available data.

Road Map for Universal Access: no available data.

National Strategy, National Plan – HIV, reproductive health, demographic safety: from 2004-2010, Albania had a national HIV response strategy, developed with the participation of UNAIDS and the Institute Of Public Health [14]. This document defined MSM as one of many vulnerable groups: ‘There is little knowledge regarding men having sex with men, including sexual practices in Albania. Although stigmatized, a homosexual community does exist in Albania and is trying to become organized... The lack of knowledge and practicing of safe sexual practices is accompanied by a lack of friendly services for men who have sex with men. Also MSM have difficulties in finding proper condoms for anal sex and lubricants. The stigma and discrimination on the part of society make very difficult for this community to make use of existing services or to be organized. Silence, stigma, denial and taboo are key concepts to understanding why too little is known and why current interventions are insufficient’ [14].

This document includes the following recommendations on MSM:

- according to experts, a general brochure accessible to everybody could be more useful than addressing MSM with specific publications;
- MSM should be included as an HIV sentinel group, regardless of small numbers;
- more MSM might be accessed by an NGO such as ALGA (Albanian Lesbian and Gay Association) working with public health staff.

There is no data on how these recommendations were implemented and what impact they had on the epidemic.

2.2. Resource analysis

Government funding of the program: no available data about funding of activities for MSM.

Donors and domestic resources:

A) The Foundation for Partnership is Health: Western Balkans Program to Fight HIV and AIDS (PHASE I)
[15]

A1. Albanian Association for Prevention and Rehabilitation from Alcohol and Drugs

Project Title: Establish a voluntary counseling and testing centre with an awareness campaign.

Project description: The project aimed to establish a voluntary counseling and testing centre in Tirana and increase community awareness of the importance of VCT. At the start, the project procured testing equipment, furniture and supplies, conducted training for staff and developed VCT protocols. It proposed to provide counseling and testing for 1000 high risk people; prepare two manuals: one for staff and one for clients; promote the project through the media; support social marketing of VCT by creating a network of organizations and organize a national conference; provide training and discussion of sensitive behavioral issues; support PLHA by involving them in project implementation, and advocate for PLHA including making referrals.

Project duration: January 2005–April 2006

Target Groups: IDU, MSM, CSW, mobile populations and Roma living in Tirana

Budget: 31,330 Euro (Partnerships in Health); 4,700 Euro (APRAD's contribution)

A2. For a Healthy Albania

Project Title: HIV prevention among high-risk groups in Elbasan Prefecture

Project description: The project aimed to assess the knowledge and practice of HIV prevention in Elbasan through focus groups and quantitative data, and increase awareness of HIV infection with information tailored to specific groups. Main activities included conducting baseline and end-of-project knowledge, attitude and practice (KAP) assessments of the target groups; training literate members of each group to be peer educators; developing and distributing leaflets/posters on HIV and AIDS; promoting and distributing free condoms accompanied with information leaflets, and publishing a final report.

Project duration: January 2005–February 2006

Target Groups: 10,000–12,000 migrants in the districts of Librazhd and Gramsh, 7,000–8,000 Roma, 100 IDUs, 50–100 CSWs and 50–100 MSM

Budget: 29,998 Euro (Partnerships in Health); 4,100 Euro (FHA's contribution)

Results to date: Baseline qualitative and quantitative KAP assessment of target groups in the prefecture of Elbasan were conducted; increased knowledge through four training sessions on HIV and AIDS for 86 migrants, 55 Roma, 6 CSWs, 6 IDUs and 5 MSM. Increased knowledge on HIV and

AIDS through peer educators reaching 15,000 Roma, 13,000 migrants, 100 IDUs, 80 CSW and 60 MSM. Three types of leaflets: one for the general population, including Roma and migrants, the other for IDU and the third for MSM and CSW. 10,700 brochures developed and distributed; 10,600 packs of condoms and distributed.

B) Global Fund (ROUND 5) [16]

Project Title: Strengthening Albania's National Response to HIV/AIDS Among Vulnerable Groups

Grant No: ALB-506-G01-H

Principal Recipient (PR): Ministry of Health, Institute of Public Health Contact

Grant Start Date: 1 April 2007

Total Funding Request: \$4,936,229, with 6% of the budget planned to be spent on MSM programs (for comparison, 8% for prevention programs for Roma and 27% for IDU).

Key directions of MSM-targeted programs:

- strengthening capacity of gay NGOs to work on HIV issues;
- conducting HIV peer education among MSM;
- advocating on legal issues affecting MSM and stigma and discrimination;
- establishing a drop-in center for MSM in Tirana.

C) Some advocacy efforts have been also mentioned: Peace Corps, US Embassy, Dutch Embassy (First Albanian Human Rights Debate Conference in Tirana) [17].

D) Aleanca Kunder Diskriminimit te LGBT (Gay-Straight Alliance Against LGBT Discrimination) is working on two issues: health and LGBT advocacy. Recently they have done a lot for anti-discrimination bill adoption in Albania.

2.3. Existing programs and projects by service area:

HIV/STI prevention: according to national indicators for the beginning of 2008 [3, 4] on the percentage of most-at-risk populations reached with HIV prevention programs, the number of MSM participating in targeted HIV prevention programs is 209.

Care and support for PLHA-MSM: no available data.

Social and psychological support for homosexually-oriented people (community centers, work with parents, coming out, self-help groups, legal support): there are two established associations for MSM in Albania (Association of Gay and Lesbians of Albania and Society Gay Albania (36)). These have periodically been involved in HIV prevention activities.

A community center is operating in Tirana within the GF project. Prevention activities among MSM are located mainly in Tirana. MSM were reached through a variety of activities including HIV/AIDS education, distribution of IEC materials and counseling. A community center for MSM in Tirana was established and is being run by an NGO. The center is frequented on average by 3–5 MSM every day.

³⁶[http://www.aidsactioneurope.org/index.php?id=181&no_cache=1&tx_windmemberlist_pi1\[country\]=Albania&tx_windmemberlist_pi1\[member\]=148&cHash=fe4c91aad2](http://www.aidsactioneurope.org/index.php?id=181&no_cache=1&tx_windmemberlist_pi1[country]=Albania&tx_windmemberlist_pi1[member]=148&cHash=fe4c91aad2)

Research, training and methodological publications: there are some local-level studies of knowledge and behavior among vulnerable groups, e. g. MSM, conducted by Project Hope in Elbasan [16]37.

Mobilization, organizational development, capacity building and leadership development: the GF project in particular is aimed at this.

3. Program gaps and recommended steps to develop services

3.1. Gaps in data about the population, risks and HIV prevalence

- No data about the size of vulnerable groups (even IDUs).
- Social, demographic and behavioral characteristics of MSM outside Tirana are not studied.
- Overlapping vulnerable groups (MSM+IDU, MSM+CSW, MSM+Roma, etc.) have never been researched.
- All behavioral surveys are represented by one questionnaire of 200 people in 2005, which means there is no monitoring as such.
- No data about more specific research on MSM (e.g., public attitudes to LGBT – only several life stories – same-sex partnership, prison studies, etc.).
- Practically no data about MSM-NGO activities; it is not known whether they exist outside Tirana. There is a degree of organizational development of MSM-service NGOs, but no data about the results of its activities.
- No data about prevention programs for migrant MSM and MSM-prisoners.
- No data about care and support programs for HIV positive people (including MSM).

3.2. Gaps in policy decisions and allocation of funds

- No data on which measures are being taken by the country to overcome homophobia and develop tolerance in a multicultural environment (excluding the fact that homosexuality was decriminalized and some steps are being made to legalize same-sex partnerships).
- Though Albania has a number of national coordination mechanisms that have been operating since 2001[16], the role of LGBT-NGOs in HIV prevention and the principles of relationships between AIDS-service and LGBT movements remain unclear:
- NAP (National AIDS Program) is a multidisciplinary team of doctors, epidemiologists, psychologists and social workers that coordinates and develops HIV/AIDS prevention activities as well as monitoring and evaluating the epidemiological situation in Albania.
- A network of strategic partners was established in 2003 including governmental, nongovernmental and international or national agencies. This will strengthen the multidisciplinary approach towards prevention and care of HIV/AIDS in Albania.
- In 2001, an inter-ministerial HIV/AIDS committee chaired by the Vice-Prime Minister was established to strengthen policy efforts against HIV/AIDS.
- There is some information about government support, including financial, for AIDS-service activities: in 2007, the contribution of Albania was comparable to that of the Global Fund (\$1,110,357 USD domestic and \$1,266,600 USD international) [4], but there is no data on whether the government support included LGBT organizations, or if they were supported by external donors.

37 There is no information about this on the website <http://www.projecthope.org>, moreover, Albania has not been included in the list of countries where this project is operating.

3.3. Gaps in the development of programs by area

Due to the lack of data, an M&E system of the national epidemic response can be considered the largest gap.

3.4. Expert recommendations to develop this activity area in the country

Taking into account the total lack of data about epidemic response programs and the identified high-risk behavior of surveyed Albanians (both MSM and non-MSM), the highest priority action might be to organize a conference with the participation of international experts, leaders of local LGBT-NGOs, AIDS-service and governmental institutions, which should result in a situation analysis and development of strategic plans of epidemic response among LGBT/MSM/WSW.

Judging from the absence of articles in English-language sociological and epidemiological journals which could describe the success of monitoring, including sentinel surveillance programs, it can be concluded that such monitoring has not been performed. It would therefore be expedient to perform another bio-behavioral survey among Albanian MSM and compare its results with the 2005 survey.

An efficient epidemic response, as well as monitoring and evaluation of this response, is impossible without strong local organizations. There is a need to focus on developing the organizational capacity of LGBT organizations, on community mobilization (especially outside Tirana) and on incentives for local LGBT organizations to integrate with the European LGBT movement.

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Annex 3. Azerbaijan country profile

The Republic of Azerbaijan is a country in the South Caucasus. It is bordered by Armenia, Georgia, the Russian Federation, Iran and Turkey, and washed by the Caspian Sea. Azerbaijan is a presidential parliamentary republic. The population of the capital, Baku, is 2,246,000; the general population is 9 million people.

1. Description of HIV prevalence and related risks among MSM

1.1. Group definition (accepted in the country):

MSM – Men having sex with men (WHO), in official documents instead of MSM more often used the term high risk group. High-risk sexual behavior, injecting drug use and sexual violence mean that MSM and their sexual partners should be considered a highly vulnerable group for HIV infection.

Structure (identity, subgroups): little available data

Size estimation: size estimation of the MSM population, as for other most-at-risk populations (IDUs, CSWs) has not been performed. As a result, needs estimation and service coverage is problematic.

Legal status, homosexual partnership: civil partnership.

Stigma and discrimination: there is a high level of stigma and discrimination because of religion. Cases are mentioned in the Sexual Orientation and Gender Identity Report, published by the US Department of State, 2010.

Three main problems faced by sexual minorities in Azerbaijan are:

- homophobia on a governmental and public level (hate speeches, negative media coverage, black PR in election campaigns);
- discrimination, violence, blackmail and violations of human rights from the police in relation to LGBT. Nine police round-ups were recorded by the Gender & Development organization (G&D) in 2008–2009 (in bars where LGBT gather); 35–60 people were arrested after every round-up, cell-phones were confiscated, all mobile numbers noted and money was extorted;
- family violence (Islamic radicalism, limits on freedom, money). G&D recorded 12 cases of violence among MSM aged 19–26 in 2009.

Punished, not punished: homosexuality is not punishable by law (since 1999),³⁸ but police workers punish MSM representatives in their own way.³⁹

1.2. Description of population

Age: the research could reach only people from 17–40 years old.* According to a Bio-Behavior Surveillance Study among five MARGs in seven HIV prevalence districts of Azerbaijan 2007-2008, conducted by MoH with support of UNHCR, UNICEF, WHO, UNODC, WHO and UNAIDS, the sample of 100 MSM in Baku consisted mainly (71.0%) of young men aged 20–29 years.

³⁸ Information from web site: http://www.gfaids.az/index.php?i_id=32&do=aidsinazerbaijan&lang=e (further in text marked **).

³⁹ Information from Gender and Development organization (further in text marked *)

Urban/rural concentration: no available data.

Family status: no available data.

Social status: no available data. According to Bio-Behavior Surveillance Study of 2007-2008 , over half the respondents had completed or begun higher education. 11% of MSM reported serving a sentence in prison.

Professional status: no available data.

Income: low. According to interview with Gender and Development leader, the low income is the main reason of MSM involvement in prostitution*.

According to G&D, which has been working in Baku since 2007, the coverage of clients on outreach routes (five meeting places) was 1,944 MSM in 2009 including 30% regular visitors. The age of MSM is between 20 and 35. Most are Baku residents or residents of other towns and villages with a permanent job in the capital, who practice unprotected sex with gay and transgender people, or sex workers.

1.3 Risk factors

Prevalence of injecting drug use, other drugs, alcohol: a high level of alcohol consumption (alcohol use in places where MSM meet). 12% of MSM used drugs by non-injection or injection method. Injecting drug use is widespread; according to UNODC data, around 0.1% of the adult population use injection heroin (WHO, 2006).

Sex work (occurrence): high. According to Gender and Development, 52 transgender sex workers are regular visitors of the organization. 27 representatives of this group have been arrested by the police and forced to have STI testing; 15 representatives were diagnosed with second stage syphilis).
“AS it is forbidden for girls to have sex before marriage, it is hard for men in our country to find the female partner. There are only two possibilities left for the people in any part of the country – to use the services of prostitute but this could be not affordable, or to go occasionally to Baku and find there homosexual passive partner near the railway station. There is well known cruising area and public toilets” (from interview with G&D leader, Rzayev Kamran).

Frequency and number of partners (per month, per three months, per six months): 0–1, 2–5, 5–10, 10+ : no available data.

Sex with women (frequency, number of partners): 41.0% of respondents reported having females as partners (in the last six months).

Use of condoms with men, women, with regular and sporadic partners: 42.6% use condoms during anal sex, 37.1% use condoms during oral sex. 70 % of MSM do not use condoms at all.*

Among MSM, 42.6% did not use a condom during their last anal sexual contact, and 37.1% did not use a condom during their last oral sexual contact.

Request for STI testing: testing results of MSM in Baku (100 respondents): HIV – 1 respondent, Hepatitis C – 14, HvsAg – 4, Syphilis – 8.

Basic knowledge of HIV issues (according to behavioral survey):

In the previous year, 38.2% of respondents were tested for HIV and had obtained their results.

Basic knowledge of STI issues (according to behavioral survey): no data available

Other factors:

- High level of migration (constant migration from regions of Azerbaijan to the capital).
- ‘Work migration’ of MSM to frontier countries (Turkey, Russia, Ukraine) for periods of 6–9 months a year. An additional factor is foreign migrant MSM who arrive in Baku to work.
- Unprotected sexual contacts (sex in public places: in toilets at the railway station, markets, parks).

1.4. Epidemiological situation

The general epidemiological situation is as follows: since 1987, 2,224 patients have been registered at the AIDS Center. The gender balance is 1,799 men and 339 women; 448 people had AIDS. The number of people who have died is 274. Over the past few years, 400–450 people annually have been infected with HIV or developed AIDS in Azerbaijan, including 92% aged 15–50 and 23.2% IDUs. 16 cases of homosexual HIV transmission were officially registered in December 2009. There is no other data on transmission among MSM.

Almost half of all HIV cases (47%) registered in Azerbaijan (as the country is experiencing a recent HIV epidemic) were recorded in 2005–2006 (EuroHIV, 2007). Almost half of all cases were registered in the capital Baku; 13% were registered among injecting drug users under the 2003 testing program. Most HIV infection cases so far are a result of shared use of injection drug paraphernalia.

Estimation of current HIV situation and forecasts for future development and implications:

- In 2007, the HIV epidemic in Azerbaijan was defined as concentrated; the most vulnerable groups to HIV are IDUs, CSW, clients of sex workers, possibly mobile population groups. The MSM on the national level is not recognized as a vulnerable group.

The epidemic is regionalized. See the following regions in descending order in regard to infection prevalence:

- Baku – 434 (32.7%)
- Sumgait – 159 (12%)
- Lenokoran – 127 (9.6%)
- Ali-Bairamly – 99 (7.5%)
- Gandzhykabal – 86 (6.5%)
- Massaly – 40 (3.0%)
- Gyandzha – 38 (2.9%)
- Atara – 33 (2.5%)
- Evlakh – 30 (2.3%)

HIV prevalence in MSM (official registration statistics): no data available.

HIV prevalence in MSM according to epidemiological surveillance: no available data.

STI prevalence: epidemiological surveillance, project data, rapid tests: high*. A high HIV prevalence (9%) and prevalence of other STIs (syphilis – 9% and chlamydiosis – 63%) was registered among female commercial sex workers. Condom use among sex workers is not widespread (WHO, AIDS Epidemic Update, Regional Summary 2006).

1.5. Legislative protection from stigma and discrimination: there is no legislation on protection from stigma and discrimination based on sexual orientation. Despite the fact that there no criminal justice for homosexual sexual relations (since 1999), there is high level of stigma related to sexual orientation. As seen in the ILGA report, most of the stigmatizing and pressure directed at MSM comes from their closest environment – parents, close relatives. MSM are one of the most stigmatized population groups, and public admittance of one's homosexuality is not common.⁴⁰

2. HIV response in the MSM community

2.1. National commitment and official documents

National HIV/AIDS Program: no available data

National Strategy, National Plan – HIV, reproductive health, demographic safety:

- The new National HIV/AIDS Strategy for 2007–2011 was developed and approved in 2007.
- The Azerbaijan Country Coordination Committee was created in 2004. In May 2005, the Global Fund and the Ministry of Health as Principal Recipient signed a grant agreement. In August 2005 the Principal Recipient was joined by eight sub-recipients: Open Society Institute, Republican AIDS Centre, Republican Narcological Dispensary, Republican Dermatology and Venereology Dispensary, National Centre for Reproductive Health and Family Planning, UNICEF, Ministry of Education, Ministry of Youth, Tourism and Sport.
- In the national HIV/AIDS Strategy, the MSM population is not identified as a separate vulnerable group.

Road Map for Universal Access: no available data.

Situation analysis (UNAIDS, other international organizations): no related data.

2.2. Resource analysis

State funding to support the program: no state funding.

State resources: in 2007 the total funds allocated by the Ministry of Health to fight AIDS amounted to 1,320,000 AZN (including different budget lines, primarily procurement of test kits for HIV and opportunistic infections, medications to treat opportunistic infections and maintenance therapy for PLHA, and other administrative costs). According to the country progress report (UNGASS 2010), total expenses on the HIV response in 2009 was \$6,052,745.29, out of which the state budget costs were \$4,145,046.18, and another \$, 916,604.11 were from international sources. There no data available on the amount spent on the prevention or care programs for MSM. According to interviews with experts, there are no data on state supported programs for MSM.

⁴⁰ HIV and AIDS in the Caucasus Region: A Socio-Cultural Approach. UNESCO. 2005

International resources: in 2007, the Global Fund Round Four allocated \$2,109,338, which includes \$1,187,970 for prevention programs (including prevention work aimed at changing behavior and harm reduction programs for vulnerable populations – IDUs, CSWs, inmates, adolescents, etc.); \$495,720 for treatment (ARV therapy and treatment of opportunistic infections); \$142,300 for care and support (including palliative care for PLHA and social support), and \$283,348 to support a favorable environment.

By 2009, Global Fund Round Four allocated \$2,532,785 (\$ 1,482,128 in 2008 and \$1,050,657 in 2009), which includes \$1,094,997 for prevention programs (including prevention work aimed at changing behavior and harm reduction programs for vulnerable populations – IDUs, CSWs, inmates, adolescents, etc.); \$495,720 for treatment (ARV therapy and treatment of opportunistic infections); \$719,062 for care and support (including palliative care for PLHA and social support); \$ 149,662 for program management; and \$569,064 USD to build institutional capacity.

Local resources: no available data. Local NGOs distribute condoms and lubricants.

Donors:

- COC Netherlands *PRECIS project (2007–2010): 372,898 Euros.
- AmfAR, Raising the Level of Knowledge of Sexual Safety and HIV/AIDS and STI Prevention, Baku, Azerbaijan: \$15,000.
- ILGA Europe, for registering cases of rights infringements: 5,000 Euros.
- German Development Institute (DIE): 6,000 Euros.
- 2010 – 75,930 Euros for organizing a behavioral and epidemiological study among the MSM community in Baku.

a. Existing HIV response programs and projects

HIV/STI prevention: no available data.

Care and support for PLHA-MSM: no available data.

Social and psychological support to homosexually-oriented people (community centers, work with parents, coming-out, self-help groups, legal support): no available data.

Advocacy, rights protection, stigma and discrimination: no available data.

Research, trainings and method guidelines publications: no behavioral research and evaluation of social networks of MSM was conducted in Azerbaijan until 2010. G&D, in cooperation with WHO and the Republican AIDS Centre, is now conducting behavior research with elements of epidemical surveillance among MSM in Baku. The research will be conducted within the framework of the PRECIS project financed by COC Netherlands and is planned to reach 450 respondents.

Mobilization, organization development, capacity building, leadership: no available data.

The Azerbaijan non-governmental organization “Gender & Development” (G&D), established on 15 March 2007, is the only civil society organization in Azerbaijan promoting LGBT rights at national and international level. During its first three years, in the framework of the PRECIS project with support from COC Netherlands, G&D developed into a reputable organization with a transparent management system, professional staff and a pool of volunteers. Today the organization successfully works to inform

the LGBT community about activities in the country and abroad, and provides legal, social, psychological and medical assistance to project beneficiaries. A woman's initiative group was formed within the NGO which is organizing the lesbian and bisexual community into an integrated organization for women.

3. Program gaps and recommended steps to improve services

3.1. Gaps in data related to population, risks and HIV prevalence

- No access to the MSM group.
- Lack of reliable data on size estimation of most-at-risk populations, HIV epidemiological data and service coverage.
- No data on migration which is one of the risk factors of HIV infection.

3.2. Gaps in political decision-making and funding allocation:

- Governmental resources are not allocated for HIV/AIDS prevention among MSM.
- No laws in the Republic of Azerbaijan protect groups and sub-groups at high risk of HIV/AIDS infection such as MSM, IDU, CSW and prisoners from discrimination.
- Lack of regulatory documentation to define care and support provision.
- Lack of regulatory documentation which defines responsibilities of social services and other services which ensure care and support provision.
- Lack of cooperation between different social and medical services.
- Gaps in legislation and normative documents regulating comprehensive prevention activities among IDUs, including harm reduction programs and substitution therapy; legislative barriers to organizing prevention work among sex workers resulting from the illegal status of sex business.
- Lack of a training system.
- Lack of coordination of activities between AIDS services and narcological services.

3.3. Gaps in program development in service delivery areas

- Lack of resources (funding, premises, trained staff) to organize prevention work among most-at-risk populations.
- Lack of trained staff (medical and non-medical); lack of experience in treating HIV infection.
- Gaps in standard health assessment; vulnerable populations rarely turn for assistance to medical facilities.
- High cost of ARV medicines and medicines to treat opportunistic infections and viral hepatitis for adults and children.
- There is no one, comprehensive system to ensure care and support service provision; service provision remains sporadic.
- Gaps in coordination between different social and medical services in the course of treatment (HIV/STI/TB/narcology/social services; NGOs); lack or insufficient laboratory equipment for monitoring of treatment.
- Lack/insufficiently developed peer counseling.
- Vulnerable populations are insufficiently covered by testing.
- Vulnerable populations remain hard to reach.
- NGOs and the PLHA community are insufficiently involved.
- PLHA are insufficiently informed about access to treatment.
- Medical staff are not motivated to work with problem vulnerable populations.

Stigmatization and discrimination at all levels (society, medical facilities, social services, law enforcement agencies, penitentiary system, work place, education institutions, mass media).

3.4. Experts' recommendations to develop service delivery areas in the country

Data: the HIV surveillance system ensures provision of reliable representative data on different population groups. However, a key disadvantage of the existing system is lack of data on HIV prevalence among most-at-risk populations, including injection drug users, female and male sex workers, and men having sex with men.

Another disadvantage effecting quality of data collection within the framework of the existing HIV surveillance system is lack of behavioral and social studies. A key priority direction in the framework of the second generation surveillance system is to organize biological and behavioral studies and studies specially tailored for most-at-risk populations.

Currently Azerbaijan needs assistance in the following spheres:

- to develop and apply new methods of epidemiological study to monitor HIV/AIDS among vulnerable populations (IDUs, CSW, MSM, inmates, migrants, street children);
- to create and develop an integrated HIV/AIDS computer data base.

Prevention and treatment: HIV positive MSM are not sufficiently involved in HIV prevention because of stigma and discrimination within the LGBT community and in society. They are barely covered by HIV services.

In Azerbaijan, most of the LGBT community will hide their sexual orientation or sexual behavior when visiting a doctor or psychologist (if they visit at all) because of the intolerant attitude they will meet. This complicates the work of health workers and contributes to the spread of HIV.

- Introduce courses on tolerance, human rights and sexual diversity in schools and universities of Azerbaijan with the goal of educating society and averting violence in the family.
- Educate Azerbaijani law enforcement agencies on human rights standards in order to ensure safety and respect for human rights when dealing with representatives of MSM communities.
- Improve the skills of the media in covering gender and sexual diversity to reduce homo-, bi- and transphobia and related stereotypes in society.
- Introduce legislation to ban the call for hatred, discrimination and violence, including against sexual orientation and gender identity in Azerbaijan.
- Develop work in the field of migration, since many MSM go abroad for different reasons (stigma and discrimination, poor living conditions, etc.) and many of them contract HIV abroad.
- Scale up access to prevention activities.
- Scale up access to antiretroviral therapy as well as to prevention and treatment services for opportunistic infections.
- Strengthen HIV and AIDS awareness programs in secondary and high schools, and universities.

- Improve understanding of MSM in society, to decrease stigma and discrimination in relation to MSM and integrate services for MSM.

Sources:

“Hidden HIV epidemic amongst MSM in Eastern Europe and Central Asia,” January 2009, UNAIDS (http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090126_MSM_Ukraine.asp accessed 17 July 2009).

C Careres, et al. "Estimating the number of men who have sex with men in low and middle income countries." *Sexually Transmitted Infections* 2006, 82 (Supplement 3): iii3-iii9.

<http://data.euro.who.int/cisid/?TabID=242565>):
Sexual Orientation and Gender Identity Report (page 27)

National Report on the Declaration of Commitment on HIV/AIDS in the Azerbaijan Republic, reporting period January 2006–December 2007, published in 2008

National Report on the Declaration of Commitment on HIV/AIDS in the Azerbaijan Republic, reporting period January 2008–December 2009, published in 2010

Forced out: LGBT People in Azerbaijan. Report on ILGA – Europe/ COC fact finding mission, 2007.

Listed below are key documents defining universal access to HIV services in the Republic of Azerbaijan:

- The Law the Republic of Azerbaijan of prevention of spread of disease caused by the HIV , 1 May 2010
- The Law of the Republic of Azerbaijan On prevention of the spread of disease caused by the Human Immunodeficiency Virus (HIV infection), 1996
- Declaration of Commitment on HIV/AIDS, 2001
- Program to fight AIDS in the framework of the Global Fund to Fight AIDS, Tuberculosis and Malaria grant
- Political Declaration on HIV/AIDS. Resolution adopted by the UN General Assembly 60/262, 2006
- National Program for HIV/AIDS prevention and control in the Republic of Azerbaijan for 2007–2011

Annex 4. Belarus country profile

1. Description of the situation with HIV prevalence and HIV infection risk among MSM

1.1. Definition of the population

Definition (accepted in the country): men who have sex with men (MSM) – males (by their biological sex) who regularly (at least once every 12 months) have sexual relationships with males. In this case sexual contact means sexual practices that are characteristic for homosexual relationships: mutual masturbation, oral-genital and anal-genital sex.⁴¹

Structure (identity, subgroups): this group is closed. By their degree of self-identification they are subdivided into the following sub-groups:

- *Open groups.* They identify themselves as gay, bisexual or transgender people. They do not conceal their sexual preferences from their close environment. They regularly visit meeting venues (on the streets, “specialized” clubs, friends etc.), and place their profiles with photos on social websites not only to find sexual partners but also to communicate with like-minded people. This group is easiest to reach with prevention interventions.
- *Semi-open group.* More numerous than the previous group. The majority of its members identify themselves as gay, bisexual or transgender people. They reveal their sexual preferences only to a limited number of people, who in rare cases include parents and close relatives. Sometimes they visit meeting venues (on the streets, “specialized” clubs, friends etc.), and place their profiles (usually without photos) on websites as a rule to find a sexual partner. Typically they build M+M couples. Sometimes they have fictitious heterosexual families. This group can be reached by peer educators.
- *Closed group.* The most numerous group of MSM. As a rule, they do not identify themselves as gay, bisexual or transgender. They conceal their sexual preferences from their close environment. They may visit street meeting venues to find a one-time sexual contact. They do not communicate with other MSM communities. They place announcements on websites ostensibly to find a heterosexual partner, but offer sexual contacts to other men. They may have one permanent partner from the same group, if he has a family and does not evoke suspicion about his sexual orientation among other people. Most of them have heterosexual families. Sometimes they engage in sexual relationships against their will (patronage relations in the work place, within closed male-only collectives, etc.). This is the most hard-to-reach group for HIV/AIDS/STI prevention.

Based on analysis of in-depth interviews, expectation of a negative family attitude towards MSM and public opinion (democratic but at the same time accusatory towards non-traditional sexual relationships) are the determinants that influence the tendency to conceal homosexual status and, as a consequence, create the context for risky behavior among MSM [1].

⁴¹ This definition was provided by “Vstrecha” civil society organization in the framework of Component № 2 of UNDP Project 00039172 “HIV/AIDS Prevention and Treatment in Belarus”.

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

“Now I see gigantic progress at the level of political leaders, decision-makers in the Ministry of Health, deputy ministers and NCC members compared to the situation in 2000 or 2002. Firstly, MSM have been recognized as an existing group, which is already very positive; there was a lot of conflict about it during the first years of project implementation. Secondly, this group is included in all reports, that is, it is officially taken into account.”

Estimation of size: no research of the size of the MSM population in Belarus has been performed, and such an estimation is difficult due to the closed character of this group. According to the expert evaluation of the AIDS Prevention Department of the National Center for Hygiene, Epidemiology and Public Health, the population of this group is about 70,000 people.⁴²

Legal status, same-sex partnership: in 1994 an article envisaging punishment for homosexual relations was removed from the Criminal Code. The current Criminal Code of Belarus includes article 167 that envisages punishment for sexual violence including sodomy, lesbianism or other sexual acts perpetrated against the will of the victim. Article 168 punishes sexual intercourse and other sexual acts (including sodomy) with an individual less than 16 years of age. There is no special legislation regulating the establishment of same-sex families or partnerships.

Situation with stigma and discrimination: there is no special legislation concerning discrimination based on sexual orientation. However, article 190 of the Criminal Code, “Violation of the equality of citizens,” stipulates punishment “for the intended direct or indirect violation or limitation of rights and freedoms, or for the establishment of direct or indirect preferences for citizens depending on their sex, race, nationality, language, origin, property status or official capacity, place of residence, religious belief, membership in civil society organizations, which inflicted significant harm to rights, freedoms and legal interests of citizens.”

According to data from the sociological research “Factors Contributing to Risky Behavior of MSM” [1]:

- 11.8% of respondents reported that they had faced a negative attitude on the part of health care workers caused by their sexual orientation.
- Respondents experienced violent treatment due to their sexual orientation, including beating (7.5%), abusive language (26.0%), intimidation and threats (12.8%), extortion (4.3%), hostile attitude (31.2%).

A public opinion poll performed by the Belarus sociological laboratory Novak commissioned by the Russian LGBT human rights advocacy project GayRussia.ru found that 14.1% of Belarus residents support public gay and lesbian events, and 24% are indifferent to them. The survey also found that 57.7% of Minsk residents and 61.9% of Belarusians reject public events held by sexual minorities [2].

1. 2. Population description

Age: For research purposes we use the definition of the reproductive age (15–59 years). There has not been any research regarding MSM after the age of 59.

Urban/rural concentration: it is hard to determine the geographical distribution of MSM in Belarus. Minsk is the only city that has some entertainment infrastructure for MSM, meaning that many MSM

⁴² Documentation supporting this fact was not provided.

living in other regions of the country often visit Minsk, or try to move there permanently. However, this has not been researched.

Family status: most respondents who participated in behavioral research in 2007 were single (73.7%), some were married (5.4%), divorced (12.5%), or separated from their partners (1.3%) [3].

Vladimir Lapitsky, coordinator of work with MSM for the Global Fund-financed HIV/AIDS project: "The majority of MSM living in small cities such as Svetlogorsk, Pinsk or Bobruisk, create heterosexual families and remain very closed for prevention interventions, being afraid of disclosure of information about their sexual preferences."

Social status: the social status of MSM is also hard to determine. According to research performed in 2007, surveyed MSM had a fairly high educational level: 13.5% of respondents had finished secondary education and 31%, specialized secondary education; 26.9% were university undergraduates and 26.6% post-graduates.

Occupation: most MSM are employed: 37% are white collar workers, 30.3% are blue collar workers, 16.5% are university students, and 7.1% are school and vocational training school students. An insignificant number of MSM do not have any specific occupation (4.4%) [3].

Economic status: evaluating their income status, 40.9% of MSM reported that they could afford normal food, but not expensive purchases; 33.7% had enough money for a normal life; 20.8% indicated that they had enough money for food but had difficulty buying other necessities (clothes, medicines, etc.) [1].

Case Study: family status, stigma, sex work, violence

In an interview with Belorusskiye Novosti, an MSM representative who opted to remain anonymous said that fear of somebody finding out "about their untraditional sexual orientation often makes people insist on their ostensible heterosexuality. Even when you come to be tested for HIV and understand that it's anonymous, still there is the fear that someone could find out about it. And if they make a positive diagnosis then it's even more difficult to come out, because they'll start asking you about your partner and you will have to give him away. It's much simpler if you are heterosexual: you can just say that you had sex with a prostitute in another city and can't remember her name or appearance" [4].

2.2. Risk factors

Prevalence of injecting drug use, other drugs and alcohol use: drug use in the studied MSM group is not prevalent and detected cases are mostly related to the use of smoking drugs, pills, powder, etc. 11.2% of questioned MSM had experience of drug use; 0.8% refused to answer. The most common drugs (57 people in total) were: smoking drugs (91.3%); tablets, sprays (41.3%); injecting drugs (12.0%). 1.8% of MSM currently use drugs; 1% refused to answer. [1].

According to survey results, more than half of the target group (58.2%) had sexual contacts after alcohol intoxication. 9.7% refused to answer, possibly trying to conceal sexual relationships of this kind. In general, alcohol use is quite high; only 8.1% of respondents said they do not drink alcohol at all, and 26% reported using alcohol several times a week [1].

Vladimir Lapitsky, coordinator of work with MSM for the Global Fund-financed HIV/AIDS project: "There are many gaps in information about MSM behavior. "Vstrecha" is trying to fill these gaps. Now we are completing the project "Factors Contributing to Risky Behaviors of MSM." This examines many aspects that were not previously studied, including alcohol use and income levels among MSM."

Sex work: it is impossible to evaluate the size of this sub-group. According to research and sentinel surveillance, the number of MSM who provide sex services for money is decreasing. Analysis of Internet dating sites performed in 2006 showed that 16% (729 of 4,597) of announcements offered "commercial sex services" [5]. Analysis of dating websites at the end of 2009 demonstrated that 1,568 (1.1%) of 145,332 dating announcements placed by men offered sex services for money. 512 of them (33%) were ready to provide sex services only to women, 672 (43%) to both women and men and 384 (24%) only to men.

According to sentinel surveillance data for 2004, 24.6% of respondents provided sexual services for remuneration, while 17.9% purchased such services. According to research performed in 2007, 11.5% of respondents engaged in commercial sexual relationships in the past 12 months. However compared to 2007 the number of respondents who purchased sex services has almost doubled (5.4% in 2007, 10.8% in 2009), while 35% did not use condoms during the most recent commercial sex.

Anna Rusanovych, acting head of the AIDS Prevention Department of the National Center for Hygiene, Epidemiology and Public Health:

"Possibly we need to focus more on the group of male sex workers and adjust our work accordingly. We are working with MSM in general, but this seemingly small area is not properly covered."

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

"MSM behavioral characteristics are typically studied and evaluated within sentinel surveillance. There is a standard number of questions that serve for monitoring purposes and are asked during a certain time. There have been no studies to research this aspect in more detail; to study a broader range of specific issues related to male sex workers. Not long ago a gender evaluation of the government program was performed. It found many additional and previously unknown facts, some of them very interesting. We had not even suspected that they could be the drivers of the epidemic. It is related to bridge-groups between target populations and their partners. In principle, we had never even thought about it. This study was the first stimulus to us to evaluate and research things we had previously overlooked. And the standard behavioral estimates are of course made within the sentinel surveillance."

Frequency and number of sexual partners: according to behavioral surveillance among MSM performed in 2009, 53.2% of respondents had more than one sexual partner in the past month [6].

Sex with women (frequency, number of female partners): around 30% of MSM had sexual contacts with women in the past 12 months. 34.4% of respondents had sexual contacts with married men [6]. According to studies in 2006 and 2007, the share of MSM who had sexual contacts with women was 18.9% in 2006 and 21.2% in 2007 [7].

Condom use with both permanent and casual, male and female partners: data from a behavioral survey among MSM (407 people in seven cities) performed in 2009 show that this group still practices behavior that can result in HIV/STI infection. 53.2% of respondents had more than one sexual partner in the past month; 53.6% used condoms consistently for sexual contacts with occasional partners (SES

2009). According to the study “Factors contributing to risky behavior of men who have sex with men,” the share of MSM who always use condoms for sexual contacts was 46.2% [1].

Seeking STI testing: according to 2009 research, 84.6% of MSM have access to STI testing and treatment. 69% of respondents have been tested for STIs and 98.3% knew their test results [1]. According to the report of the project “HIV/AIDS Prevention and Treatment in Belarus,” 1,305 MSM had been tested for HIV with pre- and post-test counseling. STIs were detected in 857 men, and 739 of them received corresponding treatment (data from 1 October 2009) [7].

General level of awareness of HIV (according to behavioral survey): in general, the basic level of knowledge about HIV/AIDS among the target group is fairly high. This is confirmed by the distribution of respondent answers to questions about HIV transmission routes. Practically all interviewed MSM named sexual contact without condoms (98%), injecting drug use (96.2%), tattooing with shared needles (95.8%). However, answering the question about whether HIV can be transmitted through insect and animal bites, 13.4% respondents were not sure and answered incorrectly. Answering a question about the possibility of infection during an erotic massage, 7.2% also could not give a definite answer [1].

General level of awareness of STI (from behavioral survey data): no available data.

1.4. Epidemiological situation

HIV prevalence among MSM (data from official statistics by registration): according to official statistics, during the entire period of observation of HIV infection (1987–2009) there have been 47 reported cases of infection among MSM, which constitutes 0.4% of all reported cases in the country. In 2008–2009 there were 14 new HIV cases in this group (30% of all reported cases among MSM) [6].

HIV prevalence among MSM by sentinel surveillance data: In 2008-2009, this indicator has grown significantly compared to 2006, from 0.2% to 3.1%. The data indicate some activation of the epidemiological process in the MSM group during the last two years against the background of growing sexual transmission of HIV. In 2006, HIV prevalence was $0.2\% \pm 0.18$; in 2008 it was $3.1\% \pm 0.9$, in 2009 it was $2.1\% \pm 0.7$ [6].

STI prevalence: sentinel surveillance (project data, rapid tests): STIs were identified in 857 out of 1,305 men; 739 of them received required treatment [8]. 588 MSM were tested for STIs in 2009 and STIs were identified in 240 men, or 41% (report data from the project “HIV/AIDS Prevention and Treatment in Belarus”).

Sentinel surveillance performed in 2005 showed that STIs were detected in 23.1% of MSM (144 positive results in 624 respondents). The highest STI prevalence (28.1%) was observed in the age group of 30+ years (41 positive results out of 146) and in the 20–29 age group (23.1%, or 90 positive results out of 390 respondents). The lowest STI prevalence among MSM was registered in the 15–19 age group (12.8%, or 5 positive results out of 39).

Case study: the growth of positive test results after the introduction of rapid tests

When HIV tests were performed with the use of rapid tests on the basis of a finger-stick blood sample, 12 results were positive among 382 tested MSM. Three years ago there was only one positive test result. We can logically conclude that the number of potential AIDS patients has grown 12-fold.

However, as Oleg Eremin, head of the national youth organization “Vstrecha”, whose activities are directly related to HIV/AIDS work among MSM, explained to Belorusskiye Novosti, there is no reason to panic although there is some cause for concern.

“Firstly, this time the blood sample was taken from the finger, while previously it was taken from the vein. This kind of analysis does not give a 100% correct result. An expanded test is needed to confirm HIV/AIDS diagnosis; that’s why we recommend that everybody who received an HIV positive result with a rapid test go to the AIDS Prevention Department (of the National Center for Hygiene, Epidemiology and Public Health). Also, the target group of tested people has changed, which also contributed to the increased number of positive test results.

Previously, when we organized such surveillance, who came to us to be tested? As a rule, they were social workers and people in their close environment, i.e., people who are tested often due to their occupation and who are usually healthy. It was very hard to attract people from the streets to be tested. Rapid tests helped us to work in the field. We came to a disco and explained to the guys what was needed. The group that was not previously reached was finally involved in the process.”

Anonymous and voluntary blood testing for HIV was performed at one of the city discos among MSM. A total of 70 people were tested and four of them had a positive result [4].

2. Epidemic response in the MSM group

2.1. National documents and commitment

National HIV/AIDS Program: prevention work among MSM, as well as among IDU and FSW was included in the National HIV Prevention Program for 2006–2010 and in the draft National HIV Prevention Program for 2011–2015.

National Strategy, National Plan – HIV, reproductive health, and demographic safety: the National Action Plan on Universal Access to HIV Prevention, Treatment, Care and Support in Belarus for 2009–2010 includes the following activities:

- improvement of access to STI diagnostics and treatment for MSM (200 patients were treated);
- access to quality condoms and lubricants for 10,000 MSM;
- provision of information and peer education on HIV/AIDS/STI prevention.

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

“Of course, the government program always takes this group into account. However, there is no separate document called “Prevention program for MSM,” though the question sometimes arises at international level. Perhaps it would be worth developing a separate sub-program related exclusively to MSM. But there are still no such documents on the state program level which would deal with MSM issues, such as the Concept of Demographic Safety, or the Social and Economic Development Plan – this group is not mentioned there and I wouldn’t say that it needs to be. Inclusion of this group in these documents should be based, for instance, on a severe epidemiological process in this group that has an effect on the whole epidemic development. Even the Concept of Demographic Safety now includes prevention of vertical transmission as it has an impact on demographic safety. That’s why it is unrealistic to expect that the MSM group should be included in other programmatic documents in this country. It may sound interesting and good, but there are no grounds for it yet.”

2.2. Resource analysis

Government funding for the program: State budget funding of activities aimed at these target groups is provided within the range of services provided to the general population (e.g. STI treatment). It is impossible to single out funds allocated to services for these groups from the total amount of state budget funding for certain services. There is no targeted allocation of state budget funds for prevention of HIV among IDU, FSW and MSM, a factor that hinders the sustainability of prevention programs among these groups [6].

Local resources: no information.

Donors: evaluation of national expenditure on HIV/AIDS in 2008–2009 in Belarus showed that prevention programs for vulnerable groups (IDU, FSW, MSM) were mostly funded by donors (Global Fund to Fight AIDS, Tuberculosis and Malaria).

Belarus was a recipient of GFATM Round 3 and will have received a total of \$24 million in HIV/AIDS funds from 2004 through December 2012, when the current Round 4 grant terminates. The program under the Round 3 HIV grant, launched in late 2004, aims to boost the national prevention efforts among vulnerable populations, including injecting drug users, sex workers, men who have sex with men, prisoners and youth. The program is also works to ensure ARV treatment, care and support for people living with HIV, including improved access to medical services for diagnosis and treatment of sexually transmitted and opportunistic infections. In addition, the program aims to decrease mother-to-child HIV transmission and supports information and education campaigns among young people.

Belarus is also a recipient of GFATM Round 8, currently in Phase 1 (Jan 2010 – Dec 2011) and will receive a total of \$13 million. The program will expand prevention, treatment and care services for most-at-risk populations, injecting drug users, sex workers, men who have sex with men, prisoners, women and youth, and will aim to improve the quality of services through capacity building of the nongovernmental organizations servicing these groups. The program will also provide prevention services to young people through schools to make treatment with antiretroviral drugs more widely available, to improve laboratory diagnosis and training of health care staff; and to provide TB treatment to HIV patients who need it.

In 2005–2010, programs for MSM were funded by the Representative Office of the Christian Children’s Fund (USAID project) and by the American Foundation for AIDS Research (AmfAR) to the amount of less than 1% of total funding of programs for MSM.

Vladimir Lapitsky, coordinator of work with MSM for the Global Fund-financed HIV/AIDS project: “It is quite hard to find funding for implementation of prevention activity among MSM in our country. Many foundations believe that since we have the Global Fund, then all activities needed for MSM and HIV/AIDS in general are already being implemented. However, the application to the Global Fund was written by the government, while civil society organizations had no decisive say in the process of application development, and many aspects that deserved attention according to civil society experts have not been funded. Also, procedures to register projects are very complicated in Belarus. The project should be registered at the Presidential Department for Humanitarian Activities, but this department will only register a project on the basis of a supporting letter from the Ministry of Health. “Vstrecha” had some projects that it could not register, including a project on work with MSM-PLHA. They had even

found a funding source, but the Ministry of Health wrote a letter saying there was no need for such activities and so the project was not registered.”

2.3. Existing programs and projects by service areas

HIV/STI prevention: in 2004–2009 the Belarus Association of UNESCO Clubs in cooperation with youth civil society organization “Vstrecha” implemented the component “HIV/AIDS Prevention among MSM” within the UNDP project “HIV/AIDS Prevention and Treatment in Belarus” funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The service package included: outreach counseling, provision of psychological support on HIV/AIDS-related issues, anonymous STI testing and treatment, distribution of condoms and water-based lubricants and information materials. Activities were implemented in Minsk, oblast cities and Svetlogorsk. In 2010, a new project was launched, financed by the Global Fund, “Ensuring universal access for key affected population groups in Belarus to HIV prevention, treatment, care and support.”

The same package of services is provided within this project, but its activities were expanded to the cities of Pinsk and Bobruisk. 16,355 people are covered with HIV/AIDS prevention activities, which constitutes 23% of the estimated number of MSM. International experts evaluated the efficiency of activities implemented within this project highly.

Care and support to PLHA-MSM: there are no targeted programs aimed at this group.

Social and psychological support to homosexually-oriented people (community centers, work with parents, coming-out, self-help groups, legal support): no targeted programs.

Advocacy, human rights protection, stigma and discrimination: no targeted programs.

Research, technical support and methodological publications: in 2010, “Vstrecha” initiated the research project “Factors Contributing to Risky Behaviors of MSM” funded by AmfAR. The project is now in its final stage.

Mobilization, organizational development, capacity building and leadership development: no targeted programs.

3. Program gaps and recommended steps to develop services

3.1. Gaps in data about the population, risks and HIV prevalence

There is a need for a comprehensive qualitative evaluation of MSM with the use of modern research methods. Comprehensive research on HIV-related MSM needs is required. There is a need for both qualitative and quantitative evaluation of the following MSM subgroups:

- male commercial sex workers;
- young MSM;
- MSM in closed communities (prisons, army);
- MSM who are drug users;
- bisexuals;
- transgender people.

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

“No special separate evaluation with specified goals and objectives for development of a particular program has been performed. A partial needs evaluation was implemented while developing the application for Round 8 of the Global Fund grant and the mechanism of sustainable funding, but it was based on already existing data. A qualitative estimate always allows for a more thorough review, but at the moment of application-writing, all MSM needs were evaluated on the basis of the existing epidemiological situation and the results of existing projects – that is, reporting documents – and that is why these gaps are based on the analytical information that was available at the time.”

Egor Novikov, civil society relations manager, USAID:

“We had a project that was being implemented by the Children’s Fund to support the network of AIDS-service organizations, and MSM needs were evaluated, but I think they were included as just one of the target groups and their needs were evaluated within the needs of other groups. They were included in the general evaluation, but if I remember correctly there was no separate evaluation.”

3.2. Gaps in political decision-making and allocation of funds

There is no government support to create a favorable environment for MSM that would improve their access to HIV/AIDS/STI prevention and treatment services. A number of legal initiatives and advocacy efforts are needed:

- a law on same-sex partnership;
- a state program or strategy development for work with LGBT/MSM on all related health and social issues;
- a law on social contracting and state funding of NGO projects aimed at MSM.

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

“We have few civil society organizations providing prevention services specifically for MSM. How many? Just one. So, while we have a serious and deteriorating problem in the country and we know that only civil society organizations are providing prevention services to this group, we have only one such organization and, naturally, cannot hope in the long run to achieve any serious breakthrough. First of all, we need to ensure comprehensive services, their quality and so on. A lot needs to be done. Of course, it can be done by one organization but it should have a big network throughout the country with specialists in different areas, e.g., monitoring, efficient practices, communication, etc. I mean experts who are focused on this target group and who would be admitted to all comprehensive councils.”

3.3. Gaps in program development by areas

- Legal counseling to MSM is not provided.
- There is a high level of stigmatization and discrimination of MSM by health care workers.
- No targeted programs for MSM-PLHA.
- No programs on advocacy, human rights protection, reduction of stigma and discrimination against MSM.
- Low material status and organizational capacity of organizations working with MSM; no conditions to motivate the volunteer movement; poor incentives for project employees.

Anna Rusanovych, acting head of the AIDS Prevention Department of the National Center for Hygiene, Epidemiology and Public Health:

“There are no separate programs focused exclusively on MSM, but HIV prevention activities in this group are included in the current government program for the prevention of HIV infection for 2006–2010 and will be included in the new program that is being developed now for 2011–2015.”

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

“Belarus has three key priorities at the international level. They include prevention among IDUs, because today this is the largest percentage of infections and remains the driving force of the epidemic; then sustainability of treatment; then care and support services, because they are not systematic now and we have only one-off projects and attempts to stimulate them. These are all strict priorities for Belarus.”

3.4. Expert recommendations for development of this activity area in the country

The following are needed for development of HIV/AIDS programs for MSM:

- expand the geography of existing HIV/AIDS/STI prevention services;
- implement educational activities for health care workers in order to reduce the level of stigma and discrimination against MSM;
- develop the system of MSM-friendly medical facilities, including opening health centers for MSM in the cities covered with prevention activities;
- expand the research areas related to MSM;
- implement programs on advocacy, human rights protection and reduction of social stigma and discrimination against MSM;
- build capacity of the youth organization “Vstrecha” and support initiative groups, including training visits, motivational packages for volunteers and leadership development activities.

In 2009, an expert evaluation of “Vstrecha” was performed within the project “HIV/AIDS Prevention and Treatment in Belarus.” International expert George Ayala provided his recommendations for further activities aimed at MSM:

1. To add activities aimed at alcohol abuse, problems with family and close environment that could increase vulnerability to HIV.
2. To continue issue of specialized educational materials on STI and HIV infection risk factors.
3. To develop the system of drop-in centers for MSM, where they could feel safe and would have an opportunity to be anonymously tested for STIs; to implement activities within HIV prevention programs.
4. To scale-up online web counseling.
5. To develop the system of hotline counseling and expand the number of subjects to include discrimination, family problems and alcohol abuse.
6. To expand the provision of anonymous STI and HIV diagnostic services for both male and female sexual partners of MSM.
7. To find resources to vaccinate MSM against hepatitis.
8. To find resources to diagnose HIV and STI among transgender people who do not identify themselves as MSM.
9. To develop the plan to inform partners and interested parties about the results of project activity, specific features of Belarusian MSM and their HIV/STI-related needs.
10. To use program data and results to look for additional resources in order to expand STI/HIV diagnostic services for MSM.
11. To perform quantitative evaluation of the MSM population and HIV prevalence in this group.

12. To determine the geographic distribution of MSM.
13. To review and adjust the salaries of project personnel and programs to build up their professional capacity.
14. To support the volunteer movement, train volunteers and develop a system to assess their performance.
15. To strengthen the evaluation of program and research activities in order to better understand the trends in risky and safer behavior of MSM and correlate prevention activities.
16. To evaluate the needs of MSM and increase funding for the prevention of HIV in proportion to these needs.
17. To expand existing services and make legal support available to MSM.
18. To implement projects and campaigns aimed at better socialization of gays and lesbians and at reduction of homophobia in society.

Eleonora Gvozdeva, UNAIDS country coordinator in Belarus:

“The first recommendation I always give: improve your knowledge about MSM. You need to have ten pages of clear information: what is this group, its size by region, its professional and educational profile, how the process is developing in the regions. Then, it is very fashionable and necessary now – and we will need to answer these questions – what is the cost of HIV prevention per one MSM compared to one IDU, is it more expensive or cheaper.”

Anna Rusanovych, acting head of the AIDS Prevention Department of the National Center for Hygiene, Epidemiology and Public Health:

“Speaking about development of existing programs, I would like to ask our civil society organizations working with risk groups to focus on development of adherence to antiretroviral therapy among PLHA. Today many people living with HIV and in need of ARV treatment simply refuse for various reasons.”

Egor Novikov, civil society relations manager, USAID:

“I have a rather traditional recommendation. No matter in which area we work, we always pay priority attention to the development of opportunities among our target groups through capacity building and strengthening the civil society they represent. Training is very important, as it is necessary to improve the administrative skills of activists from these organizations, to increase their leadership skills, because a lot depends on leadership, and of course, to ensure sustainability through better diversification of funding and other resources.”

Vladimir Lapitsky, coordinator of work with MSM for the Global Fund-financed HIV/AIDS project:

“There is a need to ensure sustainability of programs. A law on social contracting is needed on the condition that HIV/AIDS programs are funded. Many more studies are needed in order to thoroughly understand this group and focus prevention activities properly. Advocacy of not only MSM’s health, but of their human rights is also needed.”

Sources

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Annex 5. Georgia country profile

1. Description of the situation with HIV prevalence and HIV infection risk among MSM

1.1. Definition of the population

Definition (accepted in the country): men who have homosexual contacts.

Structure (identity, subgroups): “Tanadgoma” Center is working with MSM which it subdivides into the following sub-groups: commercial sex workers; not related to sex work; MSM of low social and economic status; MSM of middle and higher social and economic status.

Estimation of size: no available data.

Legal status, same-sex partnership: same-sex partnership is not legalized. The legislation of Georgia does not include any definition of MSM, with the exclusion of the Criminal Code which criminalizes homosexual contacts with minors. In general, the definition of MSM can be found in regulatory documents supporting the country’s HIV response strategy.

Situation with stigma and discrimination: (see the “Discrimination survey conducted among 120 LGBT in Georgia,” February 2006, and “Overview of Georgian Legislation in relationship to LGBT human rights,” Inclusive Foundation)

1. 2. Description of the MSM population

Age: average age is 27 (18–64) [4, “Characteristics, High-Risk Behaviors and Knowledge of STI/HIV/AIDS, and Prevalence of HIV, Syphilis and Hepatitis Among MSM in Tbilisi, Georgia: 2007,” Tanadgoma, USAID, Save the Children. Total number of respondents in this survey – 140]

Urban/rural concentration: according to the “Tanadgoma” Center, generally this group is concentrated in the capital city (Tbilisi) and other large cities such as Batumi and Kutaisi. There has been no specialized research.

Family status: around 35% are or were married to women [4].

Occupation: no available data.

Income: commercial sex workers: 100–300 lari per month (US\$ 60–165) [4]

1.3. Epidemiological situation⁴³

Number of people living with HIV: 2,519

Adults aged 15 to 49 prevalence rate: 0.1% (0.1%–0.3%)

Adults aged 15 and up living with HIV: 2,700 (1,500–6,100)

Women aged 15 and up living with HIV: 640 (<500–1500)

Children aged 0 to 14 living with HIV: 61

Deaths due to AIDS: 543

Orphans due to AIDS aged 0 to 17: N/A

⁴³ Data of official registration on September, 5, 2010 (http://aidscenter.ge/epidsituation_eng.html)

HIV prevalence among MSM (official statistics at registration): of 2,318 officially registered cases, 60 (2.5%) were MSM (official registration statistics from 17 March 2010).

HIV prevalence among MSM according to sentinel surveillance data: 3.7% (verified) [4].

STI prevalence: sentinel surveillance, project data, rapid tests: Syphilis (rapid tests) – 31.4%; Hepatitis B (rapid tests) – 10%; Hepatitis C (rapid tests) – 15.7% [4].

1.4. Risk factors for MSM

Prevalence of injecting drug use, as well as of other drugs and alcohol: around 39% use or used drugs; around 9.3% use or used injecting drugs; around 46% consume alcohol at least once a week; 21.4% consume alcohol twice a week; 5% consume alcohol every day. [4]

Sex work (prevalence): around 21% are or were engaged in commercial sex with other men [4]

Frequency and number of partners (a month, every three months, every six months): within the last six months the number of male partners was:

1–5 – 69.3%

6–10 – 15.0%

11+ – 15.7% [4]

Sex with women (frequency, number of female partners): 67.1% had sex with women; within the last six months the number of female sexual partners was:

1 – 27.7%

2–9 – 44.6%

10+ – 19.2% [4]

Condom use with men and women, with permanent and occasional partners: the following data are available:

Condom use during last oral sex – 43.6% (41/94)

Condom use during last anal sex – 61.7% (74/120)

Condom use during last anal sex with a commercial sex worker (male) – 37.5% (3/8)

Condom use during last anal sex with an occasional sexual partner (female) – 50.6% (42/83) [4]

Seeking for testing for STI: around 60.7% were tested for STI [4]

General awareness of HIV (on the basis of a behavioral survey): 97.1% have heard about HIV and/or AIDS; 24.3% gave correct answers to six key questions about HIV transmission routes [4].

General awareness of STI (on the basis of behavioral survey): 97.1% have heard about STIs and/or HIV/AIDS; 49.1% do not know key symptoms of STIs [4].

2. HIV response in the MSM group

2.1. National documents and commitment

National HIV/AIDS Program: there is a governmental program to respond to HIV/AIDS, wherein MSM are defined as a high-risk group on which certain activities are focused.

National Strategy, National Plan – HIV, reproductive health, and demographic safety: there is a National Strategy and National Plan for 2007–2010; a new National Strategy and Plan are being developed for 2011–2016.

Road Map for Universal Access: No

Situational analysis (UNAIDS, other international organizations): was conducted and issued on 14 February 2010.

Legal protection from stigma and discrimination: there is no specific legal document that would address stigma and discrimination against MSM.

2.2. Resource analysis

Government funding of the program

Georgia is a GF Round 9 recipient. The Round 9 grants extend the previous Round 2 grant through December 2012 with a total value of approximately \$14 million. Round 9 activities aim to increase the number of HIV prevention and education interventions targeting MSM in order to decrease the high risk practices among MSM and improve the access and utilization of HIV prevention and treatment services by particular MARP group.

- **Local resources, donors:** According to the 2010 UNGASS report, the annual expenditures from all sources for MSM targeted programs in Georgia were: \$242,470 was spent on MSM targeted programs in 2006;
- \$305,270 was spent in 2007; all sources including GFATM, USAID and other donors
- \$273,960 was spent in 2008.

2.3. Existing programs and projects by service area

According to Nino Tsereteli, Executive Director, Center for Information and Counseling on Reproductive Health “Tanadgoma,” since 2004 existing programs supported by GFATM, USAID and other donors, implemented by this organization, have managed to cover about 650 MSM (primary contacts). The following services are offered to MSM:

- outreach;
- training/seminars on HIV, STIs, hepatitis;
- condom and booklet distribution (three topics);
- peer education;
- HIV and STI testing (mobile laboratory);
- referral service.

On the following page are some projects implemented in the country by several civil society and international organizations. “Tanadgoma” centre is the only organization to provide direct service and referrals to MSM for HIV/STI prevention:

1. **Implementers:** RTI International, Save the Children, PATH, Tanadgoma, IOCC, Bemoni Public Union.

Funding source: USAID

Regions: Tbilisi, Kutaisi (Imereti region), Batumi (AR Adjara) and Zugdidi (Samegrelo region)

Activities: outreach, counseling, VCT, distribution of information materials and condoms, peer education for MSM.

Regions by the time of project completion: Tbilisi, Kutaisi (Imereti region), Batumi (AR Adjara), Telavi (Kahetia region) and Zugdidi (Samegrelo region).

2. **Implementers:** International Curacio Foundation, National Disease Control Center, National AIDS Centre, “Tanadgoma”, Bemoni.

Funding source: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

Regions: Tbilisi

Activities: implementation of BSS research of MSM, implementation of sentinel surveillance among MSM (this component is performed by “Tanadgoma”).

3. **Implementers:** “Tanadgoma,” Association of STI Physicians.

Funding source: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

Regions: Tbilisi, Kutaisi (Imereti district), Batumi (AR Adjara).

Activities: outreach, counseling, VCT, diagnosis and treatment of STI, distribution of information materials and condoms, peer education.

Regions by the time of project completion: Tbilisi, Kutaisi (Imereti Region), Batumi (AR Adjara), Telavi (Kahetia district), Zugdidi (Samegrelo district).

4. **Implementers:** “Tanadgoma”

Funding source: Oxfam Novib

Regions: Tbilisi.

Activities: outreach, counseling, VCT, diagnosis of hepatitis, distribution of information materials and condoms.

3. Program gaps and recommended steps to develop services

3.1. Gaps in data on the population, risks and HIV prevalence

No data about the estimated size of the MSM group.

3.2. Gaps in political decision-making and allocation of funds

Research to estimate the size of the MSM group is not funded. No funds are envisaged for the performance of routine sentinel surveillance.

3.3. Gaps in the development of programs by areas:

1. Advocacy
2. Self-help groups
3. Low coverage
4. Geographical expansion (currently, work is only being done in the two cities of Tbilisi and Batumi)
5. Training for health care providers
6. HBV vaccination
7. Case management
8. Internet-based interventions
9. Empowerment and LGBT-community mobilization

3.4 Expert recommendations for the development of this activity area in the country

All the above-mentioned gaps need to be addressed.

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Annex 6. Moldova country profile

1. Description of prevalence and risks of HIV-infection in the MSM community

1.1. Group identification

Definition (accepted in the country): MSM – men having sex with men.

Structure (identity, subgroups): the MSM group includes such sub-groups as gay, bisexual and heterosexual men.

A lack of specialized information at national level regarding safer sex between two people of the same sex, as well as the importance of HIV prevention methods among this group, situate the LGBT community within the group at risk of HIV infection.

Size estimation: estimation of the LGBT community carried out by GenderDoc-M at the end of 2009 [1] puts the number at 829, including 650 MSM and 179 WSW; 754 in Chisinau (575 MSM, 179 WSW), 33 in Balti (all MSM) and 42 in Tiraspol (all MSM)[1].

Legal status, homosexual partnerships: voluntary sexual relations between men are legal for anyone over the age of 16. Same-sex partnership is forbidden by law.

Stigma and discrimination: according to the Criminal Code of Moldova, the law on HIV/AIDS prevention does not discriminate against the LGBT community. Nevertheless discrimination towards HIV positive people based on sexual orientation does exist.

The Republic of Moldova has ratified some conventions that include aspects of health care in the context of respecting human rights and assuring access of social disadvantaged groups to medical services. These include recommendations to eradicate all forms of discrimination from national legislation, including discrimination based on sexual orientation, through adoption, modification, or abrogation of national legislation. All these recommendations are ratified but are not put into practice. According to survey data, 89% (117) of LGBT said they faced many problems and difficulties such as being misunderstood or ignored, family quarrels, being dismissed from work, being forced to visit a psychiatrist, etc. The most faced cases of discrimination were: calling names (42%); ignoring in public (25%); sexual attack or sexual harassment (27%); discrimination by the police (10%); discrimination in the street (27%), in schools (19%), at home (13.6%), at work (12.2%); in youth clubs (13.6%); in restaurants, hotels and other places (11.6%). From all respondents that were discriminated against, only seven reported it to official bodies and only two received a satisfactory response [1, 2].

1.2. Social characteristics of the population

Age: all age groups were included in the surveillance (147 people: 102 men, 45 women). Most respondents (79.5%) were under 30 years old; 9.5% were over 41 (all men). This indicates that the younger generation is more open and knowledgeable about identity and sexual orientation; it does not indicate that the over 41 age group is smaller but that their private life is more hidden.

Urban/rural group concentration: according to the surveillance this group is concentrated more in the big cities of Chisinau, Balti and Tiraspol.

The structure of the LGBT community corresponds to the general structure of nationalities in Moldova (60% Moldovans, 23% Russians, 9.5% Ukrainians, 7.5% other nationalities).

Social status: 33% (49 respondents) were students (51.1% women and 25.5% men); 51% (75) were employed (54.9% men and 42.2% women); 8.8% (13) were unemployed (10.8% men and 4.4% women); 2.7% (4) were pensioners (only men) and 4.1% fell into other categories.

Education of respondents: 4.1% (6) had a primary school education, most of them men; 19% (28) gymnasium (61% men, 39% women); 25% (37) high school (one third women, two thirds men); 47.6% (70) university; 4.1% (6) post-graduate (the gender balance for university education is 54% men and 46.6% women).

Regarding coming out and visibility: 50.3% (74) of respondents' families knew about their sexual orientation and 83% (122) said their friends were aware of their sexual orientation. These figures show that besides family a large number of people from other groups know the sexual orientation of the respondents.

1.3. Risk factors of HIV infection

Prevalence of injecting drug use, other drugs and alcohol: 4.8% never use alcohol; 28.6% use once a month but not every week; 36.7% use 1–2 times a week; 6.1% use 3–5 times a week; 3.4% use every day (alcohol abuse).

Out of all respondents, 10.5% said that alcohol use was a problem for them, and was caused by their sexual orientation: problems with family, friends and others after coming out led to continuous stress for which alcohol became a coping mechanism. 33% had sex under the influence of alcohol; the percentage of those practicing sex under the influence of alcohol is higher among men (36.3%) than among women (24.4%).

In the Republic of Moldova all drugs are illegal. 24.5% used illegal drugs (in most cases marijuana, LSD and other soft drugs). No one mentioned injecting drugs or considered drug use to be a problem for them.

Sex work (prevalence): 6% of respondents had commercial sex (for money, alcohol, drugs etc.). Most of them are men.

Condom use with men, women, regular and sporadic partners: 77.4% had penetrative sex (more practiced by men: 85.3% or 87 men) and 88.4% had oral sex in the last two years; other respondents practiced other kinds of sex (petting, reciprocal masturbation), or had no sexual contact during the last two years.

Only 38% of males (from 87 men that had sex with penetration) had protected sex; 32% (28 males) had protected sex sometimes; 13.8% (12 males) had protected sex only with occasional partners. Only 53% had protected oral sex. Condoms are the most common preventative method according to respondents' answers.

The sexual behavior of MSM in Moldova is characterized by lively dating, a high frequency of sexual intercourse, multiple sexual partners and diverse sexual practices with no use or inconsistent condom use.

General HIV knowledge: 70% of respondents (102) were tested for HIV, and most of them are informed about the ways of transmission. 3.9% are HIV positive.

Request for STI testing: Only 15% have ever been tested for STIs, which is a very small number considering that STIs are widespread. 6.8% identified gonorrhoea, 2.1% Chlamydia and 4.8% syphilis and others.

Only 33% (34 males) pass regular testicular examinations, 25.5% (26) occasionally and 42% never pass testicular examinations, indicating a very low level of awareness among MSM of factors making them vulnerable [3].

1.4. Epidemiological situation: HIV and STI prevalence

At the end of 2009 the median HIV prevalence in Moldova was 157.4 per 100,000 population. Epidemiological records of HIV infection cases show an increase in sexual transmission to 81.25% (from 75.56% in 2008), and decrease in transmission via injecting drugs to 12.16% (17.85% in 2008). Out of the total number of HIV cases via sexual transmission, 27.83% were through sexual relations with unknown partners, 34% via sexual relations abroad (with unknown and occasional partners), 16.55% when one partner (husband or wife) was HIV positive, 13.48% were sex workers with HIV positive partners and 3.06% through homosexual relations [4].

The HIV prevalence rate among adults aged 15–39 is estimated at 87.2% of the total number of infection cases; in 2008 it was 81.53%. 2009 saw a tendency for increasing new cases of HIV infection among the 15–19 age group which is estimated at 3.83% (2.15% in 2008); among 40–49 year olds it is estimated at 18.61% (15.69% in 2008). Data on infected WSW and the transgender population is not available. Moldova's HIV epidemic regarding MSM is still in a concentrated phase. National surveillance among MSM with the support of GenderDoc-M will start in April 2010.

Despite the fact that rapid tests are used in the country for pregnant women, they are not included into prevention package for MSM and thus not available.

2. Epidemic response in the MSM community

NGO "GenderDoc-M" is the oldest and still only LGBT and MSM service organization and is providing most of community services for MSM in the country. In the COC-Netherlands regional project, this organization plays the role of knowledge hub and development agent for partners in Central Asia and Caucasus. The focused HIV prevention among MSM is carried out by GenderDoc-M through workshops, seminars, summer schools, training, information campaigns for the LGBT community, outreach work, Safer Sex Promotion Parties, and distribution of free prevention means.

2.1. National commitments and official documents

National HIV/AIDS Program: at national level, state policy in the area of HIV/AIDS is implemented through the National Program on Prevention and Control of HIV/AIDS and STI for 2006–2010, which determines national strategies of priority for prevention, epidemiological surveillance and treatment. The program represents an integral, multi-sector plan. The national program has been developed as a

result of a consensus-based consultation with key stakeholders in the field, including government, international organizations, non-governmental organizations and people living with HIV, and was approved through a government decision in September 2005.

With the support of non-governmental organizations, harm reduction projects have been implemented, including projects in penitentiaries and among sexual minorities and people at high risk of infection, training of trainers and volunteers in life skills and peer education (adolescents, youth, army personnel, police, and border guards), social and psychological support, hotline counseling, training for journalists [6].

National Strategy, National Plan – HIV, reproductive health, demographic security: there is a National Strategy on HIV prevention and control. With the increasing involvement of donor-funded activities, free HIV prevention services, ARV treatment and HIV-related care and support is available for everyone. Despite this, MSM are afraid to benefit from these services because of stigma and discrimination based on sexual orientation. HIV prevention among the LGBT community is carried out by GenderDoc-M.

Reproductive health is covered by the law on reproductive health care and family planning, Nr.185-XV from 24.05.2001. Some of its stipulations intersect with aspects related to the LGBT community: the right to artificial insemination; the right of minors to reproductive health care and to sexual education (Article 8). This latter provokes the question whether the state's elaborated sexual education programs for youth include aspects of sexual orientation, and if they describe the risk of various sexual practices for heterosexual as well as homosexual people [5].

2.2 Resource analysis

State allocation for the program: governmental resources are not allocated for HIV/AIDS prevention among MSM.

Donors: Moldova is a recipient of GF Round 2, 6 and 8 grants. GFATM Round 6 program does include harm reduction activities for high risk populations. Round 8 (\$10 Million, Jan 2010-Dec 2011) focuses on care and support services for PLHIV.

Open Society Institute/Moldova provides a small grant for HIV prevention among MSM, implemented by Information Center GenderDoc-M, in the framework of GFATM program. Other prevention activities among the LGBT community are covered by relevant GenderDoc-M projects with the support of COC Netherlands, funded by the Dutch Ministry of Foreign Affairs.

2.3 Existing HIV response programs and projects

Implementing organization: Information Centre GenderDoc-M

Source of financial support: COC Netherlands, funded by the Dutch Ministry of Foreign Affairs ("Prevention and empowerment in CIS countries responding to HIV/AIDS infection among the LGBT community"); SOROS Moldova ("I love different, I love protected").

Geographical coverage: Republic of Moldova (biggest cities: Chisinau, Balti, Tiraspol).

Service package:

A. LGBT Community Well-being Program:

- outreach work in cruising areas;
- outreach work in clubs (Safer Sex Promotion Parties);
- free distribution of condoms and lubricants;
- individual counseling services (medical and psychological);
- on-line counseling;
- workshops on promotion of safe sexual behavior for the LGBT community;
- summer school for gay and bisexual men;
- sexual behavior and HIV research within the LGBT community;
- empowerment activities for parents of LGBT people;
- support groups for elderly gay people;
- support groups for HIV positive LGBT people;
- support groups for transgender people;
- GenderDoc-M library.

B. Lobbying and Advocacy program:

- registration of discrimination cases within the community;
- participation in meetings of the Anti-Discrimination Coalition;
- organization of “flash mob” events;
- organization of the Moldovan LGBT Pride “Rainbow over the Dniester”;
- organization of the round table “Aspects of implementing an effective mechanism for the rehabilitation of transgender people”;
- seminar for medical workers on transgender issues;
- publication of the LGBT magazine “Mirror”;
- development and maintenance of on-line information resources;
- summary of results of a creative contest for journalists and students covering LGBT issues;
- monitoring the Moldovan press.

C. Organizational Development program:

Internal organization development:

- advanced training for employees and volunteers;
- publication of annual progress reports;
- improvement and democratization of the organizational structure, involvement of members in the work of GenderDoc-M Information Center;

Work in the regions of Moldova:

- identification and education of LGBT community leaders;
- development of partnership relations with representatives of state and non-governmental institutions at regional level;
- providing assistance to establish and develop organizations promoting LGBT rights in northern and southern Moldova;
- organization of events at regional level in cooperation with gay-friendly individuals and organizations in order to change society’s attitudes towards the LGBT community.

Work in CIS countries:

- training in the regions of the former Soviet Union for organizations from CIS countries;
- development of information resources in order to increase the visibility of the LGBT community and their organizations in post-Soviet territory;
- offering consultations to LGBT organizations working in the post-Soviet region in the field of organizational development, lobbying and protection of the rights of sexual minorities, development of services for the LGBT community in CIS countries.

D. Women's program:

- publication of "Theme" magazine, development of web-site, forum, specialized information materials;
- development of specialized services for lesbian and bisexual women;
- organization of special seminars, discussion clubs, training and summer schools for activists and leaders of the women's movement;
- informing state structures about the problems that the LB community faces in order to integrate them into state policies;
- organization of events (together with other women's organizations and institutions protecting the rights of women) to promote women's rights, including of lesbian and bisexual women.

Regions by the end of the project: Republic of Moldova and CIS countries.

Coverage: at the end of 2009, 829 beneficiaries from the LGBT community were covered (650 MSM, 179 WSW) in Moldova: 754 people in Chisinau (575 MSM, 179 WSW), 33 MSM in Balti, and 42 MSM in Tiraspol.

Evaluation results: in the framework of the Health and Social Well-being of the LGBT Community program, the following long-term results were achieved:

- the LGBT community in Moldova has permanent free access to information and promotion materials about health including safer sexual behavior and means of protection;
- outreach activities play an important role in distributing information on safer sexual behavior among the LGBT community;
- means of protection are available for free for the LGBT community;
- interactive activities organized within the program help to consolidate the community;
- support groups for PLHA, transgender people, elderly gay people and parents of LGBT create a safer space for different segments of the community and contribute to the inclusion process within the community;
- the LGBT community has access to primary counseling services (individual, on-line);
- the organization's library provides necessary information about sexual diversity for its beneficiaries and is updated on a permanent basis [7].

3. Program gaps and recommended steps to improve services**3.1. Gaps in data on the population**

Migration is a risk factor of HIV infection, especially in summer. Because of difficult conditions in the Republic of Moldova, as it is estimated, one third of the working age population has migrated abroad. The main reason for out-migration is better employment opportunities abroad. Additional research and planning of actions is needed to address the influence of the migration toward HIV and STI in the country.

3.2. Gaps in political decision-making and allocation of funds

The Moldovan Constitution provides for equality and non-discrimination before the law based on sex, religion, ethnicity, language, opinion, welfare, etc. There are no specific regulations protecting population groups and sub-groups at high risk of HIV/AIDS such as MSM, IDU, CSW and prisoners from discrimination or hate speeches.

Governmental resources are not allocated for HIV/AIDS prevention among MSM.

3.3. Gaps in program development

MSM are included in reports but do not receive any support from the state. They are not included in different HIV prevention campaigns.

3.4. Key recommendations for program development

Many factors contribute to the vulnerability of the LGBT community, including denial by society and communities, stigma and discrimination, and human rights abuse. Adoption of anti-discrimination laws is vital.

Ensure all potential HIV positive MSM are covered by and actively involved in HIV prevention. At present HIV infected MSM are not sufficiently involved in HIV prevention because of stigma and discrimination within the LGBT community and in wider society. They are barely reached by HIV services. This is a very important risk factor that may contribute to increasing new cases of HIV infection.

Establish a gay-friendly medical workers' network. Currently when most LGBT community members go to a doctor (if they go) they hide their sexual orientation or sexual behavior because of the intolerant attitude they are likely to meet. This makes doctors' work very difficult and is also an important factor in the spread of HIV.

Assess risks of HIV/STI transmission because of labor migration from the Moldova to other countries. According to data, develop prevention approaches toward high risk groups of migrants (transport workers, clients of sex workers etc)

Stimulate dialog between the LGBT community and leaders of religious structures.

Perform evaluation and analysis of legislative and policy bases that regulate:

- access of target groups to HIV prevention and control, free services, care and support;
- the level of civil society participation in national programs.

Develop and nationally distribute information about safer sexual behavior of MSM. Currently MSM are not included in national-level HIV prevention campaigns.

Continue GenderDoc-M's work in the field of HIV prevention in order to have a greater impact.

Actively involve GenderDoc-M as an expert in the national program and the council on HIV prevention among MSM.

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Annex 7. Russian Federation country profile

1. Description of the situation with HIV prevalence and HIV infection risk among MSM

1.1. Definition of the population

The behavioral definition of MSM used for surveillance and services planning in the Russian Federation is any man had sex with another man in the previous 12 months. There is no indication that in any national document there is consensus on this definition.

Definition accepted in the country: sexual minority – derogatory term used to stigmatize and define people of homosexual or bisexual preferences as belonging to a particular community. Focuses exclusively on sexual aspect, used in a negative sense to describe the behavior of community members.

Homosexuals – stigmatizing and discriminating term referring to homosexual men. Until 1999 it was used in Russia to refer to mental health patients diagnosed with the mental condition of homosexuality.

Structure (identity, sub-groups): LGBT – lesbian community, gay community, bisexual community, transgender community

Size estimation: according to some estimates in Russia the proportion of MSM is 2–5%, or at least 4% of the male population, which amounts to 1,350,000–3,400,000. Experts of the Federal AIDS Center use 2,100,000 (4% of the male population) as a baseline figure.

Legal status, same-sex partnerships: Russian legislation including family law does not define same sex partners as special subjects with specific status (spouse, parent etc.) even if these individuals make up a family in a social sense of the word.

Family relations are defined on the principle of voluntary union between a man and woman, equal rights of spouses, settlement of family disputes in accord with mutual agreement, giving priority to bringing up children in the family, support of child development and welfare, protection of the rights of underage and disabled family members.

However, using the freedom of contract principle adopted by the Russian legislative system, same sex partners may enter into any agreement which does not directly defy legislation. An example might be an agreement on joint residence. However, such an agreement includes only articles on proprietary relations and proprietary consequences of non-proprietary actions (e.g. establishing a relationship between the right to a financial allowance and the infidelity of another partner). Legislation does not allow regulation of non-proprietary relations between partners or between partners and their children.

Situation with stigma and discrimination: the results of a sociological survey of 564 respondents in six regions organized during data monitoring helped establish the relationship between the degree of discrimination and sexual preference/gender identity. While an approximately equal number of heterosexual and LGBT respondents said they were discriminated against based on ethnic and religious grounds, discrimination based on sexual preference/gender identity was largely reported by LGBT members.

Over half of surveyed gays, lesbians and bisexuals are aware that their sexual preference is the reason they are discriminated against by the state and society. Most heterosexuals do not feel discriminated against based on sexual orientation.

The compelling necessity to conceal their sexual identity is a serious stress factor influencing the quality of life of gays and lesbians. Among respondent users of the web resource qguys.ru (more than 3,000 respondents), 54% believe that the need to conceal their sexual identity is daunting. Judging from the survey results, gays and lesbians are more frequently subject to violence and brutality by law enforcement agencies than are heterosexuals.

The Russian Federation does not support policies of discrimination, intolerance, repression and violence against people of non-traditional sexual orientation. However, this specific subject must be analyzed within the framework of existing universal human rights documents. Discrimination based on sexual orientation is not included in anti-discrimination laws. This remains one of the reasons why government authorities and law enforcement agencies refuse to act on cases of violence or threat of violence towards gay, lesbian and transgender people when these threats are related to their sexual identity.

In the past few years stigmatization of MSM/LGBT people has increased. These attitudes are reflected in public statements made by politicians. For example, open and public homophobia came from the Mayor of Moscow in relation to the planned parades of the gay community. Some Russian city and regions authorities are openly and officially campaigning against “promotion of homosexuality” by attempting to put a legislative ban on such “promotion.” This campaign limits freedom of thought, freedom of expression, access to information and distribution of information.

Punishable/non-punishable offence: In 1993 homosexuality was decriminalized. This was not as a result of informed decision-making by politicians or of lobbied interests by grassroots organizations, but for political reasons, so that Russia could become a member of the Council of Europe.

In 1999 Russia adopted the WHO-recommended International Classification of Diseases (ICD-10) used by all developed countries. It includes three types of sexual preference: heterosexual, homosexual and bisexual, none of which is a disease in need of treatment.

In the West these changes came as a result of long discussion and research. However in Russia some psychiatrists, upset by their reduced political and social status in the post-Soviet era, are sabotaging the process of decriminalization of homosexuality and continue to make homophobic public statements which are placidly accepted by the medical community.

1.2. Definition of the population

According to the results of behavior studies in ten regions of Russia, about 50% of MSM have a higher education and every fifth MSM has a monthly income of over 20,000 rubles (about \$800).

Age: no data based on a large-scale study of the group. Because homosexuality and bisexuality are not acquired, age differences and group sizes most probably do not differ. MSM are represented in all age groups.

Urban/rural concentration: no available data based on a large-scale study of the group. It is probable that big cities have a larger proportion of MSM; however this may be a result of internal migration in search of work, rather than stigmatization.

Family status: no available data based on a large-scale study of the group.

Social status: no available data based on a large-scale study of the group.

Occupation: no available data based on a large-scale study of the group.

Income status: no available data based on a large-scale study of the group.

Studies are difficult because this is a hard-to-reach group. Available data on HIV prevalence and risk behavior practices among MSM are limited to a few studies in several large cities usually based on the snowball method. Consequently all data on the community (including the information in this report) should be viewed with caution.

Studies within this group were conducted either in gay nightclubs or started out with contacts in clubs who went on to find study respondents for researchers. Consequently all available data describes MSM as young people under 30 with a high social and economic status.

According to these findings, the social characteristics of this group greatly differ from the socially-disadvantaged populations which remain the driving force behind the HIV epidemic.

1.3. Risk factors

No data based on a large-scale study of the group. Available data help identify key risk factors for HIV among MSM. Among them are a large number of sexual partners, sometimes including women as well as men, inconsistent condom use, lack of motivation to use less risky sexual practices, lack of STI and HIV testing and treatment.

Prevalence of injecting drug use, other drugs and alcohol: despite being informed about the risks associated with unsafe sex, many MSM continue to practice unprotected sex. One reason is the popular and widespread use of recreational drugs among MSM. Drugs lower self control and inhibit adequate responses to the situation. Undoubtedly alcohol use has similar effects. However the effect of alcohol on unsafe sex practices among MSM has not been researched in the framework of a separate specialized study.

Drug use is widespread among some MSM sub-groups. The preferred drugs are cannabis (29.4%), ecstasy and methamphetamines (14.9%); 2% of respondents reportedly used injecting drugs (PSI, 2007b).

Frequency and quantity of partners: a behavioral study among MSM in 10 regions of Russia suggests that 28% of respondents practice sex with men and women. Although 62% said that they had been with a stable partner for the three months prior to the interview, 59% said that they had casual sexual relations within the same period. In other words, most respondents in stable relationships also have casual sexual encounters (PSI, 2007b).

Condom use with men, women, regular and sporadic partners: the study suggests that condom use depends on the type of relationship. Among respondents engaging in casual sexual relationships, condom use during last sexual contact was the highest at 78.7%. Among respondents reporting to be in a stable relationship this percentage went down to 62.5%. The proportion of MSM who use commercial sex services is 58.2%. This data fully corresponds to data presented in the national UNGASS reports.

1.4. Epidemiological situation

HIV prevalence among MSM according to epidemiological surveillance: according to a study organized by NGOs among MSM from 2006 to 2008, recorded HIV prevalence varies from 0.75% in Krasnoyarsk to 9.26% in Nizhniy Novgorod (average prevalence rate, 3.54%). According to data presented by Russia to UNGASS in 2006, the proportion of registered people living with HIV is 0.3% of the population. When comparing the two pieces of data we can conclude that among MSM the risk of HIV infection is ten times higher than among the general population. MSM-CSW and MSM-IDU are subject to more serious infection risk and may act as bridge populations for other MSM and the general population.

Despite second generation sentinel surveillance research organized by the Federal AIDS Center and by NGOs, MSM remain under-researched and hard to reach by existing HIV prevention programs, while sexual HIV transmission comes to dominate in Russia.

Opinion on MSM needs for HIV/STI prevention programs and screening, and access to medical and psychological assistance, vary among different categories of study participants.

2. Epidemic response in the MSM group

2.1. National documents and commitment

National HIV/AIDS Program: does not include any activities among MSM.

National Strategy, National Plan – HIV, reproductive health, and demographic safety: all citizens of the Russian Federation are granted equal access to HIV-related information and a comprehensive package of services to prevent and treat HIV-infection and provide support.

HIV prevention activities are based on regularly informing Russian citizens and all visitors to the country of means of HIV prevention using all available channels, teaching methods and ways to distribute information.

Priority targets and progress towards ensuring universal access to HIV prevention, treatment, care and support in the Russian Federation include MSM in coverage indicators of vulnerable populations by prevention programs. The MSM target for 2010 is at least 30%, for 2007 – 16.83%.

Road Map to Universal Access: no open access to documents.

Situation analysis (UNAIDS, other international organizations): prevention programs in Russia lack legislative support related to vulnerable populations. To date there is no available legislation to help scale up access to prevention activities for vulnerable populations (UNAIDS, 2006b). Although many NGOs work in Russia and implement interventions, overall coverage by prevention activities is very low. According to the 2007 National Report 16.83% of MSM were covered with prevention activities. According to the 2009 National Report 22% of CSWs and 13.6% of IDUS are covered by prevention activities.

2.2. Resource analysis

State allocation for the program: none assigned.

MSM is the only population vulnerable to HIV which was not included into government-supported HIV prevention programs for 2006–2009.

Local resources: one project in the city of Orenburg. No available detailed data.

Donors: on 1 September 2004, a consortium of NGOs began implementation of the GLOBUS Project (Global Efforts Against AIDS in Russia) with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The consortium comprises the Russian NGOs “Open Institute for Health of the Nation”, “Social Development Fund on Health Focus Media” and AIDS InfoShare with international NGOs AIDS Foundation East-West (AFEW) and Public Services International (PSI).

Russian Federation is a recipient of GF Round 4 (as well as Rounds 3 and 5 that focus almost exclusively on IDUs). Round 4 (2005-2010), valued at \$120 million focuses on the treatment and care of PLHIV with a special emphasis on vulnerable populations, including MSM.

2.3 Current programs and projects by service areas

STI/HIV prevention:

- Pulsar Project in Omsk, Novosibirsk.
- LaSky Project in 10 regions (Moscow, Saint Petersburg, Kemerovo, Krasnoyarsk, Nizhniy Novgorod, Pskov, Sochi, Kazan', Samara, Ekaterinburg). In the framework of the GLOBUS Project.
- Yasen' Project, Moscow
- Moscow-based SANAM project which targets female CSWs and MSM (including sex workers) with testing and treatment, collecting and publishing statistical and special epidemiological research data as well as best practices on MSM targeted programs .

Care and support for PLHA-MSM: no available data.

Social and psychological support for homosexually oriented people (community centers, work with parents, coming out, self help groups, legal support): LaSky Project, Yasen' Project, Pulsar Project, All-Russian PLHA Association.

Advocacy, rights protection, stigmatization, discrimination: no available data.

Research, training and methodological publications: RCSO AIDS InfoShare, Moscow.

Mobilization, organizational development, capacity building and leadership development: no available data.

3. Program gaps and recommended steps to develop services

3.1. Gaps in data about the population, risks and HIV prevalence

According to the 2008 UNDP report “Living with HIV in East European Countries and the CIS,” ‘in East European countries the situation is less defined because of lack of behavioral data compared to other most-at-risk populations’ [1]. This means no one knows the exact number of HIV positive MSM, or the prevalence of risky sexual behavior among MSM, or the level of awareness or actual use of means of prevention in the Russian Federation. Russia has not supported large-scale studies of sexual behavior. There is a need for regular monitoring of knowledge and behavior on the national level with agreed upon methodology especially toward sampling and recruiting respondents in areas of low access to the population in question.

3.2. Gaps in political decision-making and allocation of funds

Specific activities on stigma reduction and development of social tolerance are of primary importance. Special focus should be given to the development of tolerance in medical and social services, among policy makers to assure sustainability of the services for MSM.

3.3. Gaps in the development of programs by area

- Capacity building for MSM-service, working in situation of strong stigmatization, in organizational development, advocacy skills and service provision approaches.
- systematic support for long-term and sustainable programs.

3.4. Expert recommendations to develop this activity area in the country

Development of programs for MSM should start with practical and necessary services which include information, advocacy and community mobilization. While acknowledging considerable progress in scale up of prevention programs for vulnerable populations, including those financed by the government, it is vital to:

- increase coverage of vulnerable populations by prevention programs which include evidence-based comprehensive packages of services with special attention to building trust between prevention program clients and providers;
- organize assessment of the effectiveness of HIV prevention programs among MSM to inform the policy makers, donors and ensure its sustainability;
- develop inter-departmental cooperation between AIDS centers, narcological services, social services and NGOs with special stigma reduction component;
- develop and implement a system of epidemiological and behavioral research among MSM;
- strengthen LGBT organizations' involvement in prevention program planning and implementation among MSM;
- develop partnerships between MSM-service NGOs and state authorities as well as developing national MSM/LGBT organizations informational exchange and networking.

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Annex 8. Ukraine country profile

1. Description of the situation with HIV prevalence and HIV-infection risk among men who have sex with men (MSM)

1.1. Definition of the population

Definition (accepted for the country): MSM are men who have sex with men regardless of whether they identify themselves as gay, bisexual or heterosexual.

Structure (identity, sub-groups): MSM are still a fairly closed group in Ukraine. MSM who identify themselves as gay are the most apparent and reachable for projects on HIV prevention among MSM.

Size estimation: according to the “National evaluation of the HIV/AIDS situation in Ukraine for the beginning of 2009” the estimated number of MSM is 95,000–213,000 [1]. The M&E Working Group decided to use the minimum figure of 95,000 for further calculation. This decision was agreed with the reference group on the LGBT community. Previous size estimation was significantly higher. According to results of the consolidated evaluation carried out by WHO and UNAIDS, the estimated number of MSM in Ukraine varies from 177,000 to 430,000 people; among them the number of HIV-positive people is 27,315.

Legal status, same-sex partnership: in 1991, Ukraine was the first of the former Soviet republics to abolish criminal punishment for voluntary sexual relationships between adult men (clause 122, part 1, USSR Criminal code).

However prejudice and stereotypes about homosexual people are still prevalent in legislative and executive bodies, the media and most of the population. Ukrainians are expelled or fired, banned in certain spheres and sometimes unable to rent apartments on the basis of their sexual orientation. Homosexual people face preconceived humiliating attitudes from governmental institutions, law bodies, the army and medical institutions. Homosexual families are deprived of the rights and freedoms stipulated by legislation for heterosexual families in Ukraine: the right to family partnership, to adopt children, to inherit property in case of one partner’s death or tutor the partner’s children, the right to medical insurance, bank credit insurance and social benefits for children and sick members in homosexual family care. The media is full of negative and stereotyped information about lesbians and gays. Some organizations still try to prescribe compulsory medical treatment for homosexual people [44].

Other than the high level of homophobia, there are no legal or regulatory obstacles to programmatic and advocacy activities targeted towards the MSM/LGBT community [6].

Situation with stigma and discrimination: MSM face widespread discrimination and a high level of stigma in one form or another. According to a behavioral survey [3], 37% of respondents indicated verbal discrimination. The most frequent discrimination indicator is the assumption that homosexual men more commonly have HIV/AIDS (almost every other MSM, or 48%, had experienced this assumption). A quarter of participants specified that they were alienated by relatives, friends and family.

⁴⁴ “Being lesbian in Ukraine: gaining strength,” IEC Women’s Network, Kiev, 2007.
http://www.feminist.org.ua/about/projekt/lesbian_ua2007.php

Other forms of discrimination are less common. For example, only 2% of respondents said they had been refused social and medical services because of their sexual orientation.

The Center “Nash Mir” commissioned some research among the public concerning attitudes towards people with homosexual orientation, which was conducted by TNS Ukraine in 2007. The results put the number of people who treat gays and lesbian as ordinary people and don’t have any stereotypes and preconceptions concerning them at 15–17% [4].

One survey conducted by GfK Ukraine³, a leading market researcher in Ukraine, showed that in a number of Ukrainian cities attitudes towards different ethnic and religious minorities are significantly more tolerant than towards gay people. The sampling was 800 people representative of Lviv and Odessa residents. The mean value on the Bogardus scale was from 1 – “I agree to accept representatives of this group as family members”, 2 – as friends, 3 – as neighbors, 4 – as business partners, 5 – as city residents, 6 – as city guests, 7 – “I would never let them come to Ukraine at all”.

Openly homophobic organizations are strengthening their position in Ukraine. These organizations hold public events and promote homophobia. The leading organization is “Love Against Homosexuality”; there are several other organizations which sometimes direct physical violence at representatives of the LGBT community or those who support them.

1. 2. Description of the population

Age, family status, social status: In 2007, the majority of surveyed MSM (62.4%) were 25 or older. 46.1% had completed secondary school and 45.8% higher education [5].

According to the latest report on “Monitoring of risky behavior and HIV-infection prevalence among MSM as a component of second generation HIV surveillance” performed in 2009 [3], the greater part of MSM (61%) are between 25 and 49 years old. Every tenth respondent is 14–19 years old. The age of the survey sample gives the only available data on the MSM population age.

Most respondents (79%) have never been married; 7% of respondents are still legally married. Every fifth respondent (20%) lives with a male partner, about 6% with a female partner. People with higher or incomplete higher education prevail among respondents (35% and 21%); while every tenth respondent is unemployed.

2.2. Risk factors

Prevalence of injecting drug use, other drugs and alcohol use: 85% of MSM use alcohol; every tenth MSM used non-injecting drugs throughout the year, and only a very small number of respondents used injecting drugs throughout the year [3].

Sex work (prevalence): the proportion of survey participants who have anal sexual contacts with commercial partners both for whom they paid, or for which they were paid, is not large: 3% and 7% correspondingly. It could be suggested that the small number of commercial partners is explained by the ease in finding casual partners – 61% of those who had anal sexual contacts during the last month had casual partners [3].

Frequency and number of partners (per month, per three months, per six months): 0–1, 2–5, 5–10, 10+: in the last six months about 80% of MSM had oral sexual contacts with two or more partners. The

average number of respondents' partners with whom they had anal sexual contacts within the past six months is 4–5 [8].

Sex with women (frequency, number of partners): more than half of respondents had had sexual contacts with women during their lifetime (58%). In the past six months 24.5% of respondents had sexual contacts with one woman, 8.8% with two, 3.7% with three. 56.8% had not had sexual contacts with women in the past six months [3].

Condom use with male, female, permanent and casual partners: condom use was high for the last penetrative anal sex with occasional (82.1%) and paid (80.4%) male partners. Among those who reported practicing oral sex with male partners, 13% used condoms during oral sex in the past six months. Among participants who reported not using a condom during the last penetrative sex with a permanent partner, the most common reason cited was that they “did not think it was necessary” (49.3%), followed by “it reduces sensation” (38.7%). The most common reason cited by MSM for not using a condom during the last penetrative sex with an occasional partner was that “it reduces sensation” (34.8%), followed by “did not have a condom on hand” (29%), and “had too much to drink” (25.8%) [5].

General level of knowledge of HIV (according to behavioral survey data): most MSM interviewed (82.1%) answered all five questions concerning HIV-infection correctly. Thus the social group of MSM is characterized by a sufficiently high level of knowledge of HIV-infection transmission routes. However, quite a substantial number of respondents made a mistake answering at least one question, demonstrating that information campaigns among this social group are still required [3].

General level of knowledge of STI (according to behavioral survey data): only 10% of respondents were unable to name any symptom of STIs. Moreover, among those who could answer the question, only 11% of respondents mentioned just one symptom. 47% of respondents mentioned 2–3 symptoms, and 42% mentioned 4 or more. It is typical that the proportion of those who could not name any symptom reduced with age, from 23% among 15–19 year olds to 6% among 25 and over ($p < 0.01$) [3].

1.4. Epidemiological situation

HIV prevalence among MSM (official statistics by registration data): In Ukraine the HIV epidemic remains concentrated in risk groups, namely IDUs, FSWs and MSM. At this stage in Ukraine, the number of new sexually transmitted cases is higher than parenteral cases. According to official data from the Ukrainian AIDS Center, 319 cases of infection through homosexual contacts were registered by 1 January 2010 [2].

HIV prevalence among MSM by sentinel surveillance data: the HIV epidemic among MSM is under-reported due to high levels of social hostility and discrimination against MSM. Stakeholders question whether such a significant caseload can be confined to the risk group usually found in concentrated HIV epidemics. Official numbers represent not the absence of an epidemic but lack of data due to the closed nature of the MSM community. According to UNAIDS (2006), 3–15% of MSM are living with HIV. According to data collected by RDS and TLS methods in 2009, the percentage of MSM infected with HIV varies from 2% to 19.3% depending on the region of Ukraine. The same data at national level puts HIV prevalence among MSM at 8.6% [3].

STI prevalence: sentinel surveillance, project data, rapid tests: there are no official statistics on STI prevalence among MSM. In 2009, within projects on HIV prevention among MSM supported by International HIV/AIDS Alliance in Ukraine, 5,533 MSM were tested for syphilis (44 results were positive), 377 were tested for gonorrhoea (20 positive results) and 380 for Chlamydia (18 positive results).

2. Epidemic response in the group of MSM

2.1. National documents and commitment

National Program on HIV/AIDS: National Program to Provide HIV Prevention, Treatment, Care and Support for HIV-infected and AIDS Patients for 2009–2013 (Law of Ukraine № 1026-VI from 19.02.2009).⁴⁵ Unfortunately MSM are not included in the list of risk groups (the list is open) within this document; however they are included in an annex to the program for 2009–2013.

National Strategy, National Plan – HIV, reproductive health, demographic safety: National Strategy and National Plan for 2007–2010; the National Strategy and National Plan for 2011–2016 are in the process of development. Complex Plan of activities to respond to HIV/AIDS in the Ukrainian Army for 2009–2013 [46].

Road map for Universal Access: Communication Map (Action Plan) on Enlargement of Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine till 2010. This document was developed in 2006. The minimum package of services for MSM and LGBT was determined: dissemination of all kinds of prevention means, STI prevention, VCT, activities at community level. Document is not updated.

In Ukraine an external evaluation revealed a number of problems in the field of MSM activities, such as inefficient support and provision of government resources and services.

Legal protection from stigma and discrimination: there is no specific legal document dealing with stigma and discrimination of MSM.

2.2. Resource analysis

Government funding for the program: in 2009, the forecast volume and sources of funding to finance the National Program for HIV Prevention, Treatment, Care and Support to HIV Infected People and AIDS Patients for 2009–2013 amounted to 70,556,000 UAH, including 54,716,000 UAH from the state budget and 15,840,000 UAH from local budgets.

The envisaged funding for the national program does not meet the needs of the HIV/AIDS epidemic response in Ukraine. Funding needs to be reviewed and increased. Under financing of budget lines is also a problem. The care and support component of the program is not funded from the national budget [9].

⁴⁵ <http://zakon.rada.gov.ua/cgi-bin/laws/main.cgi?nreg=1026-17>

⁴⁶ <http://www.mil.gov.ua/index.php?lang=ua&part=news&sub=read&id=16434>

There is a functioning National Council on HIV/AIDS in Ukraine, but it does not include any LGBT representatives. Other coordination institutions include the Coordination Council on HIV/AIDS and Tuberculosis of the Ministry of Health of Ukraine, 15 Interdepartmental working groups on HIV/AIDS, and the Ukrainian M&E unit set up as a branch of the Ukrainian AIDS Center⁴⁷.

Only one representative of the LGBT Community is included in the interdepartmental working group on providing social services for people vulnerable to HIV/AIDS and Tuberculosis.

Local Resources: regional (oblast, district and city) programs for prevention of HIV infection, treatment, care and support to people living with HIV/AIDS for 2009–2013 are practically not funded [9].

Donors: ICF “International HIV/AIDS Alliance in Ukraine” provides grants for prevention of HIV-infection among MSM supported by:

- Global Fund to Fight AIDS, Tuberculosis and Malaria, R1 i R6 (1/10/06–31/12/09) – 6,755,741,02 UAH.
- USAID (1/10/06–30/09/09) – 107,364,70 UAH.

All-Ukrainian Charity Organization “All-Ukrainian Network of People living with HIV/AIDS” is implementing the project “Improving the quality of life of HIV-positive MSM in Ukraine,” supported by the Elton John AIDS Foundation [48] 2007–2009. Total funding is \$300,000.

ILGA-Europe is a joint partner in the project “Prevention and Empowerment in the Commonwealth of Independent States (CIS)” (PRECIS), with COC Netherlands (grantee and coordinator of the project) and GenderDoc-M. These three organizations form the project's management committee. The five-year project started in January 2006 and will end on 31 December 2010. Total funding is 300,000 USD.

The Foundation for AIDS Research, Landmark Funding for HIV/AIDS Programs in Eastern Europe and Central Asia, total funding \$34,430 [49].

Within the “Ukrainian-German Partnership Initiatives on HIV/AIDS Control” the Network Project is being run by four Ukrainian organizations and “Connect Plus” from Berlin [50].

The project “HIV/AIDS Governance in Ukraine” provides help to solve the economic, social and medical consequences of the HIV/AIDS epidemic in Ukraine. Duration: 01.01.2005–31.12.2010. Within the Project is “Assessment of Needs for MSM Concerning Key Services on HIV Prevention, Care and Support” for 2009–2010, 100,000 USD.

2.3. Existing programs and projects by service area

There are 21 LGBT organizations in Ukraine; four all-Ukrainian, two interregional, fifteen local, one republican, six regional and eight municipal.

⁴⁷ http://stop-aids.gov.ua/index.php?option=com_content&view=article&id=379:26-2010-2009-&catid=42:2009-01-15-13-48-54

⁴⁸ <http://www.network.org.ua>

⁴⁹ http://media.amfar.org/article_display.cfm?article_id=5123

⁵⁰ <http://www.gay.org.ua/network/index.htm>

Prevention of HIV/STI:

- IFC “International HIV/AIDS Alliance in Ukraine” within the program "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine," funded by the GFATM Round 6 2007–2012. In 2009, 17 HIV prevention projects for MSM were working in 16 out of 27 administrative districts of Ukraine. Projects offer distribution of condoms, lubricants, information materials; peer counseling; self-help groups; safer behavior trainings; group and individual counseling; VCT with rapid tests; STI testing and treatment; counseling from a psychologist; community centers and referrals. HIV prevention projects covered over 28,000 MSM as of 1 January 2010.
- ICF “International HIV/AIDS Alliance in Ukraine” within the “Scaling-up the National Response to HIV/AIDS through Information and Services” (SUNRISE) project.
- PRECIS Project “Prevention and Capacity Building in the CIS: response to the HIV/AIDS epidemic among sexual minorities,” 2006–2010. Project Partners in Ukraine are NA LGB “League,” IEC “For Equal Rights,” PO “Insight.”

Care and support for PLHA-MSM: All-Ukrainian Network of PLWH within the "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine," GFATM-financed program 2007–2012. Grants support self-help groups and peer counseling.

Social and psychological support: within projects on HIV prevention among MSM supported by different donors, community centers are operating in Kyiv, Kryvyi Rig, Mykolayiv, Odessa, Simferopol, Kherson and Cherkassy.

Self-help groups and counseling by psychologists are among essential project services for HIV prevention among MSM in Ukraine.

Advocacy, human rights protection, stigma and discrimination: generally there is a lack of funds for advocacy projects and activities.

Three campaigns on availability of lubricants in small packages were conducted with the support of the All-Ukrainian Network of PLWH and the All-Ukrainian charitable foundation “Coalition of HIV-Service Organizations.”

In 2008–2009 a number of regional trainings and meetings were held for doctors, social workers and civil servants responsible for making decisions on the national and/or regional levels, to establish business relations and tolerant attitudes towards MSM.

Research, technical support and methodological publications: in 2009 the International HIV/AIDS Alliance in Ukraine organized four trainings for project staff, a national conference, strategic planning sessions and 10 regular meetings of the LGBT community reference group.

Social Work with People Practicing Same-sex Partnership: Theory. Methodology. Best Practices is a key 2009 publication on HIV prevention among MSM. It was developed for LGBT community leaders and activists, specialists and social workers and all those working with LGBT groups and organizations to build an environment conducive for developing necessary services for MSM. The book describes specific needs and services for LGBT, best practices and methods for combating homophobia, advocacy and lobbying, mobilization of the LGBT community and its role in the public and political life of Ukraine [7].

Recently in Ukraine more surveys have been conducted on MSM. In 2009, these surveys were conducted:

- a. "Study of a group of men, practicing sex with men, in Donetsk region" http://donbas-socproject.blogspot.com/2009/10/blog-post_04.html
- b. "Experimental study of the effectiveness of attracting clients into MSM-projects by means of social on-line networks" http://www.aidsalliance.org.ua/ru/library/research/pdf/Report_MSM.pdf
- c. "Structure of MSM social networks in Donetsk and adjoining cities" <http://donbas-socproject.blogspot.com/2009/12/blog-post.html>
- d. "Monitoring of behavior and HIV-infection prevalence among MSM as a component of second generation HIV surveillance", 2009 [3].
- e. Size estimation of MSM in 2009 [1].
- f. "Determining the needs of men who have sex with men (MSM) concerning basic services for HIV/AIDS prevention, care and support" («Визначення потреб чоловіків, які практикують секс із чоловіками (ЧСЧ) щодо основних послуг із профілактики ВІЛ/СНІДу, догляду та підтримки») <http://www.undp.org.ua/en/media/43-hiv-aids/900-promoting-human-rights-of-msm-is-set-to-play-a-key-role-in-the-national-response-to-hiv>
- g. Interview "Same-sex partnership in Ukraine", conducted at the beginning of 2009 by the Center "Nash Mir" http://gay.org.ua/publication/same_sex_partnership.pdf
- h. "Self-Identity, Social and Sexual Networks and HIV Infection Risk for MSM," Donbas-SocProject (DSP), Donetsk, Ukraine. This project will design and implement a research study focused on sociological factors of self-identity, social and sexual networks, and sexual behaviors and potential HIV exposure among MSM in the cities of Mariupol, Gorlovka, Kramatorsk, and Torez with the goal of generating data that could inform the development of HIV prevention efforts.
- i. For the first time a survey on the "Transgender Situation in Ukraine" was conducted within a project of civil society organization "Insight".

Mobilization, organizational development, capacity building and leadership development:

A number of formal communities were set up:

- Permanent Reference Group on the LGBT community and MSM projects in Ukraine (10 experts); two meetings in 2008, nine meetings in 2009.
- All-Ukrainian Union "Council of Ukrainian LGBT organizations" (eight organizations)
- Union of Ukrainian Gay Organizations (four organizations)

Two national conferences: the First National Conference "Mobilization and Advocacy of LGBT community interests" and the Second National Conference of the LGBT movement and MSM-service organizations of Ukraine "Partnership and Development." Conference work was aimed at capacity building of the LGBT community, improving the professionalism of conference participants in the field of LGBT/MSM/FSW health care, coordination of activities and supporting partners. Considerable attention was paid to LGBT community mobilization, advocacy of rights and development of necessary services, exchange of experience in the field of HIV/STI prevention and methods of working with the LGBT community. More than 160 participants from Ukraine, Russia, Belarus, Germany, Belgium and Great Britain took part.

In 2007–2009 annual meetings on strategic planning for Ukrainian MSM-service projects and LGBT organizations took place.

Three LGBT mailing groups are providing information exchange and consolidation of activities: lgbt-leaders@googlegroups.com, lgbtc@googlegroups.com, lgbt_rg@googlegroups.com.

The mobilization project “Support and development of MSM initiatives in six regions of Ukraine” is implemented by Gay Alliance-Ukraine supported by ICF “International HIV/AIDS Alliance in Ukraine”. The project goal is to support and develop the organizational capacity of initiative groups and MSM/LGBT organizations in six regions of Ukraine in order to create an enabling environment for extension services on HIV and STI prevention among MSM, and to involve MSM and LGBT representatives into the development, implementation and evaluation of HIV/STI prevention programs and advocacy activities on the local level.

The project “Development of the institutional potential of risk groups (MSM, FSW)” supported by USAID HIV/AIDS Service Capacity Project in Ukraine.

“Prevention and capacity building in the CIS: response to the HIV/AIDS epidemic among sexual minorities,” 2006–2010. PRECIS Project. Project goal: to prevent the prevalence of HIV/AIDS and other STI among the LGBT community by strengthening the potential of LGBT organizations in CIS countries.

3. Program Gaps and Recommended Steps to Develop Services

3.1. Gaps in data about the population, risks and HIV prevalence

There are a lot of data on this group, but experts have their doubts about size estimation of MSM. According to official data only 319 cases of infection through homosexual contact have been registered.

3.2. Gaps in political decisions and allocation of funds

The new national AIDS program (2009–2013) includes MSM as a vulnerable group for which specific interventions are designed. However the economic crisis puts funding of this program at risk. It has already been stated that the program is unlikely to be funded in full. Experts express concern that budget reduction will directly affect those articles dealing with primary HIV prevention where MSM, among other most-at-risk groups, are mentioned.

3.3. Gaps in program development by area

Insufficient coverage of representatives of populations most vulnerable to HIV, including MSM, with prevention services. At this stage, MSM coverage by prevention projects is about 30% of the estimated population, which is not likely to make an impact on the epidemic [11].

- Prevention programs do not fully cover MSM over 35;
- HIV prevention programs should be extended to other regions of Ukraine, western regions in particular;
- lack of programs for HIV positive MSM;
- inadequate role of governmental institutions in developing and implementing programs aimed at MSM;
- no media campaigns for MSM;
- lack of targeted professional sexology education for medical students as well as post-graduate health care providers where MSM issues are addressed;
- AIDS specialists are not well trained on how to communicate with MSM.

3.4. Expert recommendations for development of the activity area in the country

All the above-mentioned gaps need to be addressed.

- Perform an additional size estimation of MSM in Ukraine
- Extend current prevention programs
- Emphasize work with the 35+ group and find out how to reach this group
- adopt a law on discrimination on the grounds of sexual orientation
- develop a network of friendly clinics for MSM
- implement mass media campaigns focused on MSM
- Increase HIV awareness among MSM in small towns by using established local networks (apartment parties, cruising areas, Internet dating contacts)
- Introduce the case management system as an instrument for linking communities with existing services
- Establish community centers (drop-in services) in regions

Sources

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[11] UKRAINE. National report on monitoring progress towards the UNGASS Declaration of Commitment on HIV/AIDS. Reporting period: January 2008–December 2009. Kyiv 2010